following the reimbursement of self-directed services to help decision makers in determining if adjustments are needed in spending patterns to prevent a shortfall, or if underutilization of services is taking place.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR □431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The W-5 Freedom of Choice and Consent form is completed annually for all recipients in the waiver. This form requires the Family Support Specialist, or the Quality Improvement Specialist to explain the right to fair hearing in the event the recipient or family is denied the provider or service of choice. In addition to the W-5 form, the Explanation of ICF/MR Services and Fair Hearing Rights form provides more detail regarding the fair hearing process and the process used by the Department to commit persons to the State ICF-MR. This form is also used to ensure consistency in the sharing of this information with recipients and others. ARM 37.34.918 outlines the choice of services and choice of provider protections afforded to waiver recipients. ARM 37.34.919 outlines the Fair Hearing process used by the Department. Not all Department decisions can be appealed, as outlined in 37.34.902. Legal clarification of 37.34.902 follows:

37.5.131 DEPARTMENT HEARING PROCEDURES, SCOPE, AND SUBORDINATION TO CERTAIN OTHER LAW
(1) There is no right to a hearing in any matter except as specifically provided by law, including department rule.
(2) There is no right to a hearing in a contract dispute between the department and any other person or entity except as specifically provided by the terms of the contract or as specifically provided by state law.
(3) The rules in this chapter are subject to the provisions of any applicable federal statute or regulation, whether now in existence or hereafter adopted.
(4) The rules in this chapter are subject to any other provision of Montana statute or department rule applicable to the particular program or matter at issue.

Interpretation of 37.5.131- This language is for the purpose of recognizing that mandatory federal provisions for federally authorized programs are to be implemented and will govern over contrary language in the Department's general rule set. This preemption is inclusive of program specific fair hearing rules that are expressly cross-referenced in the general fair hearing rules such as the ARM 37.34.919 referenced in the context of ARM 37.5.115. ARM 37.5.115 references hearing rights for Developmental Disabilities Programs as follows:

(1) Hearings relating to the Developmental Disability Services program are available as follows:
(d) hearings contesting adverse department determinations regarding services under the Medicaid Home and Community Services program for persons with developmental disabilities are available to the extent provided and according to the procedures specified in ARM 37.5.304, 37.5.307, 37.5.310, 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, subject to the provisions of ARM 37.34.919;

37.34.918 MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: INFORMING BENEFICIARY OF CHOICE (1) A person determined by the department to require the level of care provided in an ICF/MR must be given a choice between placement in an ICF/MR or in the medicaid home and community services program.
(2) The person or legal representative must be informed of the feasible alternatives in the community, if any, available under the medicaid home and community services program. (History: Sec. 53-2-201, 53-6-113, 53-6-402 and 53-20-204, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-402 and 53-20-205, MCA; NEW, 1992 MAR p. 1490, Eff. 7/17/92; TRANS, from SRS, 1998 MAR p. 3124.)

37.34.919 MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: NOTICE AND FAIR HEARING (1) The department will provide written notice to applicants for and recipients of medicaid home and community services when determinations are made by the department concerning their status pertaining to level of care and selection or denial for placement.

(a) The department will provide a recipient with notice 10 working days before termination of services due to a determination of ineligibility.
(2) The department will provide a recipient at least 30 calendar days notice before any termination or reduction of services due to limitations upon services or insufficient program funds, as provided in ARM 37.34.902(4).
(3) A person aggrieved by an adverse department determination for a level of care determination finding the person ineligible for services may request a fair hearing as provided in 37.5.304, 37.5.305, 37.5.307, 37.5.310, 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) A person may request a review and a fair hearing as provided in ARM 37.34.335 for a non-selection or denial of a service made by the department. A person may not appeal a termination or reduction in services undertaken by the department in accordance with ARM 37.34.902(4). (History: Sec. 53-2-201, 53-6-113, 53-6-402 and 53-20-204, MCA; IMP, Sec. 53 2-201, 53-6-101, 53-6-402 and 53-20-205, 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.)

37.34.902 MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: GENERALLY (1) The medicaid home and community services program for persons who are developmentally disabled serves persons:
(a) who would otherwise require the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR); and
(b) for whom services provided through the medicaid home and community services program will not jeopardize the person's health and safety.
(2) Eligibility of applicants for the medicaid home and community services program is determined as provided in ARM 37.34.906.
(3) Placement into medicaid home and community services is determined as provided in ARM 37.34.301, et seq.
(4) Services and placements in services through the medicaid home and community services program are available only to the extent that the federal approval of the state's program permits and that available funding allows.
(5) The department, in order to comply with federal requirements or to limit expenditures to available funding, may:
(a) reduce the number of medicaid recipients that may be served under the program;
(b) postpone or waive implementation of a particular service of the program; or
(c) eliminate one or more of the services of the program. (History: Sec. 53-2-201, 53-6-113, 53-6-402 and 53 20-204, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-402 and 53 20-205, 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.)

Payment for services during an appeal:

ARM 37.34.919(4), above, does not provide for termination or reduction of services to individuals. This rule is applicable only to groups or classes of recipients should across the board reduction or terminations of specific services occur due to budget constraints or legislative actions or should expiration, termination or reduction of a waiver occur.

ARM 37.34.919 (3) provides for fairing hearings due to adverse determinations for individual recipients and allows for continuation of services during the appeal process. In specific it references ARM 37.5.316 which provides that:

(3) If a claimant requests a hearing within the period between the date of the notice and the date of the adverse action and the claimant is receiving benefits at that time, at the request of the claimant benefits shall be continued until the earlier of the expiration of the current eligibility or authorization period or issuance of a hearing decision except as provided in (7) and (8) of this rule.

ARM 37.34.316 (13) outlines the individual□s responsibility to pay for services received during the appeal process:

(13) Benefits paid to a claimant pending a hearing decision are subject to recovery by the department if the adverse action is sustained.

The disposition of services pending the resolution of the appeal process and/or fair hearing process follows:

Pre-existing services remain ongoing during the appeal and fair hearing process. Denial of eligibility is subject to the protections of the Administrative Rules of Montana as outlined in 37.34.919, above. Any denial of a requested service based on the plan of care process is subject to DDP administrative review and/or Department fair hearing, as outlined in ARM 37.34.1114, preceding. All dispute resolution issues coming to the DDP for initial review are assigned to the DDP field services bureau chief for action and tracking purposes. Records of Department fair hearings, DDP administrative reviews and outcomes are maintained by the DDP community services bureau chief.

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, in accordance with ARM 37.34.1114 and 37.34.1115. Other disputes may be addressed via provider client grievance procedures. Providers are to maintain internal dispute resolution policies in accordance with ARM 37.43.109. Under no circumstances would a waiver recipient forfeit the right to a fair hearing. The following IP rule applies to the IFSP process applicable to all family based children's waiver services.

37.34.1114 INDIVIDUAL PLAN: DECISION MAKING
(1) All decisions of an individual planning team must be made by consensus.
(2) If an individual planning team does not have consensus on a matter, the team must adjourn for no more than 5 working days, to allow time for possible resolution of the matter at issue.
(3) A team member who disagrees with the plan or wishes to comment on a matter in the plan, must notify the case manager in writing within 5 working days of receipt of the plan or modification to the plan.
(4) The case manager must schedule an individual planning meeting within 5 working days of receiving written notice that a team member disagrees with the plan or a modification to the plan.
(5) At the individual planning meeting held to reconsider a matter upon which there is disagreement, if a consensus is not reached, the unresolved issues must be clearly stated in the meeting summary. The written summary is sent to each team member.
(6) Each individual planning team member who wishes to express a view point about issues upon which there is disagreement must submit the reasons for agreement or disagreement in writing to the case manager. The case manager must send a cover letter outlining the issues to the regional manager within 10 working days of the previous individual planning meeting. The meeting summary and any written materials submitted by team members are to accompany the letter.
(7) The regional manager, within 10 days of the receipt of a letter from a case manager relating to an appeal, reviews the matter at issue, and after consideration of the meeting summary and any written materials submitted by team members, arrives at a decision in the matter.
(8) If any individual planning team member is dissatisfied with the decision of the regional manager, the team member must notify the case manager in writing within 5 working days of receipt of the regional manager's deci¬sion. The case manager must refer the appeal immediately to the individual planning appeal committee as provided in ARM 37.34.1115(3).
(10) The decision of the individual planning appeal committee is the final administrative decision of the department. (History: Sec. 53-2-201 and 53-20-204, MCA; IMP, Sec. 53-20-203, MCA; NEW, 1993 MAR p. 1353, Eff. 6/25/93; AMD, 1996 MAR p. 2188, Eff. 8/9/96; TRANS, from SRS, 1998 MAR p.

37.34.1115 INDIVIDUAL PLAN: INDIVIDUAL PLANNING APPEAL COMMITTEE (1) The individual planning appeal committee is appointed by the administrator of the disability services program.
(2) The individual planning appeal committee is composed of:
(a) an individual receiving services;
(b) a parent, guardian or advocate;
(c) case manager; and
(d) a service provider.
(3) A representative of the developmental disabilities program central office is responsible for coordinating the

activities of the appeal committee.
(4) The appeal committee must establish and make available its own operating procedures. (History: Sec. 53 2 201 and 53-20-204, MCA; IMP, Sec. 53-20-203, MCA; NEW, 1993 MAR p. 1353, Eff. 6/25/93; AMD, 1996 MAR p. 2188, Eff. 8/9/96; TRANS, from SRS, 1998 MAR p. 3124.)

37.34.109 CLIENT GRIEVANCE PROCEDURE (1) A provider shall maintain a written grievance procedure by which a client may file a complaint. A current copy of such procedure must be approved by the department.
(2) Upon entry into a program and at least every 6 months thereafter, a client must be advised by the provider of the right to present grievances. The provider shall assist clients, as may be necessary, in utilizing the grievance procedure.
(3) If the outcome of the grievance procedure is adverse to a client, the provider shall notify the person of his or her right to appeal to the department under the department's fair hearing procedure. (History: Sec. 53-20-204, MCA; IMP, Sec. 53-20-205, MCA; NEW, 1979 MAR p. 1711, Eff. 12/28/79; TRANS, from SRS, 1998 MAR p. 3124.)

Additional clarification related to dispute resolution:

Disputes related to the denial of eligibility for services could result in a request for a DDP administrative review and, depending upon the outcome, a Department fair hearing. Parents of children who do not meet the eligibility requirements for CAW services would learn of their right to appeal and fair hearing rights via the E&D contractor's letter of ineligibility. For families of children enrolled in the waiver, the plan of care serves as the basic forum for dispute resolution. The plan of care is designed to address all facets of a service recipient's life. Typically, the provider internal grievance policy is enacted when there is failure to achieve IFSP team consensus on an issue affecting the child or family. Adverse actions not resolved by the provider's internal grievance policy would lead to a DDP administrative review and ultimately, a Department fair hearing. The client always retains the right to proceed directly to Department fair hearing, as outlined on the DDP Waiver-5 form.

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:*