

# Application for a §1915(c) Home and Community-Based 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 waiver approved under authority of §1915(c) of the Social Security Act.

**B. Program Title:**

**Home and Community-Based Waiver for Individuals with Developmental Disabilities**

**C. Waiver Number: MT.0208**

**Original Base Waiver Number: MT.0208.**

**D. Amendment Number: MT.0208.R07.01**

**E. Proposed Effective Date:** (mm/dd/yy)

11/12/23

**Approved Effective Date: 11/12/23**

**Approved Effective Date of Waiver being Amended: 07/01/23**

### 2. Purpose(s) of Amendment

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

Appendix C

Update C.2.d. for accuracy of services that allows “legally responsible individuals” as paid caregivers. These services include Individual Goods and Services, Specialized Medical Equipment and Supplies, and Transportation that were previously approved for this allowance by the Centers for Medicare and Medicaid Services (CMS)

Appendix D and E

Update plan of care language and goal structure (i.e., replace quarterly reports with mid-year reviews of the plan of care, or Personal Support Plan; initial plan of care is finalized within 45 days of enrollment with an interim service plan)

Appendix I

Update rate methodology based on a provider rate study and legislative action. These rates were temporarily approved in an Appendix K.

Update Electronic Visit Verification (EVV) status and processes

Appendix J

Update Average Cost per Unit based on the rate methodology updates described in Appendix I

### 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	<input type="text"/>
Appendix A Waiver Administration and Operation	<input type="text"/>
Appendix B Participant Access and Eligibility	<input type="text"/>
Appendix C Participant Services	C-2d
Appendix D Participant Centered Service Planning and Delivery	D-1g, D2-a
Appendix E Participant Direction of Services	E-2biv
Appendix F Participant Rights	<input type="text"/>
Appendix G Participant Safeguards	<input type="text"/>
Appendix H	<input type="text"/>
Appendix I Financial Accountability	I-2a, I-2d, I-5
Appendix J Cost-Neutrality Demonstration	J-2d

**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:

## Appendix C

Update C.2.d. for accuracy of services that allows “legally responsible individuals” as paid caregivers. These services include Individual Goods and Services, Specialized Medical Equipment and Supplies, and Transportation that were previously approved for this allowance by the Centers for Medicare and Medicaid Services (CMS)

## Appendix D and E

Update plan of care language and goal structure (i.e., replace quarterly reports with mid-year reviews of the plan of care, or Personal Support Plan; initial plan of care is finalized within 45 days of enrollment with an interim service plan)

## Appendix I

Update rate methodology based on a provider rate study and legislative action

Update Electronic Visit Verification (EVV) status and processes

## Appendix J

Update Average Cost per Unit based on the rate methodology updates described in Appendix I

## Application for 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*):

Home and Community-Based Waiver for Individuals with Developmental Disabilities

**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    5 years

**Original Base Waiver Number:** MT.0208

**Waiver Number:** MT.0208.R07.01

**Draft ID:** MT.004.07.01

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

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended:** 07/01/23

**Approved Effective Date of Waiver being Amended:** 07/01/23

### 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)

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**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 in 42 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)

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**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:

**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.

The purpose of this waiver is to provide the necessary support options to help Montanans with a developmental disability achieve and maintain a good quality of life. This goal hasn't changed since the fall of 1981 when this waiver was initially approved.

The agency responsible for administering the waiver is the Developmental Disabilities Program (DDP) of the Department of Public Health and Human Services. The DDP maintains nine offices in five regions, and a central office in Helena. DDP staff are responsible for establishing eligibility for all services for children aged 8 and older (and verifying eligibility for children younger than age eight), completing annual Level of Care (LOC) activities, conducting selections for service openings, overseeing billing, contracting, attending planning meetings as needed and generally ensuring service provider compliance with the rules, policies and laws governing DDP waiver funded services.

Residential supports for persons in natural homes, group homes, foster homes, and apartments account for more than half the annual waiver expenditures. Over the years, the DDP has expanded the menu of services available to persons served in the waiver. Currently, the waiver is approved for the provision of a comprehensive services package. This waiver currently serves Montanans with a developmental disability of all ages.

Services are delivered by more than 75 enrolled providers to individuals in a variety of settings.

### 3. Components of the Waiver Request

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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*):
- |  |
|--|
| <p><b>Yes. This waiver provides participant direction opportunities.</b> Appendix E is required.</p> <p><b>No. This waiver does not provide participant direction opportunities.</b> Appendix E is not required.</p> |
|--|
- 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

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- 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. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No**
- Yes**
- If yes, specify the waiver of statewide that is requested (*check each that applies*):

**Geographic Limitation.** A waiver of statewide 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

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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. Cost-neutrality 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

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*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 non-Medicaid), 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, Developmental Disabilities Program website on July 11, 2023. The notice contained information regarding the purpose of the amendment and proposed major changes, and a provision to request a paper copy of the draft waiver. The public will be 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 11, 2023.

**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:**

Rime

**First Name:**

Carla

**Title:**

Developmental Disabilities Program Medicaid Program Officer

**Agency:**

Montana Department of Public Health and Human Services

**Address:**

PO Box 4210

**Address 2:**

111 Sanders

City:

Helena

State:

Montana

Zip:

59604

Phone:

(406) 444-6047

Ext:

TTY

Fax:

(406) 444-0230

E-mail:

CRime2@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 Analyst

Agency:

Montana Department of Public Health and Human Services

Address:

Director's Office

Address 2:

PO Box 4210

City:

Helena

State:

Montana

Zip:

59604-4210

Phone:

(406) 444-2584

Ext:

TTY

Fax:

(406) 444-1970

E-mail:

mkulawik@mt.gov

## 8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section

VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

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:

**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:

**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.*

**Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

## Public Comments and Responses:

Comment: I have a question in regard to the 0208 Comprehensive Waiver Amendment. If I have \$15,000 for respite, would I get a 4% increase to that total or \$16.04% or none?

Response: The 16.04% is an overall weighted average increase for all Waiver services. Proposed rates in MAR 37-1036 (<https://dphhs.mt.gov/assets/rules/37-1036pro-arm.pdf>) are currently open for public comment through August 18th. Both the Waiver Amendment and rates MAR are currently in the public comment period and are subject to change prior to finalization. Once the rates are adopted and if you have further questions specific to the individual cost plan, please contact the Targeted Case Manager or Regional Manager.

Comment: I am a little confused based on the PDF that was attached. I just want to make sure I understand this correctly as a self-direct consumer of the 0208 waiver. I am also not sure I understand the following from the PDF: How does "legally responsible individuals" as paid caregivers translate to services include Individual Goods and Services, Specialized Medical Equipment and Supplies, and Transportation that were previously approved for this allowance by CMS? Does this mean that a paid caregiver is given permission to purchase these items, or be paid for these items. Sorry just a little confused and wanted to make sure I could get some clarification.

Response: Appendix C of the Waiver requires that all services that permit a "legally responsible individual" be listed. These three Waiver services were inadvertently omitted from this section, although they had been previously approved. There is no functional change for Waiver recipients and those who deliver these services.

Comments: I am writing to make three public comments in regards to the 0208 waiver rate increases.

1. I understand that the 0208 waiver was just approved, so this first comment cannot be considered until the next waiver renewal. I recommend the service responsible for transportation to and from Day Supports be written into the waiver. Most states write in the waiver that Day Supports is responsible for transportation and is included in the rate. My understanding is that 4% was added to the Day Supports rate to cover transportation, implying that service is responsible. However, because it is not in the waiver, no service is designated as responsible = ongoing confusion.
2. I recommend that an enhanced transportation service/rate be considered for people who utilize wheelchairs. There is a significant cost when supporting people who utilize wheelchairs, i.e., vehicle modifications, lifts, lift maintenance, and the number of people who can fit in a vehicle is significantly decreased, which results in needing more vehicles than if not supporting people who utilize wheelchairs.
3. My understanding is that the Day Supports transportation rate included in the new rate was based on a weekly average of 33 miles for a single participant, which is 6.6 miles per day. Many people who receive Day Supports live much further than 3.3 miles from the center. I know of situations in which providers drive 30 miles one way to pick up a participant. I recommend consideration be given to these situations.

Response: Thank you for your comments. They will be taken under advisement for a future Waiver amendment or renewal. Proposed rates in MAR 37-1036 (<https://dphhs.mt.gov/assets/rules/37-1036pro-arm.pdf>) are currently open for public comment through August 18th.

Continued from G-1-d Responsibility for Review of and Response to Critical Events or Incidents.

## Self-Direct Services Delivery Responsibilities:

All self-direct employers and their staff providing self-directed DDP services are mandatory reporters. They must follow this manual. Their responsibilities are:

1. Take action to move the person from a harmful situation or to protect from harm.
2. Provide staff intervention when knowledge or the potential for harm occurs.
3. Provide medical assessment and/or treatment for a person receiving self-directed services if needed following an incident.
4. Any injury(s) suspected to be caused by abuse or neglect must be examined by a medical professional and classified as an allegation of abuse or neglect for reporting purposes and reported to APS.
5. The person, family, legal representative, and staff must cooperate with the investigation.
6. All self-direct staff must be trained on the DMS for recognizing incidents, notification procedures, and the completion of an IR.
7. The TCM may assist the self-direct provider with submitting IRs.
8. QIS investigate critical incidents in conjunction with the employer.
9. QIS may provide technical assistance if requested by the person, legal representative, or the family who are self-directing their

services.

The participant and/or family/legal representative can request access to the DMS to view his/her own records, including investigation results. The participant and/or family/legal representative can request results from the provider of their investigation.

Continued from I-2-a Rate Determination Methods

Individual plans of care (using assessment tools) will identify the specific outcomes, along with the amount and type of staff supervision and support an individual's needs on a daily basis. In order to qualify for the daily reimbursement, the individual must be present, and the provider must meet the required outcomes in the plan of care. To account for changing needs, if a plan of care team identifies the individual's needs have changed, a new MONA will be completed, and the planning team will identify what needs the person has that cannot be met with range of hours in the member's current tier. A request to change tiers must be presented to the DDP regional manager for review and approval.

Amendment effective 11/12/2023

Updated service rates based on rate study:

Day Supports and Activities

Homemaker

Residential Habilitation

Respite

Supported Employment-Follow Along Support

Private Duty Nursing

Supports Brokerage

Adult Foster Support

Residential Training Supports

Assisted Living

Level I Behavioral Support Services

Caregiver Training and Support

Companion Services

Meals

Personal Care

Personal Supports

Retirement Services

Supported Employment-Individual Employment Support

Supported Employment-Small Group Employment Support

Transportation

Updated service rates based on current resource-based relative value scale (RBRVS):

Nutritionist Services

Occupational Therapy

Physical Therapy

Psychological Evaluation, Counseling and Consultation Services

Speech Therapy

## 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.

Developmental Disabilities Program of the Behavioral Health and Developmental Disabilities Division of the Department of Public Health and Human Services

*(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:

Appendix A.2. Oversight of Performance

(a) The Developmental Disabilities Program (DDP) 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 and responsibilities of all staff related to waiver operation. There are many documents serving to outline the responsibilities of assigned staff regarding specific aspects of the waiver, including DDP rules and policies relating directly to the operation of the waiver. DDP maintains organizational charts, individual position descriptions, and web-based information serving to assist persons who need assistance in accessing information about the waiver, and who within the DDP is responsible for decision making based on the issue at hand. The waiver application is probably the most comprehensive single document in outlining the persons/positions responsible for ensuring all the requirements of the waiver are being met.

(c). The Medicaid Director or designee are ultimately responsible for ensuring that problems in the administration of the waiver are resolved. Typically, the Medicaid Director or designee are not directly involved in the day to day operational decisions of DDP staff.

**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.**

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## 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.*

Financial Management Services (FMS):

The DDP contracts with a financial management service to perform fiscal agent duties for self-direct services with employer authority. They educate employers on their responsibilities, process employee and employer paperwork, process employee timesheets according to individual cost plan. They provide workers' compensation for all employees and pay employee and employer related taxes. The FMS also generates expense reports for the employer, case manager and the state.

Case Management Services for individuals in the waiver:

The functions performed by case managers can be reviewed in A-7, but generally relate to the gathering of eligibility and referral information, needs identification (e.g. medical, educational and social), the development and monitoring of plans of care and coordination the delivery of supports to persons as outlined in the plans of care.

The contracted agency is selected through a Request for Proposal process managed by the Department of Administration Procurement Division. The agency covers all geographic areas of the state.

Contracted targeted case management and state targeted case management employees are required to comply with state plan, Federal TCM rule, DDP policy, the current versions of the case management handbook and the current version of the PSP Procedural Manual published by DDP.

The contracted agency that provides targeted case management and other services in the same region will not be allowed to provide targeted case management services to the same individuals who receive other services from the agency.

**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

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**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:

Contracted entities providing FMS and case management are reviewed against the performance requirements outlined in the Developmental Disabilities Program (DDP) quality assurance review tools specific to these services. The DDP quality assurance personnel and the DDP Waiver Specialist are responsible for monitoring, summarizing, and reporting these activities as outlined in the Assessment of Methods and Frequency.

## Appendix A: Waiver Administration and Operation

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**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:

### DISTRIBUTION OF WAIVER OPERATIONAL AND ADMINISTRATIVE FUNCTIONS

The DDP QA waiver performance measure reviews are conducted annually by the quality assurance personnel using spreadsheets developed based on approved performance measures, and the components established for compliance of each measure. The documentation relating to the outcomes of the performance measures are submitted to the Waiver Specialists following the annual review. The data from all regions of the state is aggregated by the Waiver Specialists and submitted to the DDP management staff for review and determination of compliance trends.

Non-compliance with standards results in remediation by assigned DDP staff, as outlined in the waiver appendices with performance measures under the Methods for Remediation/Fixing Individual Problems sections. The functions of contracted entities follow:

#### Financial Management Service Contract

Function: The Financial Management Service (FMS) provides assistance to individuals who self-direct services with employer authority. Broadly, this includes things such as processing claims for payment, meeting state and federal withholding requirements for staff, ensuring that qualified provider requirements for staff are met, as outlined in the contract with the DDP, the standards set forth in DDPs Request for Proposal for Fiscal Management Services, and waiver language.

## Appendix A: Waiver Administration and Operation

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**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		
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:**

**Number and percent of member files maintained by the FMS under self direction were in compliance with the contract; N: Number of members in compliance with the contract. D: Number of members reviewed.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**FMS electronic files**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of contracted case management agencies that were in compliance with DDP requirements. N: Number of case management agencies that were in compliance with DDP requirements; D: Number of case management agencies.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percent of members, under self-direction, for whom the FMS charged the administrative rate established in the contract; N: Number of members whose records reflect that the correct administrative rate was charged by the FMS; D: Number of members reviewed.

**Data Source** (Select one):

**Financial records (including expenditures)**

If 'Other' is selected, specify:

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

<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):

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 DDP completes a 100% review of the above performance measures.

The DDP Waiver Specialist, or designee, is responsible for aggregating the data generated by the DDP quality assurance personnel in the monitoring of the performance measures, above. Data will be maintained as a percentage of annual compliance with these measures. Performance data will be forwarded electronically by the DDP quality assurance personnel to the DDP Waiver Specialist at least annually, and the data will be entered onto a spreadsheet. Annual percent compliance with the performance measures will enable reviewers to determine compliance trends.

The identification of problems in the delivery of contracted services is generally the result of the application of the DDP QA review process. The annual QA Review Process is applied by the DDP quality assurance personnel to service coordination agencies, and the FMS. The QA review process is updated as needed to include measures designed to monitor compliance with new waiver requirements, policies, rules, or contracting requirements.

**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.

Quality assurance personnel perform ongoing monitoring of services in addition to the annual review. If a deficiency is discovered at any time with the FMS or case management agency, a Quality Assurance Observation Sheet (QAOS) is issued. Quality assurance personnel have the authority to respond appropriately and assure that corrective action is taken. The QAOS helps ensure DDP staff and provider staff share a written understanding of the identified area of noncompliance, there is agreement in terms of steps that need to be taken to correct deficiencies, and that correction of the findings or deficiency is completed before the QAOS can be considered accepted or “closed.” The provider must respond to the QAOS and demonstrate that they are taking appropriate steps in correcting the issue. The QIS will follow up on all QAOSs to assure that corrective action is taken before the QAOS is accepted as complete. If a situation arises and cannot be resolved at the regional level, the DDP managers are contacted to provide additional support in assuring a positive outcome. The results are compiled and maintained in the central office to complete future evidentiary reports.

**ii. Remediation Data Aggregation**

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

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**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 non-operational.

**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
<b>Aged or Disabled, or Both - General</b>					
		Aged		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Physical)		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Other)		<input type="checkbox"/>	<input type="checkbox"/>
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
		Brain Injury		<input type="checkbox"/>	<input type="checkbox"/>
		HIV/AIDS		<input type="checkbox"/>	<input type="checkbox"/>
		Medically Fragile		<input type="checkbox"/>	<input type="checkbox"/>
		Technology Dependent		<input type="checkbox"/>	<input type="checkbox"/>
<b>Intellectual Disability or Developmental Disability, or Both</b>					
		Autism		<input type="checkbox"/>	<input type="checkbox"/>
		Developmental Disability	0	<input type="checkbox"/>	<input type="checkbox"/>
		Intellectual Disability	0	<input type="checkbox"/>	<input type="checkbox"/>
<b>Mental Illness</b>					



Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Mental Illness			
		Serious Emotional Disturbance			

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

DDP uses “Determining Eligibility for Services to Persons with Developmental Disabilities in Montana: A Staff Reference Manual, by William Cook, Ph.D.” as the foundation for the eligibility criteria.

The Department, in consideration of: 1) the parameters established by the relevant legal authorities, 2) the professional knowledge base in the field of developmental disabilities, and 3) the experience and practice in the delivery of developmental disabilities services in Montana and elsewhere, has determined that a person must meet all of the following criteria to be found eligible for the receipt of state sponsored developmental disabilities services:

- A. The person has an IQ score of approximately 70 or less.
- B. The person has an adaptive behavior composite score of approximately 70 or less.
- C. The effect of the person’s developmental disability involves functional limitations in three or more areas of major life activity.
- D. The disability originated before the person attained age 18.
- E. The disability is expected to continue indefinitely.
- F. The disability meets the definition and requirements delineated in Appendix I [Eligibility Staff Reference Manual] for substantial disability and treatment needs.

The determination of whether a person is within one of the target groups is made in accordance with the criteria and procedures established in the work titled “Determining Eligibility for Services to Persons with Developmental Disabilities in Montana: A Staff Reference Manual, by William Cook, PhD.”

The following language is taken from “Determining Eligibility for Services to Persons with Developmental Disabilities in Montana: A Staff Reference Manual, by William Cook, PhD.”

Guidelines for assessment procedures necessary to determine eligibility for services

1. A current or recent assessment of intelligence using a standardized individual test designed to measure intellectual functioning.
2. A current or recent assessment of adaptive behavior. At this time, adaptive behavior will typically be measured using the Vineland Adaptive Behavior Scales, 2nd Edition or newer – Vineland.
3. A current or recent assessment of educational achievement which utilizes standardized tests to identify academic skills in reading, arithmetic and written language. This step is optional for adults. It can be helpful if the client has functional academic skills.
4. A comprehensive history should be compiled by gathering relevant records and by interviewing parents and the prospective adult client. If parents are not available, other records (including social history) should be utilized. The historical information will be used to document the following: A. Developmental history B. Medical history C. Educational history D. Social history E. Mental health history F. Other relevant historical records (e.g., past employment, past placement in services for persons with developmental disabilities, etc.)
5. A current general medical examination. (Optional-use if questions concerning medical/neurological issues are unresolved).
6. Review of current status and needs. Information gathered in this step would include: A. Current residential placement and needs B. Current employment placement and needs C. Other current needs or problems (social, emotional, medical, psychological, legal, case-management, etc.)

**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:

## 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 cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2880
Year 2	2880
Year 3	2880
Year 4	2880
Year 5	2880

**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	2777
Year 2	2777
Year 3	2777
Year 4	2777
Year 5	2777

**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	
Individuals transitioning from institutional settings to DD HCBS waiver services	
Individuals who require services due to a crisis or emergency	
Child Family Services	

## 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):

Individuals transitioning from institutional settings to DD HCBS waiver services

**Purpose** (describe):

To allow individuals, with complete DD waiver referrals and who meet the 0208 waiver eligibility criteria to access waiver slots from the Intensive Behavior Center and institutional settings.

**Describe how the amount of reserved capacity was determined:**

30 slots, based on historical counts of individual transitioning from institutions. Waiver years 1-3 reduced from 50 to 30 slots due to significant number of people transitioned to community in prior waiver years due to ICF-IID closure. Waiver years 4 and 5 were reduced to 30 from the previous Waiver Amendment and remain at 30 for the Renewal.

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

Waiver Year	Capacity Reserved
Year 1	30
Year 2	30
Year 3	30
Year 4	30
Year 5	30

## 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):

Individuals who require services due to a crisis or emergency

**Purpose** (describe):

To allow individuals who meet the 0208 waiver eligibility criteria and are on the waiting list to access waiver services due to a crisis or emergency situation that is currently threatening his/her life and/or safety. In the absence of a waiver slot, the Individual is at risk of an (institutional/higher level of care) out of home placement.

**Describe how the amount of reserved capacity was determined:**

The amount was derived from historical data of individuals with referrals for waiver services that indicated a crisis or emergency situation. Slots for waiver years 1-3 were increased from 20 to 40; waiver years 4 and 5 were increased to 40 from the previous Waiver Amendment and remain at 40 for the Renewal.

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

Waiver Year	Capacity Reserved
Year 1	40
Year 2	40
Year 3	40
Year 4	40
Year 5	40

**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):

Child Family Services

**Purpose** (describe):

To reserve capacity for children who meet 0208 waiver eligibility and are 16 years of age or older, will be transitioning out of state custody and would require institutional placement or higher level of care to meet health and safety needs, if not enrolled in waiver.

**Describe how the amount of reserved capacity was determined:**

The amount of reserved capacity was based on 150% of the average number of emergency requests for services received from Child and Family Services.

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

Waiver Year	Capacity Reserved
Year 1	12
Year 2	12
Year 3	12
Year 4	12
Year 5	12

## Appendix B: Participant Access and Eligibility

### 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 are selected for waiver services through a selection process that requires first a Developmental Disabilities eligibility determination. Once eligibility is determined the individual is placed on the statewide waiting list for 0208 Comprehensive Waiver services. Initiation of services funded through the Waiver occurs in chronological order from the waiting list based on length of time on the wait list. Exceptions to the chronological requirement may be made when a qualifying reserved capacity situation occurs.

## 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:*

Persons in the Disabled Adult Child category 42.U.S.C.1383 (c)

All other mandatory and optional groups Including:

PICKLE (members moving from Supplemental Security Income (SSI) to Social Security Disability Insurance (SSDI) - 42 CFR § 435.135 - Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977.

Adult Medicaid Expansion group - 42 CFR § 435.119 - Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL.

---

**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 post-eligibility 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 is entitled to the lesser of calculation 1 or 2:

Calculation 1  
 Maximum spousal standard – Spouse’s gross income = Maximum spousal allowance

Calculation 2  
 Shelter expenses – Basic shelter allowance = Excess shelter expense + Basic needs standard = Community spouse’s maintenance needs – gross income = Spousal allowance

The community spouse is entitled to the lesser of calculation 1 or 2.

**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:*

Basic needs standard – gross income of dependent family member. The difference of that calculation is then divided by 3 and the remaining amount is the family allowance.

**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 (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:

Basic needs standard – gross income of dependent family member. The difference of that calculation is then divided by 3 and the remaining amount is the family allowance.

**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:

Calculation 1  
 Maximum spousal standard – Spouse’s gross income = Maximum spousal allowance

Calculation 2  
 Shelter expenses – Basic shelter allowance = Excess shelter expense + Basic needs standard = Community spouse’s maintenance needs – gross income = Spousal allowance

The community spouse is entitled to the lesser of calculation 1 or 2.

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:

**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:*

**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:

DDP Eligibility Specialist (employed by the State Medicaid Agency): The primary position responsible for establishing if a waiver services applicant meets the state definition of developmental disability. Persons employed in this position have a BA degree from an accredited college in human resources, business administration, public administration or other related field and a minimum of three years of job-related experience. The DDP quality assurance personnel will continue to establish eligibility in a support role to the Eligibility Specialist, as needed.

Quality assurance personnel (employed by the State Medicaid Agency): The DDP quality assurance personnel is responsible for completing the LOC evaluations. The quality assurance personnel must possess the following qualifications:

Bachelor's degree and three years of job related experience, and preference for two years experience in the field of services for individuals with developmental disabilities.

- 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.

\*Person has a developmental disability, in accordance with 53-202 (3) MCA, as documented on the appropriate Waiver-3 form. Standardized IQ test scores and adaptive behavior scores are required for individuals age 8 and older.

\*Person has specialized services needs, documented on the Medicaid Home and Community Based Services Specialized Services Summary Sheet. Broadly, need is based on significant deficits in adaptive behaviors, significant behavior problems, or significant medical/health related issues.

\*Person, in the absence of the waiver, is at risk of placement in a more restrictive setting such as ICF-IID.

Various assessments are used to assist the quality assurance personnel in completing a Specialized Services Summary Sheet that serves as the basis of the Waiver 3 document. Standardized adaptive behavior assessment results, a standardized psychological exam, and the Montana Resource Allocation Protocol tool (MONA) may be used to assist the quality assurance personnel in completing the required LOC forms. The quality assurance personnel will conduct a face-to-face visit with the individual and primary care giver in the initial LOC.

All individuals, inclusive of 8 years of age and older, will be determined to have an intellectual/developmental disability by the Eligibility Specialist or a DDP quality assurance personnel in accordance with the requirements specified in the Eligibility Determination Form, found in Appendices L and M of the Determining Eligibility for Services to Persons With Developmental Disabilities in Montana: A Staff Reference Manual, found on the DDP website. Children under the age of 8 years may be found provisionally eligible through the Eligibility Review Panel (ERP) process.

The Eligibility Specialist and quality assurance personnel state staff adhere to prescribed standards regarding the DD eligibility determination to ensure consistency.

- 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.

The statutory criteria for commitment to the ICF-IID is at Part 1 of Title 53, Chapter 20, MCA. The tool used by the Residential Facility Screening Team in the ICF-IID commitment process is the Determination Regarding Commitment to Residential Facility form. The governing policy for this form is the Manual for the Screening of Persons Being Considered for Civil Commitment to the Montana Development Center or to a Community Treatment Plan found on the DDP website. ICF-IID commitment is based on a person having:

\*A diagnosis of developmental disability and;

\*Impairment in cognitive functioning and;

\*Behaviors that pose an imminent risk of serious harm to self or others, and because of those behaviors cannot safely or effectively be habilitated in community-based services and;

\*Placement and habilitation in the ICF-IID are appropriate for the person.

The ICF-IID commitment criteria are different than the criteria used to determine eligibility for DD waiver services. The difference is the imminent risk of serious harm applicable to persons committed to the ICF-IID. The state statute defining developmental disability is the same for the ICF-IID and the DD waiver.

- 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:

DD eligibility and the need for specialized services is completed prior to enrollment in the waiver. The child or adult has already been found DD eligible and in need of services, in accordance with applicable rules and policies found on the DDP website.

Upon enrollment in the waiver the LOC is verified by the quality assurance personnel. They complete the Waiver 3 and the Specialized Services Needs forms. They will also review a psychological assessment, Vineland, DDP eligibility determination worksheet and any other assessments available from the member's support team.

The re-evaluation

The DDP quality assurance personnel may employ various methods to ensure that reevaluations occur annually. It includes a review of the Annual Healthcare Checklist and Risk Worksheet, the consumer survey, assessments in the following domains: living, employment, educational, developmental and social. This information is utilized in updating the Specialized Services Needs form and completion of the Waiver 3. One practice is to complete the first reevaluation in less than 12 months for the purpose of grouping the entire quality assurance personnel caseload in the same month for all reevaluations. Another practice is to complete the reevaluation in less than 12 months, eventually enabling the grouping of reevaluation dates into the same month for all the individuals served by a specific provider. Regional offices are also implementing electronic reminder systems and involving administrative staff to assist in tracking. These practices reduce the potential for staff error in completing annual reevaluations in a timely manner.

- 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*):

The DDP quality assurance personnel may employ various methods to ensure that reevaluations occur annually. One practice is to complete the first reevaluation in less than 12 months for the purpose of grouping the entire quality assurance personnel caseload in the same month for all reevaluations. Another practice is to complete the reevaluation in less than 12 months, eventually enabling the grouping of reevaluation dates into the same month for all the individuals served by a specific provider. Regional offices are also implementing electronic reminder systems and involving administrative staff to assist in tracking. These practices reduce the potential for staff error in completing annual reevaluations 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:

All LOC documentation is maintained in the quality assurance personnel regional or satellite office. In addition, the eligibility documentation for individuals age 8 and over (consisting of the DDP eligibility outcome notification letter and the Eligibility Determination Form) is maintained in the DDP central office. Documentation for children younger than 8 years of age is maintained in the offices of the DDP service provider agencies.

## 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:**

**Number and percent of initial level of care determinations that were completed within 90 days of the application. N: Number of initial level of care determinations**

that were completed within 90 days of the application; D: number of all new applications.

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**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.*

**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:**

**Number and percent of initial level of care determinations that were completed according to the level of care processes and instruments described in the waiver. N:** Number of initial level of care determinations that were completed according to the level of care processes and instruments described in the waiver; **D:** Number of all new level of care determinations.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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.

100% of eligibility determinations are reviewed.

The DDP monitors the completion of timely and accurate eligibility determinations, as described in waiver performance measures and Determining Eligibility for Services to Persons With Developmental Disabilities in Montana: A Staff Reference Manual, found on the DDP website. The completion of initial level of care reviews, and the review of the qualifications of persons completing these activities is monitored by the Regional Manager. Performance measure reviews are completed annually, and all noncompliance is discussed with the DDP management team.

All approved Waivers are posted on the DDP website. This ensures that families and other persons acting on behalf of the individual have the opportunity to review the waiver language pertaining to eligibility requirements, freedom of choice, the right to fair hearing in the event of adverse outcomes, denial of services and denials of eligibility. DDP staff contact information is also posted on the website, facilitating access to more information, if desired. No-cost copies of Waiver documents will also be available upon request from the DDP central office.

**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.

DDP Staff QA Performance Issues:

The LOC QA review spreadsheets specific to DDP quality assurance personnel performance measures are maintained in an electronic file by the Waiver Specialist. Problems noted in the performance of activities related to the level of care process would result in the Regional Manager follow up with their assigned staff in addressing specific problems as they arise. Follow up occurs at the DDP regional or central office level, as needed. The Quality Assurance Observation Sheet (QAOS) is used to address problems in a timely manner.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>



Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="320 461 794 544" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="866 748 1340 831" type="text"/>

**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).

The choice between home and community-based services as an alternative to institutional care is explained to the member and/or his/her legal guardian, by the Service Coordinator, during the plan of care process. At this time the Service Coordinator will also review the member's fair hearing rights. The member or legal representative acknowledges receipt of this information on the signature page of the plan of care.

The Freedom of Choice form is completed either prior to, or at, the annual planning meeting. The service coordinator is responsible for ensuring a copy of the form is forwarded to the DDP quality assurance personnel for inclusion in the member's waiver file.

The form covers:

1. Choice of waiver services, including self-direction
2. Choice of providers of DDP funded services
3. Choice of filing a fair hearing request
4. Choice between waiver services and Intermediate Care Facilities for the Intellectually Disabled (ICF/IID)
5. Report suspected abuse, neglect, and exploitation to the appropriate reporting agency.

The informing the member of choice rules (ARM 37.34.918 and the fair hearing rules (ARM 37.5.301 through 37.5.313) are available upon request.

- 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.

Written copies of these forms are available upon request from the DDP quality assurance personnel regional or satellite offices. These documents are stored in the individual waiver files, maintained by the quality assurance personnel. They are also in the person's individual file maintained by the service coordinator.

## 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 Department operates under the Interpreter Services Medicaid Services Bureau policy. DDP and DPHHS websites provide language assistance services information and also provides interpreters upon request. The interpreter is reimbursed by submitting the Interpreter Services Invoice Verification form to:

DPHHS  
 Medicaid Services Bureau Interpreter Services  
 PO Box 202951  
 Helena, MT 59620

The Cultural and Language Services policy under the Health Resources Division provides interpretive services through face-to-face, telephonic, or electronic means. Auxiliary aids, such as readers for the blind, Braille materials, amplification devices, and qualified sign language interpreters may also be made available. There is a Montana Public Assistance Telephone Interpreter Service called Language Link in which an account can be set up to access interpreters. The case manager/service coordinator can assist a member with these accommodations.

## 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	Day Supports and Activities		
Statutory Service	Homemaker		
Statutory Service	Residential Habilitation		
Statutory Service	Respite		
Statutory Service	Supported Employment - Follow Along Support		
Extended State Plan Service	Nutritionist Services		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Private Duty Nursing		
Extended State Plan Service	Psychological Evaluation, Counseling and Consultation Services		
Extended State Plan Service	Speech Therapy		
Supports for Participant Direction	Supports Brokerage		
Other Service	Adult Foster Support		
Other Service	Assisted Living		
Other Service	Behavioral Support Services		
Other Service	Caregiver Training and Support		
Other Service	Community Transition Services		
Other Service	Companion Services		
Other Service	Environmental Modifications		
Other Service	Individual Goods and Services		
Other Service	Meals		
Other Service	Personal Care		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Personal Supports		
Other Service	Remote Monitoring Equipment		
Other Service	Remote Monitoring		
Other Service	Retirement Services		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Supported Employment - Co-Worker Support		
Other Service	Supported Employment - Individual Employment Support		
Other Service	Supported Employment - Small Group Employment Support		
Other Service	Transportation		

## 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):**

Day Supports and Activities

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Day Supports and Activities is available to a member of any age. It consists of formalized habilitation services, and staff support for the acquisition, retention, or improvement in self-help, behavioral, educational, socialization, and adaptive skills. Day Supports and Activities must also include community inclusion activities. Day Supports and Activities are member centered, preplanned, purposeful, documented, and scheduled activities which take place during typical working hours, in a non-residential setting, separate from the member's private residence or other residential living arrangement. Day Supports and Activities may occur within a day activity setting, in the community, or in both settings. Day Supports & Activities may be provided as a continuous or intermittent service.

Day Supports and Activities are expected to be evaluated based upon the following criteria:

1. It is considered by the member to be a meaningful day.
2. It is an actual learning or skill building experience.
3. It is something the person, wants, chooses, or needs to do.
4. It supports deep connections to ordinary community life.
5. It is something useful to themselves or a contribution to others.
6. It is of significant exercise or health value.
7. It is building friendships and social relationships.

Day Supports and Activities include but are not limited to:

1. The discovery and identification of skills, interests and potential for community contribution and people and places where a member's interest, culture, talent, and gifts can be contributed and shared with others with similar interests;
2. The identification and provision of support necessary for each member's personal success and achievement of plan of care outcomes. Supports may include but are not to be limited to; the identification of resources necessary for transportation, social participation, inclusion, and independence;
3. Support as needed, for a member's communication, personal care and safety as needed;
4. Increased awareness and exposure to self-determination and self advocacy; and
5. Development of a career profile and employment goal or career plan of which employment may be an identified need.

Members may utilize Individual and Small Group Employment Support, Follow Along Support, and Co Worker Support in conjunction with Day Supports & Activities.

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

Total hours for a member's attendance shall not include time spent during transporting to/from the member's residence. The provider may not bill Medicaid for services on days the member is absent from the facility, unless retainer days have been approved by the Regional Manager. Day Supports and Activities services will not duplicate or supplant other services provided under IDEA (20 U.S.C. 1401 et seq) and cannot be billed for during the same time frame as Individual or Small Group Employment Support, Follow Along Support, or Co Worker Support.

**Retainer payment:**

Providers of this service may be eligible for a retainer payment if authorized by the Regional Manager. Retainer payments made to providers of Day Supports and Activities may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bed-hold" in nursing facilities. Retainer payments will be reimbursed upon authorization by the Regional Manager.

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

**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	DDP qualified service provider

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Day Supports and Activities**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:  
 \*Be at least 17 years of age.

Within 30 days of hire receive training in:  
 \* abuse reporting,  
 \*incident reporting,  
 \*client confidentiality, and  
 \*any specialty training relating to the needs of the member served, as outlined in the plan of care.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

First aid and CPR, certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

In addition, the employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**  
**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.  
 Prior to authorization as a DDP qualified provider and annually 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:**

Homemaker

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

**HOMEMAKER SERVICES**

Homemaker services consist of general household activities provided by a homemaker when the person regularly responsible for these activities is unable to manage the home and care for himself/herself or others in the home, or is engaged in providing habilitation and support services to the member with disabilities. Homemaker tasks are strictly for the beneficiary and not other members of the household.

Services in this program include meal preparation, cleaning, simple household repairs, laundry, shopping for food and supplies and routine household care.

Homemaker services are not available under the State Plan.

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

This service is not available to members in residential settings in which primary care is funded 24/7 by the DDP (e.g., group homes and assisted living facilities). Homemaker services may be bundled with other services when delivered as a component of Self-Directed Services and Supports (SDSS) and is therefore not available as a discrete service to persons receiving SDSS.

Homemaker services provided by a non-DD service provider agency employee (i.e. business entity) are not required to submit to a background check. Under no circumstances will a homemaker who has not had a background check provide a service if the person is alone in the residential setting at the time the service is being provided.

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

**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	Homemaker entity enrolled as a Montana Medicaid Provider and authorized as a DDP qualified provider.
Agency	DDP qualified service provider and/or subcontracting for Homemaker Services.

**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 entity enrolled as a Montana Medicaid Provider and authorized as a DDP qualified provider.

**Provider Qualifications**

**License (specify):**

Workers are employees of a business entity, licensed, bonded and insured to deliver professional homemaker services

**Certificate (specify):**

**Other Standard (specify):**

Prior to hire:

\*Be at least 17 years of age.

Qualifications of the person providing the homemaker service will be reviewed and approved by the DDP qualified service provider and the member and family, if applicable.

The family or member can request the business entity complete a background check of the worker at no cost to the person in services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.

Prior to authorization as a DDP qualified provider and annually 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:**



DDP qualified service provider and/or subcontracting for Homemaker Services.

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

Prior to hire:  
\*Be at least 17 years of age.  
  
The staffing rules as outlined in ARM 37.34.2101-37.34.2111.  
  
In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.  
Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.  
Prior to authorization as a DDP qualified provider and annually 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:**

Residential Habilitation

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

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**Category 2:**

**Sub-Category 2:**

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**Category 3:**

**Sub-Category 3:**

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**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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**Habilitation- Residential**

Services designed to assist members in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Habilitation is to be provided where the member lives: Settings include group homes, congregate and non-congregate living apartments and natural homes.

All facilities covered by Section 1616(e) of the Act comply with State licensing standards that meet the requirements of 45 CFR Part 1397.

Board and room is not a covered service. Members served are responsible for paying for board and room through other funding sources such as Supplemental Security Income (SSI).

The plan of care, based upon the results of a formal assessment and identification of needs, provides the general goals and specific objectives toward which training efforts are directed. The plan of care also specifies the appropriate residential setting in which services will be provided.

Training is provided in basic self-help skills, home and community living skills, leisure and social skills. Support is provided as necessary for the care of the member. Each training objective is specified in the plan of care and is clearly related to the member's long term goal and is not simply busywork or diversional in nature.

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

Residential habilitation services are not available to members residing in assisted living or adult foster home settings.

Medicaid reimbursement for room and board is prohibited. This service will not duplicate any other services that the member receives. The provider may not bill Medicaid for services on days the member is absent from the facility, unless retainer days have been approved by the Regional Manager. 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. Members in residential habilitation may not receive the following services under the HCBS program: 1) Personal Supports; 2) Homemaker; 3) Environmental Modifications; 4) Respite; or 5) Meals. These restrictions only apply when the HCBS payment is being made for the residential service.

Retainer payment:

Providers of this service may be eligible for a retainer payment if authorized by the Regional Manager. Retainer payments may be made to providers of residential habilitation while the waiver participant is hospitalized or absent from his/her home for period of no more than 30-days per state fiscal year. Retainer payments will be reimbursed upon authorization by the Regional Manager.

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

**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	DDP qualified service provider; and/or subcontracting for Residential Habilitation

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Residential Habilitation**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider; and/or subcontracting for Residential Habilitation

**Provider Qualifications**

**License** (specify):

Residential habilitation is reimbursable in all community based residential settings, except the provision of this service in DD community group homes is contingent upon State licensure for these facilities. DD group home licensure requirements may be reviewed in ARM 37.100.301 through 37.100.340 and MCA 53-20-301 through 53-20-307.

**Certificate** (specify):

**Other Standard** (specify):

The staffing rule as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:  
 \*Be at least 17 years of age.

Within 30 days of hire receive training in:  
 \*abuse reporting,  
 \*incident reporting,  
 \*client confidentiality, and  
 \*any specialty training relating to the need of the member served, as outlined in the plan of care.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

First aid and CPR, certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

In addition, the employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHHS Office of Inspector General (OIG) for compliance with group home licensing standards, if applicable.

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

QAD licensing study is annual.

As needed by the provider, prior to authorization of payment.  
 Prior to authorization as a DDP qualified service provider and annually 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:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Respite care includes any services (e.g., traditional respite hours, recreation or leisure activities for the individual to enable the caregiver to remain at home for a break; summer camp) designed to meet the safety and daily care needs of the member and the needs of the member's care giver in relation to reducing stress generated by the provision of constant care to the member receiving waiver services. These services are selected in collaboration with the parents and are provided by persons chosen and trained by the family. Persons providing respite services will be in compliance with all state and federal respite standards. Respite services are delivered in conformity with an individualized plan of care. Respite services are temporary in nature, meaning a member is not permitted to receive respite care for a period of 24 hours per day for more than 29 consecutive days. If this level of care is needed the member's team will identify other residential service options available in the waiver that better meets the member's needs.

Respite care is for the temporary relief of the caregiver. The amount and frequency of respite care (with the exception of emergencies) is included in each members plan of care.

FFP (Federal Financial Participation) will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Age appropriate licensed day care is a respite care option for persons through age 17. Licensed day care is a subcomponent of respite and is treated as a discrete service in the plan of care, the individual cost plan and in the Department's billing and payment system. Day care is reported as respite in federal reports.

Respite cannot be used during services otherwise available through public education programs including education activities, after school supervision, daytime services when the school is not in session, or services available to preschool age children.

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

**Service Limitations:**

Respite (including day care) is only available to members residing with primary caregivers in family settings. Respite is available when a primary caregiver is not compensated for providing some or all of the supervision and support needed by the member. Reimbursement for respite in any setting may not exceed the Department's currently approved hourly respite reimbursement rate. Under no circumstances will childcare reimbursed under this service be used to replace routine childcare that a caregiver is responsible to provide.

Children from birth through age 17 may be served in licensed children's day care centers and in licensed family and group day care homes. For children under the age of 13, the waiver will cover the difference in cost between usual and customary rates and the increased rate charged by the provider to serve a child with extraordinary support needs. Children aged 13 through age 17 may be served in licensed children's day care centers and in licensed family and group day care homes, as allowed by the Montana Office of Inspector General. Under no circumstances will children be served in settings licensed to serve adults.

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

**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	An individual who works for a member or a representative of the member self directing the service with common law authority.
Agency	DDP qualified service provider; and/or subcontracting for Respite, and/or offering agency with choice employer authority.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

An individual who works for a member or a representative of the member self directing the service with common law authority.

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

Prior to hire:  
 \*Be at least 16 years of age. Only employees 18 years of age and over are permitted to provide services that are medical in nature.

Within 30 days of hire receive training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

First aid and CPR, certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

\* the person is subject to a criminal background check (at the request of the individual or legal representative).

For self-directed respite using the fiscal agent a background check is optional. In the self-direct using the fiscal agent respite employees can be 16 years of age and background checks may not be accurate for someone under 18 in the state of Montana. Employers are typically hiring a family member to the member or someone they already know, therefore the background check is optional.

If a background check is requested, the fiscal agent will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Upon hiring of a direct care staff person the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The FMS is initially responsible for ensuring that a respite worker meets the qualified provider standards and the FMS maintains records serving to document the compliance with these standards.

**Frequency of Verification:**

Annually, the DDP quality assurance reviews compliance of workers during the annual quality assurance review process, based on the requirements of the performance measure sampling process specified.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider; and/or subcontracting for Respite, and/or offering agency with choice employer authority.

**Provider Qualifications**

**License** (specify):

[Empty box]

**Certificate** (specify):

[Empty box]

**Other Standard** (specify):

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:  
\*Be at least 17 years of age.

Within 30 days of hire receive training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

First aid and CPR, certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements

In addition, the employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually 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:**

Supported Employment

**Alternate Service Title (if any):**

Supported Employment - Follow Along Support



**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Supported Employment - Follow Along Support consists of services and supports that enable a member who is paid at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities to maintain employment in a competitive, customized, or self-employment setting.

Supported Employment – Follow Along Support includes habilitation services needed to stabilize and maintain a member in a competitive, customized, or self-employment setting. Examples of stabilization and support may include, but are not limited to, the following situations described below.

1. Job in jeopardy – the member will lose his/her job without additional intervention.
2. Job promotion within same employment setting - it is determined that the new job requires more complex, comprehensive, intensive supports that can be offered under the waiver.

Extended ongoing or intermittent services needed to maintain and support a member in a competitive, customized, or self-employment setting. Outcomes and Actions needed for the member to maintain employment must be identified in the plan of care.

REIMBURSABLE ACTIVITIES: Follow Along Support:

1. Member-centered employment planning with or on behalf of the member supported,
2. Development of skills that will make the member employable for more hours or for additional duties,
3. Job promotion activities,
4. Extended supports allow for time spent at the member's work site: Observation and job support to assist the member to enhance job task skills, and monitoring at the work site to ascertain the success of the job placement,
5. The provision of job coaches who accompany the member for short-term job skill training at the work site to help maintain employment,
6. Regular contact and/or follow-up with the employers, co-workers, member, parents, family members, guardians, advocates or authorized representatives of the member, and other appropriate professionals, in order to reinforce and stabilize the job placement,
7. Facilitation of natural supports at the work site,
8. Individual program development, writing task analyses, monthly reviews, and behavioral intervention programs,
9. Advocating for the member at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment; OR with members not directly affiliated with the employment site (i.e., parents, bus drivers, case managers, school personnel, landlords, etc.) if the member is hired and currently working,
10. Assistance with financial paperwork and management related to the member's employment and/or maintaining Medicaid eligibility (which includes activities such as assisting the waiver participant in submitting pay stubs to the Office of Public Assistance)
11. Assistance with medication administration considered incidental to the Follow Along Support.

Behavioral intervention programs, when developed and approved by according to the Positive Behavioral Support rule, may be applied as a component of Follow Along Support Services when the plan is specifically designed to be implemented in the employment setting by the follow along staff. The person who developed the plan would train the follow along staff to utilize the interventions to reduce the challenging behaviors in the employment setting.

Members may utilize, Individual and Small Group Employment Support, Co Worker Support and Day Supports & Activities in conjunction with Follow Along Support.

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

A member who is unable to sustain competitive, customized, or self-employment may be considered inappropriately placed and movement to a better-fit employment setting should be considered or the person may need to be referred to, or back to, Vocational Rehabilitation for services and reimbursement, in which case, reimbursement for Supported Employment - Follow Along Support and Vocational Rehabilitation Services will not be allowed concurrently for the same job placement.

**ACTIVITIES NOT REIMBURSABLE: Follow Along Support:**

1. Transportation of a member to and from the job site.
2. Any service that is otherwise available under the Rehabilitation Act of 1973.
3. Activities taking place in a group, (i.e., work crews or enclaves).
4. Public relations activities.
5. Staff continuing education - In-service meetings, department meetings, individual staff development.
6. Incentive payments made to an employer to subsidize the employer’s participation in a supported employment program.
7. Payments that are passed through to users of supported employment programs.
8. Payments for vocational training that is not directly related to a member's supported employment program.
9. The job coach is working the job instead of the member (i.e. Member is not present, or training is not occurring).
10. Any activities which are not directly related to the member's career plan.
11. Services furnished to a minor by a parent(s), step-parent(s) or legal guardian.
12. Services furnished to a member by the member's spouse.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore documentation is required to ensure that the service is not available or is no longer available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

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

**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	DDP qualified service provider; and/or subcontracting for Supported Employment – Follow Along Support, and/or offering agency with choice employer authority.
Individual	An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Supported Employment - Follow Along Support**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider; and/or subcontracting for Supported Employment – Follow Along Support, and/or offering agency with choice employer authority.

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:  
\*Be at least 17 years of age.

Within 30 days of hire receive training in:  
\* abuse reporting,  
\*incident reporting,  
\*client confidentiality, and  
\*any specialty training relating to the need of the member served, as outlined in the plan of care.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

First aid and CPR, certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

In addition, the employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Supported Employment - Follow Along Support**

**Provider Category:**

Individual

**Provider Type:**

An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Prior to hire:

\*Be at least 17 years of age.

\*Screening and a background check of a person prior to an offer of employment as a direct care staff.

Within 30 days of hire receive training in:

\*abuse reporting,

\*incident reporting,

\*client confidentiality,

\*service documentation requirements,

\*training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

First aid certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

Upon hiring of a direct care staff person the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

In addition, the fiscal agent will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The FMS is initially responsible for ensuring that a worker meets the qualified provider standards and the FMS maintains records serving to document the compliance with these standards.

**Frequency of Verification:**

Annually, the DDP quality assurance personnel reviews compliance of workers during the annual quality assurance review process, based on the requirements of the performance measure sampling process specified.

## 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:**

Nutritionist Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Nutritionist Services

These services provided by a registered dietitian or licensed nutritionist include meal planning, consultation with and training for care givers, and education for the individual served. The service does not include the cost of meals. Nutritionist services, for adults, are not available under Montana's State Plan.

This service must be cost effective and necessary to prevent institutionalization.

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

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

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

**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	DDP qualified service provider; and/or subcontracting for Nutritionist Services.
Individual	Licensed Nutritionist, enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Nutritionist Services**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider; and/or subcontracting for Nutritionist Services.

**Provider Qualifications**

**License (specify):**

Licensed nutritionist- MCA 37-25-101 through 37-25-308

**Certificate (specify):**

**Other Standard (specify):**

Licensed Nutritionist- ARM 24.156.1301 through ARM 24.126.1308

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.  
Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Nutritionist Services**

**Provider Category:**

Individual

**Provider Type:**

Licensed Nutritionist, enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License (specify):**

Licensed nutritionist- MCA 37-25-101 through 37-25-308

**Certificate (specify):**

**Other Standard (specify):**

Licensed Nutritionist- ARM 24.156.1301 through ARM 24.156.1308

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process

**Frequency of Verification:**

As needed prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually 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:**

Occupational Therapy

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**



**Service Definition** (*Scope*):

**Category 4:**

**Sub-Category 4:**



**OCCUPATIONAL THERAPY SERVICES**

These services will be provided through direct contact between therapist and individual as well as between the therapist and other people providing services to the individual.

Occupational therapists may provide evaluation, consultation, training and treatment.

Occupational therapy services under the State Plan are limited. Maintenance therapy is not reimbursable, nor is participation in the interdisciplinary planning process.

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

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

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

**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	Licensed Occupational Therapist enrolled as a Montana Medicaid provider and as a DDP qualified service provider.
Agency	DDP qualified service provider; and/or subcontracting for Occupational Therapy.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Occupational Therapy**

**Provider Category:**

**Provider Type:**

Licensed Occupational Therapist enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License** (*specify*):

Licensed in accordance with applicable ARMS 24.165.401 through 24.165.2301

**Certificate** (specify):

**Other Standard** (specify):

MCA 37-24-101 through 37-24-311 apply

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process

**Frequency of Verification:**

As needed prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Occupational Therapy**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider; and/or subcontracting for Occupational Therapy.

**Provider Qualifications**

**License** (specify):

Licensed in accordance with applicable ARMS 24.165.401 through 24.165.2301

**Certificate** (specify):

**Other Standard** (specify):

MCA 37-24-101 through 37-24-311 apply

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process

**Frequency of Verification:**

As needed prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually 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:**

Physical Therapy

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

**PHYSICAL THERAPY SERVICES**

These services will be provided through direct contact between therapist and individual as well as between the therapist and other people providing services to the individual. Physical therapists may provide treatment training programs that are designed to:

1. Preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and activities of daily living; and
2. Prevent, insofar as possible, chronic or progressive conditions through means such as the use of orthotic prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

Therapists will also provide consultation and training to staff or caregivers who work directly with individuals.

Physical therapy services under the State Plan are limited. Maintenance therapy is not reimbursable, nor is participation in the interdisciplinary planning process.

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

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

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

**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	DDP qualified service provider; and/or subcontracting for Physical Therapy Services.
Individual	Licensed Physical Therapist enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

### Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

DDP qualified service provider; and/or subcontracting for Physical Therapy Services.

Provider Qualifications

License (specify):

Licensed in accordance with applicable ARMS 24.177.101 through 24.177.2405

Certificate (specify):

Other Standard (specify):

MCA 37-11-101 through 37-11-322 shall apply

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DDP qualified service provider subcontracting for the service.

Initially - The DDP as part of the Qualified Provider Application Process.

Ongoing - The quality assurance personnel as part of the QA review process

Frequency of Verification:

As needed prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually thereafter.

### Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**

**Service Name: Physical Therapy**

**Provider Category:**

Individual

**Provider Type:**

Licensed Physical Therapist enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License (specify):**

Licensed in accordance with applicable ARMS 24.177.101 through 24.177.2405

**Certificate (specify):**

**Other Standard (specify):**

MCA 37-11-101 through 37-11-322 shall apply

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process

**Frequency of Verification:**

As needed prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually 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:**

Private Duty Nursing

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition** (*Scope*):

**Category 4:**

**Sub-Category 4:**

**PRIVATE DUTY NURSING**

Waiver Private Duty Nursing service provides medically necessary nursing services, to members 21 years of age and older and are provided in any setting in which they are needed. Private Duty Nursing State Plan services are available only to children up to age 21.

Services may include medical management, direct treatment, consultation, and training for the member and/or caregivers.

Services provided under the home health requirement of the State Plan are limited and for those considered "home bound" and for the purposes of postponing or preventing a higher level of care.

State Plan home health services may only be provided in a member's private residence, while some members need nursing services in settings outside of the home.

Private Duty Nursing services must be specified in the plan of care. It must be ordered in writing by the member's physician, and it must be delivered by a registered nurse (RN) or a licensed practical nurse (LPN).

Waiver Private Duty Nursing services, for individuals 21 years of age and older, will be used after the State Plan home health nursing limits have been reached, or if the service required is different from that authorized under the State Plan. State Plan Home Health services include skilled nursing for people 21 and over.

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

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

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

**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	An individual providing qualified LPN or RN services and enrolled as a Montana Medicaid provider and as a DDP qualified service provider.
Agency	DDP qualified service provider and/or subcontracting for Private Duty Nursing services.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**  
**Service Name: Private Duty Nursing**

**Provider Category:**

Individual

**Provider Type:**

An individual providing qualified LPN or RN services and enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License (specify):**

Registered in accordance with MCA 37-8-101 through 37-8-444

**Certificate (specify):**

**Other Standard (specify):**

ARMS 24.159.101 through 24.159.2301 apply

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.  
 Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**  
**Service Name: Private Duty Nursing**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for Private Duty Nursing services.

**Provider Qualifications**

**License (specify):**

Registered in accordance with MCA 37-8-101 through 37-8-444

**Certificate** (*specify*):

**Other Standard** (*specify*):

ARMS 24.159.101-24.159.2301 apply

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.  
Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually 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:**

Psychological Evaluation, Counseling and Consultation Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition** (*Scope*):

**Category 4:**

**Sub-Category 4:**



Psychological Evaluation, Counseling and Consultation Services

Psychological Evaluation, Counseling and Consultation services are those services provided by a licensed psychologist, licensed professional counselor or a licensed clinical social worker within the scope of the practice of the respective professions.

Psychological Evaluation, Counseling and Consultation services may include individual and group therapy; consultation with providers and care givers directly involved with the member; development and monitoring of behavior programs; participation in the member planning process; and counseling for primary care givers (i.e., family members and foster parents) when their needs are related to problems dealing with the member with the disability. Psychological Evaluation, Counseling and Consultation services available under the Montana State Plan will be used before invoicing the waiver.

Psychological Evaluation, Counseling and Consultation services under the State Plan are limited. Under the waiver, this service is available to adults when the service is recommended by a qualified treatment professional, approved by the planning team and written into the plan of care.

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

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

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

**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	Licensed Clinical Social Worker enrolled as a Montana Medicaid provider and as a DDP qualified service provider.
Agency	DDP qualified service provider and/or subcontracting for Psychological Evaluation, Counseling and Consultation Services.
Individual	Licensed Psychologist, enrolled as a Montana Medicaid provider and as a DDP qualified service provider.
Individual	Licensed Professional Counselor, enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Psychological Evaluation, Counseling and Consultation Services**

**Provider Category:**

Individual

**Provider Type:**

Licensed Clinical Social Worker enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License (specify):**

Licensed in accordance with Montana ARM 24.219.504

**Certificate (specify):**

**Other Standard (specify):**

ARMS 24.219.101 through 24.219.615 govern the licensure of persons licensed to practice clinical social work  
MCA-37.22.101 through 37.22.411 outlining the requirements for licensed clinical social workers.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Psychological Evaluation, Counseling and Consultation Services**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for Psychological Evaluation, Counseling and Consultation Services.

**Provider Qualifications**

**License (specify):**

Licensed in accordance with Montana ARM 24.219.504 and 24.219.604

**Certificate (specify):**

**Other Standard (specify):**

The ARM and MCA site references for these professionals apply.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.  
 Applicable standards are verified by the DD service provider agency.

**Frequency of Verification:**

Prior to authorization as a DDP qualified service provider and annually thereafter.  
 As needed by the provider, prior to authorization of payment.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Psychological Evaluation, Counseling and Consultation Services**

**Provider Category:**

Individual

**Provider Type:**

Licensed Psychologist, enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License (specify):**

Licensed in accordance with Montana ARM 24.189.601 through 24.189.633

**Certificate (specify):**

**Other Standard (specify):**

ARM 24.189.101 through 24.189.2401 governing the licensure of persons licensed to practice psychology.  
 MCA 37-17-101 through 37-17-318 outlining the qualifications of a licensed psychologist

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.  
 Prior to authorization as a DDP qualified service provider and annually thereafter.

## Appendix C: Participant Services

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

**Service Type:** Extended State Plan Service

**Service Name:** Psychological Evaluation, Counseling and Consultation Services

**Provider Category:**

Individual

**Provider Type:**

Licensed Professional Counselor, enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License** (*specify*):

Licensed in accordance with Montana ARM  
24.219.504 and 24.219.604

**Certificate** (*specify*):

**Other Standard** (*specify*):

ARM 24.219.101 through 24.219.615 governing the licensure of persons practicing professional counseling  
MCA 37-23-101 through 37.23.311 outlines the licensure requirements for a licensed professional counselor.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually 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:**

Speech Therapy

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

**SPEECH THERAPY SERVICES**

These services will be provided through direct contact between therapist and individual as well as between the therapist and other people providing services to the individual.

Speech therapy services may include:

1. Screening and evaluation of individuals with respect to speech and hearing functions;
2. Comprehensive speech and language evaluations when indicated by screening results;
3. Participation in the continuing interdisciplinary evaluation of individuals for purposes of beginning, monitoring and following up on individualized habilitation programs; and
4. Treatment services as an extension of the evaluation process, which include:  
 Consultation with appropriate people involved with the individual for speech improvement and speech education activities to design specialized programs for developing each individual's communication skills in comprehension, including speech, reading, auditory training, and skills in expression.

Therapists will also provide training to staff and caregivers who work directly with individuals.

Speech therapy services under the State Plan are limited. Maintenance therapy is not reimbursable, nor is participation in the interdisciplinary planning process.

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

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

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

**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	Licensed Speech Language Pathologist (Speech Therapist), enrolled as a Montana Medicaid provider and as a DDP qualified service provider.
Agency	DDP qualified service provider and/or subcontracting for Speech Therapy services.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Speech Therapy**

**Provider Category:**

Individual

**Provider Type:**

Licensed Speech Language Pathologist (Speech Therapist), enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License (specify):**

Licensed in accordance with applicable ARMs 24.222.101 through 24.222.2402

**Certificate (specify):**

**Other Standard (specify):**

MCA 37-15-101 through 37-15-323 shall apply.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency subcontracting for the service.

Initially - The DDP as part of the Qualified Provider Application Process.

Ongoing - The quality assurance personnel as part of the QA review process

**Frequency of Verification:**

As needed prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Speech Therapy**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for Speech Therapy services.

**Provider Qualifications**

**License** *(specify):*

Licensed in accordance with applicable ARMs 24.222.01 through 24.222.2402

**Certificate** *(specify):*

**Other Standard** *(specify):*

MCA 37-15-101 through 37-15-323 shall apply

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.

Ongoing - The quality assurance personnel as part of the QA review process

**Frequency of Verification:**

As needed prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually 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):**

Supports Brokerage

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Support Brokerage Service assists the member (or the member's family, or representative, as appropriate) in arranging for, directing and managing self-directed services. Serving as the agent of the member or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and members to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring workers, managing workers and providing information on effective communication and problem-solving. The service includes providing information to ensure that members understand the responsibilities involved with directing their services. The extent of the assistance furnished to the member or family is specified in the plan of care.

As discussed in the instructions for Appendix E (Participant Direction of Services), the scope and nature of this service hinges on the type and nature of the opportunities for participant direction afforded by the waiver. Through this service, information may be provided to the member about:

- \* person centered planning and how it is applied;
- \* the range and scope of member choices and options;
- \* the process for changing the plan of care and member's budget;
- \* the grievance process;
- \* risks and responsibilities of self-direction;
- \* freedom of choice of providers;
- \* member rights;
- \* the reassessment and review schedules; and,
- \* such other subjects pertinent to the member and/or family in managing and directing services.

Assistance may be provided to the member with:

- \* defining goals, needs and preferences, identifying and accessing services, supports and resources;
- \* practical skills training (e.g., hiring, managing and terminating workers, problem solving, conflict resolution)
- \* development of risk management agreements;
- \* development of an emergency back-up plan;
- \* recognizing and reporting critical events;
- \* independent advocacy, to assist in filing grievances and complaints when necessary; and,
- \* other areas related to managing services and supports.

This service may include the performance of activities that nominally overlap the provision of case management services. Where the possibility of duplicate provision of services exists, the person's plan of care should clearly delineate responsibilities for the performance activities.

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

This service is capped annually at \$6,000 or 20% of value of the member's cost plan, whichever is smaller. These values can be exceeded for a limited time period in extraordinary circumstances, with the prior approval of the DDP Bureau Chief or designee.

This service is limited to members who direct some or all of their waiver services with employer authority.

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



**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	An individual who works for a member or a representative of the member self-directing the service with common law authority.
Agency	DDP qualified service provider offering agency with choice employer authority

**Appendix C: Participant Services**

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

**Service Type: Supports for Participant Direction**  
**Service Name: Supports Brokerage**

**Provider Category:**

Individual

**Provider Type:**

An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Persons serving as support brokers must achieve initial support broker certification which includes the demonstration of competence in:

- \*abuse reporting,
- \*incident reporting,
- \*client confidentiality,
- \*fiscal management service forms and billing procedures,
- \*scheduling of direct support workers,
- \*on call and emergency back up support models,
- \*person centered planning,
- \*individualized budgeting,
- \*recruitment, hiring and firing of direct support workers,
- \*the grievance/fair hearing process,
- \*negotiating service rates,
- \*DDP funded service options, and
- \*other skills and competencies as required by the Department.

Ongoing maintenance of certification in accordance with Department requirements.

**Other Standard** (*specify*):

Prior to hire:

- \*Be at least 18 years of age.
- \*Screening and a background check of a person prior to an offer of employment as a direct care staff.

Upon hiring of a direct care staff person the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

In addition, the fiscal agent will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Persons excluded from serving as a supports broker include:

- \*parents,
- \*spouses, or
- \*legal guardians of the member,
- \*persons who work for agencies providing other DDP-funded supports to the member, and
- \*persons who function as the conservator, payee, or who have any other fiduciary responsibilities for the member.

A person providing "supports broker" services cannot also provide other self-directed services to the same participant.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The Fiscal Management Service provider maintains records verifying compliance with the initial certification and ongoing certification requirements for support brokers employed.

**Frequency of Verification:**

Annually, the quality assurance personnel reviews compliance of workers during the annual quality assurance review process, based on the requirements of the performance measure sampling process specified.

### Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**

**Service Name: Supports Brokerage**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider offering agency with choice employer authority

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Persons serving as support brokers must achieve initial support broker certification which includes the demonstration of competence in:

- \*abuse reporting,
- \*incident reporting,
- \*client confidentiality,
- \*fiscal management service forms and billing procedures,
- \*scheduling of direct support workers,
- \*on call and emergency back up support models,
- \*person centered planning,
- \*individualized budgeting,
- \*recruitment, hiring and firing of direct support workers,
- \*the grievance/fair hearing process,
- \*negotiating service rates,
- \*DDP funded service options, and
- \*other skills and competencies as required by the Department.

Ongoing maintenance of certification in accordance with Department requirements.

**Other Standard** (*specify*):

The staffing rule as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:  
 \*Be at least 18 years of age.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Persons excluded from serving as a supports broker include:  
 \*parents,  
 \*spouses, or  
 \*legal guardians of the member,  
 \*persons who work for agencies providing other DDP-funded supports to the individual, and  
 \*persons who function as the conservator, payee, or who have any other fiduciary responsibilities for the member.

A person providing "supports broker" services cannot also provide other self-directed waiver services to the same participant.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The DDP qualified service provider employing the support broker is responsible for maintaining records verifying compliance with the initial and ongoing support broker certification requirements.

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually 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:**

Adult Foster Support

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**



**Category 3:**

**Sub-Category 3:**



**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**



This service pays for extraordinary supervision and support by a principal care giver licensed as an adult foster care provider who lives in the home. The total number of members living in the adult foster home, who are unrelated to the principal care provider, cannot exceed four persons (ARM 37.100.121).

Payments for adult foster support are not made 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 adult foster support is described in Appendix I.

Payment to an adult foster care provider is available to assist in placing and maintaining members with extraordinary support needs in licensed adult foster care settings. Reimbursements are based on assessments completed by the service coordinator. Payments are based on the member supported meeting a required threshold in the hours of direct support and supervision required of the foster care provider.

The net effect of this service option is to strengthen the foster home network available to serve adults with developmental disabilities who would otherwise require services in more restrictive and costly service settings (e.g., an ICF-IID or an adult group home).

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

Members receiving Adult Foster Support may not receive Personal Supports, Companion services, Homemaker or Personal Care services.

Residential Training Supports delivered in the context of an adult foster home will be invoiced, reimbursed and reported as a separate and distinct service from the Adult Foster Support service. Reimbursements for the service will be rolled into the cost of Adult Foster Support for the purpose of Federal reporting.

Provision has been made in the Adult Foster Support qualified provider standards for the adult foster care provider to provide Adult Foster Support only, or both Adult Foster Support and Residential Training Support. In the event the Adult Foster Support provider is not qualified to provide Residential Training Support, the service will be made available by a DDP qualified service provider.

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

**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	DDP Qualified Service Provider and/or subcontracting for Adult Foster Supports
Agency	DDP qualified service provider and/or subcontracting for Residential Training Supports

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Adult Foster Support**

**Provider Category:**

Agency

**Provider Type:**

DDP Qualified Service Provider and/or subcontracting for Adult Foster Supports

**Provider Qualifications**

**License (specify):**

MCA 50-5-101 through  
MCA 50-5-216

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.100.101 through 37.100.175

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:  
\*Be at least 18 years of age.

Within 30 days of hire receive training in:  
\* abuse reporting,  
\*incident reporting,  
\*client confidentiality, and  
\*any specialty training relating to the need of the member served, as outlined in the plan of care.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

First aid and CPR, certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

In addition, the employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency subcontracting for the service.  
 Office of Inspector General – Licensure Bureau.  
 Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the DD service provider agency, prior to authorization of payment.  
 Licensure status reviewed annually by Office of Inspector General – Licensure Bureau.  
 Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Adult Foster Support**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for Residential Training Supports

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Residential Training Supports is reimbursable only when delivered to a member living in a licensed adult foster home funded under Adult Foster Supports.  
 The staffing rule as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:

\*Be at least 18 years of age.

Within 30 days of hire receive training in:

\* abuse reporting,

\*incident reporting,

\*client confidentiality, and

\*any specialty training relating to the need of the member served, as outlined in the plan of care.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

First aid and CPR, certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

In addition, the employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.  
 Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.  
 Prior to authorization as a DDP qualified service provider and annually 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:**

Assisted Living

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Payments for services rendered in an assisted living facility, including personal care, homemaker services, medication oversight, social and recreation activities, 24-hour on-site response staff to meet the unpredictable needs of individuals and supervision for safety and security. Separate payment will not be made for those services integral to and inherent in the provision of the personal care facility service.

This service is targeted to those members with a developmental disability whose specific condition and/or physical conditions preclude placement in a less restrictive setting. Members in this service option are not precluded from attending DD waiver-funded work/day or supported employment options.



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

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

**Retainer payment:**

Providers of this service may be eligible for a retainer payment if authorized by the Regional Manager. Retainer payments made to providers of Assisted Living may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bed-hold" in nursing facilities. Retainer payments will be reimbursed upon authorization by the Regional Manager.

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

**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	Licensed Assisted Living Facility enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Assisted Living**

**Provider Category:**

Agency

**Provider Type:**

Licensed Assisted Living Facility enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License** (specify):

Licensed in accordance with MCA 50-5-101  
MCA 50-5-225 through 50-5-228

**Certificate** (specify):

**Other Standard** (specify):

ARMs 37.106.2801 through 37.106.2908 apply.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General – Licensure Bureau.  
 Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

Licensure status reviewed annually by Office of Inspector General – Licensure Bureau.  
 As needed prior to authorization of payment.  
 Prior to authorization as a DDP qualified service provider and annually 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:**

Behavioral Support Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

### Level I Behavioral Support Services (BSS)

Level I BSS are provided to participants exhibiting maladaptive behaviors that negatively impact their life and can be ameliorated through appropriate assessment and positive behavioral interventions provided by lay staff. BSS is provided to address maladaptive behaviors exhibited in all settings. BSS staff may oversee and monitor the work of others who implement behavior interventions. All behavior intervention procedures developed and implemented by the BSS staff are part of the Person-Centered Plan and are in compliance with the Home and Community Based Settings Regulations and Administrative Rules of Montana governing the use of Positive Behavioral Supports.

Level I BSS include the following:

1. Completing behavioral assessments and functional analyses of behavior and interpreting assessment and evaluation results for staff and unpaid caregivers providing services to enrolled members.
2. Designing, monitoring and modifying written behavior intervention procedures and skill acquisition procedures. Written plans of intervention developed generally require the collection of data by staff or unpaid caregivers providing direct support. Decisions made in designing, monitoring and modifying behavior intervention and skill acquisition procedures are generally based on the review and analysis of collected data.
3. Training staff and unpaid caregivers in the implementation of formal and informal procedures designed to reduce problem behaviors and/or to increase appropriate behaviors.
4. Providing guidance and information to planning team members in the setting of appropriate goals and objectives for members who need BSS.

Level I BSS may be provided by:

1. a Board-certified Behavior Analyst-Doctoral (BCBA-D), Board-certified Behavior Analyst (BCBA), or Board-certified Behavior assistant Analyst (BCaBA) under the supervision of a BCBA-D or BCBA;
2. a person with an Institute for Applied Behavior Analysis (IABA) certification or Intermediate Applied Behavior Analysis (ABA) Professional; or
3. either a person with a degree in ABA, Psychology, or Special Education who has provided documentation of training and experience in the use of the principles of ABA as approved by the Department.

### Level II Behavioral Support Services (BSS)

Level II BSS focus on developing effective behavior management strategies for individuals whose challenging behavioral issues put them at imminent risk of placement in a more restrictive residential or institutional setting. These services are designed to reduce an individual's behaviors and improve independence and inclusion in the community. BSS provides assessment, behavior plan development, training, and treatment for a range of individualized behavioral intervention needs. BSS teach and implement effective behavior intervention plans based on principles of positive behavior support. All behavior intervention procedures developed and implemented by the BSS staff are part of the Person-Centered Plan and are in compliance with the Home and Community Based Settings Regulations and Administrative Rules of Montana governing the use of Positive Behavioral Supports.

Level II BSS include the following:

1. Completing behavioral assessments and functional analyses of behavior and interpreting assessment and evaluation results for staff and unpaid caregivers providing services to enrolled members.
2. Designing, monitoring and modifying written behavior intervention procedures and skill acquisition procedures. Written plans of intervention developed generally require the collection of data by staff or unpaid caregivers providing direct support. Decisions made in designing, monitoring and modifying behavior intervention and skill acquisition procedures are generally based on the review and analysis of collected data.
3. Training staff and unpaid caregivers in the implementation of formal and informal procedures designed to reduce problem behaviors and/or to increase appropriate behaviors.
4. Providing guidance and information to planning team members in the setting of appropriate goals and objectives for members who need Behavioral Support Services.
5. Monitoring and overseeing staff, Registered Behavior Technician (RBT) or Intensive Behavior Assistant (IBA),

directly implementing treatment.  
 6. Direct implementation of treatment plans, behavior intervention procedures, skill acquisition procedures and positive behavior support plans by an RBT or an IBA.

Level II BSS may be provided by:

1. a Board-certified Behavior Analyst-Doctoral (BCBA-D), Board-certified Behavior Analyst (BCBA), or Board-certified Behavior assistant Analyst (BCaBA) under the supervision of a BCBA-D or BCBA; or
2. a person with an Institute for Applied Behavior Analysis (IABA) certification or Intermediate Applied Behavior Analysis (ABA) Professional.

Level II BSS direct treatment may be provided by (under the supervision of a BCBA-D, BCBA, or BCaBA):

1. a Registered Behavior Technician (RBT); or
2. an Intensive Behavior Assistant (IBA).

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

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

These services may not be used to pay for special education and related services that are included in a child’s Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

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

**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	An individual enrolled as a Montana Medicaid provider and as a DDP qualified service provider.
Agency	DDP qualified service provider; and/or subcontracting for Behavioral Support Services.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Behavioral Support Services**

**Provider Category:**

Individual

**Provider Type:**

An individual enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License** (*specify*):

Level I and Level II  
 (a) Board-Certified Behavior Analyst-Doctoral (BCBA-D) licensed in the State of Montana  
 (b) Board-Certified Behavior Analyst (BCBA) licensed in the State of Montana  
 (c) Board-Certified assistant Behavior Analyst (BCaBA) licensed in the State of Montana  
  
 Licensed in accordance with applicable ARMS 24.189.901-24.189.934

**Certificate** (*specify*):

Level I and Level II  
 (a) A person with an Institute for Applied Behavior Analysis (IABA) certification  
  
 Level II  
 (a) Registered Behavior Technician (RBT)  
 (b) RBTs and IBAs must obtain first aid and CPR certification within the first 30 days of employment and maintain certification thereafter.

**Other Standard** (*specify*):

Level I  
 (a) Intermediate Professional as described in the Applied Behavior Services Manual referenced in ARM 37.34.1902(11)  
 (b) Either a person with degree in Applied Behavior Analysis, Psychology, or Special Education who has provided documentation of training and experience in the use of principles of ABA as approved by the Department.  
  
 Level II  
 (a) Intermediate Professional as described in the Applied Behavior Services Manual referenced in ARM 37.34.1902(11)  
 (b) Intensive Behavior Assistant (IBA) receiving training in IDD/MI Dual Diagnosis DSP Certification from NADD, or additional training in specific coursework listed by AAIDD, and, first 3 tiers of MANDT curriculum.  
  
 Level I and Level II  
 A Montana Department of Justice background check is required.  
 Other training in accordance with DDP requirements.  
  
 MCA 37-17-401 through 37-17-406

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.  
  
 Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Behavioral Support Services**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider; and/or subcontracting for Behavioral Support Services.

**Provider Qualifications****License** (*specify*):

## Level I and Level II

- (a) Board-Certified Behavior Analyst-Doctoral (BCBA-D) licensed in the State of Montana
- (b) Board-Certified Behavior Analyst (BCBA) licensed in the State of Montana
- (c) Board-Certified assistant Behavior Analyst (BCaBA) licensed in the state of Montana

Licensed in accordance with applicable ARMS 24.189.901-24.189.934

**Certificate** (*specify*):

## Level I and Level II

- (a) A person with an Institute for Applied Behavior Analysis (IABA) certification

## Level II

- (a) Registered Behavior Technician (RBT)
- (b) RBTs and IBAs must obtain first aid and CPR certification within the first 30 days of employment and maintain certification thereafter.

**Other Standard** (*specify*):

## Level I

- (a) Intermediate Professional as described in the Applied Behavior Services Manual referenced in ARM 37.34.1902(11)
- (b) Either a person with degree in Applied Behavior Analysis, Psychology, or Special Education who has provided documentation of training and experience in the use of principles of ABA as approved by the Department.

## Level II

- (a) Intermediate Professional as described in the Applied Behavior Services Manual referenced in ARM 37.34.1902(11)
- (b) Intensive Behavior Assistant receiving training in IDD/MI Dual Diagnosis DSP Certification from NADD, or additional training in specific coursework listed by AAIDD, and first 3 tiers of MANDT curriculum

## Level I and II

A Montana Department of Justice background check is required.  
Other training in accordance with DDP requirements

MCA 37-17-401 through 37-17-406

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Applicable standards are verified by the DDP qualified service provider agency subcontracting for the service.

Initially - The DDP as part of the Qualified Provider Application Process.

Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the DDP service provider agency, prior to authorization of payment.  
 Prior to authorization as a DDP qualified service provider and annually 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:**

Caregiver Training and Support

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Caregiver training and support services for individuals who provide unpaid training, companionship or supervision to members. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance or companionship to a member. This service may not be provided in order to train paid caregivers. Caregiver training and support will be provided in the home or community environments that are part of the members typical day. Training includes instruction coaching and/or modeling to learn skills to safely and fully participate in the community. All training for individuals who provide unpaid support to the participant must be included in the members plan of care.

Services to be provided do not duplicate service coordinator services. The role of the staff person providing Caregiver Training and Support is defined by the planning team.

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

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

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT. Caregiver Training and Support can only be used when the approved service is not covered under any other private or publicly funded resource or other waiver service. The plan of care actions must be specific as to the training caregivers will receive. Providers and case managers are responsible to ensure that the specific caregiver training is not available under a Medicaid State Plan service and the waiver is the payer of last resort.

**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	DDP qualified service provider and/or subcontracting for CTS services to persons and/or offering Agency with Choice Employer Authority.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Caregiver Training and Support**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for CTS services to persons and/or offering Agency with Choice Employer Authority.

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):



The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:  
 \*Be at least 17 years of age.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DDP qualified service provider subcontracting for the service.

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually 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 Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Continued)**



Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institution to any HCBS setting. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- a. Security deposits required to obtain a lease on an apartment or home.
- b. Essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items and bath/bed linens.
- c. Set-up fees or deposits for utility or services access, including telephone, electricity, heating and water.
- d. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
- e. Moving expenses.
- f. Necessary home accessibility adaptations.
- g. Activities to assess need, arrange for and procure needed resources.

Community transition services are furnished only to the extent that they are reasonable and necessary through the service plan development process, clearly identified in the service plan and the member is unable to meet such expense or when the services cannot be obtained from other sources. Community transition services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes, such as television, cable TV access or VCRs.

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

This service is capped at \$3,000 per member, per transition. This service is not available to members transitioning into residential settings that are owned or leased by a DDP-funded service provider, rather, the residential setting must be owned, leased or rented by the member and must be considered the member's private residence.

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

**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	DDP qualified service provider.
Individual	An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Community Transition Services**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider.

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

This includes supports to members living in a residence that is owned, leased or rented by the member and must be considered his/her private residence.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Community Transition Services**

**Provider Category:**

Individual

**Provider Type:**

An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

A person or representative choosing to self-direct with employer authority may elect to purchase community transition services and supports, in accordance with the requirements outlined in the service definition, and receive reimbursement from the FMS.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The FMS is responsible for ensuring that services and supports purchased on behalf of the member do not exceed the member's cost plan allocation for this service, and all documentation requirements have been met prior to issuing reimbursement.

**Frequency of Verification:**

The DDP QIS annually reviews a sample of the service standards with one or more performance measures to ensure that services are in compliance with the QP standards and documentation requirements.

**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:**

Companion Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Non-medical care, supervision, and socialization, provided to a functionally impaired member age 14 or older. Companions may assist or supervise the member with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the member. This service is provided in accordance with a therapeutic goal in the plan of care and is not purely diversional in nature.

Companion services delivered by legally responsible relatives involve personal care or similar services of ADLs and/or IADLs, such as non-medical care, and assists/supervises the person with such tasks as meal preparation, laundry and shopping.

Companion services are not available to members receiving 24/7 DDP waiver funded supports and supervision (e.g., persons residing in a DD group home or in assisted living).

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

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

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

**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	DDP qualified service provider.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Companion Services**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider.

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** (specify):

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:  
 \*Be at least 17 years of age.

Within 30 days of hire receive training in:  
 \* abuse reporting,  
 \*incident reporting,  
 \*client confidentiality, and  
 \*any specialty training relating to the need of the member served, as outlined in the plan of care.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

First aid and CPR, certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

In addition, the employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.  
 Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually 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:**

Environmental Modifications

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:****Environmental Modifications:**

Those physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or which enable the member to function with greater independence in the home, and without which, the member would require institutionalization. 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 which are necessary for the welfare of the member.

In addition to the above, environmental modifications services are measures that provide the member with accessibility and safety in the environment so as to maintain or improve the ability of the member to remain in community settings and employment. Environmental modifications may be made to a member's home or vehicle (wheelchair lift, wheelchair lock down devices, adapted driving controls, etc. for the purpose of increasing independent functioning and safety or to enable family members or other care givers to provide the care required by the member. An environmental modification provided to a member must:

- (a) relate specifically to and be primarily for the member's disability;
- (b) have utility primarily for a member who has a disability;
- (c) not be an item or modification that a family would normally be expected to provide for a non-disabled family member;
- (d) not be in the form of room and board or general maintenance;
- (e) meet the specifications, if applicable, for the modification set by the American National Standards Institute (ANSI);
- (f) be prior authorized by the DDP.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

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

All requests require documentation of an assessed need and prior approval from DDP.

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

**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	Independent Contractor qualified to perform environmental modifications, enrolled as a Montana Medicaid provider and as a DDP qualified service provider.
Agency	DDP qualified service provider and/or subcontracting for Environmental Modifications.
Individual	An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Environmental Modifications**

**Provider Category:**

Individual

**Provider Type:**

Independent Contractor qualified to perform environmental modifications, enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

A qualified provider designated to either reimburse the individual for the procurement of environmental modifications, or for providing the requested environmental modifications is responsible for meeting the qualified provider requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually thereafter.



## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Environmental Modifications**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for Environmental Modifications.

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

A qualified provider designated to either reimburse the individual for the procurement of environmental modifications, or for providing the requested environmental modifications is responsible for meeting the qualified provider requirements.

The staffing rule as outlined in ARM 37.34.2101-37.34.2111.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.  
Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually thereafter.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Environmental Modifications**

**Provider Category:**

Individual

**Provider Type:**

An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

A person or representative choosing to self-direct with employer authority may elect to purchase environmental modifications from an approved vendor, in accordance with the requirements outlined in the service definition and receive reimbursement from the FMS.

Upon hiring of a person the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The FMS is responsible for ensuring that services and supports purchased on behalf of the member do not exceed individual cost plan allocation for this service, and all documentation requirements have been met prior to issuing reimbursement.

**Frequency of Verification:**

The DDP quality assurance personnel annually reviews a sample of the service standards with one or more performance measures to ensure that services are in compliance with the QP standards and documentation requirements.

## 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:**

Individual Goods and Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition** (*Scope*):

**Category 4:**

**Sub-Category 4:**

Individual Goods and Services are services, equipment or supplies that enhance opportunities for the person to achieve outcomes for full membership in the community as clearly identified in the plan of care. Individual goods and services fall into the following categories:

\*Memberships and Fees including but not limited to:

- Fees associated with classes for the person supported
- Social club memberships
- Fees associated with Special Olympics
- Health memberships as prescribed by a licensed health care provider
- Recreational activities specific to a habilitative goal in the plan of care

Recreational activities provided under Individual Goods and Services may be covered only when they are included in a planning outcome related to a specific residential habilitation goal.

\*Equipment and Supplies including but not limited to:

- Assistive technology devices, controls, appliances or other items that enable persons to increase their abilities to perform activities of daily living, or to recognize, control or communicate with the environment, thus decreasing the need for assistance from others.
- Accessories essential to prolong life of assistive technology devices such as batteries, protective cases, screen protectors.
- Nutritional supplements,
- Non-reusable medical supplies related to the person's disability,
- Instructional supplies,

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

Individual Goods and Services can pay for repair of equipment when the equipment meets the authorization criteria and the repair is a cost-effective alternative (e.g., is expected to last and without repair the equipment would have to be purchased new at a great cost). A maintenance or insurance agreement may be purchased for items that meet authorization criteria when the maintenance agreement is expected to be cost-effective.

Shipping and handling costs may be paid if the shipping cost is included in the price of the item, and the waiver is purchasing the item.

Reconditioned equipment may be purchased if all authorization criteria are met and the item is considered of adequate quality, expected to be durable, and the cost is commensurate with the age and condition of the item (e.g., if a new item could be purchased at the similar cost, it may be worthwhile to purchase the new item).

Nutritional supplements, vitamins, and the like may be reimbursed when there is no other source for reimbursement, and the specific items have been reviewed and approved, in writing, by the person's licensed health care provider. Individual goods and services must be directed exclusively toward the benefit of the individual and are the least costly alternative that reasonably meets the individual's assessed need and meets the following requirements A-D:

A. One or more of the following criteria are met:

1. The service, equipment or supply promotes inclusion in the community, and/or
2. The service, equipment or supply increases the person's safety in the home environment, and/or
3. The service, equipment or supply decreases the need for other Medicaid services,

B. The service, equipment or supply is designed to meet the person's functional (remedially necessary: appropriate to assist a person in increased independence and integration in their environment/community), medical (Medically necessary: appropriate and effective for the medical needs and health and safety of the person) by advancing the outcomes in the plan of care;

C. The service, equipment or supply is not available through another source; and can be accommodated within the

person’s individual cost plan without compromising the health and safety.

D. The service, equipment or supply is not experimental or prohibited.

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

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

Individual goods and services projected to exceed \$1,000 (annual aggregate) may be subject to review and approval by the DDP Regional Manager.

Equipment purchases are expected to be a one-time only purchase. Replacements, upgrades or enhancements made to existing equipment will be paid if documented as a necessity and approved by DDP Regional Manager.

The following represents a non-inclusive list of non-permissible Goods and Services:

1. Individual goods and services provided under this definition are not covered under the Individuals with Disabilities Education Act (IDEA), home-based schooling, or Section 110 of the Rehabilitation Act or available through any other public funding mechanism.
2. Goods, services or supports benefiting persons other than the individual
3. Room and board
4. Personal items and services not related to the disability
5. Gifts, gift certificates, or gift cards for any purpose
6. Items used solely for entertainment or recreational purposes
7. Personal hygiene items
8. Discretionary cash
9. General clothing, food, or beverages (not specialized diet or clothing)
10. Household furnishings
11. Household cleaning supplies
12. Home maintenance

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

**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	DDP qualified service provider and/or subcontracting for Individual Goods and Services.
Individual	An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Individual Goods and Services**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for Individual Goods and Services.

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

A qualified provider designated to either reimburse the individual for the procurement of individual goods and services, or for providing the requested goods and services is responsible for meeting the DDP qualified provider requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - the DDP as part of the Qualified Provider Application Process.  
Ongoing - the quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

Prior to authorization as a qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Individual Goods and Services**

**Provider Category:**

Individual

**Provider Type:**

An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Provider Qualifications**

**License (specify):**

**Certificate** (*specify*):

**Other Standard** (*specify*):

A person, or the representative choosing to self-direct with employer authority may elect to purchase goods and services, in accordance with the requirements outlined in the service definition, and receive reimbursement from the FMS.

Upon hiring of a person the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The FMS is responsible for ensuring that goods and services purchased on behalf of the individual do not exceed individual cost plan allocations for this service, and all documentation requirements have been met prior to issuing reimbursement.

**Frequency of Verification:**

The DDP Quality Assurance Personnel annually reviews a sample of the service standards with one or more performance measures to ensure that services are in compliance with the qualified provider standards and documentation.

## 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:**

Meals

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

Category 3:

Sub-Category 3:



Service Definition (Scope):

Category 4:

Sub-Category 4:



**MEALS SERVICES**

This service provides hot, cold, frozen, or other appropriate meals once or twice a day, up to seven days a week to a member in their own private residence. A full nutritional regimen (three meals per day) will not be provided, in keeping with the exclusion of room and board as covered services.

Some members need special assistance with their diets and the special meals service can help ensure that these members would receive adequate nourishment. This service will only be provided to members who are not eligible for these services under any other source or need different or more extensive services than are otherwise available. This service must be cost effective and necessary to prevent institutionalization.

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

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

**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	An individual who works for a member or a representative of the member self-directing the service with common law authority.
Agency	Meals service provider enrolled as a Montana Medicaid provider and qualified as a DDP provider and/or subcontracting for Meal services.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Meals**

**Provider Category:**

**Provider Type:**

An individual who works for a member or a representative of the member self-directing the service with common law authority.



**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

A member or representative choosing to self-direct with employer authority may elect to purchase meals from an approved vendor for the member, in accordance with the requirements outlined in the service definition, and receive reimbursement from the FMS.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The FMS is responsible for ensuring that services and supports purchased on behalf of the member do not exceed individual cost plan allocation for this service, and all documentation requirements have been met prior to issuing reimbursement.

**Frequency of Verification:**

The quality assurance personnel annually reviews a sample of the service standards with one or more performance measures to ensure that services are in compliance with the QP standards and documentation requirements.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Meals**

**Provider Category:**

Agency

**Provider Type:**

Meals service provider enrolled as a Montana Medicaid provider and qualified as a DDP provider and/or subcontracting for Meal services.

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

A qualified provider designated to either reimburse the subcontractor for Meals services, or for providing the requested Meals services is responsible for meeting the DDP qualified provider service requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.  
 Prior to authorization as a DDP qualified service provider and annually 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:**

Personal Care

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

**PERSONAL CARE SERVICES**

Personal Care Services Include:

1. Assistance with personal hygiene, dressing, eating and ambulatory needs of the member; and
2. Performance of household tasks incidental to the member's health care needs or otherwise necessary to contribute to maintaining the member at home;
3. Supervision for health and safety reasons.

Frequency or intensity will be as indicated in the plan of care.

For State Plan Personal Care the plan of care must be approved by a physician and developed by a licensed nurse employed by the provider. The delivery of State Plan Personal Care Services must be supervised by a licensed nurse. Waiver Personal Care does not require this.

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

This service is available under the waiver only if the scope, amount or duration of the available Medicaid State Plan Personal Care is insufficient in meeting the needs of the person. Personal care may be bundled with other services when delivered as a component of Self-Directed Services and Supports (SDSS) and is therefore not available as a discrete service to persons receiving SDSS.

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

**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	DDP qualified service provider and/or subcontracting for Personal Care services.
Agency	DDP qualified service provider

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Personal Care**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for Personal Care services.

**Provider Qualifications**

**License** (*specify*):

Agencies are licensed, bonded and insured to deliver personal care services, and enrolled as a Medicaid provider.

**Certificate** (*specify*):

**Other Standard** (*specify*):

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.  
  
Prior to hire:  
\*Be at least 17 years of age.  
  
In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DDP qualified service provider.  
  
Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.  
  
Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Personal Care**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:  
 \*Be at least 17 years of age.

Within 30 days of hire receive training in:  
 \*abuse reporting,  
 \*incident reporting,  
 \*client confidentiality, and  
 \*any specialized training unique to the needs of the member, as outlined in the plan of care.

First aid and CPR, certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

Persons assisting with meds will be med certified in accordance with ARM 37.34.114.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

Prior to authorization as a DDP qualified service provider and annually 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:**

Personal Emergency Response System (PERS)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**



**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**



PERS is an electronic device that enables members to secure help in an emergency. The member may also wear a portable "help" button to allow for mobility. The response center is staffed by trained professionals.

PERS services may be appropriate for members who live alone, or who are alone for parts of the day, and have no regular caregiver for periods of time.

Because of the limitations of the PERS service, a cell phone may be a more flexible, cost effective solution in ensuring health and safety for some individuals.

Cell phones are not for convenience or general purpose use. Guidelines for the use of cell phones include: 1. The member requires access to assistance or supports and is frequently beyond the range of coverage of a PERS system. 2. The cost of cell phone plans and monthly fees is the responsibility of the member. 3. The service coordinator and the team will evaluate the needs of the member and look at the most cost-effective options. 4. Members may elect to add an insurance feature to prevent health and safety concerns should the phone need to be replaced. 5. These cell phone guidelines will be reviewed with the member prior to or at the annual planning meeting.

Installation, maintenance and monthly fees associated with PERS services may be reimbursed with waiver funds as outlined in the plan of care. Cell phones, including installation and insurance, may be reimbursed through the Waiver with a Regional Manager prior-authorization. Monthly cell phone plans, phone cards, and minutes, which are of general utility, cannot be funded through the Waiver.

Installation, maintenance and monthly fees associated with PERS services may be reimbursed with waiver funds as outlined in the plan of care.

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

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

**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	DDP qualified service provider and/or subcontracting for Personal Emergency Response (PERS), and/or offering agency with choice employer authority.
Individual	An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Personal Emergency Response System (PERS)****Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for Personal Emergency Response (PERS), and/or offering agency with choice employer authority.

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

A qualified provider designated to either reimburse the member for the procurement of specialized medical equipment and supplies, or for providing the requested goods and services is responsible for meeting DDP qualified service provider requirements.

**Verification of Provider Qualifications****Entity Responsible for Verification:**Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.**Frequency of Verification:**As needed prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually thereafter.**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Personal Emergency Response System (PERS)****Provider Category:**

Individual

**Provider Type:**

An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Provider Qualifications****License (specify):**

**Certificate** (specify):

**Other Standard** (specify):

A person or representative choosing to self-direct with employer authority may elect to purchase personal emergency response goods and service, in accordance with the requirements outlined in the service definition, and receive reimbursement from the FMS.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The FMS is responsible for ensuring that services and supports purchased on behalf of the member do not exceed member cost plan allocation for this service, and all documentation requirements have been met prior to issuing reimbursement.

**Frequency of Verification:**

The quality assurance personnel annually reviews a sample of the service standards with one or more performance measures to ensure that services are in compliance with the QP standards and documentation requirements.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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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 Supports

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**



**Service Definition** (*Scope*):

**Category 4:**

**Sub-Category 4:**

The personal supports worker assists the member in carrying out daily living tasks and other activities essential for living in the community. Services may include assistance with homemaking, personal care, general supervision and community integration. Personal Supports may also provide the necessary assistance and supports to maintain employment in a competitive, customized, or self-employment setting and/or day service needs of the in integrated, community settings. Personal supports activities are generally defined in the plan of care and are flexible in meeting the changing needs of the member. Workers may be assigned activities that involve mentorship, and activities designed to develop or maintain skills. Personal supports workers may be required to provide non-medical transportation to a person for activities as outlined in the plan of care, including community integration activities, work or school and other community activities. A member receiving personal supports is self-directing this service with employer authority (either common law or agency with choice). Other waiver services that may overlap with the activities of the personal supports worker are prohibited.

**REIMBURSABLE ACTIVITIES:**

1. Providing supervision and monitoring for the purpose of ensuring the member's health and safety.
2. Assisting the member with hygiene, bathing, eating, dressing, grooming, toileting, transferring, or basic first aid.
3. Assisting the member to access the community. This may include someone hired to accompany and support the member in all types of community settings. Personal supports is available to a person only when the planning team has approved a back-up plan, serving to ensure the health and safety of the person in the event of a service disruption.
4. Assisting the member to develop self-advocacy skills, exercise rights as a citizen, and acquire skills needed to exercise control and responsibility over other support services, including managing generic community resources and informal supports.
5. Assisting the member in identifying and sustaining a personal support network of family, friends, and associates.
6. Assisting the member with household activities necessary to maintain a home living environment on a day-to-day basis, such as meal preparation, shopping, cleaning, and laundry.
7. Assisting the member with home maintenance activities needed to maintain the home in a clean, sanitary, and safe environment.
8. Assisting the member to maintain employment. This may include someone to accompany and support the member in a competitive, customized, or self-employment setting. The employment supports are delivered informally.
9. Assisting the member to access services and opportunities available in community settings. This may include accompanying the member to and facilitating participation in general community activities and community volunteer work.

A member receiving Personal Supports may also receive Respite.

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

A member receiving personal supports is self-directing this service with employer authority (either common law or agency with choice). Other waiver services that may overlap with the activities of the personal supports worker are prohibited. These include companion services, extended personal care services, and homemaker.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

While a person may receive both Respite and Personal Supports they can't be billed for during the same timeframe.

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

**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	DDP qualified service provider and/or subcontracting for Personal Supports, and/or offering agency with choice employer authority.
Individual	A member or a representative self-directing the service with common law employer authority.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Personal Supports**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for Personal Supports, and/or offering agency with choice employer authority.

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:

\*Be at least 17 years of age.

Within 30 days of hire receive training in:

\*abuse reporting,

\*incident reporting,

\*client confidentiality,

\*service documentation requirements,

\*training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

First aid certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

Any other training requirements as outlined by the Department.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.

Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Personal Supports**

**Provider Category:**

Individual

**Provider Type:**

A member or a representative self-directing the service with common law employer authority.

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Prior to hire:

\*Be at least 17 years of age.

\*Screening and a background check of a person prior to an offer of employment as a direct care staff.

Within 30 days of hire receive training in:

\*abuse reporting,

\*incident reporting,

\*client confidentiality,

\*service documentation requirements,

\*training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

First aid certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

Any other training requirements as outlined by the Department.

Upon hiring of a direct care staff person, the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

In addition, the fiscal agent will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

The FMS is initially responsible for ensuring that a worker meets the qualified provider standards and the FMS maintains records serving to document the compliance with these standards.

##### **Frequency of Verification:**

Annually, the quality assurance personnel reviews compliance of workers during the annual quality assurance review process, based on the requirements of the performance measure sampling process specified.

## **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:**

Remote Monitoring Equipment

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

The equipment used to operate systems such as live feed video, motion sensing system, radio frequency identification, web-based monitoring system, or other device approved by the DDP. It also refers to the equipment used to engage in live two-way communication with the member being monitored.

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

Equipment must be leased at a maximum monthly amount of \$300. This service allows for the monthly lease of remote monitoring equipment and does not duplicate any equipment purchased under Specialized Medical Equipment and Supplies.

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

**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	DDP qualified service provider and/or subcontracting for Remote Monitoring Equipment.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Remote Monitoring Equipment**

**Provider Category:**

**Provider Type:**

DDP qualified service provider and/or subcontracting for Remote Monitoring Equipment.

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

A qualified provider designated to either reimburse the subcontractor for the procurement of remote monitoring equipment, or for providing the requested remote monitoring equipment is responsible for meeting DDP qualified service provider requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.  
Prior to authorization as a DDP qualified service provider and annually 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:**

Remote Monitoring

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

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

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**Service Definition (Scope):****Category 4:****Sub-Category 4:**

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The provision of oversight and monitoring within the residential setting of a member, age 18 and older, through off-site electronic surveillance by staff using one or more of the following systems: live video feed, motion sensing system, radio frequency identification, or web-based monitoring system. It also allows a HIPAA compliant live two-way communication with the person being monitored as described in the member's plan of care. Cameras are not permitted in bathrooms or bedrooms. Any discovery of monitoring in private areas would be addressed by case managers and/or quality assurance personnel while conducting onsite visits.

Remote monitoring is available by the residential habilitation DDP qualified service provider. The Department requires that service providers are compliant with HIPAA requirements, including the Privacy and Security Rules, and utilizes a Business Associate Agreement which outlines and implements HIPAA compliance requirements, including highlighting the requirement for providers of the Department to ensure HIPAA compliance by any agency/subcontractors they employ. The HIPAA compliance officer has reviewed the remote monitoring definition and Business Associate Agreement and has determined HIPAA compliance requirements are met.

Remote monitoring shall be done in real time, not via a recording, by awake staff at a monitoring base using the appropriate connection. When remote monitoring is being provided, the remote monitoring staff shall not have duties other than remote monitoring.

The provider of remote monitoring shall have an effective system for notifying emergency personnel such as police, fire, and back up support staff for in-person response.

Remote Monitoring assists individuals in avoiding institutional or more restrictive environments by providing supervision for individuals to be able to safely live in their communities. Remote Monitoring is a service for members whose needs do not require on-site staff at all hours of the day but who still require some level of supervision. Individuals will receive the training needed to successfully utilize the technology, including how to turn off the equipment. This includes training the participant and staff on the equipment and/or devices that will be used.

The member who receives the service and each person who lives with the member shall consent in writing after being fully informed of what remote monitoring entails. If the member or a person who lives with the member has a guardian, the guardian shall consent in writing. The member's service coordinator shall keep a copy of each signed consent form with the member's plan of care.

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

Remote Monitoring shall only be used in supported living settings and is only used for the purpose of reducing or replacing the amount of residential habilitation needed.

There is no duplication of remote monitoring with other waiver services.

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

Internet connectivity is not allowed as a service payment.

**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	DDP qualified service provider and/or subcontracting for Remote Monitoring services.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Remote Monitoring**

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for Remote Monitoring services.

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.  
 Prior to hire:  
 \*Be at least 17 years of age.

Within 30 days of hire receive training in:  
 \*abuse reporting,  
 \*incident reporting,  
 \*client confidentiality, and  
 \*any specialty training relating to the needs of the member served, as outlined in the plan of care.

In addition, the employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Applicable standards are verified by the DDP qualified service provider.  
 Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**



As needed by the provider, prior to authorization of payment.  
 Prior to authorization as a DDP qualified service provider and annually 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:**

Retirement Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Retirement services are available to a member who is of the typical retirement age (age 62 or older) or is limited due to health and safety issues. Members of this service are no longer able to maintain employment due to health and safety risks OR are of retirement age. Retirement services are structured services consisting of day activities and residential support.

Retirement services may be provided in a provider operated residence (licensed DD group home) or community day activity setting and may be provided as a continuous or intermittent service.

The outcome of Retirement services is to treat each member with dignity and respect, to the maximum extent possible maintain skills and abilities, and to keep the member engaged in their environment and community through optimal care and support. Retirement services are designed to actively stimulate, encourage and enable active participation; develop, maintain, and increase awareness of time, place, weather, persons, and things in the environment; introduce new leisure pursuits; establish new relationships; improve or maintain flexibility, mobility, and strength; develop and maintain the senses; and to maintain and build on previously learned skills.

Retirement services must be furnished in a way which fosters the independence of each member. Strategies for the delivery of Retirement services must be person centered and person directed to the maximum extent possible and is identified in the plan of care.

When Retirement services are delivered in a provider operated residence (licensed DD group home), staff must meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, to provide supervision, safety and security, and to provide activities to keep the member engaged in their environment.

The personal living space and belongings of individuals living at the provider operated residence (licensed DD group home) must not be utilized by those receiving Retirement services at the residence. Only shared living spaces such as the living room, kitchen, bathroom, and recreational areas may be utilized.

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

Payments for Retirement services are not made for room and board.

Retainer payment:

Providers of this service may be eligible for a retainer payment if authorized by the Regional Manager. Retainer payments made to providers of Retirement Services may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bed-hold" in nursing facilities. Retainer payments will be reimbursed upon authorization by the Regional Manager.

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

**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	DDP qualified service provider.

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Retirement Services**

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**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider.

**Provider Qualifications**

**License (specify):**

Retirement services is reimbursable in all community based residential settings, except the provision of this service in DD community group homes is contingent upon State licensure for these facilities. DD group home licensure requirements may be reviewed in ARM 37.100.301 through 37.100.340 and MCA 53-20-301 through 53-20-307.

**Certificate (specify):**

**Other Standard (specify):**

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:

\*Be at least 17 years of age

Within 30 days of hire receive training in:

\* abuse reporting,

\*incident reporting,

\*client confidentiality,

\*any specialty training relating to the need of the member served, as outlined in the plan of care.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

First aid and CPR, certification must be obtained within the first 30 days of employment and maintained thereafter, and any other training in accordance with DDP requirements.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHHS Office of Inspector General (OIG) for compliance with group home licensing standards, if applicable.

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.

Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

QAD licensing study is annual.

As needed by the provider, prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually 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:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Specialized Medical Equipment and Supplies include:

Devices, controls or appliances, specified in the plan of care, that enable members to increase their ability to perform activities of daily living; devices, controls or appliances that enable the member to perceive, control or communicate with the environment in which they live; items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; such other durable and non-durable medical equipment not available under the State plan that is necessary to address member functional limitations; and necessary medical supplies not available under State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards or manufacture, design and installation.

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

Specialized Medical Equipment and Supplies purchases require prior approval by the DDP Regional Manager.

The following represents a non-inclusive list of non-permissible Specialized Medical Equipment and Supplies:

1. Specialized Medical Equipment and Supplies provided under this definition are not covered under the Individuals with Disabilities Education Act (IDEA), home-based schooling, or Section 110 of the Rehabilitation Act or available through any other public funding mechanism.
2. Specialized medical equipment or supplies benefiting persons other than the member
3. Room and board
4. Personal items and services not related to the disability
5. Gifts, gift certificates, or gift cards for any purpose
6. Items used solely for entertainment or recreational purposes
7. Personal hygiene items
8. Discretionary cash
9. General clothing, food, or beverages (not specialized diet or clothing)
10. Household furnishings
11. Household cleaning supplies
12. Home maintenance

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

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

**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	An individual who works for a member or a representative of the member self-directing the service with common law authority.
Agency	DDP qualified service provider and/or subcontracting for Specialized Medical Equipment and Supplies, and/or offering agency with choice employer authority.

## 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:**

Individual

**Provider Type:**

An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Provider Qualifications****License** (*specify*):
**Certificate** (*specify*):
**Other Standard** (*specify*):

A member, or their representative, choosing to self-direct with employer authority may elect to purchase specialized medical equipment and supplies, in accordance with the requirements outlined in the service definition, and receive reimbursement from the FMS.

Upon hiring a person, the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

The FMS is responsible for ensuring that equipment and supplies purchased on behalf of the do not exceed individual cost plan allocation for this service, and all documentation requirements have been met prior to issuing reimbursement.

**Frequency of Verification:**

The DDP quality assurance personnel annually reviews a sample of the service standards with one or more performance measures to ensure that services are in compliance with the QP standards and documentation requirements.

**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:**

**Provider Type:**

DDP qualified service provider and/or subcontracting for Specialized Medical Equipment and Supplies, and/or offering agency with choice employer authority.

**Provider Qualifications****License** (*specify*):
**Certificate** (*specify*):

**Other Standard** (*specify*):

A qualified provider designated to either reimburse the member for the procurement of Specialized Medical Equipment and Supplies, or for providing the requested specialized equipment and supplies, is responsible for meeting DDP qualified provider requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

Prior to authorization as a DDP qualified service provider and annually 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:**

Supported Employment - Co-Worker Support

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition** (*Scope*):

**Category 4:**

**Sub-Category 4:**

Co-Worker Support allows the DD Program and DD provider agencies to contract with a business to provide co-worker provided job supports as a part of the natural workplace. The supports will be provided directly to the member and may include:

1. the development of positive work-related habits, attitudes, skills,
2. work etiquette directly related to their specific employment,
3. health and safety aspects/requirements of their particular job,
4. assisting the member to become a part of the informal culture of the workplace,
5. job skill maintenance or assistance with incorporating new tasks,
6. facilitation of other supports at the work site such as employer sponsored employee activities beyond job tasks.
7. assistance during breaks and/or lunch.

Members participating in this service are employed by a business and are paid at or above the state’s minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. This service differs from Supported Employment – Follow Along Support in that it creates opportunity for services/supports to be provided by the local business’ employee where the member is employed. Receiving mentoring from a fellow employee increases opportunities for acceptance into and thus success in the workplace community. This service is intended to provide ongoing Co-Worker Support allowing Follow Along Support to be decreased.

Members may utilize, Individual and Small Group Employment Support, Follow Along Support and Day Supports & Activities in conjunction with Co-Worker Support.

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

The activities of this service are over and above the obligations an employer has for an employee without a disability, and does not duplicate nor supplant those provided under the provisions of the Individuals with Disabilities Education Improvement Act, or Section 110 of the Rehabilitation Act of 1973, or the Americans with Disabilities Act.

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

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

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

**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	Employer enrolled as a Montana Medicaid provider and as a DDP qualified service provider.
Agency	DDP qualified service provider and/or offering agency with choice employer authority.
Individual	An individual who works for a member or a representative of the member self-directing the service with common law authority.



**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Supported Employment - Co-Worker Support**

**Provider Category:**

Individual

**Provider Type:**

Employer enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

The co-worker is the person who must meet the qualified provider standards of the waiver while the stipend is reimbursed to the employer.  
 Relatives and legal guardians will meet all of the minimum provider qualifications specified in the waiver.

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:  
 \*Be at least 17 years of age.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Any specialty training relating to the needs of the member served, as outlined in the plan of care.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.  
 Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

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**Service Name: Supported Employment - Co-Worker Support**

---

**Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or offering agency with choice employer authority.

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

The co-worker is the person (including relatives and legal guardians) who must meet the qualified provider standards of the waiver while the stipend is reimbursed to the employer.

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:  
\*Be at least 17 years of age.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Any specialty training relating to the needs of the member served, as outlined in the plan of care.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.  
Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually thereafter.

**Appendix C: Participant Services**

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

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**Service Type: Other Service****Service Name: Supported Employment - Co-Worker Support**

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**Provider Category:**

Individual

**Provider Type:**

An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

The co-worker is a qualified provider of the waiver.  
 Relatives and legal guardians will meet all of the minimum provider qualifications specified in the waiver

Prior to hire:  
 \*Be at least 17 years of age.  
 \*Screening and a background check of a person prior to an offer of employment as a direct care staff.

Any specialty training relating to the needs of the member served, as outlined in the plan of care.

Upon hiring of a person, the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The FMS is initially responsible for ensuring that a worker meets the qualified provider standards and the FMS maintains records serving to document the compliance with these standards.

**Frequency of Verification:**

Annually, the DDP quality assurance personnel reviews compliance of workers during the annual quality assurance review process, based on the requirements of the performance measure sampling process specified.

## 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 Employment - Individual Employment Support

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Individual Employment Support consists of habilitation services and staff supports needed by a person to acquire a job/position or career advancement in the general workforce at or above the state’s minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Supported Employment - Individual Employment Support is delivered in a competitive, customized, or self-employment setting.

The outcome of this service is paid employment in a competitive, customized, or self-employment setting within the general workforce that meets personal and career goals, as documented in the plan of care. Supported Employment –Individual Employment Support services are person-centered to address the person’s employment needs and interests.

**REIMBURSABLE ACTIVITIES: Individual Employment Support:**

1. Person-centered employment planning (assisting an individual in identifying wants and needs for supports and in developing a plan for achieving integrated employment),
2. Job development,
3. Negotiation with prospective employers,
4. Job carving,
5. Job placement,
6. Career advancement activities,
7. Job analysis,
8. Training, support, coordination and communication in related skills needed to obtain and retain employment such as using community resources and public transportation,
9. Job coaching,
10. Job loss - the person may need to be referred to, or back to, Vocational Rehabilitation for services and reimbursement, in which case, concurrent reimbursement for Supported Employment – Individual Employment Support and Vocational Rehabilitation Services will not be allowed,
11. Benefits planning support,

Members may utilize, Small Group Employment Support, Follow Along Support, Co Worker Support, and Day Supports & Activities in conjunction with Individual Employment Support.

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

ACTIVITIES NOT REIMBURSABLE: Individual Employment Support:

1. Ongoing transportation of a member to and from the job site once the person has been hired.
2. Any service that is otherwise available under the Rehabilitation Act of 1973.
3. Employment activities taking place in a group, i.e., work crews or enclaves.
4. Public relations activities.
5. Staff continuing education - In-service meetings, department meetings, individual staff development.
6. Incentive payments made to an employer to subsidize the employer’s participation in a supported employment program.
7. Payments that are passed through to users of supported employment programs.
8. Payments for vocational training that is not directly related to a member's supported employment program.
9. Any other activities that are non-member specific, i.e., the member has the job and can’t work their scheduled hours so the job coach is working the job instead of the member.
10. Any activities which are not directly related to the member's career plan.
11. Services furnished to a minor by a parent(s), step-parent(s) or legal guardian.
12. Services furnished to a member by the member’s spouse.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore, documentation is required to ensure that the service is not available or is no longer available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Income from customized home-based businesses may not be commensurate with minimum wage requirements with other employment.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

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

**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	DDP qualified service provider and/or offering agency with choice employer authority.
Individual	An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Supported Employment - Individual Employment Support****Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or offering agency with choice employer authority.

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:

\*Be at least 17 years of age.

Within 30 days of hire receive training in:

\*abuse reporting,

\*incident reporting,

\*client confidentiality,

\*service documentation requirements,

\*training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

First aid certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.

Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually thereafter.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supported Employment - Individual Employment Support**

**Provider Category:**

Individual

**Provider Type:**

An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Prior to hire:

\*Be at least 17 years of age.

\*Screening and a background check of a person prior to an offer of employment as a direct care staff.

Within 30 days of hire receive training in:

\*abuse reporting,

\*incident reporting,

\*client confidentiality,

\*service documentation requirements,

\*training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

First aid certification must be obtained within the first 30 days of employment and maintained thereafter, and other training in accordance with DDP requirements.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

\*any other training requirements as outlined by the Department.

Upon hiring of a direct care staff person, the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

In addition, the fiscal agent will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The FMS is initially responsible for ensuring that a worker meets the qualified provider standards and the FMS maintains records serving to document the compliance with these standards.

**Frequency of Verification:**

Annually, the quality assurance personnel reviews compliance of workers during the annual quality assurance review process, based on the requirements of the performance measure sampling process specified.

**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 Employment - Small Group Employment Support

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**



Supported Employment - Small Group Employment Support consists of habilitation services and staff supports needed for groups of two (2) to eight (8) workers with disabilities to maintain a job/position in the general workforce at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small Group Employment examples include enclaves, mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Small Group Employment Support must be provided in a manner that promotes integration into the workplace and interaction between people with and without disabilities in those workplaces. Work occurs in business settings and hours typical for the industry.

REIMBURSABLE ACTIVITIES: Small Group Employment Support:

1. Person-centered employment planning with or on behalf of the member supported,
2. Job development,
3. Negotiation with prospective employers,
4. Job carving,
5. Job placement,
6. Job analysis,
7. Training and support in related skills needed to obtain and retain employment such as using community resources and public transportation,
8. Job coaching,
9. Benefits planning support,
10. Job promotion support,
11. Career advancement support.

People may utilize Individual Employment Support, Co Worker Support, and Day Supports & Activities in conjunction with Small Group Employment Support.

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

ACTIVITIES NOT REIMBURSABLE: Small Group Employment Support

1. Transportation of a person to and from the job site.
2. Any service that is otherwise available under the Rehabilitation Act of 1973.
3. Public relations activities.
4. Staff continuing education - In-service meetings, department meetings, individual staff development.
5. Incentive payments made to an employer to subsidize the employer's participation in a supported employment program.
6. Payments that are passed through to members of supported employment programs.
7. Payments for vocational training that is not directly related to a member's supported employment program.
8. Any activities which are not directly related to the member's career plan.
9. Services furnished to a minor by a parent(s), step-parent(s) or legal guardian.
10. Services furnished to a member by the member's spouse.

Total hours for a member's attendance shall not include time spent during transporting to/from the member's residence.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore, documentation is required to ensure that the service is not available or is no longer available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

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

**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	DDP qualified service provider and/or offering agency with choice employer authority.

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Employment - Small Group Employment Support

Provider Category:

Agency

Provider Type:

DDP qualified service provider and/or offering agency with choice employer authority.

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:

- \*Be at least 17 years of age.

Within 30 days of hire receive training in:

- \*abuse reporting,
- \*incident reporting,
- \*client confidentiality, and
- \*any specialty training relating to the need of the member served, as outlined in the plan of care.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

Any training in accordance with Department rules.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.  
 Initially - The DDP as part of the Qualified Provider Application Process.  
 Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.  
 Prior to authorization as a DDP qualified service provider and annually 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:**

Transportation

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

**TRANSPORTATION SERVICES**

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

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

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

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

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

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

The following are excluded:

- 1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the member;
- 2) Purchase or lease of a vehicle; and
- 3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of any modifications.

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

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

**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	An individual who works for a member or a representative of the member self-directing the service with common law authority.
Agency	DDP qualified service provider and/or subcontracting for transportation services, and/or offering Agency with Choice Employer Authority.
Agency	Dedicated transportation provider agency enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Transportation**

**Provider Category:**

Individual

**Provider Type:**

An individual who works for a member or a representative of the member self-directing the service with common law authority.

**Provider Qualifications**

**License (specify):**

Operator will have a valid motor vehicle license, liability insurance and proof of vehicle registration, in accordance with state laws

**Certificate (specify):**

**Other Standard (specify):**

Prior to hire:

\*Be at least 17 years of age.

Upon hiring of a direct care staff person, the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

Payment for escort services may not be made under the transportation category.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The FMS is responsible for ensuring that services and supports purchased on behalf of the individual do not exceed individual cost plan allocation for this service, and all documentation requirements have been met prior to issuing reimbursement.

**Frequency of Verification:**

Annually, the quality assurance personnel reviews compliance of workers during the annual quality assurance review process, based on the requirements of the performance measure sampling process specified.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Transportation****Provider Category:**

Agency

**Provider Type:**

DDP qualified service provider and/or subcontracting for transportation services, and/or offering Agency with Choice Employer Authority.

**Provider Qualifications****License (specify):**

Operator will have a valid motor vehicle license, liability insurance and proof of vehicle registration, in accordance with state laws.

**Certificate (specify):****Other Standard (specify):**

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:

\*Be at least 17 years of age.

Payment for escort services may not be made under the transportation category.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

The agency reimbursing the transportation service is responsible for verifying that the motor vehicle is registered and insured, and the vehicle operator is licensed to operate the vehicle.

Initially - The DDP as part of the Qualified Provider Application Process.

Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed by the provider, prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually thereafter.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Transportation**

**Provider Category:**

Agency

**Provider Type:**

Dedicated transportation provider agency enrolled as a Montana Medicaid provider and as a DDP qualified service provider.

**Provider Qualifications**

**License (specify):**

Operator will have a valid motor vehicle license, liability insurance and proof of vehicle registration, in accordance with state laws.

**Certificate (specify):**

**Other Standard (specify):**

Person providing the service must be 17 or older.

Payment for escort services may not be made under the transportation category.

Terms of minimum liability insurance are outlined in the DDP qualified service provider addendum

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Initially - The DDP as part of the Qualified Provider Application Process.

Ongoing - The quality assurance personnel as part of the QA review process.

**Frequency of Verification:**

As needed prior to authorization of payment.

Prior to authorization as a DDP qualified service provider and annually 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 is delivered by state employees or contracted entities who complete all case management functions. Targeted Case Managers have four primary functions: Comprehensive assessment and reassessment to determine needs; development and periodic revision of the member's plan of care; referral to help the member obtain needed services and supports; and monitoring and follow-up activities to ensure the plan of care is implemented, addresses the member's needs, and is revised as needed.

## 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):

- a. Name-based criminal background checks from the Montana Department of Justice are required for all DD service provider agency employees who work with individuals funded by the DDP. The background investigation is performed through the State of Montana Department of Justice. The Department of Justice looks for any documentation of criminal activity within the State of Montana. For Homemaker services provided by a non-DD service provider agency employee (i.e. business entity) and Respite services provided as self-direct with employer authority using a fiscal agent a background check is optional. In this case, the member or their representative may choose to request, at no-cost, to the member, criminal background check for workers.
- b. Name based criminal background checks are based on criminal records maintained by the Montana Department of Justice. This is a State level repository of criminal records. The background investigation is performed through the State of Montana Department of Justice. The Department of Justice looks for any documentation of criminal activity within the State of Montana.
- c. The DDP's performance measure review process requires the DDP quality assurance personnel to annually sample the DDP provider agency employee files for staff working directly with persons to ensure background checks are being completed.

**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

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### 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

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### 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.*

A legally responsible individual is a biological or adoptive parent of a recipient under 18, or a spouse of an adult recipient. The services legally responsible individuals may provide include: Residential Habilitation, Supported Employment-Follow Along Support, Companion Services, Personal Care, Personal Supports, Supported Employment-Co-Worker Support, Supported Employment-Individual Employment Support, and Supported Employment- Small Group Employment Support.

For a legally responsible person to be paid for the provision of any of the aforementioned services all of the following authorization criteria and monitoring provisions must be met.

The service(s) 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.

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.

The person-centered plan of care team, which includes the person, reviews the person's services and determines the best interests of the participant. The Waiver-5 Freedom of Choice Form documents and includes the option, choice, and preference of the person to have a legally responsible individual provide direct services. The Targeted Case Manager, who has been trained in person-centered planning, has an independent role in the development of the plan of care and delivery of services and assures representation of the person's choices.

Quality assurance personnel monitors billed services during the annual Performance Measure Review, in terms of type, scope, amount, duration, and frequency. In addition, DDP contracted provider claims are subject to SURS and PERM audits. There are not any limits on the amount of personal care or similar services for which payment may be made.

**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, including biological or adopted parent, guardian, or spouse, may be reimbursed for personal care or similar services when qualified to provide the services. These services include Day Supports and Activities, Homemaker, Residential Habilitation, Companion Services, Personal Care Personal Supports, Private Duty Nursing, Respite, Individual Goods and Services, Specialized Medical Equipment and Supplies, and Transportation. The State has administrative rules for waiver services that list criteria of care, requirements of documentation and invoicing of waiver services.

The person-centered plan of care team, which includes the person, reviews the person's services and determines the best interests of the participant. The Waiver-5 Freedom of Choice Form documents and includes options and choices with regards to who provides services. The Targeted Case Manager, who has been trained in person-centered planning, has an independent role in the development of the plan of care and delivery of services and assures representation of the person's choices.

The controls to ensure that payments are made only for services delivered are the same for all providers of waiver services. Private audits, State audits, State SURS reviews, DDP quality assurance personnel fiscal sampling process, the Targeted Case Manager responsible for monitoring service delivery, and the consumer satisfaction surveys are methods by which the delivery of services are reviewed.

**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.

**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:

The Department established an open enrollment policy for all waiver services and developed the initial set of application forms for all waiver-funded services in 2002, following the review of this waiver by the CMS Regional Office in the fall of 2000. The qualified provider enrollment documents and various other application forms have since been revised and updated. The qualified provider enrollment documents and various other application forms are available on the DDP website for all interested parties. The DDP website states that:

To become a new DDP Provider, an entity must determine which services it is able to provide under a particular funding source.

The state has no timeframes established for enrollment of waiver providers.

Note: If the provider desires to enroll as a DDP qualified service provider and the service standard (links found on the website) require an individual to have a professional license/certification to provide the service, the DDP qualification process for licensed professionals is sufficient to become a qualified provider. If the service standard is agency-based and must be delivered by an Organized Health Care Delivery System (OHCDs), a full application to become a new DDP provider must be completed. A licensed/certified individual may also subcontract with an OHCDs-designated DDP qualified provider to provide the service.

Once an entity identified services under one or more of the Waivers that they believe they are able to offer, they should review the Department rules describing what must be provided under each of those services, to determine whether they believe they can meet the requirements for that service.

Once they determine which services they can offer while meeting Department rules, they must:

For services that require an OHCDs agency-based provider: Fill out an application to become a new DDP provider

Or

For services that can be delivered by an individual who is a licensed/certified professional: Complete the enrollment process through your local Developmental Disabilities Program Regional Office.

- Complete required criminal background checks as directed in the DDP Background Check Policy.
- Make arrangements to meet liability insurance and bonding requirements.

## 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 and percent of current providers that continue to meet required licensure/certification standards and adhere to other standards prior to furnishing waiver services. N: Number of current providers that continue to meet required licensure/certification standards and adhere to other standards prior to furnishing waiver services; D: Number of continuing providers requiring licensure/certification.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input data-bbox="1078 1122 1262 1205" type="text"/>
<b>Other</b> Specify: <input data-bbox="408 1346 647 1429" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input data-bbox="1078 1346 1262 1429" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input data-bbox="1078 1570 1262 1653" type="text"/>
	<b>Other</b> Specify: <input data-bbox="719 1794 954 1877" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

**Performance Measure:**

**Number and percent of new providers that met required licensure/certification standards and adhere to other standards prior to their furnishing waiver services. N:** Number of new providers that met required licensure/certification standards and adhere to other standards prior to their furnishing waiver services. **D:** Number of new providers requiring licensure/certification.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  <input type="text"/>

<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**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:**

**Number and percent of new providers (non-certified/non-licensed) that adhered to waiver requirements. N: Number of new providers (non-certified/non-licensed) that adhered to waiver requirements; D: Number of new providers (non-certified/non-licensed).**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval = <input data-bbox="1078 1193 1262 1272" type="text"/>
<b>Other</b> Specify: <input data-bbox="408 1417 647 1496" type="text"/>	Annually	<b>Stratified</b> Describe Group: <input data-bbox="1078 1417 1262 1496" type="text"/>
	Continuously and Ongoing	<b>Other</b> Specify: <input data-bbox="1078 1641 1262 1720" type="text"/>
	<b>Other</b> Specify: <input data-bbox="719 1865 954 1944" type="text"/>	



**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of existing providers (non-certified/non-licensed) that adhered to waiver requirements. N: Number of existing providers (non-certified/non-licensed) that adhered to waiver requirements; D: Total number of all existing providers (non-certified/non-licensed).**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>

<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percent of providers hired under self-direction that adhered to waiver requirements; N: Number of providers hired under self-direction that adhered to waiver requirement; D: Number of providers hired under self-direction.

**Data Source** (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**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:**

**Number and percent of TCMs who meet training requirements in compliance with DDP training requirements and in accordance with state requirements and the approved waiver; N: Number of TCMs who meet training requirements in compliance with DDP training requirements and in accordance with state requirements and the approved waiver; D: Number of all TCMs.**

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		<input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of providers who meet training requirements in accordance with state requirements and the approved waiver; N: Number of providers who meet**

training requirements in accordance with state requirements and the approved waiver; D: Total number of providers.

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

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.

100% of self-direct recipients are reviewed for sub-assurances a, b and c-2, and stratified sampling approach is used for sub-assurance c-1.

The review of the qualifications of persons providing waiver-funded services occurs annually in the completion of the DDP QA review process. Newly qualified service providers must submit documentation verifying compliance with the qualified provider standards to the DDP as part of the qualified provider application process.

**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.

The delivery of direct services by DDP-funded agencies which are DDP qualified are subject to annual quality assurance reviews by DDP staff. In general, these problems are resolved via the application of the Quality Assurance Observation Sheet (QAOS). This form generally requires short term turn around times, and includes negotiated timeframes between DDP staff and provider staff in resolution of identified problems. At such time the problem is resolved, the QAOS has been signed and dated by both parties, and the finding is considered closed. Quality assurance personnel monitor the effectiveness of the plan on an ongoing basis. The QAOS becomes a permanent QA record, and is maintained by the provider and in the DDP regional and central offices. The specific protocol used to correct problems resulting from the application of the QA process is outlined in the Quality Assurance and Compliance Policy.

ii. Remediation Data Aggregation

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

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p><b>Annually</b></p>
	<p><b>Continuously and Ongoing</b></p>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**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.*

Members served in the waiver have individual cost plans based on assessed needs as determined by the Montana Resource Allocation Protocol (MONA), completed by the targeted case manager. The MONA generates an upper cost limit based on the person's assessed needs and choices. The person-centered plan of care team, including the person, uses this information and other assessments in the development of the plan of care and individual cost plan. Members can choose from the menu of waiver service options, based on assessed needs and identified in the plan of care. The value of the cost plan is largely based on the historical amount awarded to the member with adjustments made based on changing needs as reflected in the MONA. Members and or their families have broad flexibility and choice of services within the limit of the cost plan. All waiver services are subject to the limit, however, as the person's needs change, the individual cost limit will change to accommodate that through the DDP's Urgent needs process.

Additional time limited funds are available via crisis funds from the DDP regional offices. Crisis funds are increases in funding to meet a temporary need for additional supports. Urgent needs requests are permanent funding increases in an individual's cost plan due to a long-term need in additional supports. Crisis funds are available as crises arise. The DDP is committed to meeting the ongoing and changing needs of persons enrolled in the Waiver. The rates are fully integrated statewide, and the dollar value of cost plans is shared with members and family members. If rates are increased throughout the life of the wavier, the cost plans of participants are also increased to ensure there is no impact to the services participants have access to.

The Montana Individual Resource Allocation Protocol (MONA) Guide 12.3a is available upon request of the Department of a member's Targeted Case Manager.

**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  
11/08/2023

requirements at the time of submission. Do not duplicate that information here.

Montana submitted a Corrective Action Plan (CAP), pending CMS approval.

Montana understands that all Medicaid reimbursed HCBS settings within the state must be compliant with the following regulatory settings criteria:

- Privacy, dignity, respect, and freedom from coercion and restraint; and
- Control of personal resources.

Additionally, all provider owned/controlled Medicaid reimbursed HCBS residential settings must be compliant with the following criteria:

- A lease or other legally enforceable agreement providing similar protections,
- Privacy in their unit, including lockable doors, and freedom to furnish or decorate the unit,
- Access to food at any time,
- Access to visitors at any time,
- Physical accessibility, and
- Person-centered service plan documentation of modifications to relevant regulatory criteria.

Providers must be in compliance with these conditions by March 17, 2023, and this CAP does not request an extension of those regulatory requirements.

Montana is requesting continued time to perform re-validations, improve documentation and follow-up with providers currently implementing site specific remediation plans for all settings criteria not described above. The settings criteria in the scope of this CAP include:

- Access to the broader community,
- Opportunities for employment,
- Option for a private unit and/or choice of a roommate, and
- Choice of non-disability specific settings.

All DDP providers completed a Provider Self-Assessment (PSA) for each of their residential and non-residential settings. DDP quality assurance personnel completed at least one on-site visit using the Validation Tool assessment in the years preceding the March 2023 deadline for transitional settings and any new settings. The current site assessment results are as follows:

#### Compliant Settings

Day Supports and Activities-68

Supported Employment-2

Group Home-110

Supported Living-47

Assisted Living-3

Adult Foster-23

#### CAP Settings

Day Supports and Activities-3

Group Home-14

Supported Living-11

The DDP will continue to use the PSA and Validation Tool as primary features of the ongoing oversight process. All providers will be required to complete a new PSA at least once every five years for each distinct setting. Each new PSA cycle will initiate an PSA desk review with provider follow-up as needed. In 2023 Montana will deploy an electronic assessment and case tracking solution. This efficiency step will allow providers and the department to work effectively using provider completed assessments, discrete site level documentation, document storage and routing, and documented follow-up and results tracking. Future iterations of the solution will assist in identifying high risk settings for more frequent re-validations and/or site visits.

Additionally, the person-centered plan of care process that occurs at least annually will continue to capture member choices and ensure the HCBS criteria is adhered to.

## Appendix D: Participant-Centered Planning and Service Delivery

**State Participant-Centered Service Plan Title:**

Personal Support 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:*

The Targeted Case Manager(TCM), also known as the service coordinator, is responsible for the development of the plan of care for each waiver recipient. A TCM /service coordinator must meet the following criteria:

- \*Possess a bachelor's degree in social work or related field from an accredited college and have one year of experience in human services, or have provided case management services, comparable in scope and responsibility to that provided by the targeted case managers, to a person with developmental disabilities for at least five (5) years.
- \*Ongoing documentation of the qualifications of case managers and completions of training must be maintained by the case manager's employer.

The following training/knowledge requirements apply:

- Reporting requirements for Adult and Child Protective Services and the DDP Incident Management Policy.
- Knowledge of case management methods, procedures and practices;
- Ability to assess and reassess continuing member need;
- Ability to develop and implement member plan and determine the services most appropriate to meet the assessed need(s);
- Ability to monitor and implement the POC;
- Ability to provide guidance to assist members in utilizing community services effectively and appropriately;
- Ability to promote members' self-determination; and
- Knowledge of Medicaid, Medicaid waivers, and other community resources.

New employee training to be completed within the first three (3) months of hire:

\*In accordance with the approved State Plan Amendment

Annual Training:

\*In accordance with the approved State Plan Amendment

**Social Worker**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

## 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:*

## 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.

Upon entry into the waiver, and annually thereafter, the member, family and legal representative if appropriate, receive information on and indicate choices of waiver services, self direction, and qualified provider options via the Freedom of Choice and Consent forms. A detailed explanation of services and options is provided by the case manager/service coordinator.

The plan of care is developed to reflect what is important to the member as designed through outcomes identified in the support plan leading to independence, dignity and personal fulfillment. The person-driven and person-centered plan identifies services and supports that are appropriate to meet the member's assessed needs through completion of the following, results of which are shared with the member: a consumer survey, health and safety risk factor identification form, medical, vision, hearing, and dental examination information

The development of the plan of care reflects a person-centered planning process. The plan belongs to the member and the process helps members achieve their life goals and evolves as the member's life evolves. The plan of care is signed by the member, family and legal representative if appropriate, and participating team members, indicating approval of the plan.

Notification of the planning meeting is sent by the case manager/service coordinator to the member, family and legal representative if applicable, and other invited parties. The member, family, and /or legal representative, as appropriate reserve the right to decide who will be attending the planning meeting, except the member does not have the authority to limit attendance by his/her full legal guardian. Plan input and guidance from the member, representatives of agencies providing services, and interested others is actively encouraged by the case manager/service coordinator.

## 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 participant-centered 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) Who develops the plan, who participates in the process, and the timing of the plan:

The DDP mission is to create a system that coordinates resources, supports, and services for people to have meaningful lives in their communities. This is accomplished through the person-driven and person-centered plan of care. The member facilitates the meeting to the extent s/he feels comfortable. Recent improvements to the process have included recommendations from a stakeholder group consisting of Waiver members. The participant-centered service plan belongs to the member and the plan of care process helps people achieve his/her life goals, evolving as the member's life evolves. Montana requires that each individual enrolled in the 0208 Waiver have a plan of care. The development of the plan of care is facilitated by a case manager/service coordinator, certified in plan of care development and chosen by the member.

Developing a plan of care encourages a team approach to involve the waiver recipient, known as member, and community networks in planning for the future. Whenever possible, members should freely choose their circle of support who may be: family members and/or guardians and/or legal representatives, teachers and paraprofessionals, friends, peers acquaintances, direct support professionals, and other support professionals, and any others who are important to the member and his or her family and those involved in the member's life. In accordance with the Administrative Rules of Montana (ARM)

37.34.1107 the planning team must include: the individual with a developmental disability, if able to participate; member's advocate, if applicable; legal representative of the member, if applicable, the case manager/service coordinator for the member; staff person from each service program; and others who are chosen and approved by the member. The member is also involved in choosing when and where the plan of care meeting occurs. The service coordinator reaches out to the person to ask who should be invited, and when and where the next annual plan of care meeting will take place. After obtaining this information from the person, the service coordinator sends a written notification to the person and team members for the meeting location and time.

The plan of care process is designed to be fluid, changing as the member's life changes to include any transitions. The initial plan of care must be developed by the team with participation of the member within 45 calendar days of the member's entry into waiver services. Oftentimes, a child or adult on the waiting list have case management services. In these cases, when the person is selected for entrance into the Waiver there is already an Individualized Family Support Plan or Personal Support Plan in place to assist in determining initial Waiver services and supports. The service cost plan is temporarily developed in the interim with the full plan of care developed within 45 calendar days. The plan of care is updated at least annually, or more often as needed.

## (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:

The case manager/service coordinator is responsible to complete a consumer survey, and the Healthcare Checklist and Risk Worksheet. These documents are completed with the member upon entrance into the waiver, and annually thereafter, and assist in the development of vision statements and outcomes based on the member's needs and desires.

The residential provider agency, or the case manager/service coordinator in the absence of any residentially-based services, supplies the results of the member's annual physical, dental, hearing and vision examinations. Additionally, providers must address the living, employment, educational, developmental, social, and leisure domains according to Department policy and under the direction of the planning team.

The case manager/service coordinator and provider staff may identify additional assessments that will support the team to understand the member, what the member needs, and how best to support those needs while considering the member's wants and the use of natural supports. For members who are employed, additional information may be gathered from the member and from the supported employment coach.

An assortment of assessments and tools are available to the person, service coordinator, and plan of care team for active engagement and direction by the person to express his/her preferences and make informed choices. These include the Waiver 5 Freedom of Choice Form, Smull tools, Consumer Survey, and Health Care Checklist and Risk Worksheet. These assist the person and team in making decisions regarding goals and objectives, as well as identifying opportunities for skill acquisition.

## (c) How the participant is informed of the services that are available under the waiver:

Information regarding the services that are available under the waiver is shared with the member upon initial entrance into the waiver, and on an annual basis as part of the planning process. The Freedom of Choice form lists the available waiver services, and further identifies services which may be self-directed. It is the responsibility of the case manager/service coordinator to present detailed information on the available waiver services and self-direct options, choices between waiver services and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), choices of qualified Home and Community Based Services providers, and information regarding the state of Montana's fair hearings process. The member (guardian or legal representative, if applicable) acknowledges receipt of information and indicates choices on the Freedom of Choice and Consent form. The member (guardian or legal representative, if applicable) may change the choices made at any time. This would be reflected on an updated Freedom of Choice and Consent form, and an amended plan of care as needed.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences:

The plan of care is developed to reflect what is important to, and important for the member as designed through outcomes identified in the support plan leading to independence, dignity, and personal fulfillment. The person-driven and person-centered plan identifies services and supports that are appropriate to meet the member's assessed needs per ARM 37.34.1101

A review of the assessments and other information gathered is conducted prior to the planning meeting in order to facilitate discussion of findings to incorporate into the plan. Assessments lead to valuable information to inform outcomes and goal setting in relationship with the member's goals, needs (including health care needs), and preferences.

(e) how waiver and other services are coordinated:

Developing a PSP encourages a team approach to involve the member and community networks in assisting the member to plan for his/her future. The process involves the member first developing goals for the future and identifying all current supports to develop the member's team. This is followed by the case manager/service coordinator being actively engaged in the PSP process to facilitate team members to coordinate the resources and supports available, or for which the member is eligible, to make the member's goals a reality.

The case manager/service coordinator facilitates all plan of care meetings and the pre-plan of care information gathering process. He or she is responsible to gather information and assure coordination of all services, resources and supports. The person-centered process and plan identifies services and supports, including natural supports, private or publicly funded supports, or waiver supports. The plan of care document includes a section to identify people/agencies that support the individual, contact information, and types of services and supports provided. Each action identified in the plan of care to accomplish the member's objectives also requires the identification of entities responsible to complete the actions, as well as the implementation date.

The process involves the member developing goals for the future, while facilitating the coordination of resources and supports to make those goals a reality.

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

The Personal Supports Manual delineates responsibilities and timelines of team members responsible to gather, complete, and provide summary information for each assessment completed, or information gathered through formal and informal processes. The summary information is provided to the case manager/service coordinator during the pre-plan of care process.

As part of the plan of care meeting, the team agrees on the assignment of responsibilities to implement actions identified to assist and support the member to achieve his/her objectives. Each action identified in the plan of care to accomplish the member's objectives require the identification of entities responsible to complete the actions, as well as the implementation date.

The entities responsible for the implementation of actions provide updates via a Mid-Year Review planning team meeting facilitated by the case manager/service coordinator. During the Mid-Year Plan of Care Review meeting the member may

share highlights that have occurred since the team last met, and each objective is reviewed for success or barriers to the member attaining identified goals to determine if any revisions to the plan of care are necessary.

There are several events that could trigger the revision or updating of a member's plan of care. But, minimally the plan is updated annually. Other developments that could result in the update or revision of a plan of care include: lack of progress toward attainment of objectives as evidenced by Mid-Year Plan of Care Review meeting; change in the member's health or physical support needs; change in the member's behavior; increase in frequency or intensity or types of documented incidents; or a member's desire to change his/her goals, objectives, services, or supports.

The plan is reviewed mid-year and revised or amended as warranted. Mid-Year reviews include a review of goals and objectives; a summary of progress toward the attainment of each objective; a summary of any action taken to assure progress; review of current supports and services and if needed, revisions to the plan of care and/or associated cost plan due to changes in the member's health and medical assessment information, and/or changes in the member's goals or priorities.

Incidents involving the member are also reported and reviewed regularly by incident management committees, of which case manager/service coordinators are required members. This is in compliance with ARM 37.34.1501, and further described in Montana's Developmental Disabilities Program Incident Management Procedures Manual. Incidents warranting a "high risk review" requires the case manager/service coordinator to schedule a meeting for the team to review the plan of care and determine if a revision is needed to address the incidents.

Any member of the PSP team may request a review, a revision or both a review and revision to the PSP, as determined by the person's needs at any time.

Any new service/support must be noted in the plan of care therefore, revision to the plan of care is necessary to reflect the changes. Any revisions to the PSP require a meeting to amend the PSP. The person's case manager/service coordinator must schedule and facilitate any PSP Review/Revision meetings, providing five (5) calendar days' notice to all team members. Changes agreed upon at a Review/ Revision PSP must be implemented within 21 days of the meeting. A meeting is held with the team and changes are documented using the Review/Revision form and disseminated among the team members by the case manager/service coordinator in accordance with ARM 37.34.1102(7). Again, the plan of care should change as often as there are changes in the member's life.

The plan of care must be reviewed annually by the team and updated to accurately reflect the person's needs for supports and services. During the annual planning team meeting, the team also reviews the summary information from previous plan of care. The annual plan of care may not be extended beyond the twelfth month, ensuring no gap in implementation dates.

The case manager/service coordinator posts the completed or amended PSP on the department-approved data management system within 21 calendar days of the plan of care meeting and provides a copy, if requested, to team members who do not have access to the data management system in accordance with ARM 37.34.1102.

Some of the codes, rules and policies governing this section include:

1. Personal Support Planning Policy.
2. ARM 37.86.3301 through 37.86.3306 and 37.86.3601 through 37.86.3607 relate to the provision of services under the State Plan. Other planning meeting references include 37.34.917 and 37.34.918.
3. MCA 53-20-201 through 53-20-205 and 53-20-209.

The case manager/service coordinator is responsible for scheduling and facilitating all team meetings, and it is through these meetings that the plan of care is updated. Any team member may request a meeting to review and/or revise the plan of care, including changing circumstances of the member, such as: lack of progress in completing actions and objectives identified in the plan of care; waiver expenditures that vary significantly from approved levels; a change in member's assessed needs or goals (goals); and member desire to port to a different service provider(s) or change waiver services. Meetings are scheduled after consultation with the member to determine when and where he/she would like to hold the meeting and identify who to invite. Any review or revision of the plan of care is documented and disseminated by the case manager/service coordinator.



**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.

Assessments of risk are related to two broad areas:

1. Identification of risk factors linked to the increased potential for the abuse, neglect, or exploitation of the member.
2. Identification of risk factors, which, if not addressed, could interfere with the member's cognitive, social, and physical development, or reduce the potential for independence and/or reduce life choices and options based on behavioral issues or adaptive behavior deficits.

Risk assessment is conducted in the pre-plan of care development process. It consists of the case manager/service coordinator completing a consumer survey in which the member can express needs, health and wellness concerns, and personal lifestyle choices. The case manager/service coordinator also completes the Health Care Checklist and Risk Worksheet with the member and/or with others who know the member's medical, behavioral, environmental, and general safety history, concerns, and needs. These forms are completed at least annually as part of the plan of care development process.

Risk factors may also be identified through the review of recorded incidents involving the member. Case managers/service coordinators participate in weekly incident management committee meetings during which incidents involving members served by the provider are reviewed. In addition to reviewing individual incidents, the committees also review trends which may result in the convening of the member's planning team to conduct a high-risk review. These activities are further described in the DDP Incident Management Procedures Manual.

Mitigation of risk factors is addressed by the member and his/her planning team and are documented in the member's plan of care. Training and service objectives related to the mitigation of risk are given a very high priority during the planning process. The plan of care is revised whenever necessitated by a change in the member's health, wellness, or other risk factors.

All service provider staff and other professionals involved with the member are mandatory reporters of suspected abuse, neglect or exploitation per Montana Code Annotated (MCA) 41-3-201 for children, and MCA 52-3-811 for adults.

Back-up support to members receiving services from agency-based providers in non-congregate settings is available via on call systems linking them to assigned agency staff person. In general, back up plans for persons in congregate settings are less critical and the provider systems and policies to maintain staffing ratios are individualized by service provider agency, based on the needs of each person. DDP qualified service providers are expected to provide the DDP with all emergency back-up or on-call emergency working numbers for all services that they deliver.

Members choosing to self-direct all or part of his/her services are required to have a back-up plan developed and identified in the member's plan of care.

## 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.

Upon entry into waiver services, and at least annually thereafter, the member is afforded the choice of a qualified case manager/service coordinator, from amongst those that are available to the member. The member's choice is documented on the Freedom of Choice for Case Management form.

Information regarding the qualified waiver providers that are available is shared with the member upon initial entrance to the waiver, and on an annual basis as part of the planning process. The Freedom of Choice form lists the available waiver services, and further identifies services which may be self-directed. It is the responsibility of the case manager/service coordinator to present detailed information on the available waiver services, qualified providers of those services, and self-direct options.

The form also requires choices between waiver services and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), choices of qualified Home and Community Based Services providers, and information regarding the state of Montana's fair hearings process.

The member (guardian or legal representative, if applicable) acknowledges receipt of information and indicates choices on the Freedom of Choice and Consent form. The Freedom of Choice and Consent form is completed annually, or more frequently if the member expresses an interest in porting to, or exploring service options offered by other qualified providers.

## 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):

In waiver services, the Plan of Care is approved by the Service Coordinator/Case Manager. These plans are made available to the DDP Quality Assurance Personnel, but the Quality Assurance Personnel does not review these plans as part of the approval process. Because the Service Coordinator/Case Manager is either a state employee or an employee of an agency providing the case management only services to the individual, DDP believes there is no conflict in designating the case manager as the Department approval authority. The DDP Quality Assurance Personnel monitors a sample of the plans for quality control purposes as part of the annual QA process.

The Medicaid Program Officer/Waiver Specialist generates the sample size by entering the waiver approved unduplicated count into a sample size calculator, Raosoft.com, recommended through technical assistance received by Human Services Research Institute. A confidence interval of 95% is used. Once the sample size is generated, another website, Randomizer.org, is used to create the statistically valid sample, which is increased by 5% to create a cushion.

Plans of care developed by private case management entities for selected members are reviewed and approved by state-employed DDP quality assurance personnel (Medicaid agency) retrospectively as part of the annual performance measure review. The quality assurance personnel review the annual plan of care and any revised/amended plans of care, associated systems such as the individualized cost plan and invoicing, as well as data and checklists completed by provider 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:*

Service providers also maintain copies of the plans.

**Appendix D: Participant-Centered Planning and Service Delivery**

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**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.

(a) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare:

The case manager/service coordinator is responsible for facilitating the development of, and monitoring the implementation of the plan of care; and is also responsible for the monitoring of the member's health and welfare.

(b) The monitoring and follow-up method(s) that are used:

The entities responsible for the implementation of actions provide updates via a Mid-Year Review planning team meeting facilitated by the case manager/service coordinator. During the Mid-Year Plan of Care Review meeting the member may share highlights that have occurred since the team last met, and each objective is reviewed for success or barriers to the member attaining identified goals to determine if any revisions to the plan of care are necessary.

(c) The frequency with which monitoring is performed:

The case manager/service coordinator is required to meet with the individual for a minimum of three face-to-face contacts per year, more meetings may take place based on need. The PSP must be reviewed at least mid-year by the case manager/support coordinator and team, including the member during a Mid-Year Plan of Care Review meeting, and revised or amended by the team as warranted. The reviews include a review of vision statements and outcomes; a summary of progress toward the attainment of each goal and objectives; a summary of any action taken to assure progress; review of current supports and services and identification of any modifications needed; review of health and medical information; review of assessment information; and review of the services/supports identified in the member's cost plan to determine if they meet the member's assessed needs.

Annually, the DDP QIS also reviews a sample of plans of care as part of the Quality Assurance Review, in accordance with the QA review performance measure requirements.

The Medicaid Program Officer/Waiver Specialist generates the sample size by entering the waiver approved unduplicated count into a sample size calculator, Raosoft.com, recommended through technical assistance received by Human Services Research Institute. A confidence interval of 95% is used. Once the sample size is generated, another website, Randomizer.org, is used to create the statistically valid sample, which is increased by 5% to create a cushion.

Plans of care developed by private case management entities for selected members are reviewed by state-employed DDP quality assurance personnel retrospectively as part of the annual performance measure review. The quality assurance personnel review the annual plan of care and any revised/amended plans of care, Mid-Year Plan of Care Review meeting documentation, associated systems such as the individualized cost plan and invoicing, as well as data and checklists completed by provider staff.

The plan of care team develops and assesses the effectiveness of back-up plans as part of the annual plan of care process. DDP qualified service providers are required to maintain an emergency back-up plan with the contact phone number listed. Members choosing to self-direct services are also required to have an emergency back-up plan. These are reviewed, and updated as needed, by the plan of care team at least annually.

**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:*

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:**

**Number and percent of POCs developed by TCMs that address member assessed needs (including health and safety risk factors) either by the provision of waiver services or other means. N: Number of POCs developed by TCMs that address member assessed needs (including health and safety risk factors), either by the provision of waiver services or other means. D: Number of POCs reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         95% confidence level, +/- 5% margin of error                     </div>

<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percent of POCs developed by TCMs that address member personal goals, either by the provision of waiver services or other means. **N:** Number of POCs developed by TCMs addressing personal goals either by the provision of waiver services or other means. **D:** Number of POCs reviewed.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         95% confidence level, +/- 5% margin of error                     </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>Other</b> Specify: <input data-bbox="406 392 798 470" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input data-bbox="869 672 1260 750" type="text"/>

**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.*

**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:**

**Number and percent of POCs that were revised when warranted by changes in member needs. N: Number of POCs that were revised when warranted by changes in member needs. D: Number of POCs that warranted a change due to changes in member needs that were reviewed.**

**Data Source (Select one):**  
**Record reviews, on-site**



If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-top: 5px;">95% confidence level, +/- 5% margin of error</div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
Specify: <input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of POCs that have been updated at least annually. N: Number of POCs that have been updated at least annually. D: Number of POCs due for an annual review that were reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/> 95% confidence level, +/- 5% margin of error
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and</b>	<b>Other</b>

	<b>Ongoing</b>	Specify: <input style="width: 100px; height: 20px;" type="text"/>
	<b>Other</b> Specify: <input style="width: 100px; height: 20px;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100px; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100px; height: 20px;" type="text"/>

**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:**

**Number and percent of members who received the services in accordance with their POC, including type, scope, amount, duration, and frequency specified in their POC.**

**N: Number of members who received services in accordance with their POC, including type, scope, amount duration and frequency specified in their POC; D: Number of members reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 2px; width: fit-content;">                         95% confidence level, +/- 5% margin of error                     </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

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:**

**Number and percent of member files containing Freedom of Choice forms completed verifying that members were afforded choice among qualified providers. N: Number of member files containing Freedom of Choice forms completed verifying that members were afforded choice among qualified providers; D: Number of member files reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

<b>Agency</b>		
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">                     95% confidence level, +/- 5% margin of error                 </div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of member files containing current Freedom of Choice forms completed verifying members were afforded choice between/among waiver services.**  
**N:** Number of member files containing current Freedom of Choice Forms completed verifying members were afforded choice between/among waiver services; **D:** Number of member files reviewed.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/> 95% confidence level, +/- 5% margin of error
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>

	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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**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):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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 DDP Waiver Specialist, or designee, is responsible for aggregating the data generated by the DDP quality assurance personnel or Regional Manager in the monitoring of the performance measures, above. Data will be maintained as a percentage of annual compliance with these measures. Performance data will be forwarded electronically by the DDP QIS to the DDP Waiver Specialist at least annually, and the data will be entered onto a spreadsheet. Annual percent compliance with the performance measures will enable reviewers to determine compliance trends. Problem areas would result in the DDP Waiver Specialist notifying the DDP management team.

The identification of problems in the delivery of services is generally the result of the application of the DDP QA review process. The annual QA Review Process is applied by the DDP quality assurance personnel to providers of services. The QA review process is updated as needed to include measures designed to monitor compliance with new waiver requirements, policies, rules, or DDP qualified provider process.

**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.



The Department's process for addressing deficits is outlined in the Quality Assurance and Compliance Policy, with standards applying to the providers of children's services and providers of case management services. The outcomes of deficit findings and remediation efforts may be reviewed in QA Reports, the Quality Assurance Observation Sheets, and narratives in the CMS 372 Reports.

**ii. Remediation Data Aggregation**

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>

**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**

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**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

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### 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.

#### General Description of the Self-Direction Options:

Budget authority allows the individual, based on assessed needs, to identify the services, the amount of services they will purchase, and the provider of the services, as long as the person stays within the allocated amount and uses a provider enrolled in the waiver.

Members living in a natural home or private residence may choose to self-direct some or all of their waiver services via an employer authority using an FMS model or agency with choice employer authority model. There are no age restrictions for persons who may self-direct their services. Parents/legal representatives may choose to self-direct services FOR their children who receive waiver services. Individuals who self-direct exercise increased control of their resource allocation and increased control over the schedule of service delivery and the persons who provide their direct support.

#### Self-Direct Agency with Choice Employer Authority:

Person's in self-directed agency with choice services participate with the DDP qualified service provider by referring staff to the agency for hiring. Staff providing direct services must be approved by the person and/or designated representative. The agency serves as the legal employer for all staff providing self-directed services in this option. The person supported also partners with the DDP qualified service provider in scheduling the staff, orienting and instructing staff in their duties, in accordance with waiver requirements, supervising the staff, evaluating staff performance, verifying time worked by staff, and discharging staff from providing services. Service agreements between the DDP qualified service provider and the individual are required and are designed to be flexible. A family or an individual waiver participant has flexibility in their plan of care to choose the services, from the service array in the Montana approved waiver that best fit their assessed needs. They may utilize their individual cost plan choosing services that help to achieve the outcomes that are important to and important for them and they may choose to return to traditional agency-based services at any time.

#### Self-Direct Common Law Employer Authority:

Individuals may choose to self-direct their services using common law employer authority. The individual in service may function as the employer, or the employer may be a personal representative or a family member. "Family member" means natural parents, adoptive parents, licensed foster parents, grandparents, step-parents, siblings, aunts, uncles, guardians and individuals who have a legally granted conservatorship or properly executed power of attorney responsibility for overseeing the disabled person's finances or general care. The employer is responsible for hiring, training, supervising, scheduling and terminating their employees.

The employer may purchase support brokerage services to assist with training, scheduling and other agreed-upon functions. The financial management service (FMS) is responsible for providing information to employers on their responsibilities, for processing employer and employee paperwork and for maintaining documentation that staff hired meets the qualified provider requirements.

The FMS reviews the List of Excluded Individuals and Entities (LEIE) and Medicare Exclusion Database (MED) background checks on employees and obtains criminal background checks on direct support staff that require background checks. The FMS processes payroll and reimburses employees according to the submitted timesheet and individual cost plan. The FMS withholds and pays all taxes and arranges for workers' compensation for all employees. The FMS also provides reports to the employer, case manager/service coordinator and state. In all cases, the person who functions as the employer is subject to the initial and ongoing approval of the planning team.

#### Services available as Agency with Choice Employer Authority:

Specialized Medical Equipment and Supplies  
 Caregiver Training and Support  
 Personal Emergency Response System (PERS)  
 Personal Supports  
 Respite  
 Supported Employment - Co-Worker Support  
 Supported Employment - Follow Along Support  
 Supported Employment - Individual Employment Support  
 Supported Employment - Small Group Employment Support

Supports Brokerage  
Transportation

Services Available as Common Law Employer Authority:

Meals,  
Respite,  
Personal Emergency Response System (PERS),  
Environmental Modifications,  
Specialized Medical Equipment and Supplies,  
Personal Supports,  
Supports Brokerage,  
Community Transition Services,  
Transportation,  
Supported Employment – Individual Employment Support,  
Supported Employment – Follow Along Support,  
Supported Employment – Co-Worker Support  
Individual Goods and Services

Case managers/Service coordinators will play a critical role in the sharing of information to waiver individuals regarding self-directed service options. Case managers/Service coordinators will review the Freedom of Choice form and the supplemental addendum form with every person potentially eligible to self-direct their services, as defined in section E-1:C. This activity occurs annually. Individuals interested in pursuing the self-directed option and needing more information may access more details from their case manager/service coordinator. Information is also available from the DDP website, the FMS website and from DDP staff. Individuals who elect to self-direct their services will be assisted in doing so by their case manager/service coordinator, who will schedule a planning meeting for this purpose. Persons choosing to self-direct will be assisted by their service provider and case manager/service coordinator in establishing the level of individual involvement in self-directing their services.

Services that a member/family may choose to self-direct are indicated in Appendix C and as previously noted in this section. All other waiver services may be purchased through an agency or individual who is DDP qualified. The state Medicaid Agency provides the option of entering into a provider agreement as being designated as an OHCDs and for which specific waiver service(s). Agencies that volunteer to affiliate with an OHCDs must meet the requirements of an OHCDs. The state Medicaid Agency also provides the option of entering into a provider agreement with providers that elect not to affiliate with an OHCDs and will be designated as such in their DDP enrollment addendum. For those DDP providers who choose to be a qualified OHCDs, it enables the agency to provide third party services from other entities if requested by the service member/family. The rate paid to the member's provider agency for third party services cannot exceed DDP's standardized rate for direct payment for these services. There is no duplication of payment (pass through funding) in the coordination of third party services. The OHCDs function optimizes the ability of the member/family to choose their direct services staff and supports.

The member is not required to use their primary provider agency for the purchase of third party services. If requested by the member, the DDP will reimburse the alternative service provider directly, in accordance with the member's plan of care and individual cost plan.

Members choosing to self-direct may opt out of this option at any time, and receive agency based services under the traditional model of service delivery.

## 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

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### 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*

Persons of all ages may choose to self-direct their services if they meet the residential living requirements as outlined in E-1:c.

Individuals will be granted this option if the following conditions are met:

Self-Direct Agency with Choice Employer Authority:

The individual has identified a provider willing to assist them in self-directing their services. The case manager/service coordinator will assist by explaining the services the person would like to self-direct with the provider of choice. The case manager/service coordinator will review the proposed plan with the provider chosen by the person, to determine the feasibility. If the provider is willing to provide services in accordance with the expressed desires of the person, the case manager/service coordinator will schedule a planning meeting.

Self-Directed Services with Common Law Employer Authority:

The individual and/or their primary caregivers along with the case manager/service coordinator discuss the self direct options. If a decision is made to move forward in gathering more information the case manager/service coordinator gives the individual/primary caregivers the contact information for the financial management service (FMS) and the FMS is contacted to assist the individual and their primary caregivers and/or case manager/service coordinator to review the required paperwork. If they choose this self-direct option the FMS can assist them in enrolling in their FMS services and their case manager/service coordinator helps them in amending their plan of care and the individual cost plan to reflect the changes.

\*In both self direct service options the individual's planning team reviews and approves the plan of care incorporating self direction. The individual cost plan (ICP) is based on the plan of care, and approved by the DDP regional manager.

## 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.

**Information Provided to All Waiver Individuals:**

The self-directed service options are available to all persons currently enrolled in the waiver, subject to the criteria specified in E-1:c. A persons DDP resource allocation does not change as a function of enrollment in this service option.

The self-directed options are outlined to the person as part of the planning process and is reviewed by the person, representative (if applicable) and case manager/service coordinator prior to the annual planning meeting. A reference to the self-directed service option is included on the Freedom of Choice Form and the supplemental addendum form. This form is completed annually with the person and or their representative by the DDP quality assurance personnel or case manager/service coordinator. The supplemental addendum included with the Waiver 5 Freedom of Choice form includes more in depth, narrative information regarding: ICF-IID SERVICES IN MONTANA, FAIR HEARING RIGHTS and OPPORTUNITIES TO SELF-DIRECT. This information is intended to assist case managers/service coordinators in consistently informing waiver participants about the above mentioned items and to then leave with the waiver participant for future reference.

Individuals, representatives, and/or family members expressing interest in self-directing services may request the FMS contact information from their case manager/service coordinator. The FMS paperwork is also available on their website. The handouts outline the benefits of self-direction, the responsibilities of the individual and others and the guidelines for enrollment, continued participation and dis-enrollment in self-directed services.

DDP also developed a Self-Direct Employer Handbook which provides step by step information describing self direction of waiver services. For more information the handbook can be found on the DDP website.

Individuals and their representatives and/or family members desiring a more active role in the selection of their support workers, and/or increased flexibility in scheduling their supports may be interested in choosing a self directed service option.

The self-directed enrollment requirements and options are briefly described in the freedom of choice addendum form, specific to self direction.

The person's case manager/service coordinator may be asked to provide assistance in any of the following activities:

- scheduling a planning meeting to initiate a self-directed service option.
- helping the person select a willing service provider.
- providing any other requested assistance related to initiating the self-directed option.

The planning document for self-directed services implementation includes a narrative section describing the projected use of the resource allocation, services to be provided, proposed schedule and timeframes, additional training required for each employee, a description of how health and safety issues will be addressed, including back up, emergency and on-call systems, the role of the case manager/service coordinator and support broker if requested, and the responsibilities of the person and/or representative. The planning document must be signed off by the provider agency, case manager/service coordinator, the person and/or representative as applicable. The use of self-directed services with employer authority does not require the FMS to sign off on the plan of care. Once the decision has been made and approved to use this service option by the planning team, the FMS service is contacted for enrollment purposes.

Current providers of services may require the person to give notice of intent to port, in accordance with the requirements of the DDP Porting Policy, found on the DDP website, if the person chooses a new service provider as a primary service delivery agency, or chooses to self-direct some or all of their services with employer authority.

## Appendix E: Participant Direction of Services

### 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:

Legal representatives may direct any waiver service that is available as a participant directed waiver service. Legal representatives may also be paid for any services specified in the waiver that are payable to the legal representative of a member. However, legal representatives cannot both direct and be paid to deliver a waiver service simultaneously.

A person may freely choose a non-legal representative. The representative is approved by the planning team and will function as the representative as long as planning team members are in consensus that the representative continues to make decisions in the person's best interest. A representative is not paid for their services.

The personal representative has the same decision making authority as the person, as long as the personal representative continues to serve at the request of, and on behalf of, the person. The person, and/or legal guardian have the right to limit or terminate the authority of a personal representative, or appoint a new personal representative, at any time, for any reason.

The planning team has the right and the obligation to determine if the personal representative continues to function in the best interests of the person. This issue should be reviewed annually as part of the planning process. The team follows the incident management manual to determine if the personal representative is acting in the participant's best interest, in that they look at whether there are concerns of abuse, neglect, or exploitation with the personal representative.

A Waiver Participant or his/her legal representative has the right to file a Fair Hearing request through the Department's Office of Fair Hearing if the planning team does not approve of the person's choice for a non-legal representative. All other planning team members may bring plan of care issues to the Regional Manager for Review as indicated in the Personal Support Planning Policy.

**Self-Directed Services with Common Law Employer Authority:**

With the common law employer authority, the person or representative become the employer and are responsible for hiring, training, supervising, scheduling, and terminating their employees. In instances where the person is the employer living with a non-paid primary caregiver, the primary caregiver may function as the non-legal representative. The person functioning as the employer is subject to the initial and continued approval of the planning team.

**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
Caregiver Training and Support		



Waiver Service	Employer Authority	Budget Authority
Transportation		
Specialized Medical Equipment and Supplies		
Personal Supports		
Community Transition Services		
Respite		
Supported Employment - Small Group Employment Support		
Supported Employment - Follow Along Support		
Environmental Modifications		
Individual Goods and Services		
Supports Brokerage		
Meals		
Supported Employment - Co-Worker Support		
Personal Emergency Response System (PERS)		
Supported Employment - Individual Employment Support		

**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:**

**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:

Acumen under contract with the Department, provides our FMS services. The fiscal management service contractor must: be enrolled as an approved Medicaid provider; retain on staff a Certified Public Accountant (CPA) with at least five (5) years of experience; and be assigned a Federal Employer Identification Number (EIN) and National Provider Identifier (NPI) number. Further, the contractor must: have a basic understanding of developmental disabilities; understand the philosophy and practice of self-directed services in Montana; have sufficient funds necessary to make payroll on behalf of legal guardians at least twice monthly; and ensure staff and employees of members self-directing pass Medicaid required background investigations, including but not limited to the List of Excluded Individuals and Entities (LEIE) and Medicare Exclusion Database (MED). The contractor must also have capabilities in providing assistance in English and Spanish, and capability to communicate through TTY. The contractor must: possess federal designation as fiscal agent under IRS Rule 3504 (Acts to be Performed by Agents); comply with applicable IRS regulations; possess IRS approval for Agent status; and demonstrate effective internal controls and safeguards over the processing of transactions.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS is compensated by a one time employer enrollment fee for brand new customers only, and a one time employee enrollment fee for each new employee hired per employer. Ongoing fees are based on a per member per month fee that each individual in the FMS system pays regardless of account activity. The FMS also charges check transaction fees based on the number of checks processed each month. The monthly fee includes the processing of 2 checks, an additional fee is charged when the FMS processes more than 2 checks in a month.

**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 employment-related taxes and insurance**

**Other**

*Specify:*

FMS entities are procured using the state of Montana's procurement process.

Provide for workers' compensation insurance for all employees. Conduct background checks, verify service qualified provider standards, monitor appropriate use of Montana Code Annotated 39-3-406(p) which states that certain employers are exempt from paying minimum wage and overtime if an employee is employed in domestic service employment to provide companionship services, as defined in 29 CFR 552.6, or respite care for individuals who, because of age or infirmity, are unable to care for themselves as provided under section 213(a)(15) of the Fair Labor Standards Act, 29 U.S.C. 213, when the person providing the service is employed directly by a family member or an individual who is a legal guardian.

---

Supports furnished when the participant exercises budget authority:

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**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:*

Maintain a secure FTP website that allows DD Program staff and case managers to track the person's budget and expenditures.

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 Additional functions/activities:
 

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**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.

The DDP quality assurance personnel will be responsible for monitoring the performance of the FMS through the QA review tool. This will occur on an annual basis.

## Appendix E: Participant Direction of Services

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### 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:*

Case Management/Service Coordination activities:  
 Case managers provide members with information through the Freedom of Choice form annually. If a member chooses to self-direct a service that involves employees, then the case manager facilitates the completion of the self-direct plan of care.  
 If a member chooses to have a Support Broker, the case manager will assist in identifying the support broker, expected duties, number hours needed per month and wage paid.  
 The case manager also assists the employer in identifying any training that is needed including, first aid and training needed specific to a member.  
 Case managers also assist members in identifying back-up plans for any self-direct with employer authority services.

**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
Assisted Living	
Nutritionist Services	
Personal Care	
Caregiver Training and Support	
Transportation	
Specialized Medical Equipment and Supplies	
Remote Monitoring Equipment	
Speech Therapy	
Companion Services	
Residential Habilitation	
Psychological Evaluation, Counseling and Consultation Services	
Occupational Therapy	
Personal Supports	
Private Duty Nursing	
Adult Foster Support	
Community Transition Services	
Day Supports and Activities	
Homemaker	
Retirement Services	
Respite	
Remote Monitoring	
Supported Employment - Small Group Employment Support	
Supported	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Employment - Follow Along Support	
Environmental Modifications	
Behavioral Support Services	
Individual Goods and Services	
Supports Brokerage	
Physical Therapy	
Meals	
Supported Employment - Co-Worker Support	
Personal Emergency Response System (PERS)	
Supported Employment - Individual Employment Support	

**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:*

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**I. 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:

Dis-enrollment from self-directed services for the purpose of enrollment in traditional services is always an available option for persons choosing to self direct their services. There is flexibility within this service for the person's family members and representatives to choose the level of their involvement in the recruiting, selection and hiring of the direct support staff and/or choose a new service provider, as reviewed annually on the Waiver 5 Freedom of Choice form.

Individuals and/or their representatives, or the employers, choosing to dis-enroll from a self-directed service option would contact the case manager to schedule a planning meeting. This meeting would determine precisely what the individual wants with their resource allocation in a traditional model of service delivery.

Under no circumstances will ongoing waiver-funded services be reduced or terminated if an individual is seeking a new provider, or seeking a traditional waiver service delivery model.

## 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.

The plan of care document includes a brief section requiring a check off box for persons choosing to self-direct one or more services. The boilerplate plan of care language provides advance notice to the person or representative that participation in self-directed services may be involuntarily terminated, in the event the person or representative does not abide by the Department requirements applicable to self-directed services. The signature page of the plan of care document indicates an understanding of, and agreement with, the need to comply with the Department requirements for participation in self-directed services. The service coordinator will review this section annually with individuals, family members, guardians or representatives who choose to self-direct one or more services.

It is possible that a person or his representative may not cooperate with, abide by, or utilize the services as outlined in the plan of care. In this event, a special planning meeting would be held by the service coordinator to discuss the issues involved with, for example, non-utilization of services. In this event a plan would be developed and implemented, serving to give the person an opportunity to remain in self-directed services for a specified time period, contingent upon the person meeting agreed upon benchmarks written into the approved plan. Boilerplate language in the plan of care serving to address this issue follows:

Failure to abide with the plan of care language in managing self-directed services may result in the involuntary termination of self-directed services. In this event, agency-based services would be made available to the person.

In the event that health/safety issues pose undue risk to the person or others, and immediate intervention is deemed necessary by the team, the individual would be immediately enrolled in traditional services. Additional supports deemed necessary by the planning team to ensure the health and well-being of the person would be provided. For example, the planning team may request crisis grant funds from the DDP to increase the amount of direct care staffing provided to the person. Continued refusal by the person's family to address basic health and safety needs in traditional waiver services could result in the need for the team to initiate referrals to other agencies for the purpose of placement in a more appropriate setting. Waiver services would continue until a more appropriate living arrangement is made available.

A person whose basic health and safety needs cannot be adequately addressed in the opinion of the service coordinator and service provider may not remain in waiver services. In this event, placement in a more restrictive environment may be required.

## 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		350
Year 2		350
Year 3		350
Year 4		350
Year 5		350

**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:

DDP qualified provider agencies act as the agency with choice

**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:

The costs of such investigations are covered by the FMS entity or the agency with choice.

**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 E-1-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 C-1/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:



The methodology used to authorize payments for services, and to review and approve reimbursements to direct workers based on the delivery of agreed upon services will vary depending on the category of service. The delivery of services is based on the Individual Cost Plan (ICP) and the planning document. All services outlined in the ICP will correspond to a need outlined in the plan of care.

For members choosing to self-direct in family and private settings, self-direction can give the person, representative, or family members acting on the person's behalf additional authority, as desired, to manage the delivery of services more fully .

## 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.

The value of the individual cost plan for a newly enrolled member is derived from the Montana Resource Allocation Protocol (MONA) tool. The MONA is Montana's cost estimating information tool that is conducted for every newly enrolled waiver member or as the member's needs change. The current MONA methodology and rates detail design are available upon request.

Members or their legal guardian may choose which services they would like to self-direct and the amount allocated for each service, based on assessed needs.

## 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.

Currently, all individuals and persons acting on their behalf are informed of the details of the person's Individual Cost Plan (ICP). The cost plan details are based on the outcome of the MONA and the planning process, which, in turn, is based on assessments and the expressed desires of the person. The ICP functions as the contractual basis between the person, the provider, and the DDP in the delivery of services.

If the quantity and type of services outlined in the cost plan are not considered adequate in meeting the needs of the person, additional funds may be requested on behalf of the person by the case manager/service coordinator. Requests for additional funding go to the DDP Regional Manager. Funds are available for the purpose of adjusting cost plans with crisis pool funds for short term needs and the urgent needs process addresses long term funding changes based on assessed needs.

Members and team members are able to request budget adjustments by contacting their case manager. If additional funding is needed, the Urgent Needs request is completed by the case manager. This request is reviewed and either approved or denied by the Regional Managers. If the request is denied by the Regional Managers, a letter is sent to the member informing them of this decision and their right to request a fair hearing.

## Appendix E: Participant Direction of Services

**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:

Individuals who self-direct may opt to receive more services in one month or week and fewer services the next week. These changes can be made without prior approval in the plan of care. The Mid-Year Plan of Care Review would reflect the change in use of services. This flexibility is more available because the individual has had the option to help select their staff who then would likely be working with only that person. The service provider is responsible for monitoring the expenditure of the person's annual ICP and for advising the case manager/service coordinator, person or representative if adjustments are needed in spending patterns to prevent a shortfall prior to the end of the fiscal year.

Generally, if the provider or case manager/service coordinator has concerns regarding health and safety issues stemming from the changing needs of a person, or concerns stemming from changes in spending patterns within the person's budget, a planning meeting would be called and these concerns would be addressed.

The person has the capacity to move funds between services outlined in the cost plan and to request changes in the service categories to be delivered. Both would require team agreement and final approval from the regional manager on the ICP changes.

In situations where a person has chosen to purchase some services directly from another DDP-funded agency changes in the delivery of these services would require team agreement and Regional Manager approval on the ICP change.

**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:

The person has the capacity to move funds between services outlined in the cost plan and to make changes in the service categories to be delivered. Both would require team agreement and final approval from the regional manager on the ICP changes.

Self-Directed Agency with Choice Services:

The service provider is responsible for monitoring the expenditure of the person's annual ICP and for advising the case manager/service coordinator, person or representative if adjustments are needed in spending patterns to prevent a shortfall or underutilization prior to the end of the fiscal year.

Self-Directed Services with Common Law Employer Authority:

The employer and the case manager/service coordinator would be responsible for monitoring the expenditure of the person's individual cost plan. The FMS makes available an expenditure report, to the employer, after each payroll that services occur to help in determining if adjustments are needed in spending patterns to prevent a shortfall or underutilization of the cost plan. The case manager/service coordinator can also monitor expenditures via the ICP system.

## Appendix F: Participant Rights

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### 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.

As part of the plan of care process, the Service Coordinator/Targeted Case Manager (TCM) is to explain the right to fair hearing in the event the person or family is denied the provider or service of choice. This also includes a reduction, suspension, or termination of service. The member is also given the choice of home and community-based services as an alternative to institutional care. The member or legal representative acknowledges receipt of this information on the signature page of the plan of care. ARM 37.34.918 outlines the choice of services and choice of provider protections afforded to individuals. ARM 37.34.919 outlines the Fair Hearing process used by the Department. All MCA and ARM references may be reviewed via the State of Montana home page. When an individual is denied services, they will be given written notification by mail, within 30 calendar days, which includes the right to request a fair hearing. The written notification will be changed to include language to inform the member of their right to continue receiving waiver services during the fair hearing process. The copies of the fair hearings are maintained in the DDP Central Office.

#### 37.34.918 0208 MEDICAID HOME AND COMMUNITY-BASED SERVICES PROGRAM: FREEDOM OF CHOICE

- (1) A person determined by the department to require the level of care provided in an ICF/IID must be given a choice between placement in an ICF/IID or in the 0208 Medicaid Home and Community-Based Services (HCBS) Waiver Program.
- (2) The person or legal representative must be informed of the feasible alternatives in the community, if any, available under the 0208 Medicaid HCBS Waiver Program.
- (3) The Quality Improvement Specialist will complete the Waiver 5, Freedom of Choice form with the person during the initial face-to-face level of care determination and document, in the person's file, that the person was given the choice and record the choice the person made.
- (4) Case managers must inform the person currently served in the 0208 HCBS Waiver Program annually of feasible alternatives in the community and provide documentation for the person's file.

History: 53-6-113, 53-6-402, MCA; IMP, 53-6-101, 53-6-402, MCA; NEW, 1992 MAR p. 1490, Eff. 7/17/92; TRANS, from SRS, 1998 MAR p. 3124; AMD, 2014 MAR p. 220, Eff. 1/31/14

#### 37.34.919 0208 MEDICAID HOME AND COMMUNITY-BASED SERVICES PROGRAM: NOTICE AND FAIR HEARING

- (1) A person aggrieved by an adverse determination by the department may request a fair hearing as provided in ARM Title 37, chapter 5, subchapter 3.

History: 53-6-113, 53-6-402, MCA; IMP, 53-6-101, 53-6-402, MCA; NEW, 1992 MAR p. 1490, Eff. 7/17/92; AMD, 1995 MAR p. 1136, Eff. 6/30/95; TRANS, from SRS, 1998 MAR p. 3124; AMD, 2000 MAR p. 1653, Eff. 6/30/00; AMD, 2014 MAR p. 220, Eff. 1/31/14.

## 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.

For persons enrolled in the waiver, the planning process is the general vehicle for settling disputes. Planning meetings may be called for any reason by any team member. Other disputes may be addressed via provider individual grievance procedures. Providers are to maintain internal dispute resolution policies in accordance with ARM 37.34.109. Under no circumstances would an individual forfeit the right to a fair hearing.

#### 37.34.109 GRIEVANCE PROCEDURE

(1) Providers must have a written grievance procedure, approved in writing by the department prior to implementation, for resolution of grievances brought by persons receiving developmental disabilities services.

(2) The procedure must provide for resolution of a grievance within 45 days of receipt of the grievance. Resolution may be extended beyond 45 days only with written approval by the department.

(3) The person must exhaust the provider's grievance procedure before appeal of the matter may be made to the department under the provisions of ARM 37.5.304, 37.5.305, 37.5.307, 37.5.311, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337.

(4) Upon entry into a program and annually thereafter, the provider must advise the person of their right to present grievances. The provider must assist persons, as may be necessary, in utilizing the grievance procedure.

History: 53-20-204, MCA; IMP, 53-20-205, MCA; NEW, 1979 MAR p. 1711, Eff. 12/28/79; TRANS, from SRS, 1998 MAR p. 3124; AMD, 2013 MAR p. 165, Eff. 2/1/13.

The types of disputes would vary from provider to provider based on their written grievance procedure. A waiver participant can bypass a provider's grievance process and go straight to a fair hearing request.

## 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).

The Incident Management Policy and the Developmental Disabilities Program (DDP) Incident Management Manual is the reference source providing the following information. Reporting requirements are referenced in Montana Codes Annotated 52-3-811 and the Administrative Rules of Montana 37.34.1501. In accordance with the Developmental Disabilities Program Incident Management Manual, employees of qualified service providers, Service Coordinators and quality assurance personnel are required to report Critical Incidents.

In accordance with the DDP Incident Management Manual, employees of DDP funded Service Providers, DDP Service Coordinators and quality assurance personnel are required to report Critical Incidents by submitting critical incident reports to the DDP Data Management System (DMS).

All incidents fall into 3 categories:

#### Critical Incident

A critical incident is a significant event, act, or omission, not otherwise permitted, that has compromised the safety and well-being of a person. A critical incident is an event that requires an immediate response to protect the person and minimize risk. All critical incidents must be reported and require an investigation.

#### Non-Critical Incident

A non-critical incident is a significant event, act, or omission, not otherwise permitted, that can compromise the safety and well-being of a person. A non-critical incident is an event that requires a timely, but not immediate, response to protect the person and minimize risk.

#### Internal Incident

Other incidents not listed under critical or non-critical categories are considered internal incidents. Internal incidents can be reported but it is not required. If it is decided to report the internal incident, all the requirements in the Incident Management Manual must be followed

#### NOTIFICATIONS and REPORTING TIMEFRAMES:

Notification of all critical and non-critical incidents, for either a child or adult, should be made immediately, but no later than eight (8) hours after the incident to the developmentally disabled person's legal representative. Notifications will be made via phone call, email, text, or written form if the legal representative does not utilize the DDP's DMS.

Notification of all critical and non-critical incidents, for children and adults living in a licensed facility, should be made to the Office of Inspector General (OIG), the planning team, DDP, and any providers serving the same person, and APS/CPS (in the case of suspected abuse, neglect, and exploitation) within twenty-four (24) hours of any incident. Entry of an incident report into DDP's DMS is considered notification for those who have access to the system.

#### Incident Types:

Allegations of abuse, neglect, or exploitation: All allegations of ANE must be reported as outlined in Section 4 and are always categorized as critical.

Accident, No Apparent Injury: If not due to suspected abuse, neglect, or exploitation, is an internal incident. If reporting an injury, use Injury Types.

Absence (Unaccounted for)/Missing Person: If a person's whereabouts are unknown beyond a time normally expected as outlined in the person's POC, it is considered a critical incident.

Alcohol/Drug Abuse: Misuse of alcohol, misuse of medications, use of illicit drugs. This is a non-critical incident.

Altercation:

- Any altercations resulting in harm to another person requiring treatment at a health care provider facility, is a separate critical incident for both the aggressor and the victim. These incidents are classified as Person to Person Altercations and therefore require critical incident investigations.

- Any altercation where there is physical contact that does not require treatment at a health care provider facility is a separate non-critical incident for both the aggressor and victim.
- Any altercation where there is no physical contact is an internal incident.
- This incident type covers any incident where the altercation is directed at another person and presents a serious risk of physical or mental harm to the other person. For the purposes of this manual, Person to Person refers to both people receiving DDP-funded services.

o Person to Person Altercation – Alleged Victim/Aggressor: To be used when the person is the alleged victim/aggressor of an altercation by another person.

o Person to Staff: To be used when the person is the alleged aggressor of an altercation against a provider staff person.

o Person to Other: To be used when the person is the alleged aggressor to another person not in services or a staff, such as a family member, neighbor, or stranger.

Assault: An attack by a community member, not affiliated with services, to a person. This must be reported to APS/CPS and law enforcement immediately. This is a critical incident and requires an investigation.

Death: The permanent cessation of all vital bodily functions is a critical incident with critical notification and requires investigation.

Fire: This is a critical incident regardless of cause or extent.

HCBS settings violation: This is an incident that occurs when there is an allegation that the HCBS Settings Rule requirements has been violated and there is not a modification to the requirements identified in the Plan of Care. An HCBS settings violation that meets the definition of ANE should be categorized as Abuse, Neglect, and/or Exploitation and will be a critical incident. All other HCBS Settings violations will be categorized as non-critical.

Hospice: When a person is placed in a facility or program designed to provide palliative care and emotional support to a person with a terminal illness in a home or homelike setting it is considered a non-critical incident.

Hospitalization: Any unplanned/unscheduled admission to a hospital or any unplanned/unscheduled psychiatric hospitalization is a critical incident.

Injury Types:

- Damage inflicted on the body.
- For the purposes of this manual, injuries include:

o Allergic Reaction

o Bedsore

o Bite/String

o Bleeding

o Blister

o Burn

o Choking

o Cut

o Dislocation

o Fracture

o Frostbite

o Head Injury

o Infection

o Lesion

o Loss of Consciousness

o Pain

o Poisoning

o Rash/Hives

o Self-Injurious Behavior:

Biting Self

Cutting Self

Head Banging

Hitting Self

Probing

Scratching Self

o Sprain/Strain

o Sunburn

o Swelling/Edema

o Other

In addition to being classified by type of injury, they are also categorized by the level of the severity of the injury.



- Critical: An injury that results in admission to the hospital or there is suspected ANE that requires a report to APS/CPS.
- Non-critical: Injuries requiring treatment by staff or onsite medical personnel such as first-aid, treatment with a PRN pain medication (not over-the-counter medications), or requiring medical treatment at an off-site location (emergency room, walk in etc.) without admission to a hospital.
- Internal: An incident or injury that is temporary and results in either no injury or minor injury requiring no treatment.

#### Medication Errors:

- Medication errors apply when prescribed medications are given in a manner different than prescribed:
  - o Charting error:
    - Medication charted prior to the person taking the medication;
    - Medications given to persons and not charted;
    - Failure to chart refusals;
    - Charting for a co-worker; and/or
    - The use of ditto marks, erasing entries on the Medication Administration Record (MAR), using white-out on the MAR.
  - o Omission:
    - Medication not given to person;
    - Not obtaining refills on time; and/or
    - Sufficient quantities are not available.
  - o Order Expired:
    - Medication given beyond the stop order; and/or
    - Medication given past an expiration date.
  - o Transcription error:
    - Wrong dose or the dose on the MAR does not match the dose on the prescription and/or pharmacy label;
    - Wrong person or the name on the MAR does not match the name on the prescription and/or pharmacy label;
    - Wrong medication or the name of the medication on the MAR does not match the medication listed on the prescription and/or pharmacy label;
    - Omission or new medication that was prescribed was not written on the MAR;
    - MAR entry shows the wrong route or the route for giving the medication does not match the doctor's order written on the prescription and/or pharmacy label; and/or
    - Wrong time or the time(s) for medication administration is not the same as indicated on the prescription and/or pharmacy label.
  - o Wrong dose/Wrong person:
    - Person given the wrong dose of medication; and/or
    - A medication was given to the wrong person.
  - o Wrong medication:
    - Wrong medication was given to the person or a medication was prescribed or given to a person with an allergy to that medication.
  - o Wrong route/Wrong time:
    - A medication was given by the incorrect route; and/or
    - Medication was actually given at a time that is different than that written on the MAR or outside of the predefined time interval from its scheduled administration time (outside the window for administration).
  - o Other:
    - Physician or pharmacy errors;
    - Medium/texture/consistency or medication not given in proper form;
    - Position:
      - Medication given when person wasn't properly positioned;
    - Storage issues:
      - Administration of a drug that was stored incorrectly or for which the physical or chemical dose (integrity of the drug) has been compromised; and/or
      - Finding medication in an area not specifically indicated for medication storage or handling.
- Critical: Any Medication Error that results in admission to the hospital or death; or there is suspected ANE that requires a report to APS/CPS; or involves a controlled substance.
- Non-critical: All other Medication Errors
- Internal: Physician or Pharmacy Errors, that are discovered but not administered to the person.

**Medication Refusals:** People do have the right to refuse medication. If possible, try to find out why the medication is being refused. Do not give a second dose of medication that has been refused. Medication Refusals are non-Critical incidents.

**Possible Criminal Activity:** Suspected possible criminal activity of the person receiving services is an internal incident. If law enforcement is contacted, this will be elevated to a non-critical incident. If the person is arrested, it will be elevated to a critical incident.

**Potential Incident:** Any event that has the potential for severe injury or any other harm to a person that is narrowly avoided and needs to be addressed to ensure protection from harm is an internal incident.

**Property Damage:** For any damage exceeding \$50.00 in value is a non-critical incident.

**PRN (Pro Re Nata) Medication:** PRN is an abbreviation for the Latin pro re nata meaning “when needed” or as more commonly stated, “as needed.” It is used when a medication is to be given only under certain circumstances rather than on a regular schedule. This is considered a non-critical incident. If PRNs are used for five days over a seven-day period to treat the same condition, the incident would then meet the criteria for a high-risk review.

**Suicide Threat/Attempt:**

- An incident involving an act (attempt) to harm or injure with the perceived intent to end one’s own life is considered a critical incident.
- An incident involving a threat to harm or injure oneself with the perceived intent to end one’s own life is considered a non-critical incident.

**Unplanned Medical Visit:**

This incident type is selected when a person visits a same day care type facility, including emergency room, and it does not result in admission to a hospital, for either medical or psychological illnesses. Any unplanned medical visit (outside of routine care) is a non-critical incident.

**Restraints**

All uses of physical and mechanical restraints are reported as critical incidents.

Medically related restraints do not need to be reported.

- **Physical Restraint**

Physical Restraint means the restriction of the person's movement by holding or applying physical pressure to bring the person's behavior under control in order to avoid the risk of serious harm to the person or other person(s). The term physical restraint does not include the use of physical prompts, graduated guidance or medically related restraints.

Physical restraint may only be used as an emergency procedure.

Once the threat or emergency has passed, and the person is stable, the physical restraint must end.

- **Mechanical Restraint**

Mechanical restraint means a physical device used to restrict the person's movement or restrict the normal function of the person's body. The term mechanical restraint does not include safety devices or medically related restraints. Mechanical restraints are prohibited.

- **Medically related Restraint**

Medically related restraint means any physical equipment or orthopedic appliances, including devices used to support functional body position or proper balance, surgical dressings or bandages, supportive body bands or other restraints, including manual holds, necessary for the person to receive medical treatment, routine physical examinations, or medical tests. Medically related restraint requires a written order or other authorization from a licensed physician or any medical practitioner who is licensed to practice medicine including physicians, physician assistants, and nurse practitioners.

Medically related restraints are permitted and do not need to be reported. The need for a medically related restraint as well as its application details must be summarized in the person’s Plan of Care.

- **Safety Device**

Safety device means any device including, but not limited to, an implement, garment, gate, lock or locking apparatus, helmet, mask, glove, strap, bedrails or belt used in accordance with person’s plan of care and reduces or inhibits the person’s movement with the sole purpose of maintaining the safety of the person.

Seclusion is defined as requiring the person to remain alone in a room or any area behind a closed door which prevents

them from leaving or being observed for a period of time. Seclusion is a critical incident.

- 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 regarding abuse reporting occurs for all members as part of the annual plan of care process. This is completed by asking open ended questions from the consumer survey. Any noted skill deficiencies may result in follow up by the service coordinator including strategies developed in the plan of care. The responsibility of providing information and training to people currently rests with service providers and with service coordinators.

Parents are the primary care givers for children enrolled in waiver services. The DDP QA consumer survey used for families was updated to include questions serving to assess family knowledge of reportable incidents and the process for reporting. If training is needed, follow up would take place via the service coordinator or service provider.

In addition to the consumer survey, the Health Care Checklist and Risk Worksheet completed annually by the service coordinator assesses the participants' knowledge base with regards to the APS notification process and identifies if further training is warranted in this area.

The Waiver-5 Freedom of Choice Form, also completed annually, reviews ANE reporting and includes the phone numbers for APS and CPS.

- 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.

Notification of all critical and non-critical incidents are to be made to the developmentally disabled person's legal representative, and for person's living in a licensed facility, are to be made to the state Office of Inspector General (OIG), the planning team, the Developmental Disabilities Program (DDP), and any providers serving the same person, and APS/CPS (in the case of suspected ANE).

Providers must have policies and procedures to accomplish the following:

1. Protection from Harm

- a. Take immediate action to remove people from a harmful situation or to protect people from harm when knowledge or potential for harm, occurs.
- b. Provide prompt staff intervention when knowledge or potential for harm, occurs.
- c. Provide immediate medical assessment and/or treatment of a person if needed following an incident.
- d. Ensure provider staff that fall under mandatory reporting requirements including DSPs are trained in this manual, reporting of ANE, and mandatory reporter requirements. Staff must be trained to respond to, report, and document incidents as required in this manual. Online training is available in the DMS.
- e. Conduct Critical Investigation Review for provider critical incident investigations within 7 calendar days upon receipt of investigation. An extension, up to 7 calendar days, may be granted by the Regional Manager (RM) if the request is made prior to the initial 7 calendar days period has elapsed.
- f. Identify any potential conflict of interest and have alternative personnel to conduct investigations if a conflict exists.
- g. Upon request, provide this manual to people and/or family members and legal representatives in an easily understood format. Additionally, provide the website link to this manual.
- h. With the planning team, assess the person's level of risk, their ability to manage the risk and ability to acquire skills to help mitigate the risk.

2. Procedures for Reporting Incidents

- a. Identify and report incidents.
- b. Submit IRs and notifications of the incident per the IRRG timelines to appropriate state agencies, providers, contracted staff, legal representatives, law enforcement, and representatives from other providers (i.e., the developmentally disabled person's legal representative, and for person's living in a licensed facility, are to be made to the state OIG, the planning team, DDP, and any providers serving the same person, and APS/CPS in the case of suspected ANE.)
- c. Provide review of the incident for purposes of classifying the event and determining the need for a critical incident investigation. Additionally, the initial evaluation of the incident report determines whether follow-up action is warranted. Follow up is further evaluated at the weekly provider Incident Management (IM) Committee meeting with the DDP Quality Improvement Specialist (QIS) in attendance.
- d. Ensure persons who reports an incident or suspects ANE will be free from retaliation.
- e. Cooperate with investigators, including, having staff available for interviews within the investigation's timeframe. Failure to comply will result in corrective action.

3. Incident Management (IM) Committee Requirements

- a. Providers will establish an IM committee including leadership, an IM Coordinator, and other appropriate staff.
- b. Providers will designate a staff person as the IM Coordinator for the provider.
- c. The committee will review and assess all incidents through a systemic lens, monitor trends of IR information, and develop strategies designed to protect and prevent harm to people and make recommendations to the planning team.
- d. Conduct monthly independent trend analysis.
- e. Require weekly meetings if any incidents have occurred. If meetings do not occur, the IM Coordinator will send notification to the committee members.
- f. Ensure reports of incidents and any required documentation including IRs, trend analysis reports, and any investigation reports, are kept confidential. The names of those who report critical incidents of suspected ANE are not released unless required by law or regulation. All critical incidents must be investigated by provider staff who have been trained in investigations through DDP approved training. Complete the critical incident investigation no later than 14 calendar days from the time the incident occurs. An extension, up to 7 calendar days, may be granted if the request is made prior to the initial 14 calendar days period has elapsed to the initial request. The extension must be requested by the RM via DMS.
- g. There will be circumstances when the critical incident investigation will also be conducted by an entity external to the provider or in conjunction with another provider where a person is being served jointly by two or more providers. Disability Rights Montana also may conduct an independent investigation and has access to certain records, pursuant to 42 USC Sec.15043.
- h. Cooperate with law enforcement, APS, CPS, OIG licensing, or any outside agency that may have statutory jurisdiction over the investigation. The provider will conduct an investigation of the incident regardless of any outside investigation. The provider is only to review the facts known at the time without impeding outside agency's investigations. The provider must have staff available for interviews within reasonable timelines for the investigation.

- i. If the victim or a witness recants their testimony, the incident must still be investigated.
- 4. Follow-up of Review and/or Action Taken
- 5. The DMS will have a specific section to submit incident management committee minutes within a person's IR and can be reported on by date of meeting.

The Targeted Case Manager (TCM) has a core duty to monitor a person who receives services. When incidents occur, the TCM must monitor that the issues and needs of the person are addressed and ultimately reduce the risk of harm. This is accomplished through the planning team process. The TCM must complete the following items in DMS:

- 1. Submit an IR if an incident is observed or discovered.
- 2. Review and sign off on IRs for their caseloads, and revise POC with the planning team as needed.
  - a. The TCM will document any significant information in the social history for permanency.
- 3. Review the IM weekly minutes and monthly trend data and analyze for possible revisions to the POC regarding people on their caseload.

Based on data trends, and where a high-risk review level has been identified, the TCM will review the POC with the planning team to address the incidents and determine if a revision to the POC is necessary.

- 4. With the planning team, assess the person's level of risk, the person's ability to manage the risk and the person's ability to acquire skills to help mitigate the risk.
- 5. Attend weekly IM committee meetings.
- 6. Upon request, provide this manual to people and/or family members and legal representatives

The DDP Quality Improvement Specialist (QIS) must receive, review, and evaluate IRs submitted by providers in DMS. In addition, the QIS will investigate critical incidents. All critical incidents must be investigated by QIS and provider staff who are trained in investigations through DDP approved training. QIS responsibilities are:

- 1. Attend assigned provider's weekly IM committee meetings.
- 2. Submit IRs in DMS.
- 3. Review and sign off on all IRs, including evaluating whether follow-up action is warranted.
- 4. Review assigned provider agencies' IM committee weekly minutes and participate in high-risk reviews.
- 5. Conduct Regional Office Investigation Review for provider critical incident investigations within 7 calendar days upon receipt of investigation. An extension, up to 7 calendar days, may be granted by the RM if the request is made prior to the initial 7 calendar days period has elapsed.
- 6. With the planning team, assess the person's level of risk and their ability to manage the risk with supports.
- 7. Assess the provider's efforts to ensure the health and safety of the person and make recommendations or act as appropriate.
- 8. When APS/CPS's investigation findings are different from the provider's findings, the QIS will meet with DDP, provider leadership, and APS/CPS to discuss the discrepancy and ensure the health and safety of the member has been addressed. Outcomes from this meeting will be added to the IR notes section.
- 9. Conduct critical incident investigations within 14 calendar days from the incident date:
  - a. When circumstances warrant further investigation an extension, up to 7 calendar days, may be granted if the request is made within the initial 14 calendar days.
- 10. Complete the Death Investigation Summary and Checklist in the DMS within 30 days of death for the mortality review workgroup.
- 11. Conduct independent trend analysis using a systemic lens. The QIS may utilize claims data to ensure incident management reporting occurs per policy requirements and as part of a trend analysis by the 10th of the month, the QIS will collect trend information.
- 12. QIS will ensure trend data is available to the RM and Community Services Supervisor no later than the 20th of the following month.
- 13. QIS will identify trends and report on them during the Regional Trend Report monthly meeting. The QIS will send provider trend data monthly, but no later than the last calendar day of the month and review at provider incident management committee meeting.
- 14. QIS has the authority to issue QAOS to providers when corrective action measures are needed. The QIS will issue a QAOS to also address systemic remediation when identified through trend reports.

The DDP Regional Manager (RM) Responsibilities:

- 1. Assign the QIS to complete critical incident investigations or request other DDP staff or an additional QIS to complete an investigation when there are circumstances that lead DDP to warrant further investigation is necessary,
- 2. Review and respond to extension requests for investigations and investigation reviews in writing, within 3 days.
- 3. Request further follow-up or investigation of an incident.

4. Conduct Critical Incident Investigation Review for critical incident investigations within 7 calendar days upon receipt of investigation. An extension of up to 7 calendar days, may be granted if the request is made within the initial 7 calendar days.
5. Participate in Central Office IM review or assign a designee, as warranted.
6. Conduct monthly trend analysis meetings with the QIS and determine appropriate follow-up on trends.

Central Office Responsibilities:

1. The DDP Community Services Supervisor, Program Support Supervisor, or designee develop, revise, and disseminate the investigator's training to people who will conduct critical incident investigations.
2. The DDP Community Services Supervisor, Program Support Supervisor, or designee meet with the RMs weekly to review ANE critical incidents and critical incident investigations and reviews.
3. The DDP Community Services Supervisor, Program Support Supervisor or designee meet with the RMs monthly to review trending data.
4. Medical Director reviews medication errors, injury trends, and other medical related concerns as needed.
5. Medical Director reviews all death investigations, the Death Investigation Summary Checklist, and participates on the mortality review workgroup. Findings will be shared with the appropriate DDP staff.
6. Ensure all critical incidents involving deaths remain open until after both the mortality review workgroup has met and recommended closure is received from the Central Office.

G-1-d continued in Section B. Additional Needed Information (Optional)

- 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 Developmental Disabilities Program has primary responsibility for overseeing the reporting of and response to critical incidents that affect members, as identified above.

Investigative and follow-up activities may also be coordinated with licensing personnel and/or Adult or Child Protective Services as appropriate.

Incidents are input into the DDP data management system by provider agency staff, case management or DDP staff. The provider agency incident management committee, on a weekly basis, uses the information from the system to review incidents. This information is used to take steps to reduce or avoid re-occurrence of incidents. DDP quality assurance personnel participate in each provider agency incident management committee.

The person's plan of care team also conducts high-risk reviews when: a person experiences three or more critical incidents in the previous month or five or more critical incidents in the preceding three months; a person experiences a planned or unplanned change in condition or well-being, a new significant concern arises or has the potential to arise, or the person experiences a serious or severe injury; a person is administered PRN medications for five days over a seven-day period to treat the same condition; a person experiences a pattern or trend of incidents over a three month period that are categorized as internal or non-critical and that warrant a more thorough review and assessment of the person's needs; or a trend, potential incident, or concern is identified by a member of the team or IM committee that warrants further scrutiny.

Critical incident reports, investigation reports, and high-risk reviews are available for review by team members including state staff upon entry into the DDP data management system. The DDP central office and all regional offices meet weekly to review critical incident reports, investigation summaries, and recommendations, to identify and prevent or reduce specific occurrences in the future.

The DDP regional office conducts a monthly regional trend analysis meeting to review the compiled data. The DDP central office and regional offices also meet monthly to review state-wide trends to identify and prevent or reduce common occurrences in the future.

The DDP began implementing a Collaborative Safety Model in calendar year 2023 with continued development of the Systemic Critical Incident Review (SCIR) process over the next 12 months. The SCIR is based on methods and techniques consistent with contemporary safety science. The SCIR departs from surface level descriptions of critical incidents that typically place blame on front line workers and instead uses systemic analysis to understand how decisions, initiatives, resource allocations deeper within an organization and outside of it can surface in the outcomes experienced in everyday work.

## 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 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).



Positive Behavior Support Administrative Rules of Montana (ARM) outline conditions for the use of restrictive procedures for waiver services. The regulations are in effect during the delivery of any waiver service, regardless of settings. Restrictive procedures are considered procedures of last resort in the DDP service systems.

Physical restraints may only be used in an emergency. Once the threat or emergency has passed, and the person is stable, the physical restraint must end. All uses of physical restraints are reported as critical incidents.

Medications may be used in accordance with the review of the plan of care team and the member's physician or psychiatrist.

Mechanical restraints are prohibited and reported as critical incidents.

Medically related restraint means any physical equipment or orthopedic appliances, including devices used to support functional body position or proper balance, surgical dressings or bandages, supportive body bands or other restraints, including manual holds, necessary for the person to receive medical treatment, routine physical examinations, or medical tests. Medically related restraint requires a written order or other authorization from a licensed physician or any medical practitioner who is licensed to practice medicine including physicians, physician assistants, and nurse practitioners.

Medically related restraints are permitted and do not need to be reported as an incident. The need for a medically related restraint as well as its application details must be summarized in the person's Plan of Care.

Safety device means any device including, but not limited to, an implement, garment, gate, lock or locking apparatus, helmet, mask, glove, strap, bedrails or belt used in accordance with person's plan of care and reduces or inhibits the person's movement with the sole purpose of maintaining the safety of the person.

Positive behavior support strategies including; supporting the person in communicating choices and wishes, de-escalation methods, allowing the person to exercise as much control and decision making as possible over day to-day routines, assisting the person to increase control over life activities and their environment, teaching the person coping, communication, and emotional self regulation skills, providing opportunities for the person such as valued work, enjoyable physical exercise, allowing preferred recreational activities, modifying the environment to remove stressors for the person, and ensuring all medical needs and conditions are identified and addressed, are the alternative methods used to avoid the use of restraints.

There are scheduled and unscheduled visits by case managers and quality assurance personnel. Reporting requirements are in place through incident management policy.

Uses of emergency, restricted or prohibited procedures including restraints, must be reported as a critical incident and investigated as such. Provider agencies must have policies and procedures that protect a member from harm and procedures for reporting incidents when they occur. The DDP quality improvement specialist (QIS) receives, reviews and evaluates any incident reports including investigations and follow-up reviews.

The QIS participates in provider's weekly incident management meetings, review incident management minutes weekly, assess monthly trend data and high-risk reviews. The DDP Regional Managers (RM) complete the Administrative Review when the critical incident investigation is conducted by the QIS, conduct monthly trend analysis meetings with the QIS's of regional reports generated from data management system or reports from the DDP central office and determine appropriate follow up on trends. The DDP central office staff and regional managers meet weekly to review critical incidents and monthly to review trend data and report back to the regional office of any concerns identified for follow up.

Providers deliver trainings on proper use of restraints specific to the needs of the individual member. A number of providers subscribe to MANDT or similar trainings for their employees.

- 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:

The Developmental Disabilities Program has primary responsibility for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed.

Quality assurance personnel provide oversight and guidance through incident review and consultation with plan of care teams as needed.

## 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 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.

Physical restraints may be used in an emergency if necessary. Any restraint used in an emergency negatively impacting the health and well-being of the member, are prohibited.

With the exception of emergencies, the State has regulations requiring written consent and approval from the member/guardian in the written behavior support plan as identified in the plan of care.

Restricted or Prohibited Procedures – The unauthorized use of restricted or prohibited procedures as described in ARM Title 37, chapter 34, subchapter 14 Positive Behavior Support must be reported as a critical incident.

DDP requires, by rule, the use of positive behavior supports to encourage individual growth, improve quality of life, and reduce the use of unnecessary intrusive measures.

Compliance with the Positive Behavior Supports rule is monitored continuously by the quality assurance personnel. There are scheduled and unscheduled visits by case managers and quality assurance personnel. Reporting requirements are in place through Incident management policy. Incidents must be documented on an incident report.

Providers deliver trainings specific to the member on proper use of restraints specific to the needs of the individual. A number of providers subscribe to MANDT or similar trainings for their employees.

#### **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:

The Developmental Disabilities Program has primary responsibility for overseeing the use of restrictive intervention and ensuring that state safeguards concerning their use are followed.

Quality assurance personnel provide oversight and guidance through incident review and consultation with plan of care teams as needed.

## 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:

There are scheduled and unscheduled visits by DDP case managers and quality assurance personnel. Reporting requirements are in place through Incident Management policy.

Seclusion is documented as a critical incident, then reviewed and investigated as required in the incident management policy.

**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.

Individual medication management and follow up is the responsibility of the physician, clinical nurse specialist, psychiatrist, or other prescribing authority. The prescribing physician(s) reviews all prescribed medications, including any behavior modifying medications, at least annually as part of the plan of care process. Medication to reduce or eliminate a behavior is prohibited unless prescribed by a physician for a medical reason. Pro re Nata (PRN), or “as needed” medications also require an approved protocol signed by the physician. Provider agency direct care staff receive information on medication interactions and side-effects and are to seek medical attention when a member experiences symptoms of concern.

These various healthcare professionals determine the frequency of monitoring and follow up based on the individual’s specific circumstances in relation to the type of medication, the length of time the medication is prescribed, any other prescribed medications, height, weight, and other health conditions or issues.

The monitoring of the appropriateness of each medication and the appropriateness of multiple medications is the responsibility of the healthcare professionals who prescribe them and the pharmacist who fills the prescriptions.

Service provider direct care staff, providing assistance with medication administration, must have medication administration certification, this includes monitoring and written documentation of an individual's medication use.

The provider is also required to monitor medication errors as part of the incident management process. All medication errors must be reported to the Quality Improvement Specialist and case manager within 24 hours. Provider incident management committees are required to meet weekly when incidents have occurred. The plan of care, which is reviewed and updated at least annually, lists all medications, time of day taken, dosage/route, purpose of medication for the person, start date and prescribing professional. For the safety of individuals receiving multiple prescriptions and regarding drug interactions, all medications and supplements prescribed to an individual must be communicated to all other prescribing authorities (health care providers) of that individual immediately or at least on the next business day.

DDP providers are required to maintain information about common side effects for each medication prescribed to an individual. Staff who administer medications are required to learn about side effects as part of the mandatory medication administration certification training. Staff are trained to seek medical help should side effects or other symptoms of concern be evidenced. The provider is also required to monitor medication errors as part of the incident management process of which all staff receives training. Incident management committees consist of, at a minimum, an agency incident management coordinator, Quality Improvement Specialist and Case Manager. The Incident Management Manual requires all medication errors to be reported to the Quality Improvement Specialist and case manager within 24 hours. The legal representative is required to be notified within 8 hours and incident management committees are required to meet weekly when incidents have occurred.

As part of the annual planning process the Healthcare Checklist and Risk Worksheet is completed with each waiver participant and asks questions regarding medications as a specific topic and prompts for any follow up that may be necessary. The plan of care form, which is reviewed and updated at least annually, lists all medications, time of day taken, dosage/route, purpose of medication for the person, start date, prescribing professional and a space for any additional medication information.

In addition, the central office staff including but not limited to DDP director, community supports bureau chief, program support bureau chief, crisis prevention specialist, and state medical director, meet monthly to review trending data and report back to the regional office of any concerns. Central office staff also presents incident management trend summaries to the quality council and the medical director is available to review medication errors as needed.

**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 Medicaid agency conducts oversight and DDP requires through the Incident Management rule that providers have an incident management system in place. The requirements for Incident Management are located in the procedural manual referenced in rule which instructs all qualified providers to hold weekly incident management meetings to review all critical, non-critical and internal incidents, this includes medication administration and medication error. The DDP Quality Improvement Specialist and a case manager attend the weekly meeting. The DDP Quality Improvement Specialist reviews all incidents before the meeting. The state incident management procedures require a high-risk review if a trend is determined at the weekly meeting of provider and state staff.

The plan of care, which is reviewed and updated at least annually, lists all medications, time of day taken, dosage/route, purpose of medication for the person, start date and prescribing professional. Medication administration records may also be reviewed by Department quality assurance personnel during scheduled and unscheduled onsite visits.

Documentation of administration of a PRN medication used to reduce or eliminate a behavior is required on the member's medication administration record and is also recorded as a non-critical incident to be reviewed by the provider's Incident Management Committee. An incident report is also required when medical attention is sought when a member experiences side-effects or symptoms of concern as a result of a medication. PRN usage for five days over a seven-day period to treat the same condition requires a High-Risk Review by the Incident Management Committee and may result in a referral to the POC team to conduct a more thorough review and assessment of the member's needs. Additionally, teams may consult with the DDP contracted psychiatrist, and/or medical doctor to address concerns or questions that arise.

All medication errors are reported in an incident report, within 24 hours. Provider incident management committees meet weekly when incidents have occurred. State regional offices review incident trends monthly and State central office personnel review critical incident information weekly and trend data monthly to address deficiencies and improve practices that will improve the quality of care for members.

## 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).

Non- medical professionals may assist and supervise in the administration of medications under a DDP agreement with the Montana State Board of Nursing. Staff providing medication assistance to individuals must be med certified in accordance with the provisions of ARM 37.34.114. Staff are med certified on the basis of passing a written test covering topics such as the purpose and use of various medications, administration dos and don'ts, requirements for record keeping and proper storage, and responsibilities related to follow up in the event of med errors. The curriculum used to impart skills to staff is Health and Medication Administration Manual for Individuals with Developmental Disabilities: A Self-Paced Instructional Manual written by Dr. William Docktor and updated in 2009 by Dr. Jean Justad. This manual and medication certification process was approved by the Montana Board of Nursing. Staff must demonstrate proficiency in the curriculum by taking and achieving a passing score on the med test every two years. DDP or State of Montana Job Service staff administer the medication tests.

The med rule requires the implementation of a training objective(s) if a person is not independent in the self-administration of meds, and the conditions under which this requirement can be waived.

The med rule applies to all staff in DDP waiver funded services, including those staff providing services to adults and children living with their natural families, and in foster care. There have been numerous requests for interpretations of med rules and DDP policy statements over the years. The answers to these requests for clarification are shared statewide with all providers and copies of these documents are available on the DDP website.

**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:

Medication Errors:

Incident report is written in Data Management System within 24 hours.

Reported to DDP and Case Manager within 24 hours of witnessed incident, IR written in Data Management System within 24 hours.

Must be reported to the local DPHHS Licensing Office within twenty-four (24) hours of the incident's occurrence.

Medication Error will be critical if due to abuse/neglect/exploitation and reporting to DDP and case manager is no later than 24 hours after incident and entered into Data Management System within 24 hours.

(b) Specify the types of medication errors that providers are required to *record*:

**MEDICATION ERROR –**

Internal medication errors are physician or pharmacy errors that are discovered but not administered to the person. All other medication errors are considered Critical or Non-Critical. Critical level incidents in this category include: hospitalization, death, or incidents that are caused by suspected abuse or neglect or involves a controlled substance.

- Charting Error - Medication charted prior to the person taking the medication; medications given to persons and not charted; failure to chart refusals; charting for a co-worker; and/or the use of ditto marks, erasing entries on the Medication Administration Record (MAR), using “white out” on the MAR.
- Omission - Medication not given to person; not obtaining refills on time and/or; sufficient quantities not available.
- Order Expired - Medication given beyond the “stop order” and/or medication given past an expiration date.
- Transcription errors
  - o Wrong dose or the dose on the MAR does not match the dose on the prescription and/or pharmacy label;
  - o Wrong person or the name on the MAR does not match the name on the prescription and/or pharmacy label;
  - o Wrong medication or the name of the medication on the MAR does not match the medication listed on the prescription and/or pharmacy label;
  - o Omission or new medication that was prescribed was not written on the MAR;
  - o MAR entry shows the wrong route or the route for giving the medication does not match the doctor’s order written on the prescription and/or pharmacy label. Ex.: oral route vs. rectal route;
- Wrong time or the time(s) for medication administration is not the same as indicated on the prescription and/or pharmacy label.
- Wrong dose/wrong person
  - o Person given the wrong dose of medication. Example: MAR indicates two tablets, person given only one tablet.
  - o A medication was given to the wrong person.
- Wrong medication
  - o The wrong medication was given to the person or a medication was prescribed or given to a person with an allergy to that medication.
- Wrong route/Wrong time
  - o A medication was given by the incorrect route. The medication was actually given at a time that is different than that written on the MAR or outside of the predefined time interval from its scheduled administration time.
- Other
  - o Physician or pharmacy errors.
  - o Medium/texture/consistency or medication not given in proper form.
  - o Position: Medication specifically prescribed to be given to person when sitting upright in wheelchair not when sitting in recliner
  - o Storage issues: Administration of a drug that has was stored incorrectly or for which the physical or chemical dose (integrity of the drug) has been compromised.
- Medication Refusals: People do have the right to refuse medication. If possible, try to find out why the medication is being refused. Do not give a second dose of medication that has been refused. Medication Refusals are non-Critical incidents

Regardless of whether a person has experienced adverse side effects and/or their health/welfare is in jeopardy, some types and/or patterns of medication errors emerging from regular trend analysis of all medication errors may raise the incidents to a Critical Incident classification. As a result, service providers should respond as such and initiate investigations into those circumstances (e.g., has possible negligence occurred?).

(c) Specify the types of medication errors that providers must *report* to the state:

All medication errors must be reported following the DDP Incident Management Policy.

Internal medication errors are physician or pharmacy errors that are discovered but not administered to the person. All other medication errors are considered non-critical unless the error causes the outcome of the incident to elevate the incident to a critical notification level. Critical level incidents in this category include: hospitalization, death, or incidents that are caused by suspected abuse or neglect.

**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.

In addition to involvement in the investigations involving critical medication errors, the DDP QIS is also involved in monitoring medications as part of the DDP quality assurance process. This includes reviewing medication storage, medication documentation in the med logs, reviewing the qualifications of staff assisting with medications (medication certification must be current). In addition, a sample of direct care staff must demonstrate competence in correctly answering oral interview questions regarding medications and procedures. QIS onsite visits also occur throughout the year.

## Appendix G: Participant Safeguards

### 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 instances of 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:



**Number and percent of member POC files that document receipt of information on how to report abuse, neglect, exploitation (A/N/E) and unexpected death. N: Number of member POC files that document receipt of information on how to report abuse, neglect, exploitation (A/N/E) and unexpected death; D: Number of member POC files reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  95% Confidence level with +/- 5% margin of error.
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

**Performance Measure:**

Number and percent of abuse, neglect, exploitation(A/N/E) and unexplained death incidents reported within the required timeframe; N: Number of abuse, neglect, exploitation (A/N/E) and unexplained death incidents reported within the required timeframe; D: Number of all abuse, neglect, exploitation (A/N/E) and unexplained death incidents.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  <input type="text"/>

<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percent of provider staff who were able to identify and report critical incidents (including A/N/E) in accordance with DDP incident management policy. N: Number of provider staff who were able to identify and report critical incidents (including A/N/E) in accordance with DDP incident management policy; D: Number of provider staff.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**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:**

**Number and percent of critical incident trends where systemic intervention was implemented; N: Number of critical incident trends where a systemic intervention was implemented; D: Number of critical incident trends reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b>

		Confidence Interval =  95% confidence level, +/- 5% margin of error.
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified Describe Group:</b>  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other Specify:</b>  <input type="text"/>
	<b>Other Specify:</b>  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other Specify:</b>  <input type="text"/>

**Performance Measure:**

**Number and percent of providers that have a compliant incident management system to guide the behavior of staff inclusive of the DDP Incident Management Policy. N: Number of providers with a compliant incident management system to guide the behavior of staff inclusive of the DDP Incident Management; D: Number of all providers.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input data-bbox="1078 1061 1264 1144" type="text"/>
<b>Other</b> Specify: <input data-bbox="408 1285 647 1368" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input data-bbox="1078 1285 1264 1368" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input data-bbox="1078 1509 1264 1592" type="text"/>
	<b>Other</b> Specify: <input data-bbox="718 1733 954 1816" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

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:**

**Number and percent of restrictive interventions (including restraint) that follow State policies and procedures. N: Number of restrictive interventions (including restraint) that follow state policies and procedures. D: Number of restrictive interventions (including restraint).**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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



<b>Agency</b>		
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of members whose behavior support plans that are in compliance with the Administrative Rules of Montana governing the use of restrictive procedures. N:** Number of members whose behavior support plans are in compliance with the Administrative Rules of Montana governing the use of restrictive procedures rule; **D:** Number of members with behavior support plans that were reviewed.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/> 95% confidence level, +/- 5% margin of error
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b>	

	Specify:  <input style="width: 100%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

**Number and percent of unauthorized restrictive interventions (including restraint and seclusion) that were appropriately reported. N: The number of unauthorized restrictive interventions (including restraint and seclusion) that were appropriately reported. D: The number of all unauthorized restrictive interventions (including restraint and seclusion) that occurred.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>

<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**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:**

**Number and percent of members who have a completed Healthcare Checklist and Risk Worksheet (HCCL) and an action in the POC that corresponds with a follow-up in the HCCL. N: Number of members who have a completed HCCL and an action in the POC that corresponds with a follow-up in the HCCL; D: Number of HCCLs reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  95% confidence level, +/- 5% margin
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<p><b>Other</b> Specify:</p> <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<p><b>Other</b> Specify:</p> <input type="text"/>

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.

A random-generated statistically valid sample is drawn annually, with a 95% confidence level and +/- 5% margin of error . 100% of the sample is reviewed.

The QA Review Process is the primary mechanism designed to ensure compliance with the performance measures previously outlined. In addition, the daily review of incident reports, and the weekly review of reports generated by provider incident management committees result in follow-up activities by the provider and the assigned DDP QIS to improve services and to reduce the potential for future incidents. Incident report reviews are conducted weekly as part of the Central Office Administrative Team Incident Review Protocol. The DDP management team also meet monthly to review all incidents reported statewide for trending and follow-up.

**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.

Incidents are input into the DDP data management system by agency staff, case management or DDP staff. The provider agency incident management committee, on a weekly basis, uses the information from the system to review incidents. This information is used to take steps to avoid re-occurrence of incidents. DDP quality assurance personnel participate in each provider agency incident management committee.

Incidents are available for review by team members including state staff upon entry into the DDP data management system. Each DDP regional office conducts a monthly trend analysis meeting to review the compiled data. Furthermore, the DDP central office and all regional offices meet monthly to review and discuss state-wide trends and preventive measures.

Minutes are recorded for each Incident Management meeting and a state-wide spreadsheet is maintained and regularly updated to document immediate and follow-up responses for each critical incident.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**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)**

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### **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.



With the assistance of CMS technical assistance provided by HSRI, the DDP is using a QA process based on the performance measures outlined in the Quality Improvement sections of the various Appendices. The DDP updates the QA Review process annually as Department policies and procedures are added or refined.

The DDP quality assurance personnel are responsible for collecting and analyzing data on the performance measures. Deficiencies warrant issuance of a Quality Assurance Observation Sheet (QAOS) requiring the provider to identify remediation activities. The quality assurance personnel analyze the effectiveness of the remediation and requires further action if necessary.

A statewide spreadsheet is available on a secure site for DDP staff to enter and track QAOS. This QAOS process allows for centralized access and tracking to address systemic issues as well as client specific issues.

System improvements emphasize resolving health and safety performance issues first and foremost. When quality assurance personnel note a deficiency (either during the ongoing monitoring of services or during the annual performance measure review), a QAOS is issued. The quality assurance personnel have the authority to assure that corrective action is taken. The provider must respond to the QAOS and demonstrate that they are taking appropriate steps in correcting the issue. The quality assurance personnel will follow up on all QAOSs to assure that corrective action remediates the identified deficiency before the QAOS is accepted as complete. If a situation arises and cannot be resolved, higher level DDP management is consulted to provide additional support in assuring a positive outcome. The Medicaid Program Officer reviews the QAOSs to identify trends that require attention at a statewide level.

The performance measure quality assurance reports are compiled at least annually.

Results of deficiencies or exemplary practices are communicated using the QAOS. These results are communicated at least annually or as needed when issues are identified by quality assurance personnel.

Central Office Administrative Team Incident Review Protocol:

In order to reinforce reporting expectations of DDP staff and provide clarification on roles and responsibilities of DDP staff, DDP will implement the following protocol for the review of Critical Incidents and the subsequent investigations. A key responsibility of the waiver administration is to have processes in place which address issues of health and welfare of waiver recipients. The review will be completed by the Central Office Administrative Team.

Central Office Administrative Team (2 members must attend review):

- Community Services Supervisor
- Program Supports Supervisor
- Developmental Disabilities Program Bureau Chief
- Behavioral Health and Developmental Disabilities (BHDD) Division Administrator
- Regional Managers

Administrative Review Team Coordination:

- Community Services Supervisor will setup weekly recurring meeting for reviews.
- Administrative Team members will let Community Services Supervisor know of attendance.
- Regional Managers will follow-up on information needed

Administrative Team Critical Incident Notification:

The following Critical Incidents Reports (GER) must be uploaded to Sharepoint and information entered into the Central Office Incident Notes spreadsheet:

- Suspected abuse, neglect, or exploitation issues.
- Serious health or safety issues, including any death or suicide attempts.
- Any client to client altercations that result in medical treatment, law enforcement referrals, or APS referrals.
- Any physical restraint used at least 3 times in a 3-month period.
- Any other incidents where the regional staff have concerns regarding the health and welfare of waiver recipients

Regional Staff (upon notification of the incident):

Save a copy of the GER

Upload the GER

Find the correct Region's tab. Enter information into columns A-J of the Central Office Incident Notes Spreadsheet

NOTE: this reporting is in addition to any instruction given by your supervisor on issues which you are responsible to bring to the supervisor's attention.

Central Office Administrative Team members can review the information prior to the weekly team review meeting.

Central Office Administrative Team Review:

Review of incidents and immediate steps taken regarding the health and welfare of the waiver recipients.

Provide additional information on the spreadsheet as meeting notes

Provide feedback to the regional office staff of any issues needing further clarification or follow-up.

Following the Central Office team review, Regional Managers will complete any required follow up for their region and document the follow up

Administrative Team Investigation Review Protocol

Regional Staff (prior to Central Office Review):

With the exception of death investigations, all investigations will be reviewed by the Central Office prior to the QIS completing/closing the investigation.

Complete investigations and investigation reviews as defined in the Developmental Disabilities Program Incident Management Procedures Manual.

The investigation review must be complete within 10 working days of receipt of agency investigation documents.

If an extension is granted, the QIS must enter the new date in column

Once the QIS has completed the review documents, investigation and review documents must be uploaded within two working days by the QIS.

Investigation review documents must be typed.

Each Investigation document need to be saved and uploaded separately. Label the documents: date of incident-member ID-last name of individual- Type of Investigation Document (TRF, IRF, PR, FIRF)

If APS intent to investigate letters or notification of completion letters are available, upload those and label: date of incident-member ID - last name of individual- APS intent to investigation OR date of incident-member ID-last name of individual- APS notification of closure

If additional documentation is needed, the administrative review team will request it.

Complete Column K in the Central Office Incident Notes spreadsheet.

Central Office Review:

Administrative Team will review critical/investigation information.

Any changes needed to the investigation summary.

Approval the investigation/critical incident for closure by the QIS

Move closed investigations to the 'closed' tab of the spreadsheet.

Regional manager will notify assigned QIS of Central Office review results. The email will include any changes or follow-up needed or if the QIS can close the incident and sent the results to the provider.

Regional Office (upon completion of the Administrative Team review):

Follow-up on making any changes to the DDP investigation/investigation review.

If changes, resubmit for the Central Office review.

Upon approval from the Central Office, close the incident and send the results to the provider.

Any QAOS related to the investigation must be uploaded into the investigation/critical incident file on Sharepoint.

**Death Investigations**  
 Death investigations are reviewed by the DDP medical director and in some cases, the mortality review committee.

**Regional Office (prior to Mortality review committee):**  
 Find the mortality review tab and enter information in columns A-H  
 Complete investigations and investigation reviews as defined in the Developmental Disabilities Program Incident Management Procedures Manual and provide investigation materials to the DDP medical director

**Mortality Review Committee:**  
 Mortality Review and/or DDP Medical Director will review death investigation information.  
 Request from regional office any additional information or follow up needed to the investigation summary.  
 Approval of the investigation/ incident for closure by the Regional Office

**Regional Office (following Mortality review committee):**  
 Complete any required follow-up and enter information on tabs I-M  
 When investigation is closed, move investigation to 'closed' tab

**Central Office Review:**

- Follow up on any issues identified by Regional office

**Regional Office Follow-up from Central Office Review:**

- Follow up on any issues identified by Central office review.
- Report back, via email the follow-up results.

**Central Office Documentation:**

- Minutes from each weekly meeting will be kept in the Central Office Review Minutes folder.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Other</b> Specify:  <input type="text"/>

**b. System Design Changes**

- 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.

The DDP has the review elements in place today to ensure the performance measures are adequately monitored. The Department has developed a method for aggregating this information in a statistical format,

Staff to be involved in this activity will include waiver staff, representative regional staff, and DDP management staff in QA for children and adult services.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The QA review process is updated as needed to include measures designed to monitor compliance with new waiver requirements, policies, rules, qualified provider process.

## 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*):

*During the annual plan of care process a member satisfaction survey is completed.*

## Appendix I: Financial Accountability

### 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).

**Audit Requirements:**

*DDP providers are subject to same auditing requirements as all other Medicaid providers, and are subject to applicable requirements for A-122 and A-133 audits. DDP does not require waiver providers to secure an independent audit of their financial statements,*

*However, providers frequently have their finances audited, which are sent to our Office of Inspector General for a desk review.*

*Providers must submit an application for enrollment through our Montana Medicaid Information System (MMIS), are subject to all general Medicaid rules and processes required, and must be authorized by DDP as a qualified service provider.*

**SECTION 12: ACCOUNTING, COST PRINCIPLES AND AUDIT****A. Accounting Standards**

*The DDP qualified service provider must maintain a system of accounting procedures and practices sufficient for the Department to determine to its satisfaction that the system (1) permits timely development of all necessary cost data, (2) is adequate to allocate costs in accordance with Generally Accepted Accounting Principles (GAAP); and (3) complies with any other accounting requirements the Department specifies.*

**B. Internal Controls**

*The DDP qualified service provider must maintain and document an adequate system of internal controls that address: 1) the control environment, 2) the risk environment, 3) the risk assessment, 4) the control activities, 5) information, communications, and monitoring.*

**C. Separate Accounting of Funding**

*The DDP qualified service provider must separately account for and report the source, the receipt, and the expenditure of the different types of program funding received from the Department. Each different fund must be accounted for separately and may not be diverted or commingled.*

**D. Audits and Other Investigations**

*The DDP qualified service provider must provide authorized state and federal entities, including Montana DPHHS, the U.S. Departments of Health and Human Services, Agriculture, Energy and Education, their auditors, investigators and agents, with timely and unrestricted access to all of the provider's records, materials and information including any and all audit reports with supporting materials and work documents related to the delivery of goods and services provided for purposes of audit and other administrative activities and investigations. Access must be provided in a format acceptable to those authorized entities, who may record and copy any information and materials necessary for any administrative activity, investigation and audit or other administrative activity or investigation.*

**E. Corrective Action**

*If directed by the Department, the DDP qualified service provider must take corrective action to resolve audit findings. The provider must prepare a corrective action plan detailing actions it proposes to undertake to resolve those audit findings. The Department may direct the provider to modify the corrective action plan.*

**F. Payment for Sums Owing**

*The DDP qualified service provider must reimburse or compensate the Department in any other manner as the Department may direct for any sums of monies determined by an audit or other administrative activity or investigation to be owing to the Department.*

**G. Federal Financial Requirements**

*1) The DDP qualified service provider must maintain appropriate financial, accounting and programmatic records necessary to substantiate conformance with federal requirements governing fund expenditures.*

*2) The DDP qualified service provider must comply with the federal audit requirements set forth in 2 CFR 200.201 through 200.521*

*3) The DDP qualified service provider must comply with the federal cost and accounting principles set forth in 2 CFR 200,400 through 200.475.*

#### *H. Expenditures Of Monies To Be In Conformance with Authorities*

*The monies provided must be expended in accordance with the federal and state authorities governing: 1) the delivery of services, 2) the receipt and expenditure of the particular types of monies provided, and 3) the conduct of the DDP qualified service provider for the State.*

*I. Expenditures under \$100, may be paid by petty cash. A full accounting, including all receipts, of petty cash expenditures must be available.*

*J. Accrual accounting is required for year-end financial reports. The DDP qualified service provider may use the cash method for interim reports if the qualified service provider accrues the last month of each fiscal year's transactions.*

*The Program Compliance Bureau with the state Office of Inspector General (OIG) consists of the Quality Control Unit and Surveillance Utilization Review Section (SURS). If a provider indicates that they are struggling financially, they may be referred to OIG for a financial audit upon request. The Program Compliance Bureau of the Department will conduct financial audits upon request of DDP. If DDP quality assurance personnel find something questionable, a provider audit may be requested. Additionally, if the desk review or review of non-audited financial statements indicates issues, the Department may ask them to complete a more in-depth review. The review is initially desk-level and is generally all that is needed, however, if the data available for review is not sufficient it may lead to an on-site review. The Quality Control Unit is further mandated to perform reviews for any and all areas of suspected overpayments and as such, may be completing financial audits relative to the DDP waiver providers without being directly referred by DDP. The frequency of reviews by the Quality Control Unit is variable and depends on the circumstances as described above. Audits will be conducted in compliance with the single state audit act. The compliance staff also conduct limited scope audits or desk reviews for DDP, using agreed upon procedures. The Medicaid PERM processes also provide post-payment analysis of expenditures to identify issues.*

*Limited Scope Audits are completed when specifically requested by DDP using agreed-upon procedures. The scope, methods, and frequency would depend on the specific agreed-upon procedures.*

*The desk review is of providers who receive A-133 Audits (which is limited to those who receive Federal funds non-Medicaid of \$750,000 or more) from external auditors. The compliance staff review the report identifying audit findings which may affect services, to notify enrolled providers of potential problems. However, from the requirements of the A-133, the majority of enrolled providers do not receive audits.*

*The Surveillance Utilization Review Section (SURS) identifies incorrect billing and potential overpayments. When an overpayment is identified, SURS does a provider review by reviewing records provided by the provider and discusses it with the provider. SURS primarily does desk reviews and can go on-site if requested by the provider. The provider is sent a letter noting the findings and requesting recoupment of the overpayment, the timelines involved, and notification of fair hearing rights. SURS performs the necessary follow-up to ensure recovery. The SURS program integrity approach includes sampling new providers' claims in their new provider reviews to ensure the providers are claiming correctly. For ongoing providers, they sample a specific provider's claims if their pattern of billing is significantly different than their peers or a referral is received. The frequency of SURS reviews is variable. Samples can be drawn in a number of different ways, depending on the number of claims billed. If a sample is used no statistical extrapolation is done, only the claims reviewed will be part of a recovery. The SURS Division develops review plans in which a sample of claims may be selected based on previous patterns of errors (follow-up reviews), referrals, and national trends. If a referral is received, a member's claims or a type of service across members could be reviewed. When an overpayment is identified, SURS issues a notification of the findings with resources used during the review, a request for repayment and the process and timelines for appeal. All overpayments are maintained in the departments Accounts Receivable Management System (ARMS). SURS works with the Business and Financial Service Division to monitor the recovery of funds from the provider. The Business and Financial Services division ensures that CMS is made whole for any remaining outstanding receivables in accordance with the required timelines checks the Fiscal ARMS system monthly to ensure payment is received from the provider. DDP staff monitors the implementation of the corrective action plan if one is implemented by the DDP program.*

*In addition to the reviews by Quality Control Unit personnel and SURS, the DDP annually reviews a statistically valid sample of paid claims through the Performance Measure and Quality Assurance review. These reviews include reviewing claims paid in accordance with the reimbursement methodology specified in the approved waiver, claims coded as specified in the approved waiver, and documentation supporting the delivery of waiver services as billed by the provider. Claims for Performance Measures are initially selected by running an MMIS report with the DDP provider type and fiscal year. Claims from the universe sample are then selected using the online randomizer feature to obtain a random, representative*

sample. Each claims sample is a statistically representative sample with a 95% confidence level and +/-5% margin of error, which is determined by using the online Raosoft sample size calculator. Problems noted by the quality assurance personnel will be documented on a Quality Assurance Observation Sheet to ensure a mutual understanding of the auditing issues. The corresponding DDP Regional Manager then reviews the information and the recommended process for remediation. If there is a serious auditing exception, the DDP Regional Manager will notify the DDP Central Office including the DDP Community Services Supervisor, the Division Fiscal Bureau Chief, and the DDP Bureau Chief for guidance. DDP management staff makes the determination whether to expand the audit sample size to determine a possible trend, to request a SURS review, or whether referral to the Medicaid Fraud Hotline or Department of Justice is appropriate. Consequences for misuse of funds may include repayment, provider corrective action and/or disenrollment.

For claim payments the entire claim is paid, then the claim is allocated to the correct funding reporting category where Federal FMAP and participation is calculated and applied. Claim adjustments for inappropriate claims will zero (credit) out the payment to both state share and federal share, and then any correction would receive a new claim and claim payment amount that would follow the same funding reporting category logic where FMAP and participation is calculated and applied. Depending on the circumstances around an overpayment, DDP may also invoke a corrective action plan to change/monitor/correct processes within the agency to ensure the overpayment does not recur.

As briefly mentioned prior, if fraud is suspected, the information can be referred to the Medicaid Fraud Hotline for an investigation. If fraud is verified, the provider can be sanctioned and terminated as a Medicaid or Medicare provider. The findings are sent to the Office of Inspector General (OIG) and the licensing board of the provider (if applicable).

The Montana Legislative Audit Division completes the independent audit as required in the Single Audit Act.

## 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:

**Number and percent of members for whom adequate documentation exists to support the delivery of services for a random month. N: Number of members for whom adequate documentation exists to support the delivery of services for a random month; D: Number of members (receiving services excluding case management) reviewed.**

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

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95% confidence level, +/- 5% margin of error</div>
<i>Other</i> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>	<i>Stratified</i> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<i>Continuously and Ongoing</i>	<i>Other</i> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<i>Other</i> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> Specify:	<i>Annually</i>



<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of claims coded as specified in the approved waiver. N: Number of claims coded as specified in the approved waiver; D: Number of paid claims reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

*Number and percent of claims paid in accordance with the reimbursement methodology specified in the approved waiver. N: Number of claims paid according to the reimbursement methodology specified in the approved waiver; D: Number of paid claims reviewed.*

**Data Source (Select one):**

**Financial records (including expenditures)**

*If 'Other' is selected, specify:*

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative</i>

		<p><i>Sample Confidence Interval =</i></p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto; margin-right: auto;"> <p>95% confidence level, +/- 5% margin of error</p> </div>
<p><i>Other Specify:</i></p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p><i>Annually</i></p>	<p><i>Stratified Describe Group:</i></p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p><i>Continuously and Ongoing</i></p>	<p><i>Other Specify:</i></p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p><i>Other Specify:</i></p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<p><i>Other Specify:</i></p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<p><i>Other Specify:</i></p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**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 and percent of rates consistent with the approved rate methodology throughout the five year waiver cycle. N: Number of rates consistent with the approved rate methodology throughout the five year waiver cycle; D: Number of claims reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MMIS**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 2px; width: fit-content;">                         95% confidence level, +/- 5% margin of error                     </div>
<b>Other Specify:</b>  <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<b>Annually</b>	<b>Stratified Describe Group:</b>  <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other Specify:</b>  <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	<b>Other</b>	

	Specify:  <input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify: <input style="width: 100%; height: 30px;" type="text"/>

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.

A random-generated statistically valid sample is drawn. 100% of the sample is reviewed.

Members have prior authorization records in MMIS. Units of service can only be billed if they have been prior authorized. Providers may request a state Office of Inspector General (OIG) Quality Control Unit SURS review for the purpose of helping ensure their documentation efforts are adequate and meet requirements. Montana ARM Title 37, chapter 34, subchapter 30 outlines the billing rates and documentation requirements for reimbursement.

The DDP has the quality assurance review elements in place to ensure the annual QA review of a monthly sample of services and supports reimbursed with waiver funds for individuals served in the waiver. In addition to SURS reviews and the DDP annual review process, DDP staff may be contacted by individuals or caregivers, case managers, advocacy groups representing individuals or other persons acting on behalf of the individual if scheduled services are not delivered in accordance with the plan of care, or financial fraud or misuse of funds is suspected.

**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.

The audits conducted by DDP QIS staff are limited to the verification of the delivery of waiver services. More systemic auditing problems that are brought to the DDP central office staff may result in a request for a full program audit conducted by SURS at the Program Compliance Bureau, Quality Control Unit (recovery audit) at the Department of Justice. QAOS forms may be generated in response to findings from SURS audits or Program Compliance Bureau, Quality Control Unit (recovery audit).

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**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 non-operational.

**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 DDP rates methodology applies to all DDP qualified service providers. Provider requirements do not significantly change year to year. Rate Increases/decreases are Legislatively directed. The DD Fiscal Bureau Chief, DDP Bureau Chief, and DD Administrator all provide oversight and have an opportunity to review all rate adjustments. The Legislative Children, Families, Health, and Human Services Interim Committee also may review rates. The DDP fiscal staff is the entity responsible for the rate determination.*

*As part of the rate study that Guidehouse conducted beginning in 2021, specific costs of delivering services, including Behavioral Services, were assessed using a variety of methods. Guidehouse conducted a comprehensive cost and wage survey to gather data from providers across programs as the basis for the overall rate studies.*

*Guidehouse also reviewed the State's Medicaid claims data, and other extensive state, regional, and national benchmark metrics, basing assumptions on industry data from the federal Bureau of Labor Statistics or other public data sources when provider-reported data was unavailable or insufficient for rate setting.*

*The objectives of the study were to determine benchmark rates based on resources required to promote access to quality services going forward. As such, cost assumptions frequently rely on recent costs reported by providers as well as national and regional standards that reflect wider labor markets and costs typical of broader industries to respond to changing wage expectations. This process includes all HCBS programs and assessment by providers of costs.*

*The Guidehouse rate study included the rebasing of rates and has been temporarily approved through an Appendix K (July 1, 2023 through November 11, 2023).*

*Montana ARM Title 37. 34.3005 references the DDP Program manual and outlines the rates methodology and documentation requirements for reimbursement. In the manual it outlines rates for self-directed services function the same as traditional services, which is also noted in section E.1.a of this waiver. There are no differences in services delivered through OHCDs as referenced in E.1.a.*

*The provider fee schedule is available for access by participants on the Department's website:  
<https://dphhs.mt.gov/BHDD/DisabilityServices/developmentaldisabilities/ddpratesinf>*

*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 Foster Support*
- *Assisted Living*
- *Behavioral Support Services*
- *Caregiver Training and Support*
- *Companion*
- *Congregate Living*
- *Day Supports and Activities*
- *Homemaker*
- *Meal Services*
- *Personal Care*
- *Personal Supports*
- *Private Duty Nursing*
- *Remote Monitoring*
- *Residential Habilitation*
- *Residential Training Support*
- *Respite*
- *Retirement Services*
- *Supported Employment*
- *Supports Broker*
- *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 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 are services reimbursed at provider costs. These services include Individual Goods and Services, Environmental Modifications, Community Transition Services, Personal Emergency Response Systems, Remote Monitoring Equipment, and Specialized Medical Equipment and Supplies. Additionally, extended State Plan Waiver services are not subject to this rate determination method. They are reimbursed according to rates aligned with and published on Montana Medicaid's RBRVS professional services fee schedule and include Occupational Therapy, Physical Therapy, Speech Therapy, Psychological Services, and Nutritionist Services.*

*In addition to the standardized cost centers, geographical factors are applied for Supported Living (a residential habilitation service) and Residential Training Support. Geographical factors consider the cost of living, employment compensation, cost of housing and labor market trends.*

*In September 2016, Montana submitted the state's Access Monitoring Review Plan (AMRP) to assess Medicaid member access to medical services and determine if Montana's reimbursement rates are sufficient so medical providers will enroll and participate in Montana Medicaid. Montana included language within the AMRP addendum, submitted to CMS in January 2018, that stated Montana will monitor provider enrollment numbers and compare previous state fiscal year to current year to determine if there has been a significant reduction of providers. Montana will research trend if the overall provider network decreases by 10 percent.*

*Finally, in 2016, a JAMA study was completed that showed access to primary care services in Montana is comparable to access for private insurance and sent to CMS on February 13, 2018, after a CMS inquiry was received by Montana.*

*In 2018, the Developmental Disabilities Program began meeting with 0208 waiver providers with the goal of identifying ways to simplify and increase flexibility for services providers. This led to the creation of a specific workgroup made of provider and state DD Program staff. The workgroup focused on reimbursements that allowed more flexibility to meet fluctuating needs of individuals in congregate settings. Tiered Daily rates were developed for congregate residential sites, SE Small Group Employment, Day Supports and Activities, and Retirement services. The daily rates are identified in tiers based on a range of hours of 1:1 support a person would need in a shared staffing setting. The rates are uniform within each tier and based on a percentage of the daily hours in the tier, not the maximum hours in the tier. As individual's needs become more complex, the provider has less flexibility in meeting those supervision and support needs. The payment is not tied to the directly delivery of direct care hours, but rather based upon the provider meeting the plan of care requirements. The group also identified eliminating the geographical and economy of scale factors to further simplify the rates for congregate residential and SE Small Group, Day Supports and Activities, and Retirement, which was implemented.*



*Rate adjustments are the result of the legislative sessions which provides opportunity for public comment and feedback during the legislative process. As referenced in Main Section 6-I, the State's rule process is also an avenue for public comments. DDP considers comments at other times, including but not limited to: testimony made at interim committee hearings; emails or calls from stakeholders; surveys that DDP sends; and/or workgroups with providers that note areas of ongoing concern.*

*There is public notice, public comment period, and public hearing during which rate information is made available to waiver participants and interested parties, as rates are adopted and incorporated into administrative rule. Rates information is publicly available to participants and interested parties, on the DDP website.*

*Waiver rates are reviewed annually to ensure services remain consistent and are within Montana's Legislative appropriation. The department receives information through multiple sources, to include at a minimum, member and stakeholder feedback, provider data, and outcomes from Legislative committee appropriations. Claims history of all providers are analyzed to track and target positive or adverse trends in the number of services utilized. The state also monitors the number of HCBS provider enrollments and compares the data to the previous fiscal year to determine whether there has been a significant reduction of providers impacting access to service delivery.*

*All waiver services are preauthorized through a service authorization record in MMIS and are based on the person's Plan of Care. The member's cost plan identifies each service, the providers to deliver each service, and either the units identified as necessary or maximum cost allowable. Claims submitted for services that do not have the corresponding authorization record will be denied.*

*It is specified in the waiver service descriptions that reimbursement should not be sought from the DD waiver if another source (most commonly IDEA or Vocational Rehabilitation) is available to pay for the service. The planning teams identify alternatives. Provider agencies also appropriately seek payment from other potential sources and obtain appropriate documentation. The majority of individuals in this waiver have aged out of eligibility for school services. Planning team members and providers have demonstrated due diligence in exploring all potential service funding sources prior to committing waiver cost plan dollars.*

*Members served in the waiver have cost plans based on assessed needs as determined by the Montana Resource Allocation Protocol (MONA), completed by the case manager. The amount identified in the MONA is used to assist the individual and their team in identifying the services and supports that can be accessed via the waiver to meet the assessed needs. Since the MONA had already identified individual resource allocations, the workgroup agreed to continue to use the MONA as the assessment tool for identifying the resource allocation. The identification of the resource allocation will remain the same, however, the reimbursement for the tiered services will move from hourly to daily.*

*I-2-a continued in Section B. Additional Needed Information (Optional)*

- 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:

*Flow of Billings*

Waiver service providers bill Montana Medicaid through the MMIS system. Payments are issued directly to the providers; no funds are retained by the Department. All services are prior authorized.

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 MMIS system has a nightly member interface that verifies eligibility for Medicaid and the waiver. Case managers prior authorize all services that are identified in the member's service plan, which are maintained in the state's MMIS system. If a provider submits a claim that will exceed the limit identified in the service authorization, system edits will decrease the payment and only allow the provider to be reimbursed for amounts/units left in that service authorization. If a provider submits a claim for a service date outside of the dates specified in the service authorization, the claim will be denied. Claims for services to members that are not Medicaid eligible or enrolled in the waiver on the service date will be denied.

The DDP ongoing quality assurance review effort is designed to hold providers accountable for ensuring that services were delivered in accordance with the plan of care and the service authorizations. Additionally, if services are not delivered, there is usually a corresponding increase in reportable incidents. The incident management processes are used to address and remediate these situations. Persons who provide case management are responsible for the ongoing monitoring of service delivery per the Plan of care. Reports can be obtained to show services, units, and dollars billed by providers. This can be compared with plans of care to monitor payments vs. services delivered. Additionally, DDP has incorporated performance measures, and also a sample review of paid claims as part of the Performance Measure and our Quality Assurance processes. Inappropriate claims billed will be recouped. The SURS process conducted by the Quality Control Unit and PERM audits will help ensure the financial integrity of provider billing practices, as described in Section I-1.

For claim payments the entire claim is paid, then the claim is allocated to the correct funding reporting category where Federal FMAP and participation is calculated and applied. Claim adjustments will zero (credit) out the payment to both state share and federal share, and then any correction would receive a new claim and claim payment amount that would follow the same funding reporting category logic where FMAP and participation is calculated and applied.

*Amendment effective 11/12/2023*

Montana is currently contracted with Netsmart to develop a successful adoption of Electronic Visit Verification (EVV) for Montana providers. Open EVV registration began 09/18/2023 with the goal of being in compliance with the EVV mandate on or before 01/01/2024 and obtaining formal CMS certification by Quarter two of 2024.

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 Care, Companion, Respite, Private Duty Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, and Nutritionist services.

- 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:*

The DDP contracts with a financial management service (FMS) to perform fiscal agent duties for self-direct services with employer authority. They educate employers on their responsibilities, process employee and employer paperwork, process employee timesheets according to service authorizations. They provide workers' compensation for all employees and pay employee and employer related taxes. The FMS also generates expense reports for the employer, case manager and the state. The DDP conducts quality assurance reviews of the FMS.

The self-direct FMS operations are overseen during the annual performance measure review. The performance measure review uses a representative sample to determine:

- o if the correct administrative rate was charged by the FMS
- o if the files maintained by the FMS comply with their contract with DDP
- o if the providers of the services met ongoing qualified provider standards
- o if the wage paid to staff was the wage agreed upon

The self-direct FMS entity will be paid through the MMIS.

The 50/50 portion is paid with Medicaid Administrative funds.

**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 non-Federal 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:

The only public providers receiving payment from the DDP for waiver services are the public transportation providers.

## 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:*

(a) DDP qualified service providers are designated as OHCDS in cases where the enrolled provider subcontracts with other entities (persons or agencies) for the provision of services not provided by staff employed by the agency. Any person or agency providing services under a subcontract must meet the DDP qualified provider standards for the provision of the service. It is the responsibility of the enrolled DDP provider to ensure the QP standards for the subcontracted service are met and documentation is maintained by the agency with the OHCDS designation to support this requirement.

(b) Providers of waiver services may choose to bill DDP directly if they are an enrolled DDP provider. The potential service provider would complete an application through MMIS. After the required application and documentation has been reviewed and approved the applicant would achieve qualified provider status.

(c) Individuals are free to request the services of any qualified provider, as outlined in previous sections. Case managers are responsible for providing information to individuals and families regarding available service providers as part of the planning and pre-planning meeting process. Provider agencies currently subcontract with various providers of professional and therapy services, in response to the expressed desires of the individual and/or family.

(d) Claims break out procedure codes which allow the reporting of the delivery of all waiver services by waiver service category. This information is a critical piece of the paid claims history and audit trail, and is subject to review by independent, state, and federal auditors. (e) The provider agency designated as an Organized Health Care Delivery System (OHCDS) is accountable for maintaining documentation verifying the credentials of subcontracted staff. The Performance Measure and Quality Assurance review process reviews the qualified provider documentation for staff providing the services outlined in the plan of care and the service authorization. The DDP quality assurance personnel may choose to verify the professional licensure or certification status at the Montana Department of Labor website, in addition to reviewing the certification or licensure records of subcontracted staff maintained by the provider agency designated as an OHCDS. (f) Financial accountability is maintained as follows: Providers may subcontract for the delivery of waiver services if the enrolled DDP provider has been designated as an Organized Health Care Delivery System in their enrollment addendum. In this case, the enrolled DDP provider has the option of reimbursing another waiver service provider, at a rate equal to or less than the approved Medicaid rate. There can be no Medicaid payment made to the provider issuing the subcontract for submitting claims or processing payment, maintenance of documentation, or verification of credentials of the subcontracting entity, when the subcontracted entity bills at the Medicaid rate. The enrolled DDP provider is responsible for ensuring the subcontracted service is delivered in accordance with the plan of care, the service authorization, and the applicable qualified provider standards for the service. The enrolled DDP provider issuing the subcontract is responsible for maintenance of a "funding and service delivery paper trail", enabling auditors and DDP reviewers to verify the delivery of services in accordance with the aforementioned requirements. The DDP QA financial review occurs annually. The additional assurance of individual/unpaid caregiver survey questions linked to the delivery of services outlined in the plan of care, the service authorization and the sampled claims reduces the potential for fraudulent billing and the misuse of Medicaid funds.

**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-2-c:*

**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:

In accordance with MCA 53-20-208, counties may access local tax levies for the purpose of supporting local services to persons with developmental disabilities. These funds are not matched with Medicaid.

53-20-208. Contributions of counties and municipalities. (1) The boards of county commissioners of the several counties and the governing bodies of municipalities of this state may contribute to any developmental disabilities facility approved by the department, without regard to whether the facility is within or outside of their respective jurisdictions. Subject to 15-10-420, the boards of county commissioners of the counties may levy a tax on the taxable value of all taxable property within the county. The tax is in addition to all other county tax levies. All proceeds of the tax, if levied, must be used for the sole purpose of support of developmental disabilities services.

(2) For the purpose of carrying out the provisions of this section, boards of county commissioners and governing bodies of municipalities may appropriate out of the general fund of their respective counties or municipalities.

History: En. 80-2619 by Sec. 9, Ch. 325, L. 1974; Sec. 80-2619, R.C.M. 1947; amd. and redes. 71-2408 by Sec. 7, Ch. 239, L. 1975; R.C.M. 1947, 71-2408; amd. Sec. 131, Ch. 584, L. 1999; amd. Sec. 159, Ch. 574, L. 2001.

**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:

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**Appendix I: Financial Accountability**

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**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:**

Costs related to room and board for participants, as well as facility maintenance, upkeep and improvement related to residential program services are not covered by home- and community-based waivers. These costs were excluded from the total costs collected for the rate determination and are therefore excluded from the payment rates. The payment rates are based solely on service costs.

The models established for residential services based on the rate study's cost build-up approach explicitly exclude costs for room and board. To prevent inclusion of these costs in the provider cost and wage survey used to develop residential rate assumptions, survey reporting guidance furnished providers with clear instructions to exclude all room and board costs from reporting on allowable costs, presenting definitions of room and board costs, explaining the reasons for their exclusion, and offering allocation methodologies for providers to use to identify and remove these costs from their survey responses.

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**Appendix I: Financial Accountability**

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**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:

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**Appendix I: Financial Accountability**

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**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: ICF/IID**

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	57823.56	11540.00	69363.56	255321.00	5495.00	260816.00	191452.44
2	57823.56	11540.00	69363.56	255321.00	5495.00	260816.00	191452.44
3	57823.56	11540.00	69363.56	255321.00	5495.00	260816.00	191452.44
4	57823.56	11540.00	69363.56	255321.00	5495.00	260816.00	191452.44
5	57823.56	11540.00	69363.56	255321.00	5495.00	260816.00	191452.44

**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:	
		ICF/IID	
Year 1	2880		2880
Year 2	2880		2880
Year 3	2880		2880
Year 4	2880		2880
Year 5	2880		2880

## *Appendix J: Cost Neutrality Demonstration*

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### *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 Average Length of Stay has been updated to 282. The following from MMIS was used to determine ALOS:  
FY2019 – 281  
FY2020 – 282  
FY2021 – 283

## *Appendix J: Cost Neutrality Demonstration*

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### *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:

*The basis and methodology of these estimates are as follows. The estimates were based on actual utilization from the Agency Wide Accounting and Client Services (AWACS) for FY19, MMIS for FY20-22, and MedCompass Care Management projected individual cost plans for FY23. This historical information was used to estimate future utilization of each service.*

*The rates for Level II RBT and Level II IBA were derived from the Guidehouse rate study. The number of users was estimated based on Level I Behavioral Support Services utilization and those who would likely qualify for Level II. The units per user were estimated based on MedCompass Care Management budget vs year-to-date utilization for FY23 and projected individual cost plans for FY24.*

*Rate changes are determined by the Montana Legislature. Estimates were kept constant during the 5-year renewal period effective 7/01/23 through 6/30/27. The Department expects a possible increase in rates; however, it is not known to what extent. If an increase of 10% or more is approved, the State will submit an amendment.*

*The unit of service for Occupational Therapy, Physical Therapy, and Private Duty Nursing was changed from "hour" to "15 min."*

*The unit of service for Retirement was changed from "daily" to "hour."*

*The unit of service for Transportation was changed from "one way ride" to "month."*

*Amendment effective 11/12/2023*

*Rates are being updated to align with the updates temporarily approved in an Appendix K, effective 7/1/2023 and the current resource-based relative value scale (RBRVS).*

*The basis and methodology of these estimates are as follows. The estimates were based on actual utilization from the Agency Wide Accounting and Client Services (AWACS) for FY19, MMIS for FY20-23, and MedCompass Care Management projected individual cost plans for FY24. This historical information was used to estimate future utilization of each service.*

*Updated service rates based on rate study:*

*Day Supports and Activities*

*Homemaker*

*Residential Habilitation*

*Respite*

*Supported Employment-Follow Along Support*

*Private Duty Nursing*

*Supports Brokerage*

*Adult Foster Support*

*Residential Training Supports*

*Assisted Living*

*Level I Behavioral Support Services*

*Caregiver Training and Support*

*Companion Services*

*Meals*

*Personal Care*

*Personal Supports*

*Retirement Services*

*Supported Employment-Individual Employment Support*

*Supported Employment-Small Group Employment Support*

*Transportation*

*Updated service rates based on RBRVS:*

*Nutritionist Services*

*Occupational Therapy*

*Physical Therapy*

*Psychological Evaluation, Counseling and Consultation Services*

Speech Therapy

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' values were recalculated using information from paid claims from state fiscal years 2018 through 2021 from MMIS. Factor D' appeared to be consistent from FY18-FY21 with an increase in FY22.

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:

Waiver years 1 through 5 were projected based on fiscal years 2018, 2019, 2020, and 2021 from MMIS. There was a 0% trend identified.

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' is based on analysis of fiscal years 2018, 2019, 2020 and 2021 from MMIS. There was a 0% trend identified.

**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	
Day Supports and Activities	
Homemaker	
Residential Habilitation	
Respite	
Supported Employment - Follow Along Support	
Nutritionist Services	
Occupational Therapy	
Physical Therapy	
Private Duty Nursing	
Psychological Evaluation, Counseling and Consultation Services	
Speech Therapy	
Supports Brokerage	
Adult Foster Support	
Assisted Living	
Behavioral Support Services	
Caregiver Training and Support	
Community Transition Services	
Companion Services	
Environmental Modifications	
Individual Goods and Services	
Meals	
Personal Care	
Personal Emergency Response System (PERS)	
Personal Supports	



Waiver Services	
Remote Monitoring Equipment	
Remote Monitoring	
Retirement Services	
Specialized Medical Equipment and Supplies	
Supported Employment - Co-Worker Support	
Supported Employment - Individual Employment Support	
Supported Employment - Small Group Employment Support	
Transportation	

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** 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. 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**

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Supports and Activities Total:</b>						26809824.60
Day Supports and Activities	daily	1283	188.00	111.15	26809824.60	
<b>Homemaker Total:</b>						82912.74
Homemaker	hour	51	58.00	28.03	82912.74	
<b>Residential Habilitation Total:</b>						108186883.20
Residential Habilitation	daily	1728	335.00	186.89	108186883.20	
<b>Respite Total:</b>						4141358.10
Respite	hour	330	561.00	22.37	4141358.10	
<b>Supported Employment - Follow Along Support Total:</b>						3391003.20
Supported Employment - Follow Along Support	hour	416	155.00	52.59	3391003.20	
<b>Nutritionist Services Total:</b>						3574.08
Nutritionist Services	hour	2	18.00	99.28	3574.08	
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Occupational Therapy Total:</b>						183.92
Occupational Therapy	15 min	1	8.00	22.99	183.92	
<b>Physical Therapy Total:</b>						232.00
Physical Therapy	15 min	1	8.00	29.00	232.00	
<b>Private Duty Nursing Total:</b>						1848231.00
Private Duty Nursing	15 min	98	1270.00	14.85	1848231.00	
<b>Psychological Evaluation, Counseling and Consultation Services Total:</b>						389326.50
Psychological Evaluation, Counseling and Consultation Services	one hour	45	45.00	192.26	389326.50	
<b>Speech Therapy Total:</b>						952.80
Speech Therapy	hour	1	16.00	59.55	952.80	
<b>Supports Brokerage Total:</b>						2774.16
Supports Brokerage	hour	8	9.00	38.53	2774.16	
<b>Adult Foster Support Total:</b>						2320412.60
adult foster supports	month	40	11.00	4498.55	1979362.00	
residential training supports	hour	17	605.00	33.16	341050.60	
<b>Assisted Living Total:</b>						2976375.15
Assisted Living	daily	35	347.00	245.07	2976375.15	
<b>Behavioral Support Services Total:</b>						1595133.80
Level I	hourly	166	99.00	83.72	1375854.48	
Level II - RBT	hourly	8	289.00	47.87	110675.44	
Level II - IBA	hourly	11	259.00	38.12	108603.88	
<b>Caregiver Training and Support Total:</b>						35148.00
Caregiver					35148.00	
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training and Support	hour	60	10.00	58.58		
<b>Community Transition Services Total:</b>						3000.00
Community Transition Services	one placement	1	1.00	3000.00	3000.00	
<b>Companion Services Total:</b>						3424231.30
Companion Services	hour	266	395.00	32.59	3424231.30	
<b>Environmental Modifications Total:</b>						150471.00
Environmental Modifications	one mod or item	27	1.00	5573.00	150471.00	
<b>Individual Goods and Services Total:</b>						229375.80
Individual Goods and Services	per purchase	270	1.00	849.54	229375.80	
<b>Meals Total:</b>						86397.75
Meals	meal	25	423.00	8.17	86397.75	
<b>Personal Care Total:</b>						25624.00
Personal Care	one hour	1	800.00	32.03	25624.00	
<b>Personal Emergency Response System (PERS) Total:</b>						6600.00
Personal Emergency Response System (PERS)	month	10	12.00	55.00	6600.00	
<b>Personal Supports Total:</b>						4491532.75
Personal Supports	hour	215	755.00	27.67	4491532.75	
<b>Remote Monitoring Equipment Total:</b>						98798.40
Remote Monitoring Equipment	month	40	12.00	205.83	98798.40	
<b>Remote Monitoring Total:</b>						1121608.00
Remote Monitoring	hour	40	3140.00	8.93	1121608.00	
<b>Retirement Services Total:</b>						2878537.40
Retirement Services	hour	109	230.00	114.82	2878537.40	
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Specialized Medical Equipment and Supplies Total:</b>						37040.38
Specialized Medical Equipment and Supplies	year	26	1.00	1424.63	37040.38	
<b>Supported Employment - Co-Worker Support Total:</b>						8100.45
Supported Employment - Co-Worker Support	daily	5	141.00	11.49	8100.45	
<b>Supported Employment - Individual Employment Support Total:</b>						254325.24
Supported Employment - Individual Employment Support	hour	39	124.00	52.59	254325.24	
<b>Supported Employment - Small Group Employment Support Total:</b>						508200.00
Supported Employment - Small Group Employment Support	daily	55	200.00	46.20	508200.00	
<b>Transportation Total:</b>						1423683.00
Transportation	month	787	45.00	40.20	1423683.00	
<b>GRAND TOTAL:</b>						166531851.32
<i>Total Estimated Unduplicated Participants:</i>						2880
<i>Factor D (Divide total by number of participants):</i>						57823.56
<i>Average Length of Stay on the Waiver:</i>						282

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (6 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** 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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Supports and Activities Total:</b>						26809824.60
Day Supports and Activities	daily	1283	188.00	111.15	26809824.60	
<b>Homemaker Total:</b>						82912.74
Homemaker	hour	51	58.00	28.03	82912.74	
<b>Residential Habilitation Total:</b>						108186883.20
Residential Habilitation	daily	1728	335.00	186.89	108186883.20	
<b>Respite Total:</b>						4141358.10
Respite	hour	330	561.00	22.37	4141358.10	
<b>Supported Employment - Follow Along Support Total:</b>						3391003.20
Supported Employment - Follow Along Support	hour	416	155.00	52.59	3391003.20	
<b>Nutritionist Services Total:</b>						3574.08
Nutritionist Services	hour	2	18.00	99.28	3574.08	
<b>Occupational Therapy Total:</b>						183.92
Occupational Therapy	15 min	1	8.00	22.99	183.92	
<b>Physical Therapy Total:</b>						232.00
Physical Therapy	15 min	1	8.00	29.00	232.00	
<b>Private Duty Nursing Total:</b>						1848231.00
Private Duty Nursing	15 min	98	1270.00	14.85	1848231.00	
<b>Psychological Evaluation, Counseling and Consultation Services Total:</b>						389326.50
Psychological Evaluation, Counseling and Consultation Services	hour	45	45.00	192.26	389326.50	
<b>Speech Therapy Total:</b>						952.80
Speech Therapy	hour				952.80	
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1	16.00	59.55		
<b>Supports Brokerage Total:</b>						2774.16
Supports Brokerage	hour	8	9.00	38.53	2774.16	
<b>Adult Foster Support Total:</b>						2320412.60
adult foster supports	month	40	11.00	4498.55	1979362.00	
residential training supports	hour	17	605.00	33.16	341050.60	
<b>Assisted Living Total:</b>						2976375.15
Assisted Living	daily	35	347.00	245.07	2976375.15	
<b>Behavioral Support Services Total:</b>						1595133.80
Level I	hourly	166	99.00	83.72	1375854.48	
Level II - RBT	hourly	8	289.00	47.87	110675.44	
Level II - IBA	hourly	11	259.00	38.12	108603.88	
<b>Caregiver Training and Support Total:</b>						35148.00
Caregiver Training and Support	hour	60	10.00	58.58	35148.00	
<b>Community Transition Services Total:</b>						3000.00
Community Transition Services	one placement	1	1.00	3000.00	3000.00	
<b>Companion Services Total:</b>						3424231.30
Companion Services	hour	266	395.00	32.59	3424231.30	
<b>Environmental Modifications Total:</b>						150471.00
Environmental Modifications	one mod or item	27	1.00	5573.00	150471.00	
<b>Individual Goods and Services Total:</b>						229375.80
Individual Goods and Services	per purchase	270	1.00	849.54	229375.80	
<b>Meals Total:</b>						86397.75
Meals	meal	25	423.00	8.17	86397.75	
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Personal Care Total:</b>						25624.00
Personal Care	hour	1	800.00	32.03	25624.00	
<b>Personal Emergency Response System (PERS) Total:</b>						6600.00
Personal Emergency Response System (PERS)	month	10	12.00	55.00	6600.00	
<b>Personal Supports Total:</b>						4491532.75
Personal Supports	hour	215	755.00	27.67	4491532.75	
<b>Remote Monitoring Equipment Total:</b>						98798.40
Remote Monitoring Equipment	month	40	12.00	205.83	98798.40	
<b>Remote Monitoring Total:</b>						1121608.00
Remote Monitoring	hour	40	3140.00	8.93	1121608.00	
<b>Retirement Services Total:</b>						2878537.40
Retirement Services	hour	109	230.00	114.82	2878537.40	
<b>Specialized Medical Equipment and Supplies Total:</b>						37040.38
Specialized Medical Equipment and Supplies	year	26	1.00	1424.63	37040.38	
<b>Supported Employment - Co- Worker Support Total:</b>						8100.45
Supported Employment - Co-Worker Support	daily	5	141.00	11.49	8100.45	
<b>Supported Employment - Individual Employment Support Total:</b>						254325.24
Supported Employment - Individual Employment Support	hour	39	124.00	52.59	254325.24	
<b>Supported Employment - Small Group Employment</b>						508200.00
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Support Total:</b>						
Supported Employment - Small Group Employment Support	daily	55	200.00	46.20	508200.00	
<b>Transportation Total:</b>						1423683.00
Transportation	month	787	45.00	40.20	1423683.00	
<b>GRAND TOTAL:</b>					166531851.32	
Total Estimated Unduplicated Participants:					2880	
Factor D (Divide total by number of participants):					57823.56	
Average Length of Stay on the Waiver:						282

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** 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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Supports and Activities Total:</b>						26809824.60
Day Supports and Activities	daily	1283	188.00	111.15	26809824.60	
<b>Homemaker Total:</b>						82912.74
Homemaker	hour	51	58.00	28.03	82912.74	
<b>Residential Habilitation Total:</b>						108186883.20
Residential Habilitation	daily	1728	335.00	186.89	108186883.20	
<b>Respite Total:</b>						4141358.10
Respite	hour	330	561.00	22.37	4141358.10	
<b>Supported Employment - Follow Along Support Total:</b>						3391003.20
Supported Employment - Follow Along	hour	416	155.00	52.59	3391003.20	
<b>GRAND TOTAL:</b>					166531851.32	
Total Estimated Unduplicated Participants:					2880	
Factor D (Divide total by number of participants):					57823.56	
Average Length of Stay on the Waiver:						282



Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support						
<b>Nutritionist Services Total:</b>						3574.08
Nutritionist Services	hour	2	18.00	99.28	3574.08	
<b>Occupational Therapy Total:</b>						183.92
Occupational Therapy	15 min	1	8.00	22.99	183.92	
<b>Physical Therapy Total:</b>						232.00
Physical Therapy	15 min	1	8.00	29.00	232.00	
<b>Private Duty Nursing Total:</b>						1848231.00
Private Duty Nursing	15 min	98	1270.00	14.85	1848231.00	
<b>Psychological Evaluation, Counseling and Consultation Services Total:</b>						389326.50
Psychological Evaluation, Counseling and Consultation Services	hour	45	45.00	192.26	389326.50	
<b>Speech Therapy Total:</b>						952.80
Speech Therapy	hour	1	16.00	59.55	952.80	
<b>Supports Brokerage Total:</b>						2774.16
Supports Brokerage	hour	8	9.00	38.53	2774.16	
<b>Adult Foster Support Total:</b>						2320412.60
adult foster supports	month	40	11.00	4498.55	1979362.00	
residential training supports	hour	17	605.00	33.16	341050.60	
<b>Assisted Living Total:</b>						2976375.15
Assisted Living	daily	35	347.00	245.07	2976375.15	
<b>Behavioral Support Services Total:</b>						1595133.80
Level I	hourly	166	99.00	83.72	1375854.48	
Level II - RBT	hourly	8	289.00	47.87	110675.44	
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level II - IBA	hourly	11	259.00	38.12	108603.88	
<b>Caregiver Training and Support Total:</b>						35148.00
Caregiver Training and Support	hour	60	10.00	58.58	35148.00	
<b>Community Transition Services Total:</b>						3000.00
Community Transition Services	one placement	1	1.00	3000.00	3000.00	
<b>Companion Services Total:</b>						3424231.30
Companion Services	hour	266	395.00	32.59	3424231.30	
<b>Environmental Modifications Total:</b>						150471.00
Environmental Modifications	one mod or item	27	1.00	5573.00	150471.00	
<b>Individual Goods and Services Total:</b>						229375.80
Individual Goods and Services	per purchase	270	1.00	849.54	229375.80	
<b>Meals Total:</b>						86397.75
Meals	meal	25	423.00	8.17	86397.75	
<b>Personal Care Total:</b>						25624.00
Personal Care	hour	1	800.00	32.03	25624.00	
<b>Personal Emergency Response System (PERS) Total:</b>						6600.00
Personal Emergency Response System (PERS)	month	10	12.00	55.00	6600.00	
<b>Personal Supports Total:</b>						4491532.75
Personal Supports	hour	215	755.00	27.67	4491532.75	
<b>Remote Monitoring Equipment Total:</b>						98798.40
Remote Monitoring Equipment	month	40	12.00	205.83	98798.40	
<b>Remote Monitoring Total:</b>						1121608.00
Remote Monitoring	hour				1121608.00	
<b>GRAND TOTAL:</b>					166531851.32	
Total Estimated Unduplicated Participants:					2880	
Factor D (Divide total by number of participants):					57823.56	
Average Length of Stay on the Waiver:						282

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		40	3140.00	8.93		
<b>Retirement Services Total:</b>						2878537.40
Retirement Services	hour	109	230.00	114.82	2878537.40	
<b>Specialized Medical Equipment and Supplies Total:</b>						37040.38
Specialized Medical Equipment and Supplies	year	26	1.00	1424.63	37040.38	
<b>Supported Employment - Co-Worker Support Total:</b>						8100.45
Supported Employment - Co-Worker Support	daily	5	141.00	11.49	8100.45	
<b>Supported Employment - Individual Employment Support Total:</b>						254325.24
Supported Employment - Individual Employment Support	hour	39	124.00	52.59	254325.24	
<b>Supported Employment - Small Group Employment Support Total:</b>						508200.00
Supported Employment - Small Group Employment Support	daily	55	200.00	46.20	508200.00	
<b>Transportation Total:</b>						1423683.00
Transportation	month	787	45.00	40.20	1423683.00	
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (8 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** 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. 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**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Supports and Activities Total:</b>						26809824.60
Day Supports and Activities	daily	1283	188.00	111.15	26809824.60	
<b>Homemaker Total:</b>						82912.74
Homemaker	hour	51	58.00	28.03	82912.74	
<b>Residential Habilitation Total:</b>						108186883.20
Residential Habilitation	daily	1728	335.00	186.89	108186883.20	
<b>Respite Total:</b>						4141358.10
Respite	hour	330	561.00	22.37	4141358.10	
<b>Supported Employment - Follow Along Support Total:</b>						3391003.20
Supported Employment - Follow Along Support	hour	416	155.00	52.59	3391003.20	
<b>Nutritionist Services Total:</b>						3574.08
Nutritionist Services	hour	2	18.00	99.28	3574.08	
<b>Occupational Therapy Total:</b>						183.92
Occupational Therapy	15 min	1	8.00	22.99	183.92	
<b>Physical Therapy Total:</b>						232.00
Physical Therapy	15 min	1	8.00	29.00	232.00	
<b>Private Duty Nursing Total:</b>						1848231.00
Private Duty Nursing	15 min	98	1270.00	14.85	1848231.00	
<b>Psychological Evaluation, Counseling and Consultation Services Total:</b>						389326.50
Psychological Evaluation, Counseling and Consultation Services	hour	45	45.00	192.26	389326.50	
<b>Speech Therapy Total:</b>						952.80
Speech Therapy	hour				952.80	
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1	16.00	59.55		
<b>Supports Brokerage Total:</b>						2774.16
Supports Brokerage	hour	8	9.00	38.53	2774.16	
<b>Adult Foster Support Total:</b>						2320412.60
adult foster supports	month	40	11.00	4498.55	1979362.00	
residential training supports	hour	17	605.00	33.16	341050.60	
<b>Assisted Living Total:</b>						2976375.15
Assisted Living	daily	35	347.00	245.07	2976375.15	
<b>Behavioral Support Services Total:</b>						1595133.80
Level I	hourly	166	99.00	83.72	1375854.48	
Level II - RBT	hourly	8	289.00	47.87	110675.44	
Level II - IBA	hourly	11	259.00	38.12	108603.88	
<b>Caregiver Training and Support Total:</b>						35148.00
Caregiver Training and Support	hour	60	10.00	58.58	35148.00	
<b>Community Transition Services Total:</b>						3000.00
Community Transition Services	one placement	1	1.00	3000.00	3000.00	
<b>Companion Services Total:</b>						3424231.30
Companion Services	hour	266	395.00	32.59	3424231.30	
<b>Environmental Modifications Total:</b>						150471.00
Environmental Modifications	one mod or item	27	1.00	5573.00	150471.00	
<b>Individual Goods and Services Total:</b>						229375.80
Individual Goods and Services	per purchase	270	1.00	849.54	229375.80	
<b>Meals Total:</b>						86397.75
Meals	meal	25	423.00	8.17	86397.75	
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Personal Care Total:</b>						25624.00
Personal Care	hour	1	800.00	32.03	25624.00	
<b>Personal Emergency Response System (PERS) Total:</b>						6600.00
Personal Emergency Response System (PERS)	month	10	12.00	55.00	6600.00	
<b>Personal Supports Total:</b>						4491532.75
Personal Supports	hour	215	755.00	27.67	4491532.75	
<b>Remote Monitoring Equipment Total:</b>						98798.40
Remote Monitoring Equipment	month	40	12.00	205.83	98798.40	
<b>Remote Monitoring Total:</b>						1121608.00
Remote Monitoring	hour	40	3140.00	8.93	1121608.00	
<b>Retirement Services Total:</b>						2878537.40
Retirement Services	hour	109	230.00	114.82	2878537.40	
<b>Specialized Medical Equipment and Supplies Total:</b>						37040.38
Specialized Medical Equipment and Supplies	year	26	1.00	1424.63	37040.38	
<b>Supported Employment - Co- Worker Support Total:</b>						8100.45
Supported Employment - Co-Worker Support	daily	5	141.00	11.49	8100.45	
<b>Supported Employment - Individual Employment Support Total:</b>						254325.24
Supported Employment - Individual Employment Support	hour	39	124.00	52.59	254325.24	
<b>Supported Employment - Small Group Employment</b>						508200.00
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Support Total:</b>						
Supported Employment - Small Group Employment Support	daily	55	200.00	46.20	508200.00	
<b>Transportation Total:</b>						1423683.00
Transportation	month	787	45.00	40.20	1423683.00	
<b>GRAND TOTAL:</b>					166531851.32	
Total Estimated Unduplicated Participants:					2880	
Factor D (Divide total by number of participants):					57823.56	
Average Length of Stay on the Waiver:						282

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (9 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** 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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Supports and Activities Total:</b>						26809824.60
Day Supports and Activities	daily	1283	188.00	111.15	26809824.60	
<b>Homemaker Total:</b>						82912.74
Homemaker	hour	51	58.00	28.03	82912.74	
<b>Residential Habilitation Total:</b>						108186883.20
Residential Habilitation	daily	1728	335.00	186.89	108186883.20	
<b>Respite Total:</b>						4141358.10
Respite	hour	330	561.00	22.37	4141358.10	
<b>Supported Employment - Follow Along Support Total:</b>						3391003.20
Supported Employment - Follow Along	hour	416	155.00	52.59	3391003.20	
<b>GRAND TOTAL:</b>					166531851.32	
Total Estimated Unduplicated Participants:					2880	
Factor D (Divide total by number of participants):					57823.56	
Average Length of Stay on the Waiver:						282

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support						
<b>Nutritionist Services Total:</b>						3574.08
Nutritionist Services	hour	2	18.00	99.28	3574.08	
<b>Occupational Therapy Total:</b>						183.92
Occupational Therapy	15 min	1	8.00	22.99	183.92	
<b>Physical Therapy Total:</b>						232.00
Physical Therapy	15 min	1	8.00	29.00	232.00	
<b>Private Duty Nursing Total:</b>						1848231.00
Private Duty Nursing	15 min	98	1270.00	14.85	1848231.00	
<b>Psychological Evaluation, Counseling and Consultation Services Total:</b>						389326.50
Psychological Evaluation, Counseling and Consultation Services	hour	45	45.00	192.26	389326.50	
<b>Speech Therapy Total:</b>						952.80
Speech Therapy	hour	1	16.00	59.55	952.80	
<b>Supports Brokerage Total:</b>						2774.16
Supports Brokerage	hour	8	9.00	38.53	2774.16	
<b>Adult Foster Support Total:</b>						2320412.60
adult foster supports	month	40	11.00	4498.55	1979362.00	
residential training supports	hour	17	605.00	33.16	341050.60	
<b>Assisted Living Total:</b>						2976375.15
Assisted Living	daily	35	347.00	245.07	2976375.15	
<b>Behavioral Support Services Total:</b>						1595133.80
Level I	hourly	166	99.00	83.72	1375854.48	
Level II - RBT	hourly	8	289.00	47.87	110675.44	
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282



Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level II - IBA	hourly	11	259.00	38.12	108603.88	
<b>Caregiver Training and Support Total:</b>						35148.00
Caregiver Training and Support	hour	60	10.00	58.58	35148.00	
<b>Community Transition Services Total:</b>						3000.00
Community Transition Services	one placement	1	1.00	3000.00	3000.00	
<b>Companion Services Total:</b>						3424231.30
Companion Services	hour	266	395.00	32.59	3424231.30	
<b>Environmental Modifications Total:</b>						150471.00
Environmental Modifications	one mod or item	27	1.00	5573.00	150471.00	
<b>Individual Goods and Services Total:</b>						229375.80
Individual Goods and Services	per purchase	270	1.00	849.54	229375.80	
<b>Meals Total:</b>						86397.75
Meals	meal	25	423.00	8.17	86397.75	
<b>Personal Care Total:</b>						25624.00
Personal Care	hour	1	800.00	32.03	25624.00	
<b>Personal Emergency Response System (PERS) Total:</b>						6600.00
Personal Emergency Response System (PERS)	month	10	12.00	55.00	6600.00	
<b>Personal Supports Total:</b>						4491532.75
Personal Supports	hour	215	755.00	27.67	4491532.75	
<b>Remote Monitoring Equipment Total:</b>						98798.40
Remote Monitoring Equipment	month	40	12.00	205.83	98798.40	
<b>Remote Monitoring Total:</b>						1121608.00
Remote Monitoring	hour				1121608.00	
<b>GRAND TOTAL:</b>					166531851.32	
Total Estimated Unduplicated Participants:					2880	
Factor D (Divide total by number of participants):					57823.56	
Average Length of Stay on the Waiver:						282

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		40	3140.00	8.93		
<b>Retirement Services Total:</b>						2878537.40
Retirement Services	hour	109	230.00	114.82	2878537.40	
<b>Specialized Medical Equipment and Supplies Total:</b>						37040.38
Specialized Medical Equipment and Supplies	year	26	1.00	1424.63	37040.38	
<b>Supported Employment - Co- Worker Support Total:</b>						8100.45
Supported Employment - Co-Worker Support	daily	5	141.00	11.49	8100.45	
<b>Supported Employment - Individual Employment Support Total:</b>						254325.24
Supported Employment - Individual Employment Support	hour	39	124.00	52.59	254325.24	
<b>Supported Employment - Small Group Employment Support Total:</b>						508200.00
Supported Employment - Small Group Employment Support	daily	55	200.00	46.20	508200.00	
<b>Transportation Total:</b>						1423683.00
Transportation	monthly	787	45.00	40.20	1423683.00	
<b>GRAND TOTAL:</b>						166531851.32
Total Estimated Unduplicated Participants:						2880
Factor D (Divide total by number of participants):						57823.56
Average Length of Stay on the Waiver:						282