Application for a §1915(c) Home and CommunityBased Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Montana** requests approval for an amendment to the following Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title
Big Sky Waiver

C. Waiver Number: MT.0148
Original Base Waiver Number: MT.0148

D. Amendment Number:

E. Proposed Effective Date: 11/12/2023
Approved Effective Date of Waiver being Amended:
Effective Date of Most Recent Approved waiver: 04/04/2022
Most recent waiver renewal extension deadline: 09/28/2023

2. Purpose(s) of the Amendment.

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Appendix I
Update rate methodology based on a provider rate study and legislative action.
Add Electronic Visit Verification (EVV) status and processes.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A Waiver Administration and Operation	

Component of the Approved Waiver	Subsection(s)
Appendix B Participant Access and Eligibility	
Appendix C Participant Services	
Appendix D Participant Centered Service Planning and Delivery	
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	
Appendix H	
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	

Appendix I: Financial Accountability:
I-2a: Update rate methodology based on a provider rate study and legislative action.
I-2d: Add Electronic Visit Verification (EVV) status and processes.

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify: Update rate methodology to include the rate study conducted by GuideHouse and add Electronic Visit Verification information.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Montana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Big Sky Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

3 years (X) 5 years

Original Base Waiver Number: MT.0148

Draft ID: MT.010.07.01

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended:
Effective Date of Most Recent Approved waiver: 04/04/2022
Most recent waiver renewal extension deadline: 09/28/2023

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

The 1915(b) waiver was approved on July 1, 2011. The renewal was approved by CMS on November 6, 2017 with an effective date of January 1, 2018. The waiver limits the number of providers of case management.

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.
Specify the program:

H. Dual Eligibility for Medicaid and Medicare.
Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Big Sky Waiver (BSW) provides individuals with chronic disabilities of all ages a choice of long term care services that maximize their independence, provide quality care, and assure financial accountability. BSW is designed to provide an individual with physical disabilities or 65 years of age or older, a choice of receiving long term care services in a community setting as an alternative to an institutional setting. The individual must meet nursing home level of care. Extensive stakeholder involvement has been obtained to develop, refine, and maintain these services over the years. Stakeholders include current members of the BSW program, families, self-advocacy organizations, member advisory committees, representatives of Native American organizations, service providers and State staff. The BSW is statewide and includes Montana's seven Indian Reservations.

The waiver provides a vast array of traditional and self-directed services. Services are assessed and developed through the completion of a service plan. Each member works with their Case Management Team (CMT) or Big Sky Bonanza Independence Advisor to individually develop this plan and corresponding budget to successfully meet the identified needs. Representatives are permitted to serve on behalf of a member, if necessary. Legally responsible family members meeting specific criteria may be paid workers.

The goal of providing quality care while maintaining financial accountability will be accomplished by:
1. Conducting quality assurance reviews;
2. Including a robust Financial Accountability component to the quality assurance review;
3. Conducting satisfaction surveys with waiver participants; and 4. Providing training/education to all waiver providers;

The Community Services Bureau (CSB), of the Senior and Long Term Care Division (SLTC), Department of Public Health and Human Services, oversees the waiver. SLTC contracts with the Mountain Pacific Quality Health (MPQH), the Quality Improvement Organization (QIO), to conduct level of care assessments and disseminate information to members and potential service providers. Applicants receive level of care screenings to ensure they receive services from the most appropriate waiver. SLTC contracts with local CMTs that work in conjunction with members to develop a service plan that delineates the services and the cost of those services for each enrollee. BSW Regional Program Officers (RPOs) are available at the local level to assist providers and members with the delivery of services and offer training. CSB staff conduct quality assurance reviews to ensure that members are satisfied with the services they receive and that providers function within the rules governing the service providers. The Medicaid agency, as a whole, contracts with Conduent EDI Solutions, Inc. for Montana's Medicaid Management Information System. In those instances, in which members utilize a Big Sky Bonanza Financial Manager, the latter submits claims to Conduent for payment.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*: **Not Applicable**

No

Yes

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

No

Yes

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Costneutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and nonMedicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide

individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

Public notice to inform interested parties of the pending waiver amendment was posted in three major Montana newspapers on July 13, 2023, and on the Department of Public Health and Human Services, Community Services for Seniors and People with Disabilities website on July 13, 2023. The notice contained information regarding the purpose of the amendment and proposed major changes/additions to the 1915c waiver. In addition, a clause to request a paper copy of the draft waiver was included within the notice. The public was invited to submit questions or comments through August 11, 2023, via phone, email or mail to identified Department staff. Tribal notice of similar content was provided on July 13, 2023.

https://dphhs.mt.gov/SLTC/csb/

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Brunett

First Name: Denise

Title: Community Services Bureau Chief

Agency: Department of Public Health and Human Services

Address: P.O. Box 4210

Address 2: 1100 North Last Chance Gulch

City: Helena

State: Montana

Zip: 59604

Phone: (406) 444-4544 **Ext:** **TTY**

Fax: (406) 444-7743

E-mail: Denise.Brunett2@mt.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Kulawik

First Name: Mary Eve

Title: Medicaid State Plan Amendment and Waiver Coordinator

Agency: Department of Public Health and Human Services

Address: P.O. Box 4210

Address 2: 111 N. Sanders

City: Helena

State: Montana

Zip: 59604

Phone: (406) 444-2584 **Ext:** **TTY**

Fax: (406) 444-1970

E-mail: mkulawik@mt.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Montana**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Goal:
In response to CMS' clarification of 42 CFR 441.3019(b)(4) "multiple services that are generally considered to be separate services may not be consolidated under a single definition", BSW will implement the following transition plan. The plan will facilitate Montana's efforts to minimize potential adverse impacts to participants currently receiving the Supported Living service. In addition, the Department will ensure waiver participants can exercise free choice of providers for each service and access the full range of waiver services.

Existing BSW services provide: Homemaker, Habilitation aid/24-hour availability of staff for supervision and safety (Personal Assistance Services), Non-Medical Transportation, Specially Trained Attendant, Day Habilitation, Residential Habilitation, Prevocational Training, Supported Employment, and service coordination (Case Management).

BSW will refer members to existing community resources and State Plan services to meet the needs of Independent Living Evaluation and Behavioral programming.

Core Team:
Department staff
QIO (Mountain Pacific Quality Health)
Big Sky Waiver Case Management Teams

Actions:
• January 1, 2023 – February 28, 2023
Identify members currently receiving Supported Living services;
Evaluate members' service plans; and
Provide member referrals to community resources and State Plan services.

• March 1, 2023 – June 30, 2023
Evaluate and finalize member transition to existing BSW separate services.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The process for achieving compliance with the HCBS Settings regulations is identified within the response outlined in Attachment #2 and within the Montana HCBS Statewide Transition Plan posted on the Department website at www.dphhs.mt.gov/hcbs.

The plan was resubmitted on 12/04/2016. A Heightened Scrutiny plan has been submitted receiving initial approval. As of current, one provider was determined to be heightened scrutiny. The heightened scrutiny package was submitted to CMS in 2018 for review.

CMS approval remains in pending status. Montana assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Montana will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal. A complete copy of the Montana HCBS Statewide Transition Plan is posted on the Departments website at www.http://dphhs.mt.gov/hcbs."

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Senior and Long Term Care Division

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

(a) The Senior and Long Term Care Division (SLTC) is responsible for the design, implementation and monitoring of all activities associated with this waiver.

(b) There is no single document serving to outline the roles of all staff related to waiver operation. Multiple documents serve to outline the responsibilities of assigned staff regarding specific aspects of the waiver, including SLTC rules and policies relating directly to the operation of the waiver. SLTC maintains organizational charts, individual position descriptions and web based information serving to assist persons who need assistance in accessing information. The waiver application is the authoritative document serving to outline the person/positions responsible for ensuring all the requirements of the waiver are met (more detail regarding implementation detail is available in various SLTC and provider forms, policies, administrative directives, and rules).

(c) The Medicaid Director and his/her designee are ultimately responsible for ensuring the administration of the waiver. The Medicaid Director and his/her designee are not directly involved in the day to day operational decisions of the SLTC staff. The Big Sky Waiver Program Managers, CSB Bureau Chief and the SLTC Administrator provide the State Medicaid Director and/or his/her designee with information on the submittal of waiver renewals, or new waiver application to CMS.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Mountain Pacific Quality Health (Montana's QIO) conducts level of care assessments and disseminates information on the waiver to potential enrollees.

The Department of Public Health and Human Services' fiscal intermediary contractor, Conduent EDI Solutions, Inc. (Conduent) adjudicates claims for waiver providers through the Medicaid Management Information System (MMIS). Conduent enrolls and verifies that providers meet licensure requirements to provide waiver services.

Big Sky Waiver Case Management Teams (CMTs) enroll individuals in the Big Sky Waiver, provide case management services and conduct annual level of care re-evaluations. Case management teams will work within the

communities to identify potential providers of waiver services appropriate to meet the needs of enrollees in the waiver.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Senior and Long Term Care Division (SLTC) is responsible for contract administration and for assessing the performance of Mountain Pacific Quality Health and the Big Sky Waiver Case Management Teams. Contracts for these entities spell out duties and performance requirements.

The MMIS Contract Manager in the Director's Office directly oversees the Conduent contract. Conduent provides a report on a monthly basis to the Department which reports on contract requirements. Status meetings are held monthly.

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in

accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Mountain Pacific Quality Health will submit a management report to the Community Services Bureau (CSB) on a quarterly basis. The report will capture data on the date of level of care assessments and days elapsed between the request for level of care determination and the date the letter was sent to the applicant notifying him/her the outcome of the level of care determination. The Community Services Bureau (CSB) will monitor the report to ensure that reassessments and information regarding level of care determination is provided in a timely manner. These reviews will occur annually. CSB staff will be available for consultation regarding level of care denials when necessary. Assessment of the contract agency's performance is part of the quality management strategy outlined in Appendix H.

Case Management Teams (CMTs) will submit annual report cards to the state as well as monthly utilization reports. These reports will ensure that quality assurance measures are met in accordance with performance measures in Appendix H. CMTs will receive on-site reviews at least every three years or more frequently if necessary. CMTs are also monitored on an on-going basis by Big Sky Waiver Regional Program Officers and Program Managers via quality assurance communications.

Conduent provides a monthly report that summarizes internal monitoring of the system and processes (i.e., recipient subsystem, provider enrollment, claims processing and documents, verify changes requested for codes were made appropriately). The MMIS coordinator and senior Medicaid policy analyst meet with Conduent weekly to discuss progress and/or problems with system updates. Monthly status meetings are held between department staff and Conduent staff. In addition, Conduent completes internal audits to review their system processes and effectiveness as a contractor.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care evaluation		
Review of Participant service plans		
Prior authorization of waiver services		

Function	Medicaid Agency	Contracted Entity
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of monthly reports submitted to the State Medicaid Agency by Mountain Pacific Quality Health (MPQH. The numerator is the number of reports submitted to SMA by MPQH. The dominator is the total number of reports mandated by the SMA.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
State Medicaid	**Weekly**	**100% Review**

Agency		
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify: Mountain Pacific Quality Health	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

Performance Measure:
 # or % of mandated reports submitted to SMA by Conduent to demonstrate compliance with contractual mandates. The numerator is the number of reports submitted by Conduent to SMA. The denominator is the total number of Conduent reports mandated by the SMA.

Data Source (Select one): **Provider performance monitoring**
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify: Conduent	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
 # or % of Level of Care reevaluations completed by the case management team (CMT) within 12 months of waiver enrollment or previous assessment. The numerator is number of reviewed LOC reevaluation completed by the CMT within 12 months of waiver enrollment or previous assessment. The denominator is the total number of reviewed LOC reevaluations completed by the CMTs.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:

Case Management Team		
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The BSW Program Manager oversees the statewide operation of the waiver. Bi-weekly staff meetings are the vehicle for continuous statewide oversight of the waiver contractors. The Program Manager will review the reports submitted by Conduent and Mountain Pacific Quality Health. At the local level, the Case Management Teams are required to both audit with report cards as well as create and implement SMART goals quarterly via the Quality Improvement Project (QIP). BSW designated staff person completes Quality Assurance Reviews no less than every three years. Regional Program Officers provide ongoing program oversight of Case Management Teams. Training is implemented by all BSW staff, as needed, for policy/program changes, Federal Performance Measures and as issues are identified.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

MPQH and Conduent performance measures: If reports are not submitted as required, the contractor will be called upon that month for an explanation and if necessary, action items will be imposed. Any missing report must be submitted within 30 days of the date of discovery.

Case Management Team (CMT) performance measure: If a level of care re-evaluation has not been completed at all, the CMT must immediately schedule a meeting with the member to complete the assessment. In the event that the member no longer meets level of care, discharge will be initiated as outlined in the approved waiver. If the level of care was not completed within the required time frame, the CMT must submit an explanation to the Program Managers within 30 days of discovery. If, as a result of long term discovery, trends emerge, the Program Managers will demand more extensive pertinent remediation - such as mandated training or corrective action items to be completed within a specified time frame.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently nonoperational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged	65		
		Disabled (Physical)	0	64	
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

A physically disabled individual is defined as a person under the age of 65 who has been determined to have a physical disability and/or a traumatic brain injury diagnosis as defined by the Social Security Administration or Medicaid Eligibility Disability Services (MEDS).

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Individuals younger than 65 who meet the waiver criteria remain on the waiver moving into the aged category when they reach 65 years of age.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the costneutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	2783
Year 2	2783
Year 3	2783
Year 4	2783
Year 5	2783

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*
:

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Assisted Living At Risk Slots	
Money Follows the Person Demonstration Grant	
CC3 Slots	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Assisted Living At Risk Slots

Purpose *(describe):*

Slots are reserved as a resource for residents of assisted living facilities (ALFs) who have depleted their financial resources, as a result of their stay in the ALF, and are at risk of nursing home placement (or eviction from the ALF) due to inability to pay their costs to remain in the facility. At Risk slots require prior authorization by CSB staff.

Describe how the amount of reserved capacity was determined:

CSB has built capacity to 28 slots over the past several years which has been adequate to meet needs statewide. In general, CSB maintains between one to three open slots to ensure applicants are not hindered from receiving services. At Risk slots require prior authorization by CSB staff.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	28
Year 2	28
Year 3	28
Year 4	28
Year 5	28

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Money Follows the Person Demonstration Grant

Purpose *(describe):*

Create a sustainable system that supports community options as a first choice for individuals needing long term care services.

Goals include:
1. increase the use of home and community based services (HCBS);
2. strengthen ability of Medicaid programs to provide HCBS to people who transition out of institutions such as nursing homes;
3. develop community infrastructures that support and promote community placement; and,
4. use procedures to provide quality assurance and improvement of HCBS.

Between 2014 and 04/06/2022, Montana transitioned a total of 198 individuals using the Money Follows the Person Grant BSW continues to utilize the MFP grant and transition members that meet established MFP guidelines.

Describe how the amount of reserved capacity was determined:

Members must meet the following MFP criteria:
1. 60 consecutive days in a qualifying facility;
2. must be Medicaid eligible for at least one day prior to transition; and,
3. must qualify for HCBS waiver services.

Reserved capacity is based directly on the benchmarks established in the MFP grant for this population.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	11
Year 2	15
Year 3	18
Year 4	20
Year 5	21

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

CC3 Slots

Purpose *(describe):*

Slots are reserved for high-cost Residential Habilitation and Supported Living services and high-cost basic slots due to high acuity (e.g., vent dependent). Critical Care 3 (CC3) Slots require prior authorization by CSB staff.

Describe how the amount of reserved capacity was determined:

CSB has built capacity to 97 slots over the past several years which has been adequate to meet needs statewide. In general, CSB maintains between one to three open slots to ensure applicants are not hindered from receiving services, but slots are not left vacant. CC3 Slots require prior authorization by CSB staff.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	97
Year 2	97
Year 3	97
Year 4	97
Year 5	97

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Individuals must:

1. Be Medicaid eligible;

2. Require the level of care of a nursing facility as assessed through a medical and functional assessment;

3. Be elderly (65 years or older) or meet Social Security Administration SSA's physical disability criteria;

4. Have a need that can only be met through BSW waiver services;

5. Choose to receive waiver services; confirmed through signature of the Service Plan by the member or the member's legal representative; and

6. Not receive services from another Home and Community Based Services waiver.

Before being placed on the BSW wait list, applicants must:

a. Complete the Medicaid eligibility process;
Exceptions:
Individuals who require a resource assessment or children who need waiver of deeming to qualify for Big Sky Waiver may also be placed on the wait list, but are still required to meet all non-financial wait list criteria, and
Residents of assisted living facilities who have been covering their expenses with personal funds need of BSW coverage to continue to reside at the facility,

b. Meet all other BSW eligibility criteria, and

c. Be willing and able to accept a waiver slot.
Exception: some members may delay acceptance of their waiver slot because they are waiting for an opening at a specific adult residential facility or another specific setting to become available. There is no time limit placed on these members as they stay on the waiver wait list while waiting for the adult residential slot. These members will remain at the top of the wait list.

Case Management Teams (CMTs) manage the wait list through a prioritization process, offering slot openings as they become available to individuals determined to be most in need of, and most likely to benefit from, waiver services. The CMT will select the next prioritized individual on the wait list when a slot becomes available.

CMTs prioritize applicant entrance into BSW based on statewide criteria defined in the BSW waitlist criteria tool. The exception to the wait list criteria tool requirement are members who may have short term needs that can be met without long term placement in a waiver slot or meet Reserve Capacity criteria. Short-term admissions shall not exceed six months without prior approval from Central Office.

CMTs fill out the wait list criteria tool with all eligible members who are placed on the BSW wait list for long term slots within 45 days of referral.

CMTs will assist members in securing needed services and support until the member can be admitted to the BSW.

Wait list members are contacted on a quarterly basis to update the Wait List Tool.

Wait list communication summary:

1. A case manager will contact a member within five days of receiving a referral to set up a time to assess the member for the wait list;

2. The scheduled meeting to assess the member for the waiting list will occur within 30 days of the initial referral for waiver services; and

3. CMTs will communicate with members every 90 days to update the member on wait list status.

The Wait List Tool scores members eligible for the waiver according to 10 criteria, including:

1. Cognitive impairment;
2. Risk of medical deterioration without BSW services;
3. Risk of institutional placement or death without BSW services;
4. Need for health and safety supervision services through BSW not available (or exceeding those) through state plan, private insurance, community resources/programs and do not supplant tasks that are customarily performed by legally responsible individuals;
5. Need for social supervision community integration services through BSW not available (or exceeding those) through state plan, private insurance, community resources programs and do not supplant tasks that are customarily performed by legally responsible individuals;
6. Need for more formal (paid) services through BSW that exceed those available through other third-party resources (state plan, private insurance, community resources programs) and do not supplant tasks that are customarily performed by legally responsible individuals;
7. Need for more informal supports (family, friends, neighbors, etc.);
8. Unpaid primary caregiver requires relief through BSW for periods of time not covered or available through state plan, private insurance, or community resources programs, and the services do not supplant tasks that are customarily performed by legally responsible individuals;
9. Need for adaptive aids or environmental modifications within BSW criteria; and
10. Additional current health and safety issues that placed the individual at risk.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

§1634 State

SSI Criteria State

209(b) State

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

No

Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

% of FPL, which is lower than 100% of FPL.

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

PICKLE Citation: 42 CFR § 435.135 - Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977.

Disabled Adult Child (DAC) Citation: 42 U.S.C. 1383c(c), or, alternatively, section 1634(c) of the Social Security Act.

Adult Medicaid Expansion Citation: 42 CFR § 435.135 - Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Appendix B-5 is not submitted.*

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (*select one*):

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular posteligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(*select one*):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

ii. Allowance for the spouse only (*select one*):

Not Applicable (see instructions)

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

The Community Spouse Income Maintenance Allowance is the lesser of:

(Calculation 1)
a) The Maximum Spousal Standard* minus the community spouse's total gross monthly income; or

(Calculation 2)
A combination of:
a) The community spouse's shelter expenses (principal residence) that exceed the Basic Shelter Allowance*; plus
b) The Basic Needs Standard*; less
c) The community spouse's total gross income.

*As established by the Montana Department of Public Health and Human Services' Office of Public Assistance.

iii. Allowance for the family (*select one*):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other
Specify:

Family Maintenance Allowance:

The Basic Needs Standard* minus the gross income of the dependent family member; the difference of that calculation is then divided by 3 and the remaining amount is the family allowance.

*As established by the Montana Department of Public Health and Human Services' Office of Public Assistance.

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits. The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. **Regular Post-Eligibility Treatment of Income: 209(B) State.**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. **Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(*select one*):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

ii. Allowance for the spouse only (*select one*):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (*select one*):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Family Maintenance Allowance:

The Basic Needs Standard* minus the gross income of the dependent family member; the difference of that calculation is then divided by 3 and the remaining amount is the family allowance.

*As established by the Montana Department of Public Health and Human Services' Office of Public Assistance.

Other
Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits. The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

The Community Spouse Income Maintenance Allowance is the lesser of:

(Calculation 1)
a. The Maximum Spousal Standard* minus the community spouse's total gross monthly income; or

(Calculation 2)
A combination of:
a. The community spouse's shelter expenses (principal residence) that exceed the Basic Shelter Allowance*; plus
b. The Basic Needs Standard*; less
c. The community spouse's total gross income

*As established by the Montana Department of Public Health and Human Services' Office of Public Assistance.

Other

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Mountain Pacific Quality Health (MPQH), the State's Quality Improvement Organization (QIO)performs the initial evaluations and the level of care assessment of the member. The CMT conducts a reevaluation at least annually, and when there are significant changes in the member's needs. However, any time the CMT believes the member no longer meets the Level of Care criteria, they will consult with the CSB Regional Program Officer.

Other
Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Registered Nurses or Licensed Practical Nurses (LPN) in the State of Montana and individuals with a bachelor's degree in Social Work; exceptions must be prior authorized by the Community Services Bureau.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Level of care assessments for nursing facility level of care are conducted by the MPQH. MPQH completes the assessment, and the decision is reflected in the Screening Determination. The Screening Determination is used to determine if the individual meets level of care requirements for admission to BSW. The medical and functional assessment involves a systemic analysis of the individual's medical, functional, and environmental resources and limitations. Qualifications for the individuals who perform the initial assessment for level of care are either a licensed nurse or a bachelor's in social work; exception to this requirement must be prior authorized by the Community Services Bureau.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Re-assessments for level of care are conducted by the CMTs. Case Managers must be either a licensed nurse or a person with a bachelor's degree in social work(exceptions must be prior authorized by the Community Services Bureau). If a Case Management Team suspects during an annual visit, or at any other time, that a participant's level of care has changed significantly, they will make a referral to MPQH for a full level of care re-assessment.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

Every three months

Every six months

Every twelve months

Other schedule
Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.
Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Case Management Teams utilize a reminder notice system to ensure that re-evaluations are completed in a timely manner.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

MPQH maintains records of evaluations for at least 3 years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of new applicants that received an evaluation for level of care when there is a reasonable indication that future services are needed. Numerator is the number of new applicants who received a level of care eligibility determination showing need for institutional level of care when there was indication future services were needed. The denominator is total number of new applicants.

Data Source (Select one):
Record reviews, on-site If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify: Case Management Team	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other	**Annually**
Responsible Party for data aggregation and analysis *(* *that applies):*	**analysis***(check each that applies):*
Specify:	
	Continuously and Ongoing
	Other Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of new waiver participants whose eligibility was determined using the approved processes and instruments. The numerator is the number of new waiver participants whose eligibility was determined using the approved processes and instruments. The denominator is the total number of new waiver participants.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 5%
Other Specify: Mountain Pacific Quality Health	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b.

Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

During the preadmission screening determination Mountain Pacific Quality Health (MPQH) informs eligible members of the feasible alternatives available under the waiver and allows members to choose either institutional or waiver services.

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Freedom of choice is documented on the Screening Determination form that is sent to the member from MPQH. During the development of the service plan, members are again informed of their right to choose service settings, service options and service providers and this is documented on the service plan signature page.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Mountain Pacific Quality Health maintains the Screening Determination forms, which includes documentation of freedom of choice, for a minimum of three years. Case Management Teams keep copies of service plans which indicate freedom of choice for a minimum of three years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State will make reasonable accommodations upon request. Accommodations for foreign translators are arranged through the local college and university system. Accommodations for members who are deaf or hard of hearing are made through Montana Deaf and Hard of Hearing Services. Members are notified of the opportunity for reasonable accommodations in the Medicaid application, during the screening determination process and in the Medicaid Screening determination letter.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Case Management		
Statutory Service	Community Adult Group Homes		
Statutory Service	Community First Choice/Personal Assistance		
Statutory Service	Day Habilitation		
Statutory Service	Homemaker		
Statutory Service	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Specially Trained Attendant		
Statutory Service	Supported Employment		
Extended State Plan Service	Audiology		
Extended State Plan Service	Respiratory Therapy		
Supports for Participant Direction	Big Sky Bonanza Financial Management Services		
Supports for Participant Direction	Big Sky Bonanza Independence Advisor		
Other Service	Adult Foster Care		
Other Service	Big Sky Bonanza Goods and Services		
Other Service	Big Sky Waiver Community Supports		
Other Service	Community Transition		
Other Service	Consultative Clinical and Therapeutic Services		

Service Type	Service
Other Service	Dietetic-Nutritionist Services
Other Service	Environmental Accessibility Adaptations
Other Service	Family Training and Support
Other Service	Health and Wellness
Other Service	Homemaker Chore
Other Service	Level 1 Assisted Living
Other Service	Level 2 Assisted Living
Other Service	Level 3 Assisted Living
Other Service	Money Management
Other Service	Non-medical Transportation
Other Service	Nutrition
Other Service	Occupational Therapy
Other Service	Pain and Symptom Management
Other Service	Personal Emergency Response Systems
Other Service	Physical Therapy
Other Service	Post Acute Rehabilitation Services
Other Service	Private Duty Nursing
Other Service	Senior Companion
Other Service	Service Animals
Other Service	Specialized Child Care for Children Who Are Medically Fragile
Other Service	Specialized Medical Equipment and Supplies
Other Service	Speech Therapy
Other Service	Supported Living
Other Service	Vehicle Modifications

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

Sub-Category 2:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Adult Day Health provides a broad range of health, nutritional, recreational, and social services in settings outside the members place of residence. Adult Day Health services do not include residential overnight services. Adult Day Health services are furnished in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the member. The scope of Adult Day Health service will not duplicate State Plan services or habilitation aid services. Adult Day Health services shall be authorized and delivered using person-centered practices.

Meals provided as part of these services shall not constitute a full nutritional regiment (3 meals per day).

Transportation between the member's place of residence and the Adult Day Health center will be provided as a component part of Adult Day Health services. The cost of this transportation is included in the rate paid to providers of Adult Day Health services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is not duplicative of the Non-Medical Transportation or Nutrition service.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Provider

Provider Qualifications

License *(specify):*

Adult Day License

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1445
ARM 37.106.310

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and license renewal.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Case Management entails:
Development and review of the service plan with the member;
Reevaluation of the service plan, including a functional assessment and service delivery;
Coordination of services;
Linking members to other programs;
Monitoring implementation of service plan;
Ensuring health and safety;
Addressing problems with respect to services and providers;
Responding to crises; and
Being financially accountable for waiver expenditures for their members.

Case management assists members in gaining access to needed BSW services, State Plan services as well as needed medical, social, and other services regardless of the funding source.

Case Management services shall be delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Case Management is provided under the authority of a concurrently run 1915(b) waiver.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:

Case Management Provider Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1430
Verification of Provider Qualifications
Entity Responsible for Verification:

State

Frequency of Verification:

Upon Enrollment
Verify New CM Training Annually
Verify RN/LPN License Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Residential Habilitation
Alternate Service Title (if any):

Community Adult Group Homes

HCBS Taxonomy:

Category 1: 02 Round-the-Clock Services

Sub-Category 1: 02013 group living, other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Licensed adult group homes provide residential settings for persons with severe disabilities, as defined within Title VII of the federal Rehabilitation Act of 1973 (29 U.S.C. 796, et seq.), who otherwise are unable to live independently and who are determined to be capable of residing in noninstitutional settings. Community Adult Group Homes serve residents with a severe disability that substantially limits major life activity, such as walking, self-care, seeing, hearing, speaking, learning, reasoning, judgment, or memory and are identified to be at a much greater risk of institutional placement.

The purpose of a community group home is to provide a family-oriented, home-like residence and related residential services to persons with disabilities so as to enable those persons to enjoy a manner of living that is as close as possible to that considered to be normal in the community. Residents will reside in the least restrictive environment. Intervention will be the least intrusive into, and the least disruptive of, the person's life and represent the least departure from normal patterns of living that can be effective in meeting the resident's needs.

Group Home supports will include, by way of a person-centered approach, adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational and employment support, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs.

Community Adult Group Home services includes personal care and protective oversight and supervision. Resident needs will be met through domiciliary services, personal-social assistance and program plans and training. Residents will be encouraged to engage in meaningful activity, to develop techniques to become increasingly more independent, and to interact with the community in which they reside Community Adult Group Home services may include the provision of medical and health care services that are integral to meeting the daily needs of residents.

Community Adult Group Home services includes personal care and protective oversight and supervision. Resident needs will be met through domiciliary services, personal-social assistance and program plans and training. Residents will be encouraged to engage in meaningful activity, to develop techniques to become increasingly more independent, and to interact with the community in which they reside. Residential habilitation services may include the provision of medical and health care services that are integral to meeting the daily needs of residents.

Community Adult Group Home services will include:
•Assistance with the arrangement of medical and nonmedical transportation when needed
•Protective oversight to assure the health, safety, and wellbeing of all residents at home and in the community
•Homemaker/homemaker chore services which are to consist of general household cleaning and maintenance activities
•Personal care assistance to support residents successfully complete activities of daily living (ADL) such as bathing, dressing, grooming, and personal hygiene, and meal prep/eating
•Assistance, monitoring, and management of prescribed medications as outlined in Administrative Rules of Montana (ARM)
•Services that are provided by third parties must be coordinated in partnership between the resident and the provider. Nursing and skilled therapy services are incidental rather than integral to the provision of group home services. Payment is not to be made for twenty-four hour skilled care. Coordinated short-term skilled services may be accessed via the resident’s state plan, EPSDT, Medicare, or private insurance benefit package.

Community Adult Group Home services will also include within the rate:
•Social and recreational activities at least twice a week
•Transportation
•Money management
•Medical escort

Provider owned or leased settings where Big Sky Waiver Community Adult Group Homes services are furnished must be compliant with the Americans with Disabilities Act. Additionally, participating adult group home providers must meet the HCB setting requirements as defined within 42 CFR 441.301(c)(4)-(5), and associated CMS guidance assuring that the setting is homelike and absent of institutional-like qualities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The services under Big Sky Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

The service must be initially prior authorized by the Department to avoid a duplication of services that are integral to the rate structure of the service.

The total number of individuals served in group homes cannot exceed eight (8) residents 18 years of age or older.

Qualified onsite on-site staff must be available twenty-four-hours to respond to the health, safety, and security needs of all residents residing within the setting.

Group Home services include the provision of medical and health care services that are integral to meeting the daily needs of the resident. Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents may not be included. The provision of such routine health services and the inclusion of the payment for such services in the payment for residential habilitation services is not considered to violate the requirement that a waiver may not cover services that are available through the state plan.

Residents residing in adult group homes may not receive the following services under the waiver to avoid duplication and may not be billed separately. These restrictions apply only when payment is being made for the adult group home service.
•Personal assistance services as provided under the state plan for ADL support within the home which is intended to compensate for the loss of or supplementation of direct care staff
•Homemaker/Homemaker Chore services
•Environmental modifications to resident units or common areas
•Provider compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes
•Medical transportation reimbursement as this service is a state plan benefit
•Nonmedical transportation provided by the adult group home is a component of the adult group home service and the costs associated with transportation is included in the rate
•Home delivered meals
•Personal Emergency Response Systems for use within the home
•Reimbursement for representative payee services is prohibited

Retainer Day Payments
•Retainer payments may be made to providers of group home services while the resident is hospitalized, in nursing facility, or on vacation for a period of no more than 30-days per service plan year and may not be used for any other service if used for adult group home services. Retainer payments allows for provider reimbursement during a member's absence in order to preserve the resident's placement at the facility.
•Big Sky Waiver does not account for provider vacancy savings; therefore, retainer days can be made available to providers of adult residential services
•The provider may not bill Medicaid for services on days the member is absent from the facility unless retainer day payments are prior authorized by the resident's case management team
•The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer

Room and Board
•Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for services is described in Appendix I-5

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person
Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Community First Choice/Personal Assistance

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Community First Choice/Personal Assistance Services (CFC/PAS) under the Big Sky Waiver (BSW) may include:
1) supervision for health and safety reasons,
2) socialization,
3) escort and transportation for non-medical reasons, or
4) an extension of State Plan personal assistance services.

Nurse Supervision for PCAs
This service may be authorized if the member is receiving waiver only services from a personal assistance agency and requires a nurse for the supervision of the BSW specific personal assistance.

Billable time for nurse supervision is:

1. Intake time – this includes the time to complete the plan for services and orient the member to the program in the member's home;
2. Time spent in providing specific member orientation or training to an attendant if the service is agency based. This DOES NOT include going over the schedule;
3. Time spent charting specific to one member. This would include such activities as incident reporting and service plan development; and
4. Time spent in case conferences with other providers and/or family members and/or the member.

Shared service delivery is possible in accessible space apartment complexes; however, not all of them provide this service. Retainer payments for hospitalizations will be considered on an individual basis and if there are extensive vacancy days due to holidays or vacations, a meeting will be set up with the member to address coverage issues. Duplicate services cannot be billed for the same member for the same period of time. For example, a BSW Personal Care Attendant (PCA)/ and Community First Choice/Personal Care Attendant (CFC/PCA) cannot bill for the same hour on the same day for the same member. Administrative services cannot be billed as a waiver service. For example, an agency staff person responsible for coordinating schedules cannot be billed as a waiver service.

It is the responsibility of the provider agency to ensure that assistants are appropriately trained under agency-based services or the member under the self-directed and participant directed programs.

Since the provision of personal assistance by legally responsible individuals is not available under State Plan, individuals may use this service for assistance with ADLs by legally responsible individuals.

The Department has developed the CFC Agency Based and Self Directed Program Manuals for CFC/PAS provider Agencies. These manuals outline all policies and procedures relating to the CFC program. These manuals should be referred to for policy information regarding the extension of State Plan CFC/PAS.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Personal Assistance Services that are beyond what is required to be provided by the facility are not allowed for a member residing in adult residential settings.

This service cannot provide assistance with Activities of Daily Living (ADL) unless:
The QIO (MPQH) Service Profile is maxed at 42 hours/week, or
The Activities of Daily LIving (ADL) assistance is provided to the member outside the member's home (i.e. at work); or
The ADL need for assistance is strictly for supervision (i.e. no prompting, cuing, hands-on assistance).

The service cannot provide assistance with Instrumental Activities of Daily Living (IADLs) unless:
The member's authorized time for IADL on the QIO (MPQH) service profile is not sufficient to meet the member's needs, or
The member doesn't qualify for CFC/Personal Assistance Service (CFC/PAS) IADL because he/she doesn't qualify for ADL CFC/PAS supports, and/or the IADL needs of the member are outside the scope of IADL service provided under CFC.

Retainer Days
Providers of this service may be eligible for a retainer payment if authorized by the case management team or Independence Advisor/Financial Manager (IA/FM). Retainers are days on which the member is either in the hospital, nursing facility or on vacation and the team/IA/FM has authorized the provider to be reimbursed for services. Retainer days may not be used for any other BSW services when they are utilized for CFC/PAS. If a provider rate includes vacancy savings, retainer days are a duplication of services and may not be paid in addition. Retainer days are limited to 30 days per year.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Assistant, Specially Trained Personal Assistant
Agency	Personal Assistance Agencies, Home Care Agency, Supported Living Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community First Choice/Personal Assistance

Provider Category:

Individual

Provider Type:

Personal Assistant, Specially Trained Personal Assistant

Provider Qualifications License

(specify):

If a nurse, must be licensed by the state.

Certificate *(specify):*

Other Standard *(specify):*

The individual must:
Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);
Possess a valid Social Security Number;
Be a US citizen or possess a valid work permit;
Sign an affidavit regarding confidentiality and HIPAA;
Possess the ability to communicate effectively with the consumer/personal representative;
Possess the ability to complete documentation requirements of the program;
Demonstrate to the member specific competencies necessary to perform paid tasks;
Complete a self-declaration regarding infections and contagious diseases;
At the discretion of the member, agree to a state criminal background check;
Possess a valid drivers license and proof of automobile liability insurance if transporting the consumer;
Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect and exploitation; and
Advocate for the member to assure that the member's rights are protected and the member's needs and preferences are honored.

Verification of Provider Qualifications

Entity Responsible for Verification:

Member and Independence Advisor/FM

Frequency of Verification:

Upon enrollment and as necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community First Choice/Personal Assistance

Provider Category:
Agency
Provider Type:

Personal Assistance Agencies, Home Care Agency, Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1447

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Day Habilitation is assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, which takes place in a non-residential setting, separate from the home or facility in which the member resides. Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the member's service plan.

Day Habilitation services shall focus on enabling the member to attain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, Day Habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Day Habilitation services shall be authorized and delivered using person-centered practices.

When Day Habilitation is provided in an adult day care, the provider must be a licensed provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Reimbursement for meals is limited to two a day. This service is not duplicative of the transportation service or the meals under the distinct meals service.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1440

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Homemaker services consist of general household activities. Homemaker services are provided to members who are unable to manage their own home or when the member normally responsible for homemaking is absent.

Homemaker services do not include personal care services available under State Plan Medicaid.

Homemaker activities include household management necessary for maintaining and operating a home. This may include assisting the member with boxing, unpacking, and organizing household items. In addition, the service provides general housecleaning, meal preparation, laundry, and shopping.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service shall be provided only after homemaker services through any other entity have been exhausted. Homemaker services are not allowed for a member residing in an adult residential setting.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Homemaker
Agency	Personal Assistance Agency
Agency	Homemaker Agency, Home Care Agency
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Homemaker

Provider Qualifications License

(specify):

Certificate *(specify):*

Other Standard *(specify):*

Be 18 years of age (exceptions that are applicable within state law may be granted by the department); Possess a valid Social Security Number; be a US citizen or possess a valid work permit; possess the ability to communicate effectively with the member/personal representative; possess the ability to complete documentation requirements of the program; demonstrate to the member the specific competencies necessary to perform tasks; at the description of the member and agree to a state criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Member and Independence Advisor
The FM entity will verify provider qualifications are met and will enter into a Medicaid provider agreement with each provider on behalf of the Medicaid agency.

Frequency of Verification:

Upon enrollment and as necessary thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:

Personal Assistance Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1447 and .1450
Verification of Provider Qualifications
Entity Responsible for Verification:

State/Conduent
Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:

Homemaker Agency, Home Care Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1450

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

State License

Certificate *(specify):*

Medicare Certification

Other Standard *(specify):*

ARM 37.40.1450

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and license renewal

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 04 Day Services	**Sub-Category 1:** 04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Prevocational Training services are habilitative activities that foster employability for a member.

Must not be provided if they are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Education of the Handicapped Act. The Case Management Team must document in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142. This documentation may be obtained by working with the Department of Public Health and Human Services Vocational Rehabilitation programs;

Are aimed at preparing an individual for paid or unpaid employment and includes teaching such concepts as compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, attention span, motor skills and safety.

Services are provided to members who may or may not join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Activities included in this service are generally not directed at teaching specific job skills, but underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the member's service plan.

Prevocational Training services shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1438

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Respite care is short-term, intermittent care provided to members in need of supportive care to relieve those persons who normally provided the care. Respite care is only utilized to relieve a non-paid caregiver.

Respite care may include payment for room and board in adult residential facilities, nursing homes, hospitals, group homes or residential hospice facilities.

Respite care can be provided in the member's residence or by placing the member in another private residence, adult residential facilities, nursing homes, setting or other community setting, hospital, residential hospice, group home, therapeutic camp for children or adults with disabilities or licensed nursing facility.

Respite services shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

As a program funded by the Administration of Community Living (ACL), the State of Montana's Lifespan Respite program is not a third-party resource for the Big Sky Waiver program.

When respite care is provided, the provision of, or payment for other duplicative services under BSW is precluded (e.g., payment for respite when member is in Adult Day Health). Respite care is limited to no more than 30 consecutive days. If a member requires assistance with Activities of Daily Living (ADLs) during the respite hours, personal assistance should be used under State Plan or Big Sky Waiver Specially Trained Attendant.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Assistant/Homemaker/Specially Trained Attendant/Caregiver
Agency	Homemaker Agency
Agency	Personal Assistance Agency/Home Care Agency
Agency	Assisted Living Facility
Agency	Nursing Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:

Personal Assistant/Homemaker/Specially Trained Attendant/Caregiver

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The individual must:
(a) Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);
(b) Possess a valid Social Security Number;
(c) Be a US citizen or possess a valid work permit;
(d) Sign an affidavit regarding confidentiality and HIPAA;
(e) Possess the ability to communicate effectively with the member/personal representative;
(f) Possess the ability to complete documentation requirements of the program;
(g) Demonstrate to the member specific competencies necessary to perform paid tasks;
(h) Complete a self-declaration regarding infections and contagious diseases;
(i) At the discretion of the member agree to a state criminal background check;
(j) Possess a valid drivers license and proof of automobile liability insurance if transporting the member; (k) Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and
(l) Advocate for the member to assure that the member's rights are protected and the member's needs and preferences are honored.

In addition:
(a) Be physically and mentally qualified to provide this service to the member;
(b) Be aware of emergency assistance and/or response systems;
(c) Be trained and knowledgeable of the physical and mental conditions of the member;
(d) Be knowledge of common medications and related conditions of the member; and
(e) Be capable to administer basic first aid

Verification of Provider Qualifications

Entity Responsible for Verification:

a) Department of Public Health and Human Services/Fiscal Intermediary
b) Department of Public Health and Human Services/Quality Assurance Division
c) Applicable standards are verified by the service provider agency
d) Big Sky Waiver Program Management Staff and/or designee(s)
e) State/Conduent
f) Member and Independence Advisor/FM

Frequency of Verification:

Upon enrollment and as necessary

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:

Homemaker Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1451
A person providing respite care services must:
(a) be physically and mentally qualified to provide this service to the member;
(b) be aware of emergency assistance and/or response systems;
(c) be trained and knowledgeable of the physical and mental conditions of the member;
(d) be knowledge of common medications and related conditions of the member; and
(e) be capable to administer basic first aid

Verification of Provider Qualifications

Entity Responsible for Verification:

a) Department of Public Health and Human Services/Fiscal Intermediary
b) Department of Public Health and Human Services Office of Inspector General (OIG)/Quality Assurance Division (QAD)
c) Applicable standards are verified by the service provider agency
d) Big Sky Waiver Program Management Staff and/or designee(s)
e) State/Conduent

Frequency of Verification:

Verification will occur upon enrollment and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:

Personal Assistance Agency/Home Care Agency

Provider Qualifications License

(specify):

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1451
A person providing respite care services must:
(a) be physically and mentally qualified to provide this service to the member
(b) be aware of emergency assistance and/or response systems
(c) be trained and knowledgeable of the physical and mental conditions of the member
(d) be knowledge of common medications and related conditions of the member
(e) be capable to administer basic first aid

Verification of Provider Qualifications

Entity Responsible for Verification:

a) Department of Public Health and Human Services/Fiscal Intermediary
b) Department of Public Health and Human Services Office of Inspector General (OIG)/Quality Assurance Division (QAD)
c) Applicable standards are verified by the service provider agency
d) Big Sky Waiver Program Management Staff and/or designee(s)
e) State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Service delivery within assisted living facility settings is contingent upon State licensure for these facilities. Assisted living facilities licensure requirements may be reviewed in ARM 37.106.2801 through 37.106.2898. In addition, Assisted Living Facility staff are required to be at least 18 years of age receive training in, abuse reporting, incident reporting, client confidentiality, and any specialty training relating to the need of the member/population served. The provider shall employ no staff person who has impairments to his/her ability to protect the health and safety of the residents or who would endanger the physical or psychological wellbeing and progress of the residents. The provider will be proficient in the standards associated with privacy and confidentiality, reporting and documentation, emergency planning and preparedness, and a knowledge of the legal and protective service system. Direct care staff shall be trained to perform the services established in each resident service plan. Direct care staff shall be trained

in the use of the abdominal thrust maneuver and basic first aid. If the facility offers cardiopulmonary resuscitation (CPR), at least one person per shift shall hold a current CPR certificate. The facility shall have a sufficient number of qualified staff on duty 24 hours a day to meet the scheduled and unscheduled needs of each resident, to respond in emergency situations, and all related services. Facility staff may not perform any health care service that has not been appropriately delegated under the Montana Nurse Practice Act or in the case of licensed health care professionals that is beyond the scope of their license.

Certificate *(specify):*

Other Standard *(specify):*

Administrative Rules of Montana 37.40.1451 Home and Community-Based Services for Elderly and Physically Disabled Persons: Respite Care, Requirements

37.40.1435 Home and Community-Based Services for Elderly and Physically Disabled Persons: Adult Residential Care, Requirements

Providers must be enrolled as a Montana Medicaid provider and have a provider agreement according to Administrative Rules of Montana 37.85.401; 37.85.402

Administrative Rules of Montana 37.106.302 Minimum Standards Of Construction: General Requirements

Safety Devices:
Montana Code Annotated 50-5-1201 - 50-5-1205
Administrative Rules of Montana 37.106.2901 - 37.106.2908

Montana Code Annotated 2019
Title 50. Health and Safety
Chapter 5. Hospitals and Related Facilities
Parts 1 through 13

Montana Code Annotated 2019
Title 52. Family Services
Chapter 3. Adult Services
Part 8. Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act

Verification of Provider Qualifications

Entity Responsible for Verification:

a) Department of Public Health and Human Services/Fiscal Intermediary
b) Department of Public Health and Human Services Office of Inspector General (OIG)/Quality Assurance Division(QAD)
c) Applicable standards are verified by the service provider agency
d) Big Sky Waiver Program Management Staff and/or designee(s)
e) State/Conduent

Frequency of Verification:

a) Verification will occur upon provider enrollment and re-verified as necessary
b) HCBS Settings Criteria will be verified upon provider enrollment and re-verified as necessary
c) Montana's Office of Inspector General (OIG)/Quality Assurance Division(QAD) will license and survey all facilities as outlined within Administrative Rules of Montana 37.106.310 Licensing:
Procedure For Obtaining A License: Issuance And Renewal Of A License

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:

Nursing Facility

Provider Qualifications

License *(specify):*

State Nursing Facility License

A skilled nursing care facility shall comply with the Conditions of Participation for Skilled Nursing Facilities as set forth in 42 CFR 405, Subpart K. An intermediate care facility shall comply with the requirements set forth in 42 CFR 442, Subparts E and F. Facility staff are required to be at least 18 years of age receive training in, abuse reporting, incident reporting, client confidentiality, and any specialty training relating to the need of the member/population served. The provider shall employ no staff person who has impairments to his/her ability to protect the health and safety of the residents or who would endanger the physical or psychological wellbeing and progress of the residents. The provider will be proficient in the standards associated with privacy and confidentiality, reporting and documentation, emergency planning and preparedness, and a knowledge of the legal and protective service system. Direct care staff shall be trained to perform the services established in each resident service plan. The facility shall have a sufficient number of qualified staff on duty 24 hours a day to meet the scheduled and unscheduled needs of each resident, to respond in emergency situations, and all related services. Facility staff may not perform any health care service that has not been appropriately delegated under the Montana Nurse Practice Act or in the case of licensed health care professionals that is beyond the scope of their license.

Certificate *(specify):*

Other Standard *(specify):*

State of Montana ARM 37.40.1451

Verification of Provider Qualifications

Entity Responsible for Verification:

a) Department of Public Health and Human Services/Fiscal Intermediary
b) Department of Public Health and Human Services Office of Inspector General (OIG)/ Quality Assurance Division (QAD)
c) Applicable standards are verified by the service provider agency
d) Big Sky Waiver Program Management Staff and/or designee(s)
e) State/Conduent

Frequency of Verification:

a)Upon enrollment and upon renewal of license
b)Montana's Quality Assurance Division (QAD) will license and survey all facilities as outlined within Administrative Rules of Montana 37.106.310 Licensing: Procedure For Obtaining A License: Issuance And Renewal Of A License

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Specially Trained Attendant

HCBS Taxonomy:

Category 1: 17 Other Services	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

The Specially Trained Attendant (STA) service provides specialized supportive services to a member requiring providers specially trained to meet the unique needs of the member. Areas of special training may include assisting a member with a traumatic brain injury, dementia, or extensive physical disabilities. This service shall not duplicate or supplant services available through other BSW services, State Plan Medicaid, Vocational Rehabilitation, Department of Education, or other third-party payers. This service shall only be available to members whose needs exceed the services available through Community First Choice State Plan Personal Assistance Services.

STA care services may include:
1. Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) and Socialization/Supervision for individuals whose disability requires services by an attendant with additional training. It is typically utilized for individuals with brain injuries, severe dementia or severe physical disabilities whose needs cannot be met by standard PAS.
These attendants must have the following training and qualifications:
a. Basic personal assistant services training as defined by the Community Services Bureau;
b. Ten (10) hours of disability-specific training; and
c. Four (4) hours of member-specific training.

2. STA/Life Coach that assist individuals to acquire, retain and improve self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings. These providers must have extensive knowledge of the community and community resources.
They are not required to have basic PAS training.

3. Private Duty Nursing (PDN) for members who receive continuous and extensive nursing services. This service is intended for members who receive continuous nursing. It is not intended for the short term, occasional, or intermittent type nursing. This service is typically used for members whose nurse(s) is/are assigned only to them and the nurse would lose income if the individual is absent (Heavy Care/CC3 members).
EXAMPLE: If a person only uses PDN for bowel programs and that nurse works for many other members, this would be billed under regular PDN. If the nurse works only for one or two members exclusively and would lose income and not be able to work elsewhere during the member's absence, then STA PDN should be used.

It is the responsibility of the provider agency to ensure that attendants are appropriately trained under agency-based services or the member under the self-directed and member-directed programs. It is the responsibility of the Case Management Team to define, document and arrange for any specialized training for a Specially Trained Attendant. Verification of training shall be maintained in the member's case file.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

STA ADL may not be used in conjunction with Community First Choice ADL.

Retainer Days
Providers of this service may be eligible for a retainer payment if authorized by the case management team or IA/FM.

Retainer payments allow providers to be reimbursed when the member is absent from the home or adult residential care facility due to entry to a hospital or nursing facility or on vacation (absence from services). Retainer payments are available to keep members from losing their caregivers or placement in a residential care facility.
Payment for retainer days may not exceed 30 days per Service Plan year.
Retainer days for STA service:
1. ADL/IADL and Socialization/Supervision – only use retainer days when and if the attendants cannot work for others while the member is absent and they would lose income.
2. STA/Life Coach – only use retainer days when and if the attendants cannot work for others while the member they work with is absent and they would lose income.
3. STA Private Duty Nursing – only use retainer days when and if the STA PDN nurse cannot work for others while the member they work with is absent and they would lose income.

Members residing in a Community Adult Group Home or Level 3 Facility shall not receive this service. Specially Trained Attendants may receive retainer payments when they cannot work for others while the member is absent, resulting in a loss of income for the attendant.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider
Agency	Home Care Agency
Agency	Personal Assistance Agencies
Individual	Personal Assistant
Individual	

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Specially Trained Attendant

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

ARM 37.40.1447

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Specially Trained Attendant

Provider Category:
Agency
Provider Type:

Home Care Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1447
Verification of Provider Qualifications
Entity Responsible for Verification:

State/Conduent
Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Specially Trained Attendant

Provider Category:
Agency
Provider Type:

Personal Assistance Agencies
Provider Qualifications
License *(specify):*

ARM 37.40.1447
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Specially Trained Attendant

Provider Category:

Individual

Provider Type:

Personal Assistant

Provider Qualifications License
(specify):

If a nurse, must be licensed by the state.

Certificate *(specify):*

Other Standard *(specify):*

The individual must:
Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);
Possess a valid Social Security Number;
Be a US citizen or possess a valid work permit;
Sign an affidavit regarding confidentiality and HIPAA;
Possess the ability to communicate effectively with the member/personal representative;
Possess the ability to complete documentation requirements of the program;
Demonstrate to the member specific competencies necessary to perform paid tasks;
Complete a self-declaration regarding infections and contagious diseases;
At the discretion of the member agree to a state criminal background check;
Possess a valid driver's license and proof of automobile liability insurance if transporting the member;
Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and
Advocate for the member to assure that the member's rights are protected, and the member's needs and preferences are honored.

Verification of Provider Qualifications
Entity Responsible for Verification:

Member and IA/FM

Frequency of Verification:

Upon enrollment and as necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Specially Trained Attendant

Provider Category:

Individual

Provider Type:

Specially Trained Personal Assistant

Provider Qualifications

License *(specify):*

If a nurse, must be licensed by the state.

Certificate *(specify):*

Other Standard *(specify):*

The individual must:
Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);
Possess a valid Social Security Number;
Be a US citizen or possess a valid work permit;
Sign an affidavit regarding confidentiality and HIPAA;
Possess the ability to communicate effectively with the member/personal representative;
Possess the ability to complete documentation requirements of the program;
Demonstrate to the member specific competencies necessary to perform paid tasks;
Complete a self-declaration regarding infections and contagious diseases;
At the discretion of the member agree to a state criminal background check;
Possess a valid driver's license and proof of automobile liability insurance if transporting the member;
Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and
Advocate for the member to assure that the member's rights are protected, and the member's needs and preferences are honored.

Verification of Provider Qualifications

Entity Responsible for Verification:

Member and IA/FM

Frequency of Verification:

Upon enrollment and as necessary.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

	Category 1:	Sub-Category 1:
Category 4:	03 Supported Employment	03021 ongoing supported employment, individual
Sub-Category 4:		
	Category 2:	**Sub-Category 2:**
	03 Supported Employment	03022 ongoing supported employment, group
	Category 3:	**Sub-Category 3:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Supported employment includes activities needed to sustain paid work by BSW members, including supervision and training for members for whom unsupported or competitive employment at or above the minimum wage is unlikely. Supported employment is conducted in a variety of settings. Supported employment may include group community employment such as crews, enclaves or individual community employment.

When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by BSW members as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting by the employer or for items the employer is required to provide under the Americans with Disabilities Act.

Supported employment services rendered under BSW are not available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142. This documentation may be obtained by working with the DPHHS Vocational Rehabilitation program.

Transportation may be provided between the member's place of residence and the job site, or between job sites (in cases where the member is working in more than one place) as a component part of supported employment services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1438

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable). **Service Type:**

Extended State Plan Service

Service Title:

Audiology

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Services that are provided when the limits of audiology services under the approved Medicaid State Plan are exhausted or for maintenance and habilitation purposes. The scope and nature of these services do not otherwise differ from audiology services furnished under the Medicaid State Plan. Audiology services include screening and evaluation of members with respect to hearing function.

Audiology services shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency or Hospital
Agency	Home Care Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Audiology

Provider Category:

Agency

Provider Type:

Home Health Agency or Hospital

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1462

Verification of Provider Qualifications

Entity Responsible for Verification:

Conduent/State

Frequency of Verification:

Upon enrollment and renewal license/certification.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Audiology

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1462

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable). **Service Type:**

Extended State Plan Service

Service Title:

Respiratory Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11110 respitory therapy
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Services include direct treatment, ongoing assessment, equipment monitoring and upkeep, pulmonary education and rehabilitation. This service is not available to individuals who are eligible to receive such services through Medicaid State Plan (including EPSDT benefits).

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Respiratory Therapist
Agency	Home Health Agency or Hospital
Agency	Home Care Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Respiratory Therapy

Provider Category:

Individual

Provider Type:

Respiratory Therapist

Provider Qualifications License

(specify):

State License

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1463
ARM 37.40.1477
A member's legally responsible individual may provide respiratory services if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and renewal of license.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Respiratory Therapy

Provider Category:

Agency

Provider Type:

Home Health Agency or Hospital

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1463

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and renewal of license/certification.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Respiratory Therapy

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1463

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Big Sky Bonanza Financial Management Services

HCBS Taxonomy:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Category 1:	**Sub-Category 1:**
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**

This service provides finance, employer, payroll, and related functions for the member/personal representative. This service assure that the funds to provide services and supports outlined in the member service plan are implemented through a self-directed approach and are managed and paid appropriately as authorized. This is a mandatory service for all member directed waiver members.

The Financial Manager (FM) acts as the common law employer (employer of record) and the member acts as the managing employer. Since the FM is the employer, this entity is responsible for all employee related expenses and liability risks that may be incurred if a worker's compensation or unemployment claim is filed.

More specifically, the FM will:

1. Member Enrollment:
Accept referral from the member/personal representative to process the employment packet;
Prepare and distribute an application package of information that is clear and easy for the potential employee to understand and follow; and
Provide needed advice and technical assistance regarding the role of a FM to the member, their personal representatives, and others.

2. Individual Employed to Provide Services:
Process employment application package and documentation for prospective individual to be employed (as agency employee);
Complete criminal background checks on prospective member referred worker and maintain results on file, if requested by the member;
Establish and maintain record for each individual employed and process all employment records;
Withhold, file, and deposit FICA, FUTA, and SUTA taxes in accordance with
Federal IRS and DOL, and state rules (if applicable);
Process all judgments, garnishments, tax levies or any related holds on a member's worker as may be required by local, state or federal laws;
Generate and distribute IRS W-2's and/or 1099's, wage and tax statements and related documentation annually to all member-employed providers who meet the statutory threshold earnings amounts during the tax year by January 31st; and
Withhold, file and deposit federal and state income taxes (if applicable) in accordance with federal IRS and state Department of Revenue Services rules and regulation; and
Administer benefits for member-employed providers (if available).

3. Payroll and Accounting:
Generate payroll checks in a timely and accurate manner, as approved in the member's self-direct spending plan, and in compliance with all federal and state regulations;
Develop a method of payment of invoices and monitoring expenditures against the self-direct spending plan for each member;
Receive, review and process all invoices from individuals, vendors or agencies providing member-directed goods or services as approved in the member's self-direct spending plan authorized by the Division;
Process and pay non-labor related invoices; and
Generate utilization reports along with payroll reflecting accurate balances for members/personal representatives, Big Sky Bonanza IA, Regional Program Officers (RPOs) and the Division.

4. Management:
Execute provider agreements with any individual or entity that will be reimbursed with Medicaid waiver funding;
Establish and maintain all member records with confidentiality, accuracy, and appropriate safeguards; Respond to calls from member or their personal representatives and employees regarding issues such as withholdings and net payments, lost or late checks, reports and other documentation;
File claims through the MMIS for member-directed goods and services and prepare checks for individually hired workers; and
Generate service management and statistical information and reports.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)*:

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Living Center, Self Direct Personal Assistance Service Agency, Case Management Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Big Sky Bonanza Financial Management Services

Provider Category:

Agency

Provider Type:

Independent Living Center, Self Direct Personal Assistance Service Agency, Case Management Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

FM services must be delivered by entities that are established as legally recognized in the United States, qualified/registered to do business in the State of Montana, approved as a Medicaid provider and approved by the CSB. Approval will include, at a minimum, ensuring the provider demonstrates the capacity to perform the required responsibilities through undergoing and passing a Readiness Review performed by the State.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Big Sky Bonanza Independence Advisor

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Big Sky Bonanza Independence Advisor (IA) services include an array of member-directed support activities to ensure the ability of members to direct their care successfully. Members can choose from any qualified and enrolled provider. This is a mandatory service under the Big Sky Bonanza option only. This service substitutes case management services by the Case Management Teams under the Big Sky Waiver.

An IA can help members or their personal representatives:

1) learn how to successfully self-direct services;

2) develop a person-centered Service Plan (SP);

3) access waiver services, Medicaid State Plan services, and other needed medical, social or educational services regardless of funding source;

4) develop, implement, and monitor a monthly spending plan;

5) identify risks and develop a plan to manage those risks;

6) develop an individualized emergency backup plan;

7) make allowable purchases and ensure those purchases are listed in the spending plan;

8) negotiate payments for necessary and allowable goods and services;

9) work with the Financial Manager (FM) to track expenditures;

10) monitor the provision of the services to ensure the member's health and welfare; and

11) coordinate with the FM to ensure that members or personal representatives' budget appropriately to meet their needs as defined in the SP.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Living Center, Personal Assistance Agency, Supportive Living Provider
Individual	Independence Advisor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Big Sky Bonanza Independence Advisor

Provider Category:

Agency

Provider Type:

Independent Living Center, Personal Assistance Agency, Supportive Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

An IA must complete the Community Services Bureau (CSB) mandatory training and receive formal training as an IA before providing services. Training includes:
1) the person-centered planning process;
2) principles of member-direction;
3) developing a comprehensive Support and Services Spending Plan (SSSP);
4) Department program policy and processes;
5) program reporting and documentation requirements;
6) community resources; and
7) techniques to enhance member-directing skills for members.

Other Standard *(specify):*

A certified IA must exhibit a professional commitment to the described duties and successfully demonstrate the ability to:
1) understand the principles of member-direction, IA and member roles, State and federal program policies and local regional, state and federal resources;
2) participate as a member of the support team;
3) follow written and verbal instructions;
4) communicate successfully with members, personal representative and Financial Managers;
5) establish community networks;
6) recognize and report abuse, neglect and exploitation;
7) comply with CSB Serious Occurrence Report policies;
8) advocate on the behalf of members and teach self-advocacy;
9) assist with developing an appropriate comprehensive SSSP that includes Medicaid, non-Medicaid, traditional and member-directed services;
10) instruct, counsel and guide members in problem solving and decision making; and
11)comply with program reporting and documentation requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

State

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Big Sky Bonanza Independence Advisor

Provider Category:

Individual

Provider Type:

Independence Advisor

Provider Qualifications License

(specify):

Certificate *(specify):*

An IA must complete the CSB mandatory training and receive formal training as an IA before providing services. Training includes:
1) the person-centered planning process;
2) principles of member-direction;
3) developing a comprehensive Support and Services Spending Plan (SSSP);
4) Department program policy and processes;
5) program reporting and documentation requirements;
6) community resources; and
7) techniques to enhance member-directing skills for members.

Other Standard *(specify):*

A certified IA must exhibit a professional commitment to the described duties and successfully demonstrate the ability to:
1) understand the principles of member-direction, IA and member roles, State and federal program policies and local regional, state and federal resources;
2) participate as a member of the support team;
3) follow written and verbal instructions;
4) communicate successfully with members, personal representative and Financial Manager;
5) establish community networks;
6) recognize and report abuse, neglect and exploitation;
7) comply with Community Services Bureau Serious Occurrence Report policies;
8) advocate on the behalf of members and teach self-advocacy;
9) assist with developing an appropriate comprehensive SSSP that includes Medicaid, non-Medicaid, traditional and member-directed services;
10) instruct, counsel and guide members in problem solving and decision making; and
11) comply with program reporting and documentation requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

State

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Foster Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Adult Foster Care Homes provide a home-like safe environment, light housekeeping, custodial care, and supervision to aged or physically disabled adults 18 years of age or older who require assistance in meeting their basic needs. Residents' needs are to be addressed in a manner that supports and enables residents to maximize their ability to function at the highest level of independence possible at home and in the community.

Adult foster care services are to include the delivery of personal care and supportive services that are provided in a licensed private home by a principal care provider who lives in the home. A qualified onsite provider, staff member, or adult member of the household, excluding a Big Sky Waiver Participant, must be available twenty-four-hours to respond to and meet the health, safety, and security needs of all residents residing within the setting as outlined in Administrative Rules of Montana (ARM).

Adult Foster Care services will include:
•Assistance with the arrangement of medical and nonmedical transportation when needed
•Protective oversight to assure the health, safety, and wellbeing of all residents at home and in the community
•Access to social and recreational activities at home and in the community
•Homemaker/homemaker chore services which are to consist of general household cleaning and maintenance activities
•Personal care assistance to support residents successfully complete activities of daily living (ADL) such as bathing, dressing, grooming, and personal hygiene, and meal prep/eating

•Assistance, monitoring, and management of prescribed medications as outlined in Administrative Rules of Montana (ARM)
•Periodic nursing evaluations are to occur as outlined in Administrative Rules of Montana (ARM)
•The adult foster care service is to include unskilled assistance with ADLS and IADLs, meal preparation, and routine health care services excluding any unskilled services that may be provided to the resident under the state plan or EPSDT.
•Nursing and skilled therapy services are incidental rather than integral to the provision of adult foster care services. Payment is not to be made for twenty-four hour skilled care. Coordinated short-term skilled services may be accessed via the resident's state plan, EPSDT, Medicare, or private insurance benefit package

Provider owned or leased settings where Big Sky Waiver services are furnished must be compliant with the Americans with Disabilities Act. Additionally, participating adult foster care home providers must meet the HCB setting requirements as defined within 42 CFR 441.301(c)(4)-(5), and associated CMS guidance assuring that the setting is homelike and absent of institutional-like qualities

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The services under Big Sky Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The total number of individuals served in adult foster care homes cannot exceed four residents, 18 years of age or older, living in the home, and are unrelated to the principal care provider.

Payment rendered for adult foster care home services will encompass the services and supports that are furnished on an integrated basis. Additionally, payment for adult foster care services does not include payments made, directly or indirectly, to members of the resident's immediate family. The adult foster care home provider may arrange for the provision of some services to be delivered on an individual contractual basis as outlined in Administrative Rules of Montana (ARM).

Residents residing in adult foster care homes may not receive the following services under the Big Sky Waiver program to avoid duplication and may not also be billed separately. These restrictions apply only when payment is being made for the adult foster care home service.
•Personal assistance services as provided under the state plan for ADL support within the setting. However, personal assistance services and/or non-medical transportation/mileage for socialization may be utilized by the resident for the supervision of their health and safety when accessing the community unsupported by the responsible adult foster care homeowner or designated responsible individual(s)
•Homemaker/Homemaker Chore services
•Environmental modifications to resident units or common areas
•Provider compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes
•Respite may be provided in a adult foster care home for recipients of other service types but may not be provided for residents already residing in the setting
•Medical transportation reimbursement as this service is a state plan benefit
•Nonmedical transportation provided by the adult foster care home is a component of the service and the costs associated with transportation are included in the rate
•Home delivered meals
•Personal Emergency Response Systems for use within the home

Retainer Day Payments
•Retainer payments may be made to providers of adult foster care homes while the resident is hospitalized, in nursing facility, or on vacation for a period of no more than 30-days per service plan year and may not be used for any other service if used for adult foster care home services. Retainer payments allows for provider reimbursement during a member's absence in order to preserve the resident's placement at the facility.
•Big Sky Waiver does not account for provider vacancy savings; therefore, retainer days can be made available to providers of adult foster care services.
•The provider may not bill Medicaid for services on days the member is absent from the home unless retainer day payments are prior authorized by the resident's case management team.
•The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer.

Room and Board

•Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for services is described in Appendix I-5

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Big Sky Bonanza Goods and Services

HCBS Taxonomy:

Category 1: 17 Other Services

Sub-Category 1: 17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

These are services, supports, supplies or goods not otherwise provided through this waiver or the Medicaid State Plan.

These items must address an identified need in the member's person-centered service and support plan and meet any of the following requirements:

The item or service would:

1) Decrease the need for other Medicaid services;

2) Promote inclusion in the community;

3) Promote the independence of the member;

4) Fulfill a medical, social, or functional need based on unique cultural approaches; or

5) Increase the member's safety in the home or community.

In addition goods and services purchased must meet the following criteria:

1) Meet the member's identified needs and outcomes as outlined in their service plan;

2) Goods and services collectively must provide an alternative to institutional placement;

3) Be a cost-effective means of addressing an identified need in the service plan; and

4) Be of sole benefit to the member.

The Department review the member's service plan, for approval, will determine whether the goods and service address the following outcomes:
1) maintain the member's ability to remain in the community;
2) enhance the member's community inclusion and family involvement;
3) develop or maintain the member's personal, social, physical or work-related skills; and
4) increase the member's independence.

The Department will also review the member's service plan for goods and services that may not be paid for with waiver funds.

This includes any support services or good:

1) Available through Medicaid State Plan;

2) Covered by any other third-party payer such as Medicare, the Veteran's Administration, or state educational or vocational agencies;

3) Used for leisure and recreational purposes only and not determined necessary for the member to remain in the home and community;

4) That is an item or support normally furnished by the member's parents, spouse, or family member residing in the same household or

5) That does not meet an identified need.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to members in the Bonanza self-managed option. Goods or services in excess of $5,000 must receive prior authorization from the CSB designated staff.

Big Sky Bonanza Goods and Services cannot duplicate Environmental Accessibility Adaptations or Specialized Medical Equipment and Supplies. This is monitored through the prior authorization process completed by the Fiscal Manager.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dependent Upon Service/Support Required

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Big Sky Bonanza Goods and Services

Provider Category:
Agency

Provider Type:

Dependent Upon Service/Support Required

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Dependent upon specific provider ARM 37.40.1425

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Big Sky Waiver Community Supports

HCBS Taxonomy:

Category 1: 17 Other Services	**Sub-Category 1:** 17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Big Sky Bonanza Community Supports is an all-inclusive service available for members in the participant-directed Big Sky Bonanza option. Services include assisting the member with:

1) Basic living skills such as eating, drinking, toileting, personal hygiene, dressing, transferring and other activities of daily living;

2) Improving and maintaining mobility and physical functioning;

3) Maintaining health and personal safety;

4) Carrying out household chores and preparation with meals and snacks;

5) Accessing and using transportation with providers possessing a valid Montana driver's license;

6) Participating in community experiences and activities;

7) Relieving unpaid caregivers at those times when such relief is in the best interest of the member or caregiver; and

8) Receiving childcare for medically fragile children who, because of their disability, cannot be served in traditional child care settings.

Individuals recruited for this service will be selected, hired and managed by the member.

This service shall be authorized and delivered using person-centered planning practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service may be used for childcare only when it is above and beyond routine child care for which the primary caregiver is responsible. This service is necessary for high medical acuity children who cannot attend a traditional day care due to need for increased medical/physical supervision. This service request must be verified in writing by the child health care professional and a copy of the verification maintained in the child‘s chart. Payment for specialized childcare may be rendered by legally responsible individuals when such services are deemed extraordinary care. Extraordinary care means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

Members receiving this service may not simultaneously receive non-medical transportation, respite, personal assistance (state plan or waiver), specialized child care, residential habilitation or respite.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Support Service Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Big Sky Waiver Community Supports

Provider Category:

Individual

Provider Type:

Community Support Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The provider must:

*Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);

Possess a valid Social Security Number;

Be a US citizen or possess a valid work permit;

Sign an affidavit regarding confidentiality and HIPAA;

Possess the ability to communicate effectively with the member/personal representative;

Possess the ability to complete documentation requirements of the program;

Demonstrate member specific competencies necessary to perform paid tasks;

Complete a self-declaration regarding infections and contagious diseases;

At the discretion of the member agree to a state criminal background check;

Possess a valid drivers license and proof of automobile liability insurance if transporting the member;

Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and

Advocate for the member to assure that the member's rights are protected and the member's needs and preferences are honored.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Member/IA/FM

Frequency of Verification:

Upon enrollment and as necessary thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the member is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a member to establish a basic household including: security deposits that are required to obtain a lease on an apartment or home; essential household furnishings required, including furniture, window coverings, food preparation items and bed/bath linens; usual and customary set up fees or deposits for utility or service access, including telephone, electricity, heating and water; activities to assess need, and arrange for and procure resources. May be used to provide coverage of moving expenses for members who are transitioning from an institutional or another provider-operated living arrangement to a private residence where the person is directly responsible for his or her own living expenses.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community Transition Services do not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversion/recreational purposes.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dependent Upon Specific Service/Support Required

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Dependent Upon Specific Service/Support Required

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Dependent upon specific provider ARM 37.40.1422

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consultative Clinical and Therapeutic Services

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1: 11130 other therapies

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

These are services that assist unpaid and or paid caregivers in carrying out member service plans and are necessary to improve the members independence and inclusion in the community. This service is geared towards members with traumatic brain injuries or more complex disabilities that require a more clinical approach and specialized interventions. Consultation activities are provided by professionals in psychiatry, psychology, neuropsychology, physiatry, behavior management, or others specializing in specific intervention modalities The service may include:

1) clinical evaluations by these professionals;
2) development of a supplemental home/community treatment plan which is incorporated into the individual Service plan;
3) training and technical assistance to implement the treatment;
4) monitoring the treatment and interventions; and
5) one-on-one consultation and support for paid and non-paid caregivers

Professionals will work closely with case managers to ensure treatment plans are implemented and followed.
An entity, inclusive of its staff, providing consultative clinical and therapeutic services must be qualified generally to provide the services and specifically to meet each members define needs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Psychologist, Psychiatrist, Neuropsychologist, Physiatrist, Rehabilitation Counselor, Professional Counselor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Services

Provider Category:

Individual

Provider Type:

Psychologist, Psychiatrist, Neuropsychologist, Physiatrist, Rehabilitation Counselor, Professional Counselor

Provider Qualifications License

(specify):

As required by state law by the Board of Medical Examiners or the Professional Licensing Bureau.

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1465

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and renewal of license.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Dietetic-Nutritionist Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

medically restricted diets or for members who do not eat appropriately to maintain health.

qualifications in MCA 37-25-302.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title

Agency **Nutritionist**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Dietetic-Nutritionist Services

Provider Category:

Agency

Provider Type:

Nutritionist

Provider Qualifications

License *(specify):*

A licensed nutritionist must provide dietitian services. Licensed nutritionist must meet the qualifications in MCA 24-156-1301 and 1304.

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1475

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and license renewal.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1: 14 Equipment, Technology, and Modifications

Sub-Category 1: 14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Environmental Accessibility Adaptions are physical adaptions to a member's home needed to ensure the member's health, welfare and safety, or increased functional independence in the home. The adaptions must provide for the members access ability, increased independence, or safety in the home.

This service shall be authorized and delivered using person-centered practices.

This service must be a cost-effective means of addressing an identified need in the service plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services are limited to a one-time purchase. The service cannot include the construction of more than one ramp in a residence. The Division, at its discretion, may authorize an exception to this limit.

This service is not duplicative of those services provided under specialized medical equipment.

Adaptions cannot include general housing or appliance maintenance, including but not limited to plumbing, heating systems, and leisure items.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the member, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, central air conditioning, etc.

All services shall be provided in accordance with applicable state or local building codes. All adaptions must meet Americans with Disabilities Act (ADA) and American National Standard Institute (ANSI) standards and specifications when feasible.

Environmental Accessibility Adaptations in excess of $5,000 must be prior authorized by the Regional Program Officer (RPO). The prior authorization must include 2 estimates or bids. If two bids cannot be obtained, documentation must be present to show what efforts were made to secure multiple bids. Situations involving one bid require review and approval by the Regional Program Officer.

All bids must include an estimate of the cost to include a detailed list of the amount of materials, (the amount of labor, number of hours to complete the project and amount charged per hour and other miscellaneous costs).

Provider costs of submitting an estimate or bid are not payable by the Big Sky waiver program.

In general, the lowest bid must be accepted. However, a member may choose a bid that is within 10% had the lowest bid.

A provider prior authorization for Environmental Accessibility Adaptions cannot be authorized or given to the provider prior to the member receiving the service. The service must be received by the member prior to payment by Big Sky Waiver.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Construction Company, Building Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Construction Company, Building Contractor

Provider Qualifications

License *(specify)*:

Montana Contractor License

Certificate *(specify)*:

Other Standard *(specify)*:

ARM 37.40.1485

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Training and Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Services whereby an employee of the child and Family Services provider enrolled with the department is responsible for assisting families with training and support issues associated with their child aged 0 through 21 with disabilities and not eligible for Developmental Disabilities Division services. More specifically, Family Training and Support includes:

1) Providing training to families and others who work or play with the child. Training would include general orientation about the trials disabling condition as well as training specific to the needs of the child and his or her family and how best to meet those needs.

2) Serving as consultant to families in terms of developmental stages and teaching activities that families can do with their child that would help in the developmental process.
3) Collaborating with the case managers and families to develop strategies for environmental modifications or adoptions that would be beneficial to the child.
4) Periodically assessing child, including conducting developmental assessments, in order to discover unmet needs, determine progress or lack of progress and identifying areas of strength that can be emphasized.
5) Providing emotional support to families, including active listening, problem solving and suggesting resources such as peers and others within the disability community who could offer support.
6) Advocating for the families' needs with the case management team and others who may offer supports and services.
7) Assisting the family and case management team with transition and referral to special education, including Part C.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Child and Family Training Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Support

Provider Category:

Individual

Provider Type:

Child and Family Training Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Bachelor's degree with a specialty in child development.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent/Case Manager/IA/FM

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

other therapies

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1: 11130

Category 2:

Sub-Category 2:

Health and Wellness

HCBS Taxonomy:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Each service provides opportunities for members to integrate in an inclusion setting with non-disabled peers for healthy and wellness activities within their community.

- These services focus on healthy habits thereby preventing or delaying higher cost institutional care.
- Weight loss - Members who are at a healthy weight are less likely to acquire conditions that increase the risk of institutionalization. (i.e., uncontrolled diabetes) In addition the ability for members to move freely within the community could improve.
- Smoking Cessation -Members who are able to quit smoking may not acquire severe medical conditions such as COPD, lung cancer, etc. Acquiring these conditions could lead to the use of oxygen, shortness of breath and restrictions in physical activities. Without these conditions the ability for members to move freely within the community improves.
- Healthy Lifestyles – Members can take classes to address issues regarding living with a disability through the independent living centers. This information increases the capacity of the member to self-advocate, navigate community resources and improve overall health and socialization skills. These skills keep members in the community and out of an institution.
- Health Club Memberships – Members can participate and utilize health club services to improve overall health and well-being. Since members go to these facilities in the community, they are increasing activities outside of their home and more likely remain in the community. In addition, using a private health club gets the member into a nondisability specific exercise program. This service is authorized for individuals with conditions that would benefit from gym activities.
- Art Therapy – Members have access to art therapy as a means to express themselves and aid in coping with such conditions as depression, memory loss, traumatic brain injury, chronic illness, etc. Participation in this service requires members to access providers in the community. These services can increase the members ability to cope and increase confidence for community living and avoid institutionalization.
- Cost associated with adaptations and direct support needed to participate in recreational activities such as skiing, horseback riding and swimming- By providing this service; members are outside of their homes and integrated into healthy settings. Members who participate adaptive activities are unlikely to be institutionalized. This cost does not include the fee for the recreational activity, such as ski-lift tickets, horse rentals, swimming pool entrance fees or lessons, professional guide fees and the like.
- Hydrotherapy: a modality that involves the use of agitated water to relieve muscle spasms, improve circulation or promote the healing of wounds.
- Hippotherapy: a physical therapy treatment strategy that uses equine movement as part of an integrated intervention program to achieve functional outcomes.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person
Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Wellness Classes/Health Clubs/Fitness Centers
Agency	Dependent Upon Specific Service Provided

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:

Agency

Provider Type:

Wellness Classes/Health Clubs/Fitness Centers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Dependent upon specific provider
o Health lifestyle providers include the independent living centers, private providers, local medical facilities.
o Hippo therapy – horse therapy business or individual providers.
o Art therapy – eligible art instructors, or therapists.
o Health Club Memberships – locally owned clubs, YMCAs or medical centers with associated health facilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:

Agency

Provider Type:

Dependent Upon Specific Service Provided

Provider Qualifications

License *(specify):*

As Required by state Law

Certificate *(specify):*

Other Standard *(specify):*

Dependent upon specific provider
o Health lifestyle providers include the independent living centers, private providers, local medical facilities.
o Hippo therapy – horse therapy business or individual providers.
o Art therapy – eligible art instructors, or therapists.
o Health Club Memberships – locally owned clubs, YMCAs or medical centers with associated health facilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Homemaker Chore

HCBS Taxonomy:

Category 1: 08 Home-Based Services
Sub-Category 1: 08060 chore
Category 2:
Sub-Category 2:
Category 3:
Sub-Category 3:
Category 4:
Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Homemaker Chore activities include cleaning a home requiring extensive clean-up beyond the scope of general household cleaning available under the Homemaker service.

Homemaker Chore activities may include:
1. Heavy cleaning (e.g., washing windows or walls);
2. Yard care;
3. Walkway maintenance;
4. Wood chopping and stacking, and
5. Extermination.

This service is available to assist members unable to manage homemaker tasks, in the home, due to medical and functional limitations.
These activities must not include:
1. Household tasks that are provided in conjunction with an ADL or Instrumental Activities of Daily Living (IADLs);
2. Tasks to support other household members;
3. Tasks to support companion animals, pets, or other animals not designated as Service Animals; or
4. Homemaker services available under State Plan Medicaid.
5. Costs associated with moving from one residence to another.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services shall be provided only after other Homemaker services through any other entity have been exhausted. Homemaker services are not allowed for a member residing in an adult residential setting.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Homemaker
Agency	Personal Assistance Agency
Agency	
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Homemaker Chore

Provider Category:

Individual

Provider Type:

Homemaker

Provider Qualifications License

(specify):

Certificate *(specify):*

Other Standard *(specify):*

Be 18 years of age (exceptions that are applicable within state law may be granted by the department); possess a valid Social Security Number; be a US citizen or possess a valid work permit; possess the ability to communicate effectively with the member/personal representative; possess the ability to complete documentation requirements of the program; demonstrate to the member the specific competencies necessary to perform tasks; at the discretion of the member agree to a state criminal background check; and, if transporting the member, possess a valid driver's license and proof of automobile liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Member and IA/FM

Frequency of Verification:

At enrollment and as necessary thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Homemaker Chore

Provider Category:
Agency
Provider Type:

Personal Assistance Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1447 and 1450
Verification of Provider Qualifications
Entity Responsible for Verification:

State/Conduent
Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Homemaker Chore

Provider Category:
Agency
Provider Type:

Homemaker/House Cleaning Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1450

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Homemaker Chore

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Medicare Certification

Other Standard *(specify):*

ARM 37.40.1450

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Level 1 Assisted Living

HCBS Taxonomy:

Category 1: 02 Round-the-Clock Services	**Sub-Category 1:** 02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Assisted living facilities assist individuals 18 years of age or older and who are frail, elderly, or physically disabled by facilitating supportive health and service coordination to maintain the residents' independence, individuality, and dignity. Assisted living facilities serve adults who cannot or who chooses not to live independently.

Assisted living facilities shall provide safe, cost effective services to include twenty-four hour residential care support services, adequate sleeping and living areas, and adequate recreational areas for residents as outlined in Administrative Rules of Montana (ARM). Assisted living services will encompass the comprehensive array of holistic services and supports that are furnished on an integrated basis by the facility’s own employees.

Assisted living facility services will include:
•Assistance with the arrangement of medical and nonmedical transportation when needed
•Protective oversight to assure the health, safety, and wellbeing of all residents at home and in the community
•Access to social and recreational activities at home and in the community
•Homemaker/homemaker chore services which are to consist of general household cleaning and maintenance activities
•Personal care assistance to support residents successfully complete activities of daily living (ADL) such as bathing, dressing, grooming, and personal hygiene, and meal prep/eating

•Assistance, monitoring, and management of prescribed medications as outlined in Administrative Rules of Montana (ARM); and
•Periodic nursing evaluations are to occur as outlined in Administrative Rules of Montana (ARM)

Services that are provided by third parties must be coordinated with the assisted living provider. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not to be made for twenty-four hour skilled care. Coordinated short-term skilled services may be accessed via the resident's state plan, EPSDT, Medicare, or private insurance benefit package

Provider owned or leased settings where Big Sky Waiver services are furnished must be compliant with the Americans with Disabilities Act. Additionally, participating assisted living facility providers must meet the HCB setting requirements as defined within 42 CFR 441.301(c)(4)-(5), and associated CMS guidance assuring that the setting is homelike and absent of institutional-like qualities

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The services under Big Sky Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Residents residing in assisted living facilities may not receive the following services under the Big Sky Waiver program to avoid duplication and may not also be billed separately. These restrictions apply only when payment is being made for the assisted living service.
•Personal assistance services as provided under the state plan for ADL support within the facility which is intended to compensate for the loss of or supplementation of direct care staff. However, personal assistance services and/or non-medical transportation/mileage for socialization may be utilized by the resident for the supervision of their health and safety when accessing the community unsupported by the assisted living facility
•Homemaker/Homemaker Chore services;
•Environmental modifications to resident units or common areas;
•Provider compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes;
•Respite may be provided in a residential habilitation setting for recipients of other service types but may not be provided for residents already residing in the assisted living facility;
•Medical transportation reimbursement as this service is a state plan benefit;
•Nonmedical transportation provided by the assisted living facility is a component of the assisted living service and the costs associated with transportation is included in the rate;
•Home delivered meals; and
•Personal Emergency Response Systems for use within the facility

Retainer Day Payments
•Retainer payments may be made to providers of assisted living facility services while the resident is hospitalized, in nursing facility, or on vacation for a period of no more than 30-days per service plan year and may not be used for any other service if used for assisted living services. Retainer payments allows for provider reimbursement during a member's absence in order to preserve the resident's placement at the facility.
•Big Sky Waiver does not account for provider vacancy savings; therefore, retainer days can be made available to providers of adult residential services.
•The provider may not bill Medicaid for services on days the member is absent from the facility unless retainer day payments are prior authorized by the resident's case management team.
•The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer.

Room and Board
•Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)*:

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Level 2 Assisted Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Level two assisted living services will include:
•Assistance with the arrangement of medical and nonmedical transportation when needed;
•Protective oversight to assure the health, safety, and wellbeing of all residents at home and in the community;
•Access to social and recreational activities at home and in the community;
•Homemaker/homemaker chore services which are to consist of general household cleaning and maintenance activities;

•Personal care assistance to support residents successfully complete activities of daily living (ADL) such as bathing, dressing, grooming, and personal hygiene, and meal prep/eating;
•Assistance, monitoring, and management of prescribed medications as outlined in Administrative Rules of Montana (ARM); and
•Periodic nursing evaluations are to occur as outlined in Administrative Rules of Montana (ARM).

Services that are provided by third parties must be coordinated with the assisted living provider. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not to be made for twenty-four hour skilled care. Coordinated short-term skilled services may be accessed via the resident's state plan, EPSDT, Medicare, or private insurance benefit package

Provider owned or leased settings where Big Sky Waiver services are furnished must be compliant with the Americans with Disabilities Act. Additionally, participating assisted living facility providers must meet the HCB setting requirements as defined within 42 CFR 441.301(c)(4)-(5), and associated CMS guidance assuring that the setting is homelike and absent of institutional-like qualities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The services under Big Sky Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

•A resident must have resided in the licensed assisted living facility for over 30-days;
•The service must be prior authorized by the Department in collaboration with the requesting assisted living provider to avoid a duplication of services;
•The facility must demonstrate past success and/or failures to remedy the resident's presenting problem;
•Providers must submit to the department a resident-focused summary outlining the proposed plan of care to which the service will be applied;
•At a minimum, documentation to be submitted by the provider to the department will include the resident's assisted living facility's service plan, progress notes and charting, and any other applicable/relevant medical records all of which are to be lawfully obtained; and
•The service may be approved on a temporary or long-term basis depending on the individual resident's circumstances and/or actual outcomes.

Residents residing in assisted living facilities may not receive the following services under the Big Sky Waiver program to avoid duplication and may not also be billed separately. These restrictions apply only when payment is being made for the assisted living service.
•Personal assistance services as provided under the state plan for ADL support within the facility which is intended to compensate for the loss of or supplementation of direct care staff. However, personal assistance services and/or non-medical transportation/mileage for socialization may be utilized by the resident for the supervision of their health and safety when accessing the community unsupported by the assisted living facility;
•Homemaker/Homemaker Chore services;
•Environmental modifications to resident units or common areas;
•Provider compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes;
•Respite may be provided in a residential habilitation setting for recipients of other service types but may not be provided for residents already residing in the assisted living facility;
•Medical transportation reimbursement as this service is a state plan benefit;
•Nonmedical transportation provided by the assisted living facility is a component of the assisted living service and the costs associated with transportation is included in the rate;
•Home delivered meals; and
•Personal Emergency Response Systems for use within the facility

Retainer Day Payments
•Retainer payments may be made to providers of assisted living facility services while the resident is hospitalized, in nursing facility, or on vacation for a period of no more than 30-days per service plan year and may not be used for any other service if used for assisted living services. Retainer payments allows for provider reimbursement during a member's absence in order to preserve the resident's placement at the facility.
•Big Sky Waiver does not account for provider vacancy savings; therefore, retainer days can be made available to providers of adult residential services.
•The provider may not bill Medicaid for services on days the member is absent from the facility unless retainer day payments are prior authorized by the resident's case management team.
•The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer.

Room and Board
•Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Level 3 Assisted Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Assisted living facilities assist individuals 18 years of age or older and who are frail, elderly, or physically disabled by facilitating supportive health and service coordination to maintain the residents' independence, individuality, and dignity. Assisted living facilities serve adults who cannot or who chooses not to live independently.

Assisted living facilities shall provide safe, cost effective services to include twenty-four hour residential care support services, adequate sleeping and living areas, and adequate recreational areas for residents as outlined in

Administrative Rules of Montana (ARM). Assisted living services will encompass the comprehensive array of holistic services and supports that are furnished on an integrated basis by the facility's own employees.

Level three assisted living facility services will include:
•Assistance with the arrangement of medical and nonmedical transportation when needed;
•Protective oversight to assure the health, safety, and wellbeing of all residents at home and in the community;
•Access to social and recreational activities at home and in the community;
•Homemaker/homemaker chore services which are to consist of general household cleaning and maintenance activities;
•Personal care assistance to support residents successfully complete activities of daily living (ADL) such as bathing, dressing, grooming, and personal hygiene, and meal prep/eating;
•Assistance, monitoring, and management of prescribed medications as outlined in Administrative Rules of Montana (ARM); and
•Periodic nursing evaluations are to occur as outlined in Administrative Rules of Montana (ARM).

Services that are provided by third parties must be coordinated with the assisted living provider. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not to be made for twenty-four hour skilled care. Coordinated short-term skilled services may be accessed via the resident's state plan, EPSDT, Medicare, or private insurance benefit package

Level Three Assisted Living includes within the rate:
•Social and recreational activities at least twice a week;
•Transportation;
•Money management; and
•Medical escort.

Provider owned or leased settings where Big Sky Waiver services are furnished must be compliant with the Americans with Disabilities Act. Additionally, participating assisted living facility providers must meet the HCB setting requirements as defined within 42 CFR 441.301(c)(4)-(5), and associated CMS guidance assuring that setting is homelike and absent of institutional-like qualities

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The services under Big Sky Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The service must be initially prior authorized by the Department to avoid a duplication of services that are integral to the rate structure of the service.

Providers of this service must specialize in the care of individuals with severe disabilities.

Residents residing in assisted living facilities may not receive the following services under the Big Sky Waiver program to avoid duplication and may not also be billed separately. These restrictions apply only when payment is being made for the assisted living service.
•Personal assistance services as provided under the state plan for ADL support within the facility which is intended to compensate for the loss of or supplementation of direct care staff. However, personal assistance services and/or non-medical transportation/mileage for socialization may be utilized by the resident for the supervision of their health and safety when accessing the community unsupported by the assisted living facility;
•Homemaker/Homemaker Chore services;
•Environmental modifications to resident units or common areas;
•Provider compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes;
•Respite may be provided in a residential habilitation setting for recipients of other service types but may not be provided for residents already residing in the assisted living facility;
•Medical transportation reimbursement as this service is a state plan benefit;
•Nonmedical transportation provided by the assisted living facility is a component of the assisted living service and the costs associated with transportation is included in the rate;
•Home delivered meals;
•Personal Emergency Response Systems for use within the facility; and

•Reimbursement for representative payee services is prohibited.

Retainer Day Payments
•Retainer payments may be made to providers of assisted living facility services while the resident is hospitalized, in nursing facility, or on vacation for a period of no more than 30-days per service plan year and may not be used for any other service if used for assisted living services. Retainer payments allows for provider reimbursement during a member's absence in order to preserve the resident's placement at the facility.
•Big Sky Waiver does not account for provider vacancy savings; therefore, retainer days can be made available to providers of adult residential services.
•The provider may not bill Medicaid for services on days the member is absent from the facility unless retainer day payments are prior authorized by the resident's case management team.
•The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer

Room and Board
•Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Money Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

The Money Management service is designed to provide ongoing support for legally competent individuals to manage their budget or support to the acquisition of money management (financial budgeting) skills. Exceptions may be authorized by designated state staff on a case by case basis for those individuals who have a payee assigned through SSA but require support to manage non-SSA income/benefits and/or remaining funds allocated to the member. The purpose of this service is to offer opportunities for waiver participants to increase their ability to provide for their own basic needs, increase their ability to cope with day to day living, maintain more stability in their lives and maintain the greatest degree of independence possible.
The member shall maintain account ownership and control; the provider shall never have full or partial ownership or personal possession of the member's funds and must not have direct access to member's financial accounts.

This service may not be used to provide payee services or to pay payee-related fees and/or services.

This service may not be used to aid with general paperwork, such as applying for assistance programs such as Medicaid, SNAP, LIEAP, college admissions, etc.

Money Management service may not be used to supplant the following:

1. Payee services (e.g., Social Security Administration and Veteran Administration payee services); 2.
CFC Skill Acquisition services; or
3. CFC Correspondence Assistance.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Members residing in a Community Adult Group Home or Level 3 Facility shall not receive this service.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Consumer Credit Counseling Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Money Management

Provider Category:
Agency
Provider Type:

Consumer Credit Counseling Agency
Provider Qualifications
License *(specify):*

Current business license.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Community Services Bureau
Frequency of Verification:

Upon initial enrollment and every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:

Non-medical Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Non-Medical Transportation means travel furnished by common carrier or private vehicle for non-medical reasons as defined in the member service plan. Non-Medical Transportation may be provided when required transportation services exceed the Montana State plan and Community First Choice or are unique to the Big Sky Waiver. Non-medical transportation may include bus passes, paratransit tickets, and taxi fares.

Medical transportation is available under the State Plan Medicaid program.

Transportation Services must meet the following criteria:

1) Be provided only after volunteer, State Plan Medicaid or other publicly funded transportation programs have been exhausted or determined to be inappropriate; and

2) Be provided by the cost effective mode.

Transportation providers must provide proof of:

1) A valid Montana driver's license;

2) Adequate automobile insurance; and

3) Assurance that vehicle is in compliance with all applicable federal, state and local laws and regulations.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Cabs, Home and Health Care Agencies, Vans & Buses, Ambulance Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-medical Transportation

Provider Category:

Agency

Provider Type:

Cabs, Home and Health Care Agencies, Vans & Buses, Ambulance Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1488

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter or upon license renewal.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nutrition

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Services which consist of the provision of hot or other appropriate meals once or twice a day, up to seven days a week. In keeping with the exclusion of room and board as covered services, a full nutritional regimen of three meals per day will not be provided.

Nutrition providers must be nonprofits or public agencies that provide congregate or home delivered meals on a regular basis to people who cannot provide themselves with regular meals because of their functional needs.
Nutrition providers must be enrolled as Medicaid providers.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Meals on Wheels, Area Agencies on Aging, Restaurants, Retirement Homes

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutrition

Provider Category:

Agency

Provider Type:

Meals on Wheels, Area Agencies on Aging, Restaurants, Retirement Homes

Provider Qualifications License
(specify):

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1476

Verification of Provider Qualifications
Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

The scope and nature of these of these services do not otherwise differ from Occupational Therapy Services furnished under the State plan, except that palliative therapies and maintenance therapy will continue to be provided as previously approved. Montana's HELP Act was implemented January 1, 2016, and includes the removal of the limitations to restorative Occupational Therapy. Maintenance therapies continue to be provided under waiver services.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization.
A member's legally responsible individual may provide Occupational Therapy or Speech Therapy if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

The service is not available to individuals who are eligible to receive such services through Medicaid State Plan (including EPSDT benefits).

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Agency	Home Care Agency
Agency	Hospital/Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:
Individual

Provider Type:

Occupational Therapist

Provider Qualifications License
(specify):

State License

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1460
A member's legally responsible individual may provide Skilled Nursing, Physical Therapy, Occupational Therapy or Speech Therapy if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

Verification of Provider Qualifications
Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and renewal of license

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:
Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1460

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:
Agency

Provider Type:

Hospital/Home Health Agency

Provider Qualifications

License *(specify):*

Licensed as required by Montana law and regulations

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1460

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and license/certification renewal.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute. **Service Title:**

Pain and Symptom Management

HCBS Taxonomy:

Category 1: 17 Other Services	**Sub-Category 1:** 17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

All treatments require written documentation by a health care professional indicating that the treatment will not harm the member prior to initial authorization and must meet evidence-based criteria as determined by the National Institute of Health (NIH).

This service allows for the provision of traditional and non-traditional methods of pain management. Treatments include but are not limited to:

1. Acupuncture;
2. Reflexology;
3. Massage Therapy;
4. Craniosacral Therapy;
5. Hyperbaric Oxygen Therapy;
6. Mind-body therapies such as hypnosis and biofeedback; and
7. Chiropractic Therapy;

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Massage Therapists, Chiropractors, Acupuncturists, Specialized RN
Agency	Psychologist, Counselor, Life Coach, Hypnotist
Agency	Hospitals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Pain and Symptom Management

Provider Category:

Agency

Provider Type:

Massage Therapists, Chiropractors, Acupuncturists, Specialized RN

Provider Qualifications

License *(specify):*

Montana Board of Massage Therapy
Montana Board of Chiropractors
Montana Board of Medical Examiners
Montana Board of Nursing

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1428

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and upon license renewal.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Pain and Symptom Management

Provider Category:
Agency

Provider Type:

Psychologist, Counselor, Life Coach, Hypnotist

Provider Qualifications

License *(specify):*

Montana Board of Social Work Examiners and Professional Counselors
Montana Board of Psychologists

Certificate *(specify):*

Certified Life Coach
Certified Hypnotist

Other Standard *(specify):*

ARM 37.40.1428

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and upon every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Pain and Symptom Management

Provider Category:

Agency

Provider Type:

Hospitals

Provider Qualifications

License *(specify):*

Montana Licensed Hospital

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and license or certification renewal.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response Systems

HCBS Taxonomy:

Category 1: 14 Equipment, Technology, and Modifications

Sub-Category 1: 14010 personal emergency response system (PERS)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

The Personal Emergency Response System (PERS) is an electronic, telephonic or mechanical system used to summon assistance in event of an emergency. The system must alert medical professionals, support staff or other designated individuals to respond to a member's emergency. Montana State Plan Community First Choice 1915(k) services provide PERS under State Plan, a waiver PERS device would be available to waiver members only if the State Plan PERS do not meet the member's individual need.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Reimbursement is not available for purchase, installation or routine monthly charges of a telephone or cell phone.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	PERS provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems

Provider Category:

Agency

Provider Type:

PERS provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1486

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

The scope and nature of these services do not otherwise differ from Physical Therapy Services furnished under the State plan, except those palliative therapies, and maintenance therapies to prevent deterioration, will continue to be provided by this waiver. Maintenance therapies continue to be provided as previously approved. Montana's HELP Act was implemented January 1, 2016, and includes the removal of the limitations to Physical Therapy. Maintenance therapies continue to be provided under waiver services.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process. This service is not available to individuals who are eligible to receive such service through Medicaid State Plan (including EPSDT benefits).

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E
Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency or Hospital
Individual	Physical Therapist
Agency	Home Care Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:

Home Health Agency or Hospital
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1461
Verification of Provider Qualifications
Entity Responsible for Verification:

Conduent/State
Frequency of Verification:

Upon enrollment and renewal license/certification

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:
Individual
Provider Type:

Physical Therapist

Provider Qualifications License
(specify):

State license

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1461
A member's legally responsible individual may provide Physical Therapy services if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

Verification of Provider Qualifications

Entity Responsible for Verification:

Conduent/State

Frequency of Verification:

Upon enrollment and renewal of license.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:
Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1461

Verification of Provider Qualifications

Entity Responsible for Verification:

Conduent/State

Frequency of Verification:

Upon enrollment and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Post Acute Rehabilitation Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10070 psychosocial rehabilitation
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11120 cognitive rehabilitative therapy
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Post-acute Rehabilitation is a residential or a non-residential program for persons with a traumatic brain injury, or other severe disability that would benefit from these services. It is intended to maximize functional independence through therapeutic intervention that provides intensive therapies three to five days a week.

Members are taught strategies to overcome barriers created by their disability, learn compensatory techniques for memory loss and behavior problems and relearn day-to-day living skills. The goal of this program is to facilitate integration into the community and in addition to reducing the level of disability of the member.
Therapies provided under this service cannot duplicate those available under the State Plan nor will they be provided simultaneously with occupational, speech, or physical therapies provided under the waiver.

Post Acute Rehabilitation is provided by an agency under the direction of an interdisciplinary team consisting of a board certified physiatrist, a licensed neuro-psychologist, or a licensed psychologist, occupational, speech, physical therapists, and other appropriate support staff. A provider of this service must be accredited by CARF as a Community Re-Entry Program of Persons with a Traumatic Brain Injury or receive such accreditation within two years of commencement of this service under the BSW program.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Therapies provided under this service are not duplicative of those available under state plan nor will they be provided simultaneously with occupational, speech or physical therapies provided under this waiver.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Health Care Provider, Rehabilation or Medical

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Post Acute Rehabilitation Services

Provider Category:

Agency

Provider Type:

Health Care Provider, Rehabilation or Medical

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

ARM 37.40.1446

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter or upon license renewal.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Private Duty Nursing

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
05 Nursing	05020 skilled nursing
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Service provides nursing services by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) licensed to practice in Montana. These services are provided to a member at home or in an adult residential care facility. Private Duty Nursing services are medically necessary services provided to members who require continuous in- home nursing care that is not available from a home health agency. Private Duty Nursing service provided by an LPN must be supervised by an RN, physician, dentist, osteopath, or podiatrist authorized by State law to prescribe medication and treatment. Private Duty Nursing may be prescribed only when Home Health Agency Services, as provided in ARM

37.40.701, are not appropriate or available and must comply with the Montana Nurse Practice Act. Services are provided according to the members service and support plan, which documents the members specific healthrelated need for nursing. Use of a nurse to routinely check skin condition, review medication use or perform other nursing duties in the absence of a specific identified problem, is not allowable. General statements such a monitor health needs are not considered sufficient documentation for the service. Services are not available to individuals who are eligible to receive such service through the Medicaid State Plan(including EPSDT benefits) If Private Duty Nursing is not available under State Plan, i.e., Private Duty Nursing supervision or Private Duty Nursing respite, then waiver Private Duty Nursing is allowable. Private Duty Nursing is not a State Plan service for adults.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A member's legally responsible individual may provide private duty nursing if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care/Health Care Provider
Individual	Licensed Practical Nurse, Registered Nurse

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:
Agency
Provider Type:

Home Care/Health Care Provider

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A member's legally responsible individual may provide nursing services if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.ARM 47.40.1477

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter or upon license renewal.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse, Registered Nurse

Provider Qualifications

License *(specify):*

State of Montana LPN or RN License

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1477
A member's legally responsible individual may provide private duty nursing if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/IA/FM

Frequency of Verification:

Upon enrollment and license renewal.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Senior Companion

HCBS Taxonomy:

Category 1: 08 Home-Based Services	**Sub-Category 1:** 08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Senior Companion services are directed at providing companionship in the home. This service is not appropriate for a member who requires hands-on assistance with personal care needs or assistance with homemaking or the completion of tasks or chores.

The provision of Senior Companion service shall not include:
1. Activities provided in conjunction with an ADL, IADL, supervision or community integration;
2. Activities to support health and safety when the member has a medical or functional need for monitoring, supervision, or community inclusion;

3. Nursing care;
4. Activities to provide medical care; or
5. Personal Attendant Services available under State Plan Medicaid.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service will not be provided simultaneously with other BSW services.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Senior Companion Programs through Area Agencies on Aging.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Senior Companion

Provider Category:

Agency

Provider Type:

Senior Companion Programs through Area Agencies on Aging.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of these services are Senior Companion programs that are a part of Area Agencies on Aging.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Service Animals

HCBS Taxonomy:

Category 1: 17 Other Services	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

A service animal, as currently defined under the Americans with Disabilities Act, is trained to do work or perform particular tasks, which benefit an individual with a disability or an individual who is aged. Examples of these tasks may include guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders or sounds, pulling a wheelchair or fetching dropped items or other tasks specific to the individual. The service animal is intended to increase autonomy, to decrease functional limitations, to access the home or public environment, to provide for safety and to reduce the risk of institutionalization.

The service may include:

1. Supplies if specifically related to the performance of the service animal to meet the specific needs of the member. If not provided by the training organization, these supplies may include leashes, harness, backpack, and mobility cart; and
2. Care for the service animal if specially related to the health and maintenance of that animal. These services may include veterinarian care, transportation for veterinarian care, license and/or registration. Grooming may also be included only if member or their caregiver are unable to provide this maintenance.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service animal supplies do not include: 1.
Food to maintain the animal; and

2. Any supplies for the following:
3. Pets, companion animals, social therapy animals;
4. Guard, police, rescue, sled, tracking or any other animal not specifically designated as a service animal; and
5. Wild, exotic or any other animals not specifically supplied by a training program on the approved provider list.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Child Care for Children Who Are Medically Fragile

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04080 medical day care for children

Category 2:

Sub-Category 2:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

This service provides daycare for medically fragile children who, because of their disability, cannot be served in traditional childcare settings. This service is limited to medically fragile children and may not be used to provide services that are the responsibility of the parent.

This service need must be verified in writing by the child's health care professional and the case management team must maintain a copy of the verification in the child's chart. Payment for specialized childcare may be rendered by legally responsible individuals when such services are deemed extraordinary care.

Extraordinary care means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

A provider of this service must be physically and mentally able to perform the duties required and must be literate and able to follow orders.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Caregiver
Agency	Home Care Agency, PAS Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Child Care for Children Who Are Medically Fragile

Provider Category:
Individual
Provider Type:

Caregiver
Provider Qualifications License
(specify):

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1452
Verification of Provider Qualifications
Entity Responsible for Verification:

State/IA/FM
Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Child Care for Children Who Are Medically Fragile

Provider Category:
Agency
Provider Type:

Home Care Agency, PAS Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1452

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Specialized medical equipment and supplies include devices, controls, or appliances to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Items reimbursed with waiver funds shall be in addition any medical equipment and supplies furnished under the State Plan Medicaid and shall exclude those items, which are not of direct or remedial benefits to the member. All items shall be applicable standards of manufacture, design and installation.

Also includes items for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under State Plan Medicaid.

- Must promote increased accessibility, independence with ADLs and IADLS and increase health and safety in the home and community.
- May require a consultation by a licensed or certified professional.
- Must be a cost-effective means of addressing an identified need in the service plan.
- May include warranty coverage if cost effective.

Specialized medical equipment must be limited to a one time purchase or rental with the exception of non-durable supplies not covered under Medicaid state plan. The Department may authorize exceptions to this through prior authorization.

All medical equipment should meet or exceed existing safety and performance specifications provided by the manufacturer.

This service shall be authorized and delivered using person-centered practices.

Prior to reimbursement of specialized medical equipment or supplies for children under 21, a Medicaid State Plan denial must be obtained and kept as part of the member's case record. A copy of the EPSDT denial must be included in the member's case file and submitted with all prior authorization requests submitted to the Community Services Bureau.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Specialized Medical Equipment and Supplies will be limited to a one-time purchase with the exception of supplies not covered by State Plan Medicaid services. The Division, at its discretion, may authorize an exception to this policy. Purchases in excess of $5,000 must receive prior authorization from the RPO. This service is not duplicative of those services provided under environmental accessibility adaptations.

Excluded items include, but are not limited to:

1. items used for leisure, recreation, education, and vocational purposes only and not determined to be necessary for the member to remain in their home or community.
2. Items of clothing
3. Basic household furniture

The prior authorization must include at least two estimates or bids when the Specialized Medical Equipment and Supplies exceed $5,000. Provider costs of submitting an estimate or bid are not payable by the Big Sky Waiver program.

Consultation and written approval by the RPO required prior to approval of medication Lock Box and medication dispensing units.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supplier of DME and Retailers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Supplier of DME and Retailers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1487

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Speech Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

The scope and nature of these services do not otherwise differ from Speech therapy services furnished under the State plan, except that palliative therapies and maintenance therapy will continue to be provided as previously approved. Montana's HELP Act was implemented January 1, 2016, and includes the removal of the limitations to Speech Therapy. Maintenance therapies continue to be provided under waiver services.
This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization.

A member’s legally responsible individual may provide speech therapy if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E
Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Individual	Speech Therapist
Agency	Home Health Agency or Hospital

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech Therapy

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1462

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech Therapy

Provider Category:

Individual

Provider Type:

Speech Therapist

Provider Qualifications License
(specify):

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1462
o A member's legally responsible individual may provide Speech Therapy if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

Verification of Provider Qualifications
Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and renewal of license.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech Therapy

Provider Category:
Agency

Provider Type:

Home Health Agency or Hospital

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1462

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and renewal license/certification.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Supported living is a comprehensive habilitation service designated to support individuals with significant functional and/or medical limitations, including brain injuries, in the community. Members receiving Supported living services may reside in any non-institutional setting.

Supported living is a bundled service which includes independent living evaluation, homemaking, habilitation aides, behavioral programming, non-medical transportation, specially trained attendants, day habilitation, Residential Habilitation, prevocational training, supported employment, 24-hour availability of staff for supervision and safety, and service coordination to coordinate supported living services. A Case Management Team (CMT) may decide not to use a bundled service instead oversees separate services.

Members of this service must have identifiable BSW goals that are reviewed by the CMT every 6 months or more frequently if necessary. Supported Living providers must show progress in the achievement of these goals. If progress is not apparent, the CMT must renegotiate the rate to reflect diminished goals.

In contrast to post-acute rehabilitation, which provides short-term rehabilitative treatment, supported living is a long term support service.

This service shall be authorized and delivered using person-centered practices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

As this is a high-cost service, enrollment is limited. Supported Living candidates must be prior authorized by the CSB.

An individual in Supported Living may not receive other waiver services that would be duplicative to those included in the supported living plan. These include adult day health, day habilitation, homemaker, homemaker chore, personal assistance, prevocational services, Residential Habilitation, respite, nonmedical transportation, community supports, senior companion, and supported employment.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Living

Provider Category:
Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1438

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Vehicle modifications are modifications made to a personal vehicle that will allow the member to be more independent. These modifications would be specified in the service plan as necessary to enable the member to integrate into the community more fully and to ensure their health, safety and welfare. This service does not include regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of modifications.

This service does not include adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the member.

This service covers modifications including, but not limited to:
- Vehicle lifts, ramps, lowered floors, and other modifications to allow for wheelchair access.
- Driver-specific adaptions.
- Remote-start systems.

This service also includes consultation on the modifications and/or training on the use of the vehicle modifications.

This service must be authorized and delivered using person-centered practices.

This service must be a cost-effective means of addressing an identified need in the service plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Vehicle Modifications in excess of $5,000 must be prior authorized by the Regional Program Officer (RPO). The prior authorization must include 2 estimates or bids. If two bids cannot be obtained, documentation must be present to show what efforts were made to secure multiple bids. Situations involving one bid require review and approval by the RPO.

All bids must include an estimate of the costs to include a detailed list of the number of materials, the labor (number of hours to complete the project and amount charged per hour), and other miscellaneous costs.

Provider costs of submitting an estimate or bid are not payable by the Big Sky Waiver program.

In general, the lowest bid must be accepted; however, a member may choose a bid that is within 10% difference of the lowest bid.

A provider prior authorization for Vehicle Modifications cannot be authorized or given to the provider prior to the member receiving the service. The service must be received by the member prior to payment by Big Sky Waiver.

A Vehicle Modification cannot be separated into multiple referrals or multiple prior authorizations; all supplies and labor costs for one Vehicle Modification must be included in one referral and one prior authorization.

Service Delivery Method *(check each that applies)*:

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies)***:**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Automotive Repair Shops

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Automotive Repair Shops

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.40.1485

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management will be provided under the authority of a 1915(b)(4) waiver to be providers of this service.

Case Management is provided by Medicaid enrolled provider agencies. In order to provide quality services, the agencies must have employees with the education, and competencies necessary to meet the needs of the individuals they serve. Case management teams must include a nurse licensed to practice in the State of Montana, a BSW social worker and appropriate clerical and support staff.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

For a legally responsible individual, including biological and adoptive parents of recipients under 18, spouses of adult recipients, and court appointed guardians to be paid for the provision of BSW services all of the following authorization criteria and monitoring provisions must be met.

The service must:

1) Meet the definition of a service/support as outlined in the federally approved waiver plan;

2) Be necessary to avoid institutionalization;

3) Be a service/support that is specified in the member service and support plan;

4) Be provided by a parent or spouse who meets the provider qualifications and training standards specified in the waiver for that service;

5) Be paid at a rate that does not exceed what is allowed by the department for the payment of similar services; and

6) Not be an activity that the family would ordinarily perform or is responsible to perform.

The family member who is a service provider will comply with the following:

1) For self-directed personal assistance the family member must maintain and submit time sheets and other required documentation for hours paid; and

2) Married individuals must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the service plan.

Extraordinary care means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Relatives may be paid for providing waiver services only if the relative is qualified to provide the service. Legal guardians are considered legally responsible individuals and may be paid for providing waiver services when they meet the criteria specified for legally responsible individuals.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Providers that meet provider requirements are welcome to enroll as a Medicaid provider. All requests for enrollment in the Medicaid Program must be made to Conduent EDI Solutions, Inc. The provider enrollment process is managed online by Conduent via Montana's MPATH provider services system. Conduent assists providers to navigate the online system and provide status reports on the enrollment process. The enrollment forms must be completed in their entirety before Conduent can approve and process the enrollment application. Conduent will forward completed enrollment forms to the Senior and Long Term Care Division for approval, procedure codes and rates.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number/percent of providers required to be licensed or certified that were verified to continually meet state licensure/certification standards. The numerator is the number of providers required to be licensed or certified that were verified to continually meet state licensure/certification standards. The denominator is the total number of providers that require a license or certification.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other	**Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
Specify:	
	Continuously and Ongoing
	Other Specify:

Performance Measure:
Number/percent of new providers required to be licensed/certified that were verified to initially meet state licensure/certification standards. The numerator is the number of new providers required to be licensed or certified that were verified to inititally meet state licensure/certification standards. The denominator is the total number of new providers that require a license or certification.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and	**Other**

	Ongoing	Specify:
	Other Specify: Upon Enrollment	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of nonlicensed/noncertified providers that continually meet waiver requirements. The numerator is the number of nonlicensed/noncertified waiver providers that continually meet waiver requirements. The denominator is the total number of ongoing nonlicensed/noncertified waiver providers.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify: Conduent	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
 # or % of new nonlicensed/noncertified providers that meet waiver requirements. The numerator is the number of new nonlicensed/noncertified waiver providers that meet waiver requirements. The denominator is the total number of new nonlicensed/noncertified waiver providers.

Data Source (Select one): **Provider performance monitoring**
If 'Other' is selected, specify:
Conduent

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:

Conduent		
	Continuously and Ongoing	**Other** Specify:
	Other Specify: Upon Enrollment	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The # or % of Financial Managers (FM) who receive state approved waiver training.
The numerator is the number of new FMs who receive state approved waiver training.
The denominator is the total number of new FMs.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
 # or % of new case managers who receive state approved waiver training. The numerator is the number of new case managers who receive state approved waiver training. The denominator is the total number of new case managers.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:

Case Management Teams		
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Department does not do criminal background checks; however, Conduent EDI Solutions, Inc. checks with licensing entities within the Department of Labor and Industries, the Office of Inspector General (OIG), Excluded Individual and Entities List, and Medicare exclusion lists prior to enrolling a provider. The hardcopy of the Licensee Lookup System indicates any adverse action or information regarding the enrolled provider and may prevent that individual or agency from being enrolled as a waiver provider. When a provider's license is renewed Conduent will once again check the Excluded Individual and Entities List, Medicare Exclusion list and the Licensee Lookup System prior to re-enrollment of provider. Non licensed/certified providers will be re-evaluated every two years by Conduent to ensure that they still meet department standards. All contracts issued by the Department go through a review process to insure the potential contractor is not on the Federal list of debarred

contractors. CSB and/or Conduent staff provide on-going training to agencies, as necessary, to ensure that agencies are informed of relevant changes in state and federal policy and procedure. They assist in the training of new agency oversight staff around program policy and procedure (at agency request). Providers will not be enrolled if they:

a. Do not meet required qualifications;
b. Fail background checks; or
c. Have their license/certification revoked.

b. Methods for Remediation/Fixing

Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Providers that do not have the required qualifications, license, or certification for the specific waiver service cannot be enrolled as a waiver provider for that service. If a providers license/certification has been revoked, that agency/individual will no longer be allowed to provide the service. Repayment procedures will be initiated for payment of services provided after the license/certification expiration date. Members will be given a new choice of providers if available and assisted in the transition process.

Big Sky Bonanza Independence Advisors (IA) and Big Sky Bonanza Financial Managers (FM) will be trained and certified prior to enrollment as a provider. Case Managers (CM) will be trained within the first year of employment.

If an IA, FM or CM failed to go through the appropriate training a Quality Assurance Communication (QAC) will be issued and the provider must respond within 30 days explaining the reason for lack of training. Members will be given a new choice of providers. If the IA, FM or CM want to continue to provide the service they must participate in the next scheduled training.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*

Other Type of Limit. The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

In 2015, contracted Big Sky Waiver adult residential providers completed Provider Self-Assessments (PSA) for each licensed brick and mortar residential and nonresidential setting operated. All PSAs were reviewed, and remediation plans were requested for areas that presented to the department as initially noncompliant based on the providers responses. In December 2016, Montana received initial approval of its Statewide Transition Plan (STP). Since then, one PSA indicated that the setting would meet heightened scrutiny; therefore, an evidentiary package has been submitted to CMS for review and consideration. As of current, the facility is not an enrolled Medicaid provider and is unable to serve waiver beneficiaries until full remediation is confirmed. In March of 2020, the onsite validation visits were put on hold due to the COVID-19 public health emergency. An approved Appendix K application later allowed the flexibility for Montana to conduct electronic validation visits with the intent to later return to the site in-person assuring the findings and outcomes were accurate and maintained consistency. In June 2021, a letter was emailed to providers and stakeholders on the status of the STP and future steps and activities. Montana's STP information can be found at https://dphhs.mt.gov/hcbs. As required by CMS and as outlined in 42 CFR 441.301(c)(4)-(5), Montana's transition plan addresses the areas of assessment, remediation, validation, and public input.

DPHHS will continue to partner with Medicaid members, providers, advocates, and other critical stakeholders throughout this process to assure that members and providers have access to needed information to assist with transition activities. Expected outcomes will be that Medicaid members will be served in a way that will enable them to live and thrive in integrated community settings. Montana assures that the settings transition plan, included with this waiver amendment, will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Ongoing monitoring process will be established and executed to ensure that a setting that achieves compliance continues to meet HCBS settings requirements.

Reflecting Level Two Assisted Living Facilities- Behavior Management and/or Transition Diversion, the Montana is not introducing a "new" setting but expanding upon the existing assisted living facility service already being offered to Medicaid beneficiaries under the waiver. Since 2014, Montana has partnered with adult residential assisted living facility providers facilitating evaluation, validation, and remediation efforts to assure that facility meets HCBS settings requirements. All new provider applicants will undergo the settings PSA and remediation and validation process prior to final enrollment and full implementation of the contracted Medicaid service. Furthermore, ongoing monitoring and remediation efforts will be fulfilled by the state. Montana assures that the settings transition plan, included with this waiver amendment, will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Ongoing monitoring process will be established and executed to ensure that a setting that achieves compliance continues to meet HCBS settings requirements.

Currently, Montana considers all enrolled assisted living facilities to be fully compliant with HCBS Settings criteria and are not subject to the STP. The full list of the specific settings where individuals will reside while receiving the service are as follows:
•(Montana Licensed) Assisted Living Facility

A full list of the specific settings where individuals will receive residential habilitation services can be found at https://dphhs.mt.gov/qad/Licensure/index. Licensed assisted living facilities may provide for one, or all, category endorsements while following parameters established in rule as outlined in ARM 37.106.2801 through 37.106.2898.

Montana's home and community-based settings serve as an alternative to institutional placement and takes into account the quality of an individuals' experiences. As a result, Medicaid beneficiaries served can also be provided the opportunity to choose from the additional residential habilitation sites listed below as determined appropriate:
•(Montana Licensed) Community Homes for Persons with Severe Disabilities (Community Adult Group Homes) •(Montana Licensed) Adult Foster Care Homes

In addition to the following Non-Residential sites:
•(Montana Licensed) Adult Day Care Centers
•Supported Living (community-based)
•(Montana Licensed) Day Habilitation Centers (day supports and activities to be delivered within a setting, community, or both)
•Pre-vocational, Vocational, including Group/Sheltered Employment (community settings, provider sites; competitive, customized or self-employment setting; general workforce)

Regardless of the type of residential site chosen by the Medicaid beneficiary, HCBS settings regulations and assurances will be adhered to supporting that all home and community-based settings meet criteria detailed within 42 CFR 441.301(c)(4)-(5).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Social Worker
Specify qualifications:

Other
Specify the individuals and their qualifications:

Members with support of Big Sky Bonanza Independence Advisor (IA) and Big Sky Bonanza Financial Manager

(FM). The qualifications of the IA and FM are specified in Appendix C.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Montana contracts for Case Management Teams, who are required by proposal response and subsequent state contract, to professionally provide and present non-biased information to members regarding all qualified providers of services without influencing the member decision. The member makes the choice of provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Members will develop the service plan with their Case Management Team (CMT) or Big Sky Bonanza Independence Advisor (IA) and Big Sky Bonanza Financial Manager (FM). The member may choose to have a support team present to participate in the plan development. The support team may include family, friends, and anyone else of the member's choosing. The Case Management Team will maximize the extent to which a member participates in the service planning process by explaining the person-centered planning process; assisting the member to explore and identify his/her preferences, desired outcomes, goals, and the services and supports that will assist him/her in achieving desired outcomes; identifying and reviewing with the member issues to be discussed during the planning process; and giving each member an opportunity to determine the location and time of planning meetings, participants attending the meetings, and frequency and length of the meetings. The member will have the authority to determine who is included in the process of service plan development. The member or his/her legal representative authorizes the service and support plan once it is completed.

Big Sky Bonanza members selecting to direct their own care receive information and training to assist in service plan development during the participant-direction training. Members will develop the Support Services and Spending Plan (SSSP) with their IA and a support team. The support team may include family, friends, and anyone else of the member's choosing. The IA will maximize the extent to which a member participates in the service planning process by explaining the person-centered planning process; assisting the member to explore and identify his/her preferences, desired outcomes, goals and the services and supports that will assist him/her in achieving desired outcomes; identifying and reviewing with the member issues to be discussed during the planning process; and giving each member an opportunity to determine the location and time of planning meetings, participants attending the meeting and frequency and length of the meetings. The self directing member is responsible for directing the plan development process. The IA will assist the member in the plan development, but will not direct the process. The member will receive a copy of the final SSSP upon approval by the Department.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participantcentered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A service plan is a written plan for services developed by the Case Management Team (CMT)and members to assess and determine the members status and needs. The service plan also outlines the services that will be provided to the members to meet their identified needs as well as the cost of those services. An initial service plan must be developed prior to the member's enrollment. New service plans must be completed at least annually or when the members condition warrants it. The CMT shall consult with the member and/or the member's representative and the attending health care professional. The CMT may also consult family members, relatives, psychologists, medical personnel and other consultants as necessary, with the members approval. The member signs off on the service plan and receives a copy for his/her files.

Each individual service plan shall include at least the following components:

1) Diagnosis, symptoms, complaints and complications indicating the need for services;

2) A description of the member's functional level;

3) Specific short-term objectives and long-term goals, including discharge potential or plan;

4) Discharge plan;

5) Any orders for the following:
a) Medication;
b) Treatments;
c) Restorative and rehabilitative services;
d) Activities;
e) Therapies
f) Social services
g) Diet; and,
h) Other special procedures recommended for the health and safety of the member to meet the objectives of the service plan;

6) The specific services to be provided, the frequency of services and the type of provider;

7)
service plan;

8) A cost sheet which projects the annualized costs of BSW; and

9) Signatures of all individuals who participated in the development of the service plan including the member and/or representative and the CMT.

All plans of care are subject to review by the Department. The Department has delegated the review function to BSW Program Managers or a designated Community Services Bureau (CSB) staff. The reviewer is responsible for reviewing all portions of the plan utilizing the criteria outlined below.

Review of the individual service plan will be based on the following:

1) Completeness of plan which includes all necessary services listed in terms of amount, frequency and planned providers;

2) Consistency of plan with screening information regarding the member needs;

3) Presence of appropriate signatures; and

4) Cost-effectiveness of plan.

The initial enrollment date is the date the member begins receiving waiver services. This date should be entered in the Service Plan form case notes. The CMT must notify CSB whenever a Medicaid member is being admitted in the waiver program. The Service Plan must provide documentation of the member's Service Plan costs. It includes all waiver

services to be provided, the frequency, amount and projected annualized cost of the services. The CMT prepares the Service Plan cost sheet after the Service Plan has been developed.

The cost sheet is created/updated:
a. To determine initial program eligibility;
b. When a Service Plan amendment is created; and
c. When a Service Plan annual review is completed.

The CMT must explain the cost sheet to the member and/or representative and provide the final cost plan to the member and/or representative either in person or by mail. The CMT should review the cost sheet with the member at the sixmonth visit. BSW Regional Program Officers prior approve high-cost service plans to maintain quality assurance standards and not for eligibility purposes. The Department determines the Service Plan cost limit. Members who exceed the Service Plan cost limit are not eligible for waiver services except as prior authorized by the Department.

A member cannot carry over a service from one service plan time-period to the next. Any unused services remaining at the end of the service plan time-period expire and cannot be used. Member cannot utilize services outside of the service plan time-period authorized; services cannot be used in once service plan time period and accrued in a following service plan time-period.

The member is not officially admitted to the program until both the intake meeting has been held to a develop a service plan and the SLTC-55 form has been received from the OPA. The date of admit cannot be prior to the date of eligibility on the SLTC-55 form.

Members in the participant directed option will receive training in preparation for the greater role they play in the SSSP and delivery process. After the training, the Big Sky Bonanza Independence Advisor (IA) will support the member to maximize his/her involvement in the SSSP process. The member will actively participate in the definition of his/her needs through the assessment. The summary of member health status and risk factors, as reported by Mountain Pacific Quality Health during the initial level of care determination, will also be provided to the member and the IA to assist in the planning process. The member and IA will convene a service and support planning meeting with individuals of the members choosing, which may include family members, providers, consultants, advocates and friends. The IA will support the member in directing the meeting to develop and complete the member's Service Plan. The Service Plan will descibe the member's goals and outline the individualized supports to meet those goals. IA will assure that the SSSP is complete and meets all of the documentations requirements. Within 14 days following the meeting, the member with assistance from the IA as needed, will complete the SSSP. The member and IA will review and sign off on the plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk identification and management, including an emergency backup plan, are included in the member's service plan. Appropriate emergency back up plans will be defined and planned for through the completion of the risk assessment form by the member and case manager. The emergency back up plan may include an assessment of critical services and a back up strategy for each identified critical service.

Back up may include:

1. Member backup incorporated into the plan;

2. Informal backup (family, friends, and neighbors);

3. Enrolled Medicaid provider network (personal assistant agencies); and

4. System level (local emergency response).

Back up services can be included and paid by Big Sky Waiver.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the development of the plan, the member selects providers from a list prepared by the Case Management Team (CMT) or the Big Sky Bonanza Independence Advisor. If the member is unsatisfied with the available agencies, the CMT or the member may solicit other providers for the service who would be required to enroll as a Medicaid provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Plans are reviewed for accuracy by the delegated CSB staff during the on-site quality assurance process.

For members using the Big Sky Bonanza option, the Support Services and Spending Plans are reviewed and approved by the designated CSB staff.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

Medicaid agency

Operating agency

Case manager

Other
Specify:

Big Sky Bonanza Independence Advisors and Big Sky Bonanza Financial Managers.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Case Management Team (CMT) and Big Sky Bonanza Independence Advisor (IA)/Big Sky Bonanza Financial Manager (FM) monitor the implementation of the Service Plans. The CMT and IAs/FMs meet with the member at least every six months to ensure that selected services are provided as outlined in the plan of care. These meetings also address health and welfare of the member. The monitoring visits will include a review of the member's service utilization history, a review of usage and effectiveness of the emergency back up plan and an evaluation of the quality and effectiveness of services. The CMT or IA/FM will identify any problems that need to be addressed and document the strategy to attend to the issue and the work on resolution. Serious Occurrence Reports (SOR) are mandated for incidences in which the members health and safety are at risk. These reports are sent to the RPO for review. The RPO will assist in problem solving strategies, as needed, to assist in resolution of issues beyond the scope of the member, the CMT and IA/FM. The semi-annual monitoring will also include a review of member access to non-waivers services identified in the service and support plan.

The CMT and IA/FM and service providers are mandatory reporters of abuse, neglect, and exploitation. The CMT and IA/FM will complete a SOR and file a report with the appropriate entity sending a copy of the report to the RPO for quality assurance monitoring.

In addition, the CMT and IA/FM shall consult with Central Office on any SOR: a.
Not resolved at the local level;
b. Requiring attention in response to reoccurring issues; or
c. Requiring system changes. **b. Monitoring Safeguards.** *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The entities are monitored by the RPOs on an on-going basis and by the designated CSB staff during the quality assurance process to ensure implementation of plan of care and member health and welfare. When an entity provides Case Management, IA and other waiver services, they must assure Conflict of Interest standards are met. Members are to be offered non-biased information of all qualified providers available to provide services to the

memeber. The member's chart must contain documentation the member had freedom of choice when selecting available providers.

Appendix D: Participant-Centered Planning and Service Delivery
Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of waiver participants in a rep sample whose Person-Centered Plan (PCP) address the needs identified in the Level of Care Screen (LOC Screen) and determination. The numerator is the number of participants in the sample whose PCPs address the needs identified in the LOC screen & determination and the denominator is total # of waiver participants in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative**

		Sample Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
 # or % of waiver participants in a representative sample whose PCPs address the waiver participant's personal goals. The numerator is the number of waiver participants in the sample whose PCPs address the waiver participants personal goals and the denominator is the total number of participants in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of waiver participants in a representative sample whose PCPs address identified health and safety risks through a contingency plan. The numerator is the number of waiver participants in the sample whose PCPs address health and safety risks through a contingency plan and the denominator is the total number of waiver participants in the sample.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of waiver participants whose PCPs were reevaluated at least every 180 days, or revised as needed, to address changing needs. Numerator is the number of waiver participants in the sample whose PCPs were reevaluated every 180 days, or revised as needed, to address changing needs. The denominator is total number of participants in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**

Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of waiver participants in a rep sample whose scope and type of services are delivered as specified in the PCP. The numerator is the of waiver participants in a rep sample whose scope and type of services are delivered as specified in the PCP and the denominator is the total number of waiver participants in the sample.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:

	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
 # or % of waiver participants in a rep sample whose amount of services is delivered as specified in the PCP. The numerator is the number of waiver participants in a rep sample whose amount of services is delivered as specified in the PCP. The denominator is the total of waiver participants in the sample.

Data Source (Select one):
Record reviews, on-site If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other	**Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	Continuously and Ongoing
	Other Specify:

Performance Measure:
 # or % of waiver participants in a rep sample whose frequency and duration of services are delivered as specified in the PCP. The numerator is the number of waiver participants in a rep sample whose frequency and duration of services are delivered as specified in the PCP. The denominator is the total number of waiver participants in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:

	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

 # or % of new participant records in a rep sample with documentation that specifies choice offered between institutional care and waiver services. The numerator is the number of new participant records in a rep sample with appropriate documentation that specified choice was offered between institutional and waiver services. The denominator is the total number of new participants in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
 # or % of waiver participants in a representative sample whose PCPs show a choice between/among HCBS waiver services and qualified waiver service providers. The numerator is the number of waiver participants in the sample whose PCPs show a choice between/among HCBS waiver services and qualified waiver service providers. The denominator is the total number of waiver participants in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =

		95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Designated CSB staff will conduct on-site review of Case Management Teams (CMTs) at least every three years. However, if a significant issue or deficiency is discovered at any time, a targeted review would be completed and include on-site activities. Assessing the Service Plan is part of that process. The CSB staff will address any errors or missing information with the CMT for correction. When a plan is not developed in accordance with program policy and procedure the CSB staff work with the CMT to take appropriate corrective action. The CSB staff will respond to any immediate concerns related to the health and safety of the member. Data collected in the review will be entered into the quality assurance database and a report will be submitted to CSB for approval. Issues identified will be shared with CMTs through a Quality Assurance Communication (QAC). CMTs are required to respond to the QACs with resolution efforts according to the specified time frames. All QACs corresponding to a review must be resolved and returned to CSB prior to closure of the review. If a CMT identifies areas of noncompliance during their internal audits, they will take action to immediately rectify the problem and update the Service Plan if necessary. If CSB staff identify a significant discrepancy between scope of services in plan and amount of services actually provided the case will be referred to the Regional Program Officer for follow up with the CMT.

Case Management Teams are required to complete a Quality Improvement Project (QIP) quarterly and submit the QIP to the Regional Program Officer for review. The QIP topic identified must be specific, measurable, and relevant to the quality and/or policy implementation of waiver services provded to members participating in the program.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When plans do not indicate that the following performance measures were met the Case Management Team (CMT) or the Big Sky Bonanza Independence Advisor (IA) will immediately set up a meeting with the member to review the appropriate documentation and/or sign the Service Plan.

The performance measure requires the following:

1) Indication that the Service Plan meets personal goals and needs including health and safety;

2) Traditional service plans developed in conjunction with the CMT;

3) Indication that member received choice between institutional care and waiver home and community based services;

4) Indication that member received choice of services and service providers; and

5) 180 day service plan re-evaluation

If there appears to be a pattern of failure to do this within an CMT, a written remediation plan will be required within 30 days describing initiated safeguards to ensure plans will meet the performance standards.

If during on-site reviews and meetings with members, the designated CSB staff determine that service plans do not sufficiently address members' needs, they will initiate a Quality Assurance Communication. The CMT will have 30 days to respond with a remediation plan to correct the deficiency. If necessary, the RPO will follow up with training or further instructions for the agency. When the service plan review is not completed within 180 days, the CSB staff will initiate a Quality Assurance Communication. The CMT will have 30 days to respond with a remediation plan to correct the deficiency.

When paid claims indicate that services were not provided in type, scope, amount, duration and frequency as indicated in the service plan, the designated CSB staff will immediately issue a Quality Assurance Communication to the agency requesting an explanation of any discrepancy and remediation plan within 30 days.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Nature of the Opportunity of the Big Sky Bonanza (BSB) option:
Individuals of all ages (and/or their legal guardians or parents) may self-direct some or all of their services as well as accessing traditional agency-based delivered services as needed.
They are provided the opportunity:
1) To select and manage staff who perform personal assistant type services under the category of BSB Community Support Services (Employer Authority) and
2) To purchase allowable goods and services using a self-direct budget (Budget Authority).

Members may direct: BSB Goods and Services, and Private Duty Nursing.

Members may also access other services, that are available under the traditional provider-managed model. Members may elect to receive traditional services and/or member-directed services but, at a minimum, must select to direct BSB Community Support Services and BSB Goods and Services if they have selected the member-directed option.

How Participants May Take Advantage of the BSB Option:
Upon intake into the waiver, case managers will inform every applicant about the BSB option. When a member on the waitlist becomes eligible for a waiver slot the case manager will inform them of the BSB option at that time. If a member indicates initial interest in the program designated staff will provide an orientation guide about the self-direct

opportunities with the waiver. Waiver members will have the option to select either the traditional elderly/disabled model or the BSB option. The member will be given extensive information about unique service offerings available under BSB during the member training.

Entities Who Support Members:
Members will be able to choose from several agencies and individuals providing support services, ensuring they are successful with the member-directed experience. Once a member receives orientation material and selects BSB, they will receive training. The BSB Independence Advisor (IA) will work with the member to develop a service and support plan (plan of care).

When the service and support plan is developed and approved and the self-direct budget has been authorized the IA and the member will begin implementation.
During the implementation and management of the service and support plan, the IA will:
1) Advise, train, and support the member, as needed and necessary,
2) Assist with the development and execution of the spending plan and negotiate payment rates,
3) Assist to develop an emergency backup plan,
4) Identify risks or potential risks and develop a plan to manage those risks,
5) Assist with recruiting, interviewing, hiring, training, managing, and/or dismissing workers, and
6) Assist with monitoring health and welfare. This position will also serve as an advocate agent to the member and will provide training to promote self-advocacy.

The IA and member will routinely interact with the Financial Manager (FM). The Division will maintain a list of certified FMs. Members are provided with a list of FM providers and shall select the FM provider of their choice.

The FM will:
1) Complete all necessary payroll and employment forms,
2) Report and pay payroll and employment tasks,
3) Monitor and manage the spending plan,
4) Certify and enroll the IA, and
5) Monitor spending in the services and supports plan.

The designated CSB staff will approve each member's service and support plan, self-direct spending plan, emergency plan, and plan to manage risks to ensure health and welfare are safeguarded.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

Participant: Employer Authority. As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The most important component of the outreach strategy is developing and disseminating material to inform current and potential members about the benefits and potential liabilities of self-directing under the Big Sky Bonanza (BSB) option. Member material will include a general overview of the program and comprehensive details specific to self-direction and member responsibilities and liabilities.

The Division and community partners provide members interested in the BSB program option with an orientation that describes member-direct options, emphasizes the rights and responsibilities of the member, and outlines the potential liabilities associated with self-direction.

When a member decides to participate in the BSB option, he/she attends a training session and receives a member training manual that outlines program policy and procedures, the member is assigned a BSB Independence Advisor who provides skill assessment and training related to member direction and outlines the person-centered planning support and service plan development process. The training will occur prior to entrance into the BSB option and development of the service and support plan.

At any time during the outreach stages a member is free to opt out of the BSB option and select to receive services via the traditional provider-managed model.

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: *(check each that applies)*:

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A personal representative will be required for any potential enrollee who has impaired judgment as identified on the assessment tool and/or is unable to:

1) Understand his/her own personal care needs;

2) Make decisions about his/her own care;

3) Organize his/her lifestyle and environment by making these choices;

4) Understand how to recruit, hire, train, and supervise providers of care;

5) Understand the impact of his/her decisions and assume responsibility for the results; or

6) When circumstances indicate a change of competency or ability to member-direct demonstrated by non-compliance with program objectives.

The following may request a personal representative be appointed for BSB:
a. The potential enrollee;
b. Mountain Pacific Quality Health;
c. A BSW case manager;
d. The Big Sky Bonanza Financial Manager; or
e. The Big Sky Bonanza Independence Advisor.

A personal representative may be a legal guardian, other legally appointed personal representatives, a family member, or a friend. The personal representative must be willing and able to fulfill the responsibilities as outlined in the Personal Representative Agreement and must demonstrate:

1) A strong personal commitment to the member;

2) Ability to be immediately available to provide or obtain backup services in case of an emergency or when an attendant does not show;

3) Demonstrate knowledge of the members preferences;

4) Agree to a predetermined frequency of contact with the member;

5) Be willing and capable of complying with all criteria and responsibilities of members;

6) Be at least 18 years of age; and

7) Obtain approval from the potential enrollee and/or a consensus from other family members to serve in this capacity if applicable.

A personal representative may not be paid for this service nor be the member's IA, a paid worker of Big Sky Bonanza Community Supports or paid to provide any other waiver service to the member. The overall management of personal representatives will assist CSB to assure health and welfare of each member in Participant Direction. Each personal representative will be required to complete and sign a Personal Representative Agreement and an Authorized Personal Representative Designation Form and attend the member training.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Private Duty Nursing		
Big Sky Waiver Community Supports		
Big Sky Bonanza Independence Advisor		
Specialized Medical Equipment and Supplies		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

Financial Management

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services are provided by a variety of entities that meet the provider qualifications for this service. This could include: Independent Living Centers, Self Direct Personal Assistance Service Provider Agencies and Case Management Provider Agencies.

Interested potential providers express their interest to the SLTC Division and begin the process of becoming a FM provider: meeting initial provider qualifications, passing a readiness review, completing required training and receiving certification.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

N/A

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employmentrelated taxes and insurance

Other

Specify:

Upon request by member, complete criminal background checks on prospective providers/attendants and maintain the results on file.

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Financial Manager services must be delivered by entities that are established as legally recognized in the United States, qualified/registered to do business in the State of Montana, approved as a Medicaid provider and certified

by the Community Services Bureau (CSB). Certification standards will include, at a minimum, ensuring the provider demonstrates the capacity to perform the required responsibilities through undergoing and passing a Readiness Review performed by the State.

The designated CSB staff provide Big Sky Bonanza option program manuals to every provider, train FM providers before they enroll and will provide ongoing training to agencies, as necessary, to ensure that agencies are informed of relevant changes in state and federal policy and procedure and to assist in the training of new agency oversight staff around program policy and procedure (at agency request).

FM providers submit quarterly report cards and utilization reports to the CSB. On-site follow-up review are conducted every three years or more frquently if necessary. In between the designated CSB staff monitor FMs on an on-going basis utilizing quality assurance communications.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Senior Companion	
Supported Living	
Specialized Child Care for Children Who Are Medically Fragile	
Private Duty Nursing	
Prevocational Services	
Occupational Therapy	
Adult Day Health	
Health and Wellness	
Post Acute Rehabilitation Services	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Case Management	
Community Transition	
Level 1 Assisted Living	
Respiratory Therapy	
Specially Trained Attendant	
Non-medical Transportation	
Money Management	
Big Sky Waiver Community Supports	
Homemaker Chore	
Environmental Accessibility Adaptations	
Day Habilitation	
Level 2 Assisted Living	
Pain and Symptom Management	
Family Training and Support	
Speech Therapy	
Consultative Clinical and Therapeutic Services	
Community Adult Group Homes	
Supported Employment	
Big Sky Bonanza Independence Advisor	
Nutrition	
Vehicle Modifications	
Specialized Medical Equipment and Supplies	
Adult Foster Care	
Homemaker	
Personal Emergency Response Systems	
Big Sky Bonanza Goods and Services	
Respite	
Level 3 Assisted Living	
Dietetic-Nutritionist Services	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Community First Choice/Personal Assistance	
Big Sky Bonanza Financial Management Services	
Audiology	
Service Animals	
Physical Therapy	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Big Sky Bonanza Independence Advisors (IAs) must complete the Department's mandatory training before providing services. IA Agencies must be able to assure that IA employees have no vested interest in who is selected to provide services and that members have the choice of providers and type of services. Before providing Big Sky Bonanza BSB services, the IA Agency must provide the Department with a statement describing which BSB services will be provided in addition to the IA services with assurance there are no other providers available to provide the service(s)in the geographical area. The statement should include assurances that the services are included in the member's Support Services Spending Plan.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Members in Big Sky Bonanza (BSB) may, at any time, return to the traditional provider managed model. Members will notify their Independence Advisor (IA) of their intention. The IA and the case managers will coordinate services and supports to ensure that no break in vital services and a timely revision of the service plan occurs. The reason for the

return will be recorded and information will be entered into the Quality Assurance (QA) database as part of the QA management strategy.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

When the quality management system identifies an instance where the participant-directed option is not in the best interest of the member and corrective action (additional training or change of a personal representative, etc.) does not ameliorate the situation, the member will be informed in writing of the plan to transfer to the traditional provider managed service delivery model. This could occur due to failure to follow self-direct policies, mismanagement of the individual budget or failure to participate in the planning of their services. Community Services Bureau, in collaboration with the IA and case manager will ensure that no break in vital services and a timely revision of the service plan occurs. The member may appeal this decision by requesting a fair hearing through the Department of Public Health and Human Services Fair Hearing process.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		25
Year 2		25
Year 3		25
Year 4		25
Year 5		25

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The Big Sky Bonanza Financial Management (FM) service entity functions as an agency with choice model.

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Costs for criminal background checks will be included in the reimbursement to the Big Sky Bonanza Financial Manager.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Every member in the Big Sky Bonanza (BSB) option has access to a self-direct budget to hire staff and purchase approved services, supports and goods. The Community Services Bureau (CSB) will manage the overall budget with the intent of maintaining cost neutrality and ensuring that money is allocated according to member need, as outlined in the service and support plan. The self-direct budget will represent a portion of the total budget for the waiver member.

BSB members, working with their BSB Independence Advisor (IA) and a support team of their choosing, will assess their needs, develop their goals based on needs, and develop a service and support plan (plan of care) to meet their goals. This plan may include both traditional provider-managed and self-direct services. Once all of the member's goals are addressed they are prioritized and the services the member has selected to self-direct are priced out into a spending plan. The member and IA will receive training on developing an individual self-direct budget to ensure consistency in the budget development process across consumers. Ongoing training will be provided, upon request, by the designated CSB staff.

When CSB approves the service and support plan they authorize traditional service use, which is accessed using the normal procurement process, and authorize services that the member has elected to self-direct, which is the BSB budget amount. The BSW Program Managers will make the final determination on all BSB budget amounts. CSB will develop and monitor the member's waiver budget using the same methodology in place for the

traditional model to ensure consistency across the two and within the self-direct waiver. The process involves a designation from MPQH, assessment to identify needs, development of goals based on needs, and agreement on the type and amount of services and supports needed to meet the goals. Policy and rate methodology are posted on the Division's website and available to the public.

The self-direct budget is calculated over a twelve month time period. The self-direct budget amount is what the member will use to direct all member directed services and supports, as designated in his/her Support Service and Spending Plan. The FM assists the member in managing his/her self-direct budget.

Members have the authority to decide which services, goods or supports to purchase and how much money to pay for each item within the self-direct budget. A suggested range of rates for services is available as a point of reference for the planning stages.

Members will have the ability to designate and allocate dollars within their self-direct budget, during the fiscal year, for larger one-time purchases. These dollars may be used to purchase goods and services outlined in the service and support plan.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

CSB will determine a self-direct budget amount and will inform the member of the amount. Each member, with the assistance of his or her Big Sky Bonanza Independence Advisor, will develop a service plan and a self-direct spending plan, using this amount, and submit it to CSB for approval. The member and IA will use the self-direct budget amount to finalize the monthly spending plan for self-direct services and submit it to the FM. The member may contact the FM at any time during the month to determine his or her balance and the FM will apprise the member of the budget amount at least monthly through a monthly spending report. During the member training the member is informed of the procedure for requesting an adjustment to the self-direct budget amount. The member is offered the opportunity to request a Fair Hearing when his/her request for an adjustment to the budget is denied or the amount of the budget is decreased.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority iv. Participant Exercise of

Budget Flexibility. *Select one*:

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Members have the flexibility to manage their services and modify their self-direct budget without requiring the prior preparation of a revised service plan. Self-direct funds may be reallocated when the following criteria are met:

1. The change is within a service category that has been selected for self-direction;

2. The change does not change the total dollars allocated for the member-direct service category; and

3. The change includes only those supports and services that are authorized in the members support and service plan.

Members must notify the FM when they plan to exercise their authority to reallocate funds prior to implementing the changes. Upon making the change the member must meet with the IA to document the changes in the service and support plan.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Monitoring oversight of the self-direct budget is the responsibility of the FM and IA. The FM will provide written balances of the member's spending plan at least monthly to the member and IA and at the request of the member, the IA or CSB.

The FM will monitor expenditure, flag significant budget variances, and ensure that the purchase of goods and services and submitted timesheets match the members self-direct spending plan. Incidents of over expenditure are handled on an incident-by-incident basis by the FM. The FM will meet with the member on a semi-annual basis to review budget expenses and respond to any concerns.

The IA will track underutilization monthly and contact the member to resolve potential service delivery problems.

The self-direct budget is calculated in twelve-month increments. The member is responsible for developing a monthly self-direct spending plan, which will be utilized to track over and under expenditures.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Members are notified of the fair hearing process when they complete the Medicaid application. They are also notified of the fair hearing process when they are notified of the choice of waiver vs. institutional services during the Mountain Pacific Quality Health level of care assessment. If a member is denied services, disenrolled from the program, have services suspended, terminated, or reduced, they are again provided fair hearing rights in writing. In accordance with Administrative Rules of Montana (ARM) 37.40.1407, .1408, .1426, an adverse action notice is any action to terminate, decrease or deny Big Sky Waiver (BSW) services or coverage. Timely and/or adequate notice must be provided for all adverse actions. For termination of BSW coverage, a notice is sent to the member and/or representative with fair hearing rights. For termination, denial or decrease of a specific BSW service(s) a notice is sent to the member and/or representative with fair hearing rights.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process *(complete Items b through e)*

No. This Appendix does not apply *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All persons employed by an agency participating in the Medicaid program, pursuant to MCA 52-3-811, are mandatory reporters of suspected abuse, neglect or exploitation of children, elderly, or members with disabilities. They are also required to complete a Serious Occurrence Report (SOR), utilizing the Quality Assurance Management System (QAMS) database, when a situation calls for it. A SOR must be completed anytime an individuals life, health, or safety has been put at risk. This includes all reports that meet the guidelines for suspected abuse, neglect or exploitation (MCA 52-3-803) submitted to Adult Protective Services or Child Protective Services. In addition, circumstances warranting a SOR include:

1. Suspected or known physical, sexual, emotional or verbal abuse;
2. Neglect of the member, self-neglect or neglect by responsible caregivers;
3. Sexual harassment by an agency employee or member;
4. Any injury that results in hospital emergency room or equivalent level of treatment. The injury may be either observed or discovered. A SOR would be required for any injury that occurred within the last 90 days;
5. An unsafe or unsanitary working or living environment which puts the worker and/or member at risk;

6. Any event which is reported to APS, CPS or Law Enforcement, the Ombudsman or QAD/Licensing;

7. Referrals to the Medicaid Fraud Control Unit (MFCU);

8. Psychiatric emergencies - admission to a hospital or a mental health facility for a psychiatric emergency;

9. Medication emergency when there is a discrepancy between the medication that a physician prescribes and what the individual actually takes and which results in hospital emergency room or equivalent level of treatment or hospital admission; or any medication error occuring during the provision of Medicaid reimbursed nursing services; and

10. Suicide, suicide attempt or suicide threat.

11. Unexpected deaths.

All designated service providers are mandated to complete a Serios Occurrence Report utilizing the QAMS database within ten working days of receiving information or witnessing the incident. The provider agency must document cause and effect of the incident and the action plan to correct or prevent incidents from occurring in the future. The RPO is responsible for ensuring an appropriate response by the provider agency.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information on identifying, addressing, and protecting someone from abuse, neglect and exploitation and how to notify the appropriate authorities is provided to members upon admission to the waiver and annually thereafter, by the case manager or independence advisor/financial manager. Members can also access information on the Divisions website at www.http://dphhs.mt.gov/sltc. Additional information on incident management, abuse, neglect and exploitation and member protection may be covered as needed at ongoing consumer training sessions and CSB member focus groups.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Investigations involving Abuse, Neglect and Exploitation and/or criminal activity:

Reports of abuse, neglect and exploitation are made to Adult Protective Services (APS) or Child Protective Services (CPS) for evaluation, reporting, and investigation. Adult and Child Protective Services are emergency intervention activities which may include: investigating complaints, coordinating family and community support resources, strengthening current living situations, developing and protecting personal financial resources and facilitating legal intervention. All reports come through a centralized intake hotline where trained staff assess the situation and send a report to field staff. Local APS or CPS social workers evaluate, assess, prioritize and follow-up on all cases within their jurisdiction.

Child Protective Services are provided to children under 18 in the state of Montana. The timeline for response to CPS reports depends on the incident. Any report that is assessed at the level of imminent danger is responded to within 24 hours. For all other reports response time varies depending on the nature of the report, location, and whether local law enforcement is involved. Before a case is closed a safety assessment is conducted to assess whether appropriate action was taken.

Adult Protective Services are provided to persons over the age of 60, physically or mentally disabled adults (as defined by the Department through SSI or vocational rehabilitation) and adults with developmental disabilities who are at risk of physical or mental injury, neglect, sexual abuse or exploitation. APS provides voluntary protective services to any individual in their jurisdiction. However, APS is unable to provide involuntary protective services to physically or

mentally disabled adults. All APS reports are assessed by regional supervisors for imminent risk and capacity of the individual. Cases are triaged using social work methodology and serious cases are responded to first. A computer data system has a built in alert system to track cases and open investigations. Any report that is referred for investigation has 90 days to be closed.

The Division coordinates with APS and CPS at their direction and request. Each investigation will be different and we will become involved only to the extent that they direct. APS and CPS notify participants and/or their legal representatives concerning investigative results. Division staff would coordinate and assist at their request.

In situations where APS cannot follow up (i.e. incident is outside scope of APS jurisdiction or the individual doesnt substantiate the report) the RPO is notified and provides necessary referral and follow up (see SOR below).

APS, CPS, Medicaid providers and Regional Program Officers make referrals, when necessary, to local law enforcement or other entities. Referrals to local law enforcement include illegal activities, theft, embezzlement and incidents involving significant abuse.

Incidents and events outside the scope of APS, CPS or local law enforcement authority are reported to the pertinent provider agency. The agency investigates the incident and provides follow-up, when needed. The provider agency (or in the case of self-direct services the Big Sky Bonanza Independence Advisor (IA) and the member document the scope of the incident, the incidents cause and effect, and work with the member to develop an action plan to correct or prevent the incident from occurring in the future. This information is captured on a Serious Occurrence Report (SOR), within the Quality Assurance Management System (QAMS) database and must be submitted within 10 days of the incident (or knowledge of the incident). The IA will follow up on SOR outcomes during the monthly member meeting and track follow-up activity in the member's file. When needed the IA will assist with modifications to the member Service and Support plan to prevent future incidents. The Regional Program Officer (RPO) is responsible for ensuring an appropriate and timely response is provided by the provider agency and/or IA and member. On the SOR form, there is a section where the RPO may comment on the incident and mark any follow-up action taken, including providing training, case conference, and/or sanctions.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Community Services Bureau (CSB) Central Office is responsible for overseeing the operation of the serious occurrence incident management system. All critical events or incidents involving a member warrant a Serious Occurrence Report (SOR) that is entered into the QAMS database and submitted to the local RPO who oversees the incident management process and ensures that appropriate reporting and follow-up occurs at the local level. The RPO will enter follow-up and resolution activities related to the SOR into the QAMS database. The QAMS database and summative reports will capture information on incident type, member characteristics, incident response time, remediation outcomes, and timeliness.

As necessary, Adult Protective Services (APS) or Child Protective Services (CPS), and Central Office Staff will work together to develop and implement strategies for prevention using reports from their respective databases. APS and central office staff developed a parallel desk level procedure and ongoing communication strategy when an investigation into allegations of abuse, neglect, or exploitation involves a member on the Community First Choice program and/or Big Sky Waiver program. Letters of intent to investigate are sent to the Quality Assurance Program Manager to assure that critical incident reporting mandates are being followed, as well as closure letter results of the investigation. Closure letters indicating substantiated cases of abuse, neglect, or exploitation are tracked for trends, as well as federal reporting requirements.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of

3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Department of Public Health and Human Services/Senior and Long Term Care Division (SLTC) is responsible for detecting unauthorized use of restraints or seclusion. Community Services Bureau (CSB) designated staff perform routine quality assurance reviews that include home visits with members and standards for member satisfaction. CSB staff also provide ongoing training with providers and members to assure health and welfare. The Division operates a serious occurrence reporting system as a part of the overall quality management of the waiver. Serious occurrence reports (SOR) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the Quality Assurance reviews of providers to assure appropriate reporting and resolution of incidents.

Reflecting Level 2 Assisted Living services, behavior modification practices will be assured to always be void of all classes of restraint, retaliation, reprisal, abuse, and neglect. Personal liberties, resident rights, and freedom of movement will be supported by the facility and maintained per state and federal regulation.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of

restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Public Health and Human Services/Senior and Long Term Care Division (SLTC) is responsible for detecting unauthorized use of restrictive interventions. Community Services Bureau (CSB) staff perform routine quality assurance reviews that include home visits with members and standards for member satisfaction. CSB staff also provide ongoing training with providers and members to assure health and welfare. The Division operates a serious occurrence reporting system as a part of the overall quality management of the waiver. Serious occurrence reports (SOR) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the Quality Assurance reviews of providers to assure appropriate reporting and resolution of incidents.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Department of Public Health and Human Services/Senior and Long Term Care Division (SLTC) is responsible for detecting unauthorized use of restraints or seclusion. Community Services Bureau (CSB) staff perform routine quality assurance reviews that include home visits with members and standards for member satisfaction. CSB staff also provide ongoing training with providers and members to assure health and welfare. The Division operates a serious occurrence reporting system as a part of the overall quality management of the waiver. Serious Occurrence Reports (SOR) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the Quality Assurance reviews of providers to assure appropriate reporting and resolution of incidents.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Montana Licensed adult foster care homes, assisted living facilities, and group homes provide medication management and oversight. The licensed provider who employs trained and qualified staff is responsible for keeping track of medication management standards while ensuring the resident takes their medication safely as

prescribed. Medications are to be safely secured and/or stored as required by the Department of Labor and Industry and as outlined within the applicable Administrative Rules of Montana (ARM).

Medication management standards can be reviewed with Administrative Rules Of Montana (ARM)
•Assisted Living Facility Rules (37.106.2801 - 37.106.2898)
•Community Homes for Persons with Physical Disabilities (37.100.401 - 37.100.440)
•Adult Foster Care Homes (37.100.101 - 37.100.175)

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The state Licensing Bureau of the Medicaid Agency ensures appropriate medication management during quality assurance reviews. The reviews are conducted every 1-3 years. Case managers ensure that waiver members receive their medication as prescribed and report any mismanagement, harmful practices or crimes to the appropriate authorities. Case managers are also required to complete a serious occurrence report (SOR) in those instances.

The SOR system is used as a repository for reporting and monitoring serious incidents that involve members. Information is analyzed to assist the member, family and provider agency in the development, implementation and modification of the member's service plan and to assist the Department in program wide quality oversight, accountable and improvement efforts.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Licensed practical nurses, registered nurses and licensed medication aides administer medication in accordance with the Montana Nurse Practice Act. Under the self-directed Community First Choice/Personal Assistance Services (CFC/PAS) option the administration of medication by personal assistants is exempt from the Nurse Practice Act. Member requirements to participate in the CFC/PAS self-directed option:

ARM 37.40.1101 - 1135 CFC/PAS, member requirements: To qualify for self-directed CFC/PAS, the member must: have a medical condition which results in the need for personal assistance services; be capable of assuming the management responsibilities of assistants or have an immediately involved representative willing to assume this responsibility; have authorization from a physician or health care professional to participate in the program; and be capable of making choices about activities of daily living, understand the impact of these choices and assume the responsibility of the choices. The member must be capable of acting as though the personal assistant is their employee for the purposes of selection, management and supervision of the personal assistant, although

the personal assistant is the employee of a self-directed personal assistance provider. The member has the primary responsibility in the scheduling, training and supervision of the personal assistant. The member has the right to require that a particular assistant discontinue providing services to the member. The member may have an immediately involved representative assume some or all of the responsibilities imposed by this rule. An immediately involved representative is a person who is directly involved in the day to day care of the member. An immediately involved representative must be available to assume the responsibility of managing the member's care, including directing the care as it occurs in the home.

37.40.1007 Self-directed Personal Assistance Services, General Requirements The member may be authorized to have the personal assistant perform health maintenance activities. These include urinary system management, bowel treatments, administration of medications and wound care.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies). *Complete the following three items:*

(a) Specify state agency (or agencies) to which errors are reported:

Serious Occurrence Reports must be submitted to the local Regional Program Officer of the Community Services Bureau whenever there is an issue concerning medication errors or possible mismanagement of medication.

(b) Specify the types of medication errors that providers are required to *record:*

Providers must record medication doses missed or refused by member and why, and unexpected effects of medication or medication error.

(c) Specify the types of medication errors that providers must *report* to the state:

Providers must report a Medication Emergency: When there is a discrepancy between the medication that a physician prescribes and what the member actually takes, and this results in a hospital emergency room or equivalent level of treatment or hospital admission; or any medication error occurring during the provision of Medicaid reimbursed nursing (Private Duty Nursing, Home Health or Hospice) services.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

The State Medicaid agency is responsible for monitoring the performance of waiver providers. Licensed facilities are reviewed by the state Licensing Bureau and Conduent EDI Solutions, Inc.

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")* **i. Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of Serious Occurrence Reports (SORs) including instances of abuse, neglect and exploitation that received appropriate response and follow-up by waiver personnel within the required timeframe. The numerator is the number of SORs that received a response and follow-up by waiver personnel within the required timeframe. The denominator is the total number of reported SORs in the sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid	**Weekly**	**100% Review**

Agency		
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	Continuously and Ongoing
	Other Specify:

Performance Measure:
 # or % of Serious Occurrence Reports, (SORs) in the rep sample, including instances of abuse, neglect and exploitation, that were reported within required time frames. The numerator is the number of SORs in the rep sample that were reported within the required timeframe. The denominator is the total number of reported SOR's in the sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:

	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
 # or % of participants or representatives receiving education on identifying/reporting abuse, neglect, exploitation & other critical incidents. The numerator is the number of participants/personal representatives who received education to identify & report abuse, neglect, exploitation, other critical incidents. The denominator is the total number of waiver participants or representatives.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify: Upon enrollment	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
# of incidents reported that have been effectively resolved and will the extent possible prevent similar incidents. Numerator is the number of incidents effectively resolved. The denominator is the total number of incidents reported.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:

	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify: At least every three years in conjuction with the Quality Assurance Review.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of complaints involving allegations of abuse, neglect, and exploitation (ANE) reported and resolved by Adult Protective Service (APS). The numerator is the # or % of complaints against waiver providers reported and resolved by APS. The denominator is total complaints against waiver providers reported to APS involving allegations of ANE.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify: At least every three years in conjunction with the Quality Assurance Review.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of waiver participants who received care from a medical professional within the past 12 months. The numerator is the number of participants who had a medical claim in the past 12 months The denominator is the total number of participants in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing

Responsible Party for data aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
	Other Specify: At least every three years in conjunction with Quality Assurance Reviews.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Regional Program Officer (RPO) will review all Serious Occurrence Reports(SORs), entered in the Quality Assurance Management System database, on an ongoing basis. They will review for incident type, response time and remediation activities. Staff of the CSB will provide information to all members and providers on how to identify and report abuse, neglect and exploitation. Community Services Bureau (CSB) Central Office Staff will provide technical assistance as needed and/or follow-up with the local RPO/Providers when an unreported incident has been identified. **b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

In instances in which members have not received the appropriate information, Serious Occurrence Reports (SOR) were not responded to in a appropriate time frame or SORs did not receive the appropriate follow-up, the RPO or Program Managers will issue a Quality Assurance Communication to which the provider must respond within a given time frame and action steps.

As part of the ongoing review of SORs, the RPO, when necessary, will take immediate and appropriate action to remediate situations when the health or welfare of a member has not been safeguarded. During the staff meetings, prevention strategies will be developed to respond to patterns and trends. As necessary, Adult Protective Services, Child Protective Services and CSB will work together to develop and implement strategies for prevention.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Community Services Bureau (CSB) of the Department conducts a comprehensive evaluation of services to recipients to meet the Bureau's quality assurance requirements. Department staff will perform announced quality assurance reviews. The purpose of the review is to ensure that optimal services are being provided to members and that program rules and policies are being followed. Quality assurance results are utilized to improve the programs and services.

The Quality Management (QM) process involves a strategy to ensure that individual members have access to and are receiving the appropriate services to meet their needs. This requires ongoing development and utilization of individual quality standards and working with Case Management Teams (CMTs), Big Sky Bonanza Independence Advisor, Big Sky Bonanza Financial Management (FM), and other providers to evaluate individualized personal outcomes and goals. CMTs and FMs are required to complete Quality Improvement Projects (QIP)and submit findings to designated CSB staff quarterly.

The QM process also involves the CSB Quality Assurance (QA) Reviews. The QA review is a strategy designed to collect and review data gathered from providers and individual members on quality assurance measures. Provider standards and quality indicators are used to ensure that quality assurances are met. In addition, at a regional level, the Regional Program Officer (RPO)/CMT will identify trends and systemic issues and provide remediation, as necessary.

Finally the QM process involves the Central Office. The Central Office staff will perform five main QM functions: 1. Ongoing review of QM discovery information, 2. Monitoring of QA Review, 3. Review of data during staff meeting, and utilization of data to develop remediation strategies and establish priorities for quality improvement, 4. Evaluate and revise the QM strategy, and 5. work with the CSB staff to develop and implement performance indicators.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
	08/16/2022

State Medicaid Agency **Weekly**

Operating Agency **Monthly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
Sub-State Entity	**Quarterly**
Quality Improvement Committee	**Annually**
Other Specify: Case Management Teams	**Other** Specify: Biennial QI Committee Meetings

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Review and Revision of the Quality Management Strategy
An evaluation of the effectiveness of system changes to the QM infrastructure will take place during the staff meetings. The review will occur as necessary, but at least on an annual basis. The BSW Program Managers will gather information for the review using feedback from the Community Services Bureau (CSB) staff, information from discovery methods, and provider input. The review will evaluate the effectiveness, efficiency and appropriateness of the QM system design changes.

The Quality Assurance (QA) team will review summaries of discovery information for trends, patterns, and areas of concern. As issues arise they will be prioritized and strategies developed to address them. An evaluation of the QA infrastructure will be a part of the staff meetings. This review will occur as necessary, but at least on an annual basis and will evaluate the effectiveness, efficiency and appropriateness of the QA system.

At the regional level, the Regional Program Officers (RPO)/Case Management Teams (CMTs) will identify trends and systemic issues and provide assessment information to the CSB on a quarterly basis. The delegated CSB staff will perform QA functions through ongoing review of discovery information; monitoring QA reviews; quarterly staff meetings and working with the QA team to develop and implement performance indicators. CMT's will keep CSB staff informed of effectiveness of design changes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Activities for the quality improvement:

1. CMTs will work with RPOs to establish and monitor performance standards;

2. CMTs will conduct a program self-assessment to reflect upon how program structure and policies affect members and their ability to self-direct;

3. CSB staff will assess trends in QA/QM at a state a federal level for best practices; and

4. Make recommendations on quality improvement strategies.

The Community Services Bureau staff will work with the Case Management Teams to develop Quality Improvement Projects (QIPs) quarterly.
The waiver performance standards will measure quality-related to:

1. Independence/Choice;

2. Relationships (between members, workers, and support team);

3. Knowledge and support;

4. Health, Safety, and

5. Financial accountability.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

No

Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

Big Sky Waiver utilizes a member survey which is a state-developed tool. Member surveys are issued annually. Results are compiled by central office to evaluate setting satisfaction and utilized in the ongoing quality assurance review process.

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the*

financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Public Health and Human Services (Department) provides financial oversight to assure that claim coding and payment are in line with the waiver reimbursement methodology. The Department does not require waiver providers to secure an independent audit of their financial statements. Paid claims reports will be run by the Senior and Long Term Care (SLTC) Division of the Department on a monthly basis (or as needed). These reports will depict the services utilized, the number of waiver participants using each service, the number of units utilized, and the total dollar amount paid for each service. As a part of the quality assurance reviews, financial accountability will be assessed. Case managers and Big Sky Bonanza Financial Managers are required to prior authorize waiver services.

They inform Conduent EDI Solutions, Inc. of the allowed services and the number of units or dollar amounts for which providers are permitted to bill for each member. The Quality Assurance Division (QAD) of the Department will conduct financial audits upon request of the SLTC Division.

Case management providers are required to conduct internal audits of their records to ensure the waiver member files include the necessary documentation to support the member's identified needs. The person-centered plans must be accurate and complete; services must be aligned to address the identified needs; the cost sheet must match the services provided, and all required information must be included in the file.

Community Services Bureau (CSB) staff will complete desk audits every three years or as necessary. The desk audits include waiver paid claims by members and by service. The State Plan expenditures are reviewed to ensure State Plan funds have been used prior to waiver funds. The claims are compared with the cost sheet and person-centered plan to ensure the waiver member is receiving the services identified on the cost sheet. Any discrepancies are discussed with the case management teams and they are provided assistance in the development of a quality improvement plan.

The Surveillance Utilization Review (SURS) of the Quality Assurance Division conducts provider audits by reviewing records provided by the provider. When an overpayment is identified through the SURS process, SURS staff discusses the overpayment details with the provider and requests the overpayment by formal notice. Providers are notified of their fair hearing rights through the notification from SURS staff. If fraud is identified providers can be sanctioned and be discontinued as Medicaid and Medicare providers. The findings are sent to the Office of Inspector General (OIG) and the licensing board of the provider.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # or % of waiver claims in a representative sample coded and paid according to the reimbursement methodology in the waiver. The numerator is the number of waiver claims in the sample coded and paid according to the reimbursement methodology in the waiver. The denominator is the total number of paid waiver claims in this sample.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
State Medicaid Agency	***Weekly***	***100% Review***
Operating Agency	***Monthly***	***Less than 100% Review***
Sub-State Entity	***Quarterly***	***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
Other *Specify:*	***Annually***	***Stratified*** *Describe Group:*
	Continuously and Ongoing	***Other*** *Specify:*
	Other *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
State Medicaid Agency	***Weekly***
Operating Agency	***Monthly***
Sub-State Entity	***Quarterly***
Other *Specify:*	***Annually***
	Continuously and Ongoing
	Other *Specify:*

Performance Measure:
 # or % of paid waiver claims within a representative sample with adequate documentation that services were rendered. The numerator is the number of claims in the sample with adequate documentation of services rendered. The denominator is the total number of claims in the sample.

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
State Medicaid Agency	***Weekly***	***100% Review***
Operating Agency	***Monthly***	***Less than 100% Review***
Sub-State Entity	***Quarterly***	***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
Other *Specify:*	***Annually***	***Stratified*** *Describe Group:*

	Continuously and Ongoing	***Other*** *Specify:*
	Other *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
State Medicaid Agency	***Weekly***
Operating Agency	***Monthly***
Sub-State Entity	***Quarterly***
Other *Specify:*	***Annually***
	Continuously and Ongoing
	Other *Specify:*

Performance Measure:
Number of claims that are coded and paid only for services rendered. The numerator is the number of claims that are coded and paid only for services rendered. The denominator is the total number of claims coded and paid.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for	***Frequency of data***	***Sampling Approach****(check*

data collection/generation *(check each that applies):*	***collection/generation*** *(check each that applies):*	*each that applies):*
State Medicaid Agency	***Weekly***	***100% Review***
Operating Agency	***Monthly***	***Less than 100% Review***
Sub-State Entity	***Quarterly***	***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
Other *Specify:*	***Annually***	***Stratified*** *Describe Group:*
	Continuously and Ongoing	***Other*** *Specify:*
	Other *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
State Medicaid Agency	***Weekly***
Operating Agency	***Monthly***
Sub-State Entity	***Quarterly***
Other *Specify:*	***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	Continuously and Ongoing
	Other *Specify:*

Performance Measure:
Number of claims submitted that are consistent with the participant service plan. The numerator is the number of claims submitted and paid that are consistent with the participant service plan. The denominator is the total number of claims submitted and paid.

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
State Medicaid Agency	***Weekly***	***100% Review***
Operating Agency	***Monthly***	***Less than 100% Review***
Sub-State Entity	***Quarterly***	***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
Other *Specify:*	***Annually***	***Stratified*** *Describe Group:*
	Continuously and Ongoing	***Other*** *Specify:*

	Other *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
State Medicaid Agency	***Weekly***
Operating Agency	***Monthly***
Sub-State Entity	***Quarterly***
Other *Specify:*	***Annually***
	Continuously and Ongoing
	Other *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number of rates consistent with the approved rate methodology throughout the 5-year waiver cycle. Numerator is the number of rates consistent with the approved rate methodology. The denominator is the total number of rates throughout the 5-year waiver cycle.

Data Source *(Select one):*

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
State Medicaid Agency	***Weekly***	***100% Review***
Operating Agency	***Monthly***	***Less than 100% Review***
Sub-State Entity	***Quarterly***	***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
Other *Specify:*	***Annually***	***Stratified*** *Describe Group:*
	Continuously and Ongoing	***Other*** *Specify:*
	Other *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
State Medicaid Agency	***Weekly***
Operating Agency	***Monthly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
Sub-State Entity	***Quarterly***
Other *Specify:*	***Annually***
	Continuously and Ongoing
	Other *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The CSB staff will conduct audits of every three years of participant records to ensure the waiver services are aligned to address the identified needs, the cost sheet matches services provided, and paid claims support services authorized. ***b. Methods for Remediation/Fixing Individual Problems***

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

Claims that do not have the appropriate procedure codes and/or rates are denied by the MMIS system. Claims that are suspended because of Medicaid eligibility are forwarded to the Department for review and action. Depending upon the number and reasons for denials, training will be made available to providers by Conduent EDI Solutions, Inc. or the Department. CSB staff will always assist providers who encounter on-going problems with the billing system.

In instances in which claims are incorrectly paid, providers will be required reimburse the Department. If the provider fails to do so, the amount owed will be recouped from future claims submitted.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
State Medicaid Agency	***Weekly***
Operating Agency	***Monthly***
Sub-State Entity	***Quarterly***
Other *Specify:*	***Annually***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	Continuously and Ongoing
	Other *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently nonoperational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Senior and Long Term Care Division has operated a HCBS waiver program for elderly and physically disabled persons since the early 1980s. Payments for waiver services will be consistent with efficiency, economy and quality of care and will be enough to enlist providers. Services will be reimbursed via fee for service; there will be no interim rates, no prospective payments, and no cost settlements.

Payment rendered for assisted living services will encompass the comprehensive array of services and supports that are furnished on an integrated basis; therefore, the provider's own employees must directly furnish some or all services to residents. The assisted living provider may arrange for the provision of some services to be delivered on an individual contractual basis as outlined in Administrative Rules of Montana (ARM).

Proposed fee schedules are posted as part of the Administrative Rule of Montana process for public comment when fees are changed, added, or deleted. Services are reimbursed according to the approved/finalized fee schedule by outlining the maximum allowable rate per service. Fee schedules, past and current, for the Big Sky Waiver. A printed copy of the fee schedule can be requested by Waiver members and/or the public at any time. The waiver participant in partnership the case management team develops the person-centered service plan. Upon completion, the service plan and the cost sheet are made available to the waiver participant as the services are identified, by at a minimum, the individual service, rate, duration, and frequency.

In 2021-2022, the Department of Public Health and Human Services contracted a comprehensive rate study across Medicaid community services reimbursed by the Department, including its three operating 1915(c) waivers. The objectives of the rate models included in this study were to:

- Recognize reasonable and necessary costs of providers
- Standardize rates
- Reflect participant needs
- Increase transparency
- Facilitate regular updates
- Provide fiscal stability for providers and the state

The rate study included a provider cost and wage survey, distributed to all providers delivering services under review. The division and its contractor worked with key stakeholders from December 2021 to August 2022 to conduct the rate study and develop proposed waiver program rates. Stakeholder involvement included the following workgroups:

- Rate Workgroup – Composed of small and large community providers who reviewed the survey design and materials, gave input on rate component assumptions, and developed related recommendations for consideration by the Steering Committee.
- Steering Committee – Composed of key state agency staff, the lieutenant governor, legislators, and consumer and provider representatives who reviewed and selected key rate assumptions based on materials developed by the contractor and recommendations from the Rate Workgroup.

Rates were developed through an independent rate build-up methodology based on cost and wage data from providers and other state and national data sources. The independent rate build-up methodology comprises direct care and indirect care components and uses assumptions about types of employees; wage rates; employee-related expenses (ERE); direct care staff productivity; occupancy and absence factors; supervision; staffing patterns; staff mileage and client transportation costs, along with general program support and administration costs. Some components vary between services while others are the same across the services. This rate determination methodology was used to calculate rates for the following services:

- Adult Day Care
- Case Management
- Case Management Plus Supported Living Coordination
- Community Supports Services
- Consultative Clinical and Therapeutic Services
- Daily Habilitation
- Family Training and Support
- Financial Manager
- Homemaker and Homemaker Chores
- Independence Advisor
- Nutrition (Meals)
- Nutrition Classes, Nutritionist
- Nutrition Counseling, Dietician
- Personal Assistance Services
- Prevocational Services
- Private Duty Nursing
- Registered Nurse Supervision
- Residential Habilitation (Level 1, Adult Group Home, Level 3)
- Respite Care
- Senior Companion
- Special Child Care for Children
- Specialized Nursing Services
- Specialized Trained Attendant
- Supported Employment
- Supported Living
- Transportation

Available funding is being applied across all studied rates using the same methodology. To reduce existing disparities in rates, this methodology increases rates by a percentage of the difference between current and benchmark rates “the gap”. The department is able to fund about 69.5% of the “gap” between the current rate and the benchmark rate. Waiver services not subject to this rate determination method will be amended to receive an approximate 4% rate increase appropriated in the 2023 Montana Legislative Session.

HCBS rates to be reviewed annually to ensure services remain consistent and are within Montana's Legislative appropriation. The department will collect information through multiple sources, to include at a minimum, member and stakeholder feedback, provider data, outcomes from Legislative committee appropriations, and the State of Montana Access Plan. Claims history of providers to be analyzed to track and target positive or adverse trends in the number of services utilized. The state to monitor the number of HCBS provider enrollments and compare the data to the previous fiscal year to determine whether there has been a significant reduction of providers impacting access to service delivery.

.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Waiver service providers bill Montana Medicaid through the Montana Medicaid Management Information System (MMIS) managed by Conduent EDI Solutions, Inc.). Payments are issued directly to the providers; no funds are retained by the Department. All services are prior authorized by provider and by units.

Edits are in place with MMIS to ensure all services are allowable and reimbursed at the appropriate rate. The providers are enrolled as Medicaid waiver providers in the MMIS. Each provider has a charge file of the services (procedure codes) that they are approved to provide. These files are updated annually with the appropriate fiscal year reimbursement rate and the services. Department staff provides the information to the fiscal intermediary for updating.

Members are initially entered into the Medicaid eligibility system (CHIMES) as Medicaid and waiver eligible. The eligibility file is transferred nightly to the MMIS.

MMIS has edits to ensure the person receiving the service is eligible for the service, and the prior authorization and provider charge file are reviewed. If all is appropriate, the claim is paid. If there is an error anywhere in this process, the claim is denied.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The state's Montana Medicaid Management Information System (MMIS) (managed by Conduent EDI Solutions, Inc.) has a recipient eligibility system that verifies eligibility for Medicaid and the waiver. Case management teams or financial managers prior authorize all services in the members service plan. These prior authorizations are submitted to the states fiscal intermediary (MMIS). Case managers receive monthly utilization reports from providers documenting units of service provided. These reports are compared to individual service plans, compiled and forwarded to the Community Services Bureau. The data is tabulated and further compared to paid claims data from MMIS.

Utilization reports, cost sheets and service plan for the sampled members are reviewed to determine the date of the claim is within the period authorized by the plan of care, in the amount and type of service as specified in the plan of care. Inappropriate claims billed will be recouped.

Montana will implement a EVV solution on 09/18/2023. The EVV solution will be integrated into the MMIS system as an integral part of assuring pre-payment validations occur. The system meets the three essential tests of pre-payment validation. There are a series of validations for payments.

First, this integration will establish eligibility by determining if an open waiver span exists. This information is received from the MMIS eligibility system. If the span does not exist, the claim will not be created.

Second, services approved in the plan of care require a prior authorization to be entered and active in the MMIS system. A prior authorization for the service must exist for the appropriate days of services or the service is deemed outside the scope of the plan of care. The claim will not be created.

Third, Montana’s EVV system is a cellular check in /check out system. The direct care worker must complete the processes, including indicating tasks that are completed and sign off by the member or an approved member representative. When a check in or a log-out is not present in the system, the claim will not advance for payment. When cellular coverage is not available, the offline data is held until such time the visit can be uploaded.

The waiver has the following services covered under EVV: Personal Assistance Services/Attendant, Specially Trained Attendant, Community Supports Services, Respite, Specialized Child Care for Children, Supported Living, Physical Therapy-Individual, Occupational Therapy-Individual, Speech Therapy-Individual, Nutritional Counseling-Dietician, Private Duty Nursing and Senior Companion.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Big Sky Bonanza Financial Managers (FM) operate as limited fiscal agents and make payment for the member in the participant directed option (BSB option). The FM submits claims to Medicaid for payment and monitors expenditures. Quarterly utilization reports are reviewed by the Community Services Bureau staff.

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the nonFederal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

No. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

Yes. State or local government providers receive payment for waiver services. *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Nursing facilities that receive county tax dollars may provide respite services to members who are on the waiver. Local city-county health departments that receive city or county tax dollars may provide case management services or direct nursing services to members who are on the waiver.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

Not Applicable*. There are no local government level sources of funds utilized as the non-federal share.*

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any

intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The Department sets reimbursement for room and board in residential settings. Upon admission, providers are notified that the waiver will not cover the cost of room and board for the recipient.

The method used by the program to exclude the costs of room and board include separating room and boards costs from service costs in determining payment rates. The Montana Medicaid provider portal lists links to the Big Sky Waiver policy manual which notifies providers, “Medicaid reimbursement for room and board in prohibited.”

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to

the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	15418.85	13624.00	29042.85	38564.00	2172.00	40736.00	11693.15
2	15396.65	13624.00	29020.65	38564.00	2172.00	40736.00	11715.35
3	15396.65	13624.00	29020.65	38564.00	2172.00	40736.00	11715.35
4	15396.65	13624.00	29020.65	38564.00	2172.00	40736.00	11715.35
5	15396.65	13624.00	29020.65	38564.00	2172.00	40736.00	11715.35

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	2783	2783
Year 2	2783	2783
Year 3	2783	2783
Year 4	2783	2783
Year 5	2783	2783

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The FY 2019 average length of stay was 315 days. The assumption was made that the ALOS may not be impacted by the slight increase in enrollment from the Money Follows the Person demonstration grant. The FY 2019 ALOS will be used in each waiver year for Appendix J.

The acuity of the BSW member has been changing, but it has been offset by members that we serve for a short period of time for a specific set of services. This includes case management, home modifications or specialized equipment not available through state plan Medicaid. The increase in short term members will stabilize the ALOS.

The FY 2019 ALOS will be used in each waiver year for Appendix J.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D was determined using FY 2019 baseline data and no increases were anticipated for years one through five.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' was determined using FY 2019 baseline data and no increases were anticipated for years one through five.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G was determined using FY 2019 baseline data and no increases were anticipated for years one through five.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' was determined using FY 2019 baseline data and no increases were anticipated for years one through five.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health	
Case Management	
Community Adult Group Homes	
Community First Choice/Personal Assistance	
Day Habilitation	
Homemaker	
Prevocational Services	
Respite	
Specially Trained Attendant	
Supported Employment	
Audiology	
Respiratory Therapy	
Big Sky Bonanza Financial Management Services	
Big Sky Bonanza Independence Advisor	
Adult Foster Care	
Big Sky Bonanza Goods and Services	
Big Sky Waiver Community Supports	
Community Transition	
Consultative Clinical and Therapeutic Services	
Dietetic-Nutritionist Services	
Environmental Accessibility Adaptations	
Family Training and Support	
Health and Wellness	
Homemaker Chore	
Level 1 Assisted Living	
Level 2 Assisted Living	
Level 3 Assisted Living	
Money Management	
Non-medical Transportation	
Nutrition	
Occupational Therapy	
Pain and Symptom Management	
Personal Emergency Response Systems	
Physical Therapy	
Post Acute Rehabilitation Services	
Private Duty Nursing	
Senior Companion	
Service Animals	

Waiver Services	
Specialized Child Care for Children Who Are Medically Fragile	
Specialized Medical Equipment and Supplies	
Speech Therapy	
Supported Living	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

GRAND TOTAL:	**42910666.84**
Total: Services included in capitation:	
Total: Services not included in capitation:	42910666.84
Total Estimated Unduplicated Participants:	**2783**
Factor D (Divide total by number of participants):	**15418.85**
Services included in capitation:	
Services not included in capitation:	15418.85
Average Length of Stay on the Waiver:	305

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**111512.70**
Adult Day Health		15 minutes	29	1686.52	2.28	**111512.70**	
Case Management Total:							**7634157.49**
Specialized		day	23	218.37	19.14	**96130.84**	
Day		day	2442	271.25	11.38	**7538026.65**	
15 minutes		15 minutes	0	0.00	16.13	**0.00**	
Community Adult Group Homes Total:							**1042749.73**
Community Adult Group Homes		day	16	315.48	206.58	**1042749.73**	
Community First Choice/Personal Assistance Total:							**6989018.94**
Community First Choice/Personal Assistance		15 minutes	1238	1020.87	5.53	**6989018.94**	
Day Habilitation Total:							**63724.43**
Day Habilitation						**63724.43**	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**2783**
Factor D (Divide total by number of participants):	**15418.85**
Services included in capitation:	
Services not included in capitation:	15418.85
Average Length of Stay on the Waiver:	305

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**2783**
Factor D (Divide total by number of participants):	**15418.85**
Services included in capitation:	
Services not included in capitation:	15418.85
Average Length of Stay on the Waiver:	305

		day	13	59.18	82.83		

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		2783
Factor D (Divide total by number of participants):		15418.85
Services included in capitation:		
Services not included in capitation:		15418.85
Average Length of Stay on the Waiver:	305	

08/16/2022

Independence Advisor Total:							

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15418.85
Services included in capitation:	
Services not included in capitation:	15418.85
Average Length of Stay on the Waiver:	305

08/16/2022

Wellness Total:							

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		2783
Factor D (Divide total by number of participants):		15396.65
Services included in capitation:		
Services not included in capitation:		15396.65
Average Length of Stay on the Waiver:		305

08/16/2022

Monthly		month	52	5.03	71.32	18654.46	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 minutes	0	0.00	58.81		
Supported Living Total:							**61802.43**
Supported Living		day	2	132.43	233.34	**61802.43**	
Vehicle Modifications Total:							**111437.44**
Vehicle Modifications		service	35	0.77	4134.97	**111437.44**	
					GRAND TOTAL:		**42910666.84**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		42910666.84
					Total Estimated Unduplicated Participants:		**2783**
					Factor D (Divide total by number of participants):		**15418.85**
					Services included in capitation:		
					Services not included in capitation:		15418.85
					Average Length of Stay on the Waiver:		305

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**111512.70**
Adult Day Health		15 minutes	29	1686.52	2.28	**111512.70**	
Case Management Total:							**7634157.49**
Specialized		day	23	218.37	19.14	**96130.84**	
Day		day	2442	271.25	11.38	**7538026.65**	
15 minutes		15 minutes	0	0.00	16.13	**0.00**	
Community Adult							**1042749.73**

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Homes Total:							
Community Adult Group Homes		day	16	315.48	206.58	1042749.73	
Community First Choice/Personal Assistance Total:							6989018.94
Community First Choice/Personal Assistance		15 minutes	1238	1020.87	5.53	6989018.94	
Day Habilitation Total:							63724.43
Day Habilitation		day	13	59.18	82.83	63724.43	
Homemaker Total:							854530.60
Homemaker		15 minutes	503	374.20	4.54	854530.60	
Prevocational Services Total:							102119.88
Prevocational Services		hour	19	666.84	8.06	102119.88	
Respite Total:							33613.45
Individual		15 minutes	14	447.87	4.54	28466.62	
Residential		day	3	4.61	372.15	5146.83	
Specially Trained Attendant Total:							1295271.51
Specially Trained Attendant		15 minutes	371	376.00	5.82	811866.72	
Specially Trained Attendant - LPN		15 minutes	5	5866.41	9.26	271614.78	
Specially Trained Attendant - RN		15 minutes	4	4544.85	11.65	211790.01	
Supported Employment Total:							25134.68
Supported Employment		15 minutes	10	185.77	13.53	25134.68	
Audiology Total:							0.00
Audiology		visit	0	0.00	58.81	0.00	
Respiratory Therapy Total:							0.00

GRAND TOTAL:	42848864.41
Total: Services included in capitation:	
Total: Services not included in capitation:	42848864.41
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						0.00	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

08/16/2022

Therapeutic Procedures	15 minute	0	0.00	11.83	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						0.00	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

08/16/2022

Dietetic Services		15 minutes	0	0.00	15.78		

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						0.00	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

Occupational Therapy	visit	0	0.00	64.14	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Are Medically Fragile							
Specialized Medical Equipment and Supplies Total:							685162.87
Supplies		item	743	0.24	2067.48	368673.03	
Equipment		item	356	0.43	2067.48	316489.84	
Speech Therapy Total:							0.00
Speech Therapy		visit	0	0.00	58.81	0.00	
Supported Living Total:							0.00
Supported Living		day	0	0.00	233.34	0.00	
Vehicle Modifications Total:							111437.44
Vehicle Modifications		service	35	0.77	4134.97	111437.44	

GRAND TOTAL:	42848864.41
Total: Services included in capitation:	
Total: Services not included in capitation:	42848864.41
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							111512.70

GRAND TOTAL:	**42848864.41**
Total: Services included in capitation:	
Total: Services not included in capitation:	42848864.41
Total Estimated Unduplicated Participants:	**2783**
Factor D (Divide total by number of participants):	**15396.65**
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**2783**
Factor D (Divide total by number of participants):	**15396.65**
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health		15 minutes	29	1686.52	2.28	111512.70	
Case Management Total:							7634157.49
Specialized		day	23	218.37	19.14	96130.84	
Day		day	2442	271.25	11.38	7538026.65	
15 minutes		15 minutes	0	0.00	16.13	0.00	
Community Adult Group Homes Total:							1042749.73
Community Adult Group Homes		day	16	315.48	206.58	1042749.73	
Community First Choice/Personal Assistance Total:							6989018.94
Community First Choice/Personal Assistance		15 minutes	1238	1020.87	5.53	6989018.94	
Day Habilitation Total:							63724.43
Day Habilitation		day	13	59.18	82.83	63724.43	
Homemaker Total:							854530.60
Homemaker		15 minutes	503	374.20	4.54	854530.60	
Prevocational Services Total:							102119.88
Prevocational Services		hour	19	666.84	8.06	102119.88	
Respite Total:							33613.45
Individual		15 minutes	14	447.87	4.54	28466.62	
Residential		day	3	4.61	372.15	5146.83	
Specially Trained Attendant Total:							1295271.51
Specially Trained Attendant		15 minutes	371	376.00	5.82	811866.72	
Specially Trained Attendant - LPN		15 minutes	5	5866.41	9.26	271614.78	
Specially						211790.01	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

08/16/2022

Trained Attendant - RN	15 minutes	4	4544.85	11.65			

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

08/16/2022

Community Transition	service	3	0.00	2067.48	0.00	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-medical Transportation Total:							**169927.78**
Trip		service	95	42.63	12.82	**51919.08**	
Miles		mile	679	526.66	0.33	**118008.71**	
Nutrition Total:							**436901.68**
Nutrition		meal	397	187.80	5.86	**436901.68**	
Occupational Therapy Total:							**0.00**
Occupational Therapy		visit	0	0.00	64.14	**0.00**	
Pain and Symptom Management Total:							**264479.06**
Pain and Symptom Management		visit	158	23.13	72.37	**264479.06**	
Personal Emergency Response Systems Total:							**19124.84**
Installation		item	7	0.65	103.38	**470.38**	
Monthly		month	52	5.03	71.32	**18654.46**	
Purchase		item	0	0.00	829.99	**0.00**	
Physical Therapy Total:							**1161.96**
Physical Therapy		15 minutes	1	41.41	28.06	**1161.96**	
Post Acute Rehabilitation Services Total:							**0.00**
Post Acute Rehabilitation Services		day	0	0.00	800.02	**0.00**	
Private Duty Nursing Total:							**793227.72**
RN Supervision		15 minutes	0	0.00	15.83	**0.00**	
RN		15 minutes	164	201.53	11.65	**385043.22**	
LPN		15 minutes	173	254.80	9.26	**408184.50**	
Senior Companion							**1762.98**

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Senior Companion		15 minutes	6	212.92	1.38	1762.98	
Service Animals Total:							10337.40
Service Animals		service	1	5.00	2067.48	10337.40	
Specialized Child Care for Children Who Are Medically Fragile Total:							232732.43
Specialized Child Care for Children Who Are Medically Fragile		15 minutes	20	1995.99	5.83	232732.43	
Specialized Medical Equipment and Supplies Total:							685162.87
Supplies		item	743	0.24	2067.48	368673.03	
Equipment		item	356	0.43	2067.48	316489.84	
Speech Therapy Total:							0.00
Speech Therapy		visit	0	0.00	58.81	0.00	
Supported Living Total:							0.00
Supported Living		day	0	0.00	233.34	0.00	
Vehicle Modifications Total:							111437.44
Vehicle Modifications		service	35	0.77	4134.97	111437.44	

GRAND TOTAL:	42848864.41
Total: Services included in capitation:	
Total: Services not included in capitation:	42848864.41
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	*2783*
Factor D (Divide total by number of participants):	*15396.65*
Services included in capitation:	
Services not included in capitation:	*15396.65*
Average Length of Stay on the Waiver:	*305*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:	2783	
Factor D (Divide total by number of participants):	15396.65	
Services included in capitation:		
Services not included in capitation:	15396.65	
Average Length of Stay on the Waiver:		305

Adult Day Health Total:

Adult Day Health

Case Management Total:

Specialized

Day

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:	2783	
Factor D (Divide total by number of participants):	15396.65	
Services included in capitation:		
Services not included in capitation:	15396.65	
Average Length of Stay on the Waiver:	305	

Attendant - LPN

Specially Trained Attendant - RN

Supported Employment Total:

Supported Employment

Audiology Total:

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

08/16/2022

Community Transition Total:	0.00

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

08/16/2022

Management	15 minues	35	208.00	5.82	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 minutes	173	254.80	9.26		
Senior Companion Total:							**1762.98**
Senior Companion		15 minutes	6	212.92	1.38	**1762.98**	
Service Animals Total:							**10337.40**
Service Animals		service	1	5.00	2067.48	**10337.40**	
Specialized Child Care for Children Who Are Medically Fragile Total:							**232732.43**
Specialized Child Care for Children Who Are Medically Fragile		15 minutes	20	1995.99	5.83	**232732.43**	
Specialized Medical Equipment and Supplies Total:							**685162.87**
Supplies		item	743	0.24	2067.48	**368673.03**	
Equipment		item	356	0.43	2067.48	**316489.84**	
Speech Therapy Total:							**0.00**
Speech Therapy		visit	0	0.00	58.81	**0.00**	
Supported Living Total:							**0.00**
Supported Living		day	0	0.00	233.34	**0.00**	
Vehicle Modifications Total:							**111437.44**
Vehicle Modifications		service	35	0.77	4134.97	**111437.44**	

GRAND TOTAL:	**42848864.41**
Total: Services included in capitation:	
Total: Services not included in capitation:	42848864.41
Total Estimated Unduplicated Participants:	**2783**
Factor D (Divide total by number of participants):	**15396.65**
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

ii.

Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields.*

All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							111512.70
Adult Day Health		15 minutes	29	1686.52	2.28	111512.70	
Case Management Total:							7634157.49
Specialized		day	23	218.37	19.14	96130.84	
Day		day	2442	271.25	11.38	7538026.65	
15 minutes		15 minutes	0	0.00	16.13	0.00	
Community Adult Group Homes Total:							1042749.73
Community Adult Group Homes		day	16	315.48	206.58	1042749.73	
Community First Choice/Personal Assistance Total:							6989018.94
Community First Choice/Personal Assistance		15 minutes	1238	1020.87	5.53	6989018.94	
Day Habilitation Total:							63724.43
Day Habilitation		day	13	59.18	82.83	63724.43	
Homemaker Total:							854530.60
Homemaker		15 minutes	503	374.20	4.54	854530.60	
Prevocational Services Total:							102119.88
Prevocational Services		hour	19	666.84	8.06	102119.88	
Respite Total:							33613.45
Individual		15 minutes	14	447.87	4.54	28466.62	
Residential		day	3	4.61	372.15	5146.83	
Specially Trained Attendant Total:							1295271.51

GRAND TOTAL:		42848864.41
Total: Services included in capitation:		
Total: Services not included in capitation:		42848864.41
Total Estimated Unduplicated Participants:		2783
Factor D (Divide total by number of participants):		15396.65
Services included in capitation:		
Services not included in capitation:		15396.65
Average Length of Stay on the Waiver:	305	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specially Trained Attendant		15 minutes	371	376.00	5.82	811866.72	
Specially Trained Attendant - LPN		15 minutes	5	5866.41	9.26	271614.78	
Specially Trained Attendant - RN		15 minutes	4	4544.85	11.65	211790.01	
Supported Employment Total:							25134.68
Supported Employment		15 minutes	10	185.77	13.53	25134.68	
Audiology Total:							0.00
Audiology		visit	0	0.00	58.81	0.00	
Respiratory Therapy Total:							0.00
Therapeutic Procedures		15 minutes	0	0.00	11.83	0.00	
Visit		visit	0	0.00	25.85	0.00	
Big Sky Bonanza Financial Management Services Total:							53924.85
Big Sky Bonanza Financial Management Services		month	30	10.07	178.50	53924.85	
Big Sky Bonanza Independence Advisor Total:							53924.85
Big Sky Bonanza Independence Advisor		month	30	10.07	178.50	53924.85	
Adult Foster Care Total:							154360.96
Adult Foster Care		day	8	185.53	104.00	154360.96	
Big Sky Bonanza Goods and Services Total:							108852.82
Goods and Services (Services)		service	26	8.10	516.87	108852.82	
Goods and Services (Goods)		service	0	0.00	516.87	0.00	

GRAND TOTAL:	42848864.41
Total: Services included in capitation:	
Total: Services not included in capitation:	42848864.41
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Big Sky Waiver Community Supports Total:							**970598.78**
Big Sky Waiver Community Supports		15 minutes	27	6176.65	5.82	**970598.78**	
Community Transition Total:							**0.00**
Community Transition		service	0	0.00	2067.48	**0.00**	
Consultative Clinical and Therapeutic Services Total:							**2168.01**
Consultative Clinical and Therapeutic Services		service	1	5.66	383.04	**2168.01**	
Dietetic-Nutritionist Services Total:							**0.00**
Dietetic Services		15 minutes	0	0.00	15.78	**0.00**	
Environmental Accessibility Adaptations Total:							**532542.79**
Environmental Accessibility Adaptations		service	81	1.59	4134.97	**532542.79**	
Family Training and Support Total:							**2457.68**
Family Training and Support		15 minutes	5	55.92	8.79	**2457.68**	
Health and Wellness Total:							**76647.33**
Health and Wellness		service	95	4.46	180.90	**76647.33**	
Homemaker Chore Total:							**75231.88**
Homemaker Chore		service	82	3.55	258.44	**75231.88**	
Level 1 Assisted Living Total:							**14509930.24**
Level 1 Assisted Living		day	752	185.53	104.00	**14509930.24**	
Level 2 Assisted Living Total:							**2720611.92**
Level 2 Assisted Living		day	104	185.53	141.00	**2720611.92**	
Level 3 Assisted Living Total:							**2667153.10**

GRAND TOTAL:	**42848864.41**
Total: Services included in capitation:	
Total: Services not included in capitation:	42848864.41
Total Estimated Unduplicated Participants:	**2783**
Factor D (Divide total by number of participants):	**15396.65**
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	30

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 3 Assisted Living		day	51	315.48	165.77	2667153.10	
Money Management Total:							42369.60
Money Management		15 minues	35	208.00	5.82	42369.60	
Non-medical Transportation Total:							169927.78
Trip		service	95	42.63	12.82	51919.08	
Miles		mile	679	526.66	0.33	118008.71	
Nutrition Total:							436901.68
Nutrition		meal	397	187.80	5.86	436901.68	
Occupational Therapy Total:							0.00
Occupational Therapy		visit	0	0.00	64.14	0.00	
Pain and Symptom Management Total:							264479.06
Pain and Symptom Management		session	158	23.13	72.37	264479.06	
Personal Emergency Response Systems Total:							19124.84
Installation		item	7	0.65	103.38	470.38	
Monthly		month	52	5.03	71.32	18654.46	
Purchase		item	0	0.00	829.99	0.00	
Physical Therapy Total:							1161.96
Physical Therapy		15 minutes	1	41.41	28.06	1161.96	
Post Acute Rehabilitation Services Total:							0.00
Post Acute Rehabilitation Services		day	0	0.00	800.02	0.00	
Private Duty Nursing Total:							793227.72
RN Supervision						0.00	

GRAND TOTAL:	42848864.41
Total: Services included in capitation:	
Total: Services not included in capitation:	42848864.41
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	303

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 minutes	0	0.00	15.83		
RN		15 minutes	164	201.53	11.65	385043.22	
LPN		15 minutes	173	254.80	9.26	408184.50	
Senior Companion Total:							1762.98
Senior Companion		15 minutes	6	212.92	1.38	1762.98	
Service Animals Total:							10337.40
Service Animals		service	1	5.00	2067.48	10337.40	
Specialized Child Care for Children Who Are Medically Fragile Total:							232732.43
Specialized Child Care for Children Who Are Medically Fragile		15 minutes	20	1995.99	5.83	232732.43	
Specialized Medical Equipment and Supplies Total:							685162.87
Supplies		item	743	0.24	2067.48	368673.03	
Equipment		item	356	0.43	2067.48	316489.84	
Speech Therapy Total:							0.00
Speech Therapy		visit	0	0.00	58.81	0.00	
Supported Living Total:							0.00
Supported Living		day	0	0.00	233.34	0.00	
Vehicle Modifications Total:							111437.44
Vehicle Modifications		service	35	0.77	4134.97	111437.44	

GRAND TOTAL:	42848864.41
Total: Services included in capitation:	
Total: Services not included in capitation:	42848864.41
Total Estimated Unduplicated Participants:	2783
Factor D (Divide total by number of participants):	15396.65
Services included in capitation:	
Services not included in capitation:	15396.65
Average Length of Stay on the Waiver:	305