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 waiver's 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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The significant changes to the approved waiver that are being made in this renewal application are as follows:

1) Adding the availability of a Self Determination option.
2) Adding Ravalli County to Missoula Service area.
3) Removing the underutilized service of Day Habilitation.
4) Additional services that may be removed or reduced in number of units due to minimal utilization are Respite, per diem; and Personal Assistance, per diem.
5) Moving the Wellness and Recovery Action Plan (WRAP), and the Illness and Management Recovery (IMR), to the Health and Wellness service.
6) Adding the Environmental Accessibility Adaptations services and Peer Services. Deleted Psychosocial Consultation and Counseling and replaced with Consultative Clinical and Therapeutic Services.
7) Moving the members funded under the Money Follows the Person grant to the SDMI Waiver on day 366 of the program.
8) The addition of the waiver-specific HCBS Transition Plan to bring the SDMI waiver into compliance with federal regulations issued by the Centers for Medicare and Medicaid Services on March 17, 2014, defining permissible Home and Community Based settings.
9) Due to public comments the Adult Day Health will remain as a service. In FY 2015, the providers have started utlizing this service.

The possible additions to the SDMI waiver slots have not been added to the waiver renewal application. The state is waiting on final approval from House Appropriations and passage of HB 2.

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*):
Behavioral Health Severe and Disabling Mental Illness Home and Community Based Services
C. **Type of Request: renewal**

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.0455
Draft ID: MT.013.02.00

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

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/15

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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 Eligiblity 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 Behavioral Health Waiver for Adults with Severe Disabling Mental Illness (SDMI Waiver) is designed to provide an individual with SDMI a choice of receiving long term care services in a community setting as an alternative to receiving long term care services in a nursing home setting. The individual with SDMI must meet nursing home level of care and reside in an area of the state where the SDMI Waiver is available.

The objective of the SDMI Waiver is rehabilitation and recovery, while encouraging the individual to accept personal responsibility for services and desired outcomes. The State will ensure the providers of HCBS services possess and demonstrate the capability to effectively serve individuals with SDMI.

Concurrently, another goal includes providing quality care while maintaining financial accountability. SDMI Waiver providers will be enrolled Montana Medicaid providers and all payments will occur through the MMIS. The providers of waiver services receive payments directly and providers retain 100% of these payments. Public and non-public providers receive the same amount of Medicaid reimbursement. There are no intergovernmental transfer policies or certified public expenditures of non-state public agencies included within the SDMI Waiver.

The goal of providing quality care while maintaining financial accountability will be accomplished by:
-Conducting quality assurance reviews;
-Conducting satisfaction surveys with waiver participants;
-Completing regular audits of SDMI Waiver providers' records for compliance;
-Providing training/education to all waiver providers; and
-Monitoring all waiver expenditures.

The SDMI Waiver will not be available statewide and will be located in five geographical areas based on an urban core. Those areas are Yellowstone County (including counties of Big Horn, Carbon, Stillwater and Sweet Grass), Silver Bow County (including counties of Beaverhead, Deer Lodge, Granite,Powell, and southern Jefferson) and Cascade County (including counties of Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Phillips, Teton and Toole), Missoula County (including Ravalli), and Lewis and Clark County (including northern Jefferson County).

The package of services to be included in the SDMI waiver are: Adult Day Health, Case Management, Supported Living, Personal Assistance and Specially Trained Attendant Care, Habilitation and Residential Habilitation as a sub-category, Homemaking,Peer Support, Respite Care, Outpatient Occupational Therapy, Consultative Clinical and Therapeutic services including extended Mental Health Services, Substance-Use Related Disorder services, Dietetic and Nutrition Services, Nursing Services, Personal Emergency Response Systems, Specialized Medical Equipment and Supplies, Non-Medical

Transportation, Community Transition, Pain and Symptom Management, Environmental Accessibility Adaptations, and Health and Wellness which includes Illness Management and Recovery; and Wellness Recovery Action Plan. Services are reimbursed fee for service; there is no managed mental health plan.

The Department of Public Health and Human Services, Addictive and Mental Disorders Division is the lead agency for the operation of the SDMI waiver. The State Medicaid Director is the Branch Manager for the Department of Public Health and Human Services.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

○ **Not Applicable**

○ **No**

◉ Yes

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

○ No

◉ Yes

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

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

The SDMI Waiver will not be available statewide and will be located in five geographical areas based on an urban core. Those areas are Yellowstone County (including counties of Big Horn, Carbon, Stillwater and Sweet Grass), Silver Bow County (including counties of Beaverhead, Deer Lodge, Granite, Powell, and southern Jefferson), Cascade County (including counties of Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, Phillips and Toole), Missoula County (including Ravalli county), and Lewis and Clark County (including northern Jefferson).

☑ **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:

The SDMI Waiver will not be available statewide and will be located in five geographical areas based on an urban core. Those areas are Yellowstone County (including counties of Big Horn, Carbon, Stillwater and Sweet Grass), Silver Bow County (including counties of Beaverhead, Deer Lodge, Granite, Powell, and southern Jefferson), Cascade County (including counties of Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, Phillips and Toole), Missoula County (including Ravalli County), and Lewis and Clark County (including northern Jefferson).

5. Assurances

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

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

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

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

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

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

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

based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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

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

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

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

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 in-

patients 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 Input for Initial Approval of Waiver - Effective December 1, 2006 included the following:
Service Area Authorities (SAA) were established by the Montana Legislature as stakeholder entities for the purpose of collaboration with the Department of Public Health and Human Services (Department) for planning and oversight of mental health services. There are three SAAs, each of which has a board of directors with a majority of members who are individuals with mental illness and family members. The Addictive and Mental Disorders Division has met with each of the SAA Boards as well as with a group of individuals with mental illness delegates regarding the development of the waiver. Information will be posted on the Department's website for the general public's review and opportunity to comment. Administrative Rules of Montana have been proposed and, as part of the state's required review process, a public hearing has been held to provide information about the waiver and to solicit oral and written comments before the proposed rules are finalized.

The Department notified in writing all federally-recognized Tribal Governments regarding the intent to submit an application for a home and community based services waiver. The Tribal entities were notified officially on July 3, 2006 and provided 30 days to submit their comments and views. The Department offered to meet with Tribal entities at their request.

For the proposed amendment Administrative Rules of Montana have been proposed, a public hearing was held May 2012 to solicit oral and written comments. The Department notified in writing the federally recognized Tribal Governments in regards to the proposed amendment. The Tribal entities were notified officially on January 20, 2012.

The renewal application to be effective July 1, 2015 notified in writing all federally recognized Tribal Governments, Montana Health Coalition and interested parties on February 18, 2015. Public notices were printed, February 15, 2015, in three of the major daily newspapers for Montana. Letters were sent to Mental Health Advisory Council, Local Advisory Councils, Service Area Authorities, Mental Health Centers, waiver participants and providers on February 19, 2015. The application is available through the Addictive and Mental Disorders Division website or upon request a hard copy will be made available. A public meeting was held on February 26, 2015 to discuss the SDMI waiver renewal and transition plan. The renewal application and transition plan were made available for review February 21, 2015 at the AMDD website. A public comment form was included on this website to offer the public another convenient way to comment. The State, upon request, made hard copies available of the renewal application and transition plan. A second public notice was sent to the federally recognized Tribal Governments, Montana Health Coalition and interested parties on February 27, 2015. Letters were sent to the Mental Health Advisory Council, Local Advisory Councils, Service Area Authorities, Mental Health Centers, waiver participants, and providers on February 27, 2015. The second notice included the addition of Peer Support, replacing Consultation with Consultative Clinical and Therapeutic Services, and additional service that may be deleted or reduce in utilization is Day Habilitation. The public comment period was February 21 through March 24, 2015. The public comment period was extended through March 30, 2015. Public comments were summarized and addressed.

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:	Armstrong
First Name:	Marcia
Title:	Mental Health Medicaid Program Manager
Agency:	Montana Department of Public Health and Human Services Addictive and Mental Disorde
Address:	PO Box 202905
Address 2:	100 North Park Avenue, Suite 300
City:	Helena
State:	Montana
Zip:	59620-2905
Phone:	(406) 444-2878 **Ext:** [ ] **TTY**
Fax:	(406) 444-4435
E-mail:	marmstrong@mt.gov

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

Last Name: Kulawik

First Name: Mary Eve

Title: Medicaid State Plan Amendment and Waiver Coordinator

Agency: Department of Public Health and Human Services

Address: PO Box 4210

Address 2: 111 N. Sanders

City: Helena

State: Montana

Zip: 59604

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

Fax: (406) 444-1970

E-mail: mkulawik@mt.gov

8. Authorizing Signature

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Dalton

First Name: Mary E

Title: State Medicaid Director

Agency: Department of Public Health and Human Services

Address: PO Box 4210

Address 2: 111 N. Sanders

City: Helena
State: Montana
Zip: 59604
Phone: (406) 444-4084 **Ext:** ☐ TTY
Fax: (406) 444-1970
E-mail: mdalton@mt.gov

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☑ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Decision made to eliminate Day Habilitation service. This service had not been utilized for the last two Fiscal Years.

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.

Rule Overview

The Centers for Medicare and Medicaid Services (CMS) issued a final rule, effective March 17, 2014, which sets new requirements for states offering home and community-based long term services and supports. The new rule defines requirements for the person-centered planning process; person-centered service plan; review of the person-centered service plan; the qualities of home and community-based settings; assurances of compliance with the requirements; and transition

plans to achieve compliance with the requirements. The rule also identifies settings that are not home and community-based (42 CFR §441.301).
Each state that operates a Home and Community-Based Service (HCBS) waiver under 1915(c), or a State Plan under 1915(i), of the Social Security Act that was in effect on or before March 17, 2014, is required to file a Statewide Transition Plan, hereinafter referred to as the Statewide Settings Transition Plan. The Statewide Settings Transition Plan must be filed within 120 days of the first 1915(c) waiver renewal or 1915(i) State Plan Amendment (SPA) that is submitted to CMS after the effective date of the rule (March 17, 2014), but not later than March 17, 2015. The Statewide Settings Transition Plan must either provide assurances of compliance with 42 CFR §441.301 or set forth the actions that the State will take to bring each 1915(c) HCBS waiver and 1915(i) State Plan into compliance by March 17, 2019, and detail how the State will continue to operate all 1915(c) HCBS waivers and 1915(i) State Plans in accordance with the new requirements.

What does the new Rule Means
As indicated in the informational summary that accompanied Montana's statewide HCBS transition plan, the overarching theme of the rule is: "The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS."
The rule also requires that the setting:
• Is selected by the individual from options that include non-disability specific settings and options for private units. Individuals must also have choice regarding the services they receive and by whom the services are provided.
• Ensures the individual right of privacy, dignity and respect, and freedom from coercion and restraint.
• Optimizes independence and autonomy in making life choices without regimenting such things as daily activities, physical environment, and with whom the individual interacts.

When a residential setting is owned or controlled by a service provider, additional requirements must be met:
• At a minimum, the individual has the same responsibilities and protections from eviction that tenants have under state or local landlord/tenant laws; or when such laws do not apply, a lease, or other written residency agreement must be in place for each HCBS participant to provide protections that address eviction processes and appeals comparable to the applicable landlord/tenant laws.
• Each individual has privacy in their sleeping or living unit. This includes having entrance doors which can be locked by the individual with only appropriate staff having keys; individuals having a choice of roommates in shared living arrangements; and having the freedom to furnish and decorate their own sleeping or living areas.
• Individuals have the freedom and support to control their own schedules and activities, including having access to food and having visitors of their choosing.

These requirements may only be modified when an individual has a specific assessed need that justifies deviation from a requirement. In such cases, the need must be supported in the HCBS person-centered service plan.

The Department of Public Health and Human Services (DPHHS) submitted Montana's statewide transition plan to CMS on December 12, 2014. Montana's transition plan addresses the areas of public input, assessment, remediation, and program administration.. DPHHS will partner with Medicaid members, providers and provider associations, advocates and other stakeholders throughout this process to allow for input into the process and to assure that members and providers have access to needed information to assist with transition activities. The final outcome will be that Medicaid members will be served in a manner that will enable them to live and thrive in integrated community settings.

As required by CMS, Montana is submitting a transition plan specific to its 1915(c) Behavioral Health Severe and Disabling Mental Illness (SDMI) Home and Community Based Waiver.

Public Input
A public meeting was held to discuss the SDMI Waiver renewal and the transition plan on February 26, 2015 from 9:00 am to 10:30 am, at the Sanders Auditorium, 111 N. Sanders Avenue, Helena, Montana. The public meeting could also be accessed by webinar at https://hhsmt.webex.com/hhsmt and a toll free number. The renewal application to be effective July 1, 2015 notified in writing all federally recognized Tribal Governments, Montana Health Coalition and interested parties on February 18, 2015. Public notices were printed, February 15, 2015, in three of the major daily newspapers for Montana. Letters were sent to Mental Health Advisory Council, Local Advisory Councils, Service Area Authorities, Mental Health Centers, waiver participants and providers on February 19, 2015. The application is available through the Addictive and Mental Disorders Division website or upon request a hard copy will be made available. A public meeting was held on February 26, 2015 to discuss the SDMI waiver renewal and transition plan. The renewal application and transition plan were made available for review February 21, 2015 at the AMDD website. A public comment form was included on this website to offer the public another convenient way to comment. The State, upon request, made hard copies available of the renewal appplication and transition plan. A second public notice was sent to the federally recognized Tribal Governments, Montana Health Coalition and interested parties on February 27, 2015. Letters were sent to the Mental Health Advisory Council,

Local Advisory Councils, Service Area Authorities, Mental Health Centers, waiver participants, and providers on February 27, 2015. The second notice included the addition of peer services, replacing Consultation with Consultative Clinical and Therapeutic Services, and additional service that may be deleted or reduce in utilization is day habilitation. The public comment period was February 21 through March 24, 2015. The public comment period was extended through March 30, 2015. Public comments were summarized and addressed.

Assessment
States are required to review and analyze all settings in which Medicaid HCBS are delivered and settings in which individuals receiving Medicaid HCBS services reside, and to report the results to CMS. Montana is planning a multi-faceted approach to assessment. This began with a high-level assessment of the types of settings where HCBS are provided. This stage did not identify specific providers or locations, but identified general categories of settings that are likely to be in compliance, and settings that are not yet, but could become compliant. (See Attached Chart with High Level Settings Analysis)

In addition to assessing State standards, requirements and practices, DPHHS must also assess compliance at the provider and, in particular, at the individual provider level on an ongoing basis.

Other planned avenues for assessment include:
• Development of a provider self-assessment tool to compile baseline HCBS compliance information
• State analysis of provider self-assessments and on-site reviews to evaluate for validity and determine compliance;
• Development of a member assessment tool to compile setting satisfaction information and incorporation of this survey/assessment tool into ongoing quality assurance review processes;
• Development of a tool to standardize and incorporate assessment of settings into the HCBS quality assurance onsite review process.

The tools developed will address questions recommended by CMS as part of the assessment process and, as such, are based on the nature and quality of the experience of individuals supported by that agency/facility. Each of these assessments will help determine which programs/settings are in compliance and which ones need some changes to come into compliance. As the assessment process is completed for a setting, DPHHS will notify the provider of the results.

The provider self-assessment tool will be made available to providers, stakeholders, advocates, beneficiaries of waiver services, and interested parties for review and comments as part of the ongoing public notice process. Because all DPHHS waivers share many of the same providers, the SDMI Waiver provider self-assessment process will be done in collaboration with the other department waiver staff.

DPHHS may also assess individual settings/types of settings to further document compliance.
The Department has not made a decision on the process to be used to conduct specific site evaluations.

The Department will be developing a member experience survey that will be distributed to members, stakeholders, advocates, providers and interested parties for review and comments in the ongoing public notice process. The member survey will have the similar questions recommended by CMS for their perspective of the settings.

Remediation
DPHHS will take a series of steps to guide providers in making the transition to full compliance with HCBS settings, such as informational letters, updates to the Administrative Rules of Montana and provider manuals, and other targeted communications.

For settings that are found not to be in compliance, the provider will be required to submit a corrective action plan to DPHHS that describes the steps to be taken and expected timelines to achieve compliance. Consideration of corrective action plans by the State will take into account the scope of the transition to be achieved and the unique circumstances related to the setting in question.

In order to continue to receive federal Medicaid funds for waiver services, Montana must comply with the "settings" requirements. If a provider is unable or unwilling to remediate a setting, it may be necessary to transition an individual to a compliant setting. In any instance where an individual would need to move to an alternate setting, the individual will be given timely notice, notified of opportunity for a fair hearing, and afforded a choice of alternative providers through the person-centered planning process.

Program Administration
DPHHS is assessing to what extent its rules, standards, policies, licensing requirements and other provider requirements ensure settings comport with the HCBS settings requirements. In addition, DPHHS assesses and describes the Department oversight process to ensure ongoing compliance.

Upon conducting the compliance assessment, if the Department determines that existing standards meet the federal settings requirements and the State's oversight process is adequate to ensure ongoing compliance, the State will describe the process that it used for conducting the compliance assessment and the outcomes of that assessment.
However, if the State determines that its standards may not meet the federal settings requirements, the State will include the following in its Statewide Settings Transition Plan: (1) remedial action(s) to come into compliance, such as proposing new state regulations or revising existing ones, revising provider requirements, or conducting statewide provider training on the new state standards; (2) a timeframe for completing these actions; and (3) an estimate of the number of settings that likely do not meet the federal settings requirements.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

◉ **The waiver is operated by the State Medicaid agency.**

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
Addictive and Mental Disorders Division
(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
(a) The Addictive and Mental Disorders Division (AMDD) 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. Multiple documents serve to outline the responsibilities of assigned staff regarding the specific aspects of the waiver, including AMDD rules and policies relating directly to the operation of the waiver. AMDD maintains organizational charts, individual position descriptions and web-based information serving to assist persons who need assistance in accessing information about the waiver and the staff within AMDD who are responsible for decision making based on waiver issues. The waiver application is the authoritative document serving to outline the person/positions responsible for ensuring all the requirements of the waiver are met (more detail regarding implementation detail is available in various AMDD and provider forms, policies, administrative directives and rules).
(c) The Medicaid Director and his/her designee are ultimately responsible for ensuring that problems in the administration of the waiver are resolved. The Medicaid Director and his/her designee are not directly involved in the day to day operational decisions of the AMDD staff. The Waiver Program Managers, Mental Health Services Bureau Chief and the AMDD administrator share information and a copy of the waiver with the State Medicaid Director and/or his/her designee prior to submittal of waiver renewals, amendments or new waiver application to CMS. The AMDD Administrator reports directly to the State Medicaid Director.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

◎ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
The Mountain Pacific Quality Health (MPQH) will conduct the level of care assessments, including Level I activity. As appropriate, MPQH will refer individuals to the waiver case management teams. MPQH is a QIO.

Community Mental Health Centers will complete the Level II screens for individuals who are identified by MPQH as having mental illness and have had inpatient psychiatric admission within the last two years. The Level II screen will determine if active treatment is necessary. Community Mental Health Centers will determine if SDMI criteria are met and advise MPQH.

The Department of Public Health and Human Services' fiscal intermediary contractor for MMIS, will adjudicate the claims for waiver providers. The contractor will assist providers of waiver services with enrollment. In addition, the contractor is responsible for verification of providers.

Case Management Teams will enroll individuals in the SDMI Waiver and provide case management services. Case management teams will work within the communities to identify potential providers of waiver services appropriate to meet the needs of enrollees in the waiver. The enrolled individuals will select their providers of their waiver services.

The Request For Proposal (RFP) process is not used for case management teams. The case management teams do not provide any other services except case management. Each waiver recipient chooses their providers for waiver services. The waiver participant can choose their case managers, if meet the qualifications required, regardless of the team. This choice is documented in each file. Community Program Officers (CPOs) will work within the communities to identify potential providers of waiver services appropriate to meet the needs of participants in the waiver. The case management agencies will not provide other direct waiver services. Other protections include: every other year face to face waiver participant satisfaction surveys, the freedom of choice documentation, and all providers have policies outlining the corporate/dispute resolution procedure.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Department of Public Health and Human Services, Addictive and Mental Disorders Division will be responsible for assessing the performance of contracted entities.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Mountain Pacific Quality Health will submit a Management Report to Addictive and Mental Disorders Division (AMDD) of the Department of Public Health and Human Services on a quarterly basis. The report will capture data on the date of level of care assessments, the outcome of the assessments and days elapsed between the request for level of care determination and the date the letter was sent to the applicant notifying him/her of the PASRR level of care determination outcome. AMDD will monitor the report to ensure that assessment and information regarding level of care determination is provided in a timely manner. AMDD will annually review 100% of level of care determinations, through the onsite case management site reviews, to ensure accuracy and consistency in the application of the level of care instrument. All level of care denials will be sent to the Mental Health Services Bureau for review. Assessment of the contract agency''s performance is part of the quality assurance process.

Community Mental Health Centers are contracted to complete PASRR Level II screens and resident reviews. AMDD has a program officer who communicates with Mountain Pacific Quality Health (MPQH)and Mental Health Centers to monitor their performance. The program officer is responsible for authorizing payment to contractors who have completed the Level II evaluations and the Clinical Manager will provide feedback and direction to PASRR providers regarding quality of work, procedural change and any other PASRR related activity.

Fiscal Intermediary contractor submits a monthly Report Card that summarizes internal monitoring contractor does over the system and processes (i.e. recipient subsystem, provider enrollment, claims processing and documents, verify changes requested for codes were made appropriately). The MMIS coordinator and senior Medicaid policy analyst meet with Fiscal Intermediary contractor on an ongoing basis to discuss progress and/or problems with system updates. Monthly status meetings are held between department staff and contractor staff. In addition, the contractor completes internal audits to review their system processes and effectiveness as a contractor. This information is shared with the state in the form of a Service Auditor's Report.

Case Management Teams are assessed by Community Program Officers (CPOs) on an annual basis. CPOs will review documentation, person centered recovery plan, waiting lists, staffing, budgets, consumer choice and satisfaction, provider relationships, incident reporting and overall case management of waiver participant needs. On a quarterly basis, the CPOs will monitor waiting lists in the geographic area where the waiver is available. The Mental Program Manager reviews the waiting list and will determine when to reallocate unused capacity to areas where additional capacity may be needed. Reallocation will occur following the review of the waiting list information and discussed with the CPOs. Other providers are assessed on one to three year intervals dependent upon their previous review's outcome. Senior and Long Term Care (SLTC) Division, Community Services Bureau oversees the personal assistance services.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☑
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☑	☑
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 State's quality improvement strategy, provide information in the following fields to detail the State's 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:
The Case Management Team will follow the protocol described in policies and procedures. 100% of files for each Case Management Team will be reviewed. Numerator is the demonstration of case management teams following protocols as defined in quality assurance review Denominator is the total number of files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

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

b. **Methods for Remediation/Fixing Individual Problems**

i. Describe the State's 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.

AMDD has total oversight over the waiver. The AMDD Central Office and the CPOs act at the local and statewide level to provide routine and ongoing waiver oversight of the waiver program quality measures and

waiver providers. At the local level the CPO, in their Quality Assurance reviews, provide ongoing oversight of the SDMI waiver participants and providers. Training is provided to participants and providers, as needed, for policy/program changes and when issues are identified.

Discovery - AMDD has total oversight over the waiver. The MPQH, Community Mental Health Centers, Fiscal Intermediary Contractor, Case Management Teams, Senior and Long Term Care Division, and Quality Assurance Division have operational responsibilities and activities with the waiver. The AMDD Program Manager and Community Program Officers (CPO) act at the local and statewide level to provide routine and ongoing waiver oversight. Monthly quality assurance team meetings are the vehicle for continuous statewide oversight of the waiver contractors. The monthly team meetings will review the reports and the performance of case management teams and providers. At the local level the CPO and Program Manager provide oversight in the annual quality reviews. The CPO provides ongoing oversight of the case management teams, waiver participants and providers. Training is provided to participants and providers, as needed, for policy/program changes and when issues are identified.

Remediation - The Community Program Officers (CPO) and Program Manager will review 100% of the waiver participant files. Reviews include examination of case notes, person centered recovery plan (with amendments and changes), Level of Care determination, Level of Care re-evaluation documentation, prior authorization for services and support, monthly expenditures, Cost Sheet, admittance form, serious occurrence reports, and documentation of training. The CPO will respond to any immediate concerns. Data collected in the review will result in a report that will be submitted to the Case Management Agency and to AMDD.

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently 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
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☑ Mental Illness					
	☑	Mental Illness	18		
	☐	Serious Emotional Disturbance			

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

"Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the following criteria:
(a) has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital (Warm Springs campus) at least once; or
(b) has recurrent thoughts of death, recurrent suicidal ideation, a suicide attempt, or a specific plan for committing suicide; or
(c) has diagnosis of (excluding diagnoses with mild, NOS (not otherwise specified), and due to physiological disturbances and physical factors):
(i) schizophrenia, schizotypal and delusional disorders;
(ii) mood disorders;
(ii) neurotic and stress related disorders; or
(iv) borderline personality disorder; and
(d) has ongoing functioning difficulties because of the mental illness for a period of at least six months or for an obviously predictable period over six months, as indicated by at least
two the following:
(i) a medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;
(ii) the person is unable to work in a full-time competitive situation because of mental illness;
(iii) the person has been determined to be disabled due to mental illness by the social security administration;
(iv) the person maintains a living arrangement only with ongoing supervision, is homeless, or is at imminent risk of homelessness due to mental illness; or
(v) the person has had or will predictably have repeated episodes of decompensation; or
(vi) inability to care for personal needs due to mental health symptoms.

Licensed mental health professionals determine whether an individual meets SDMI criteria.

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	225
Year 2	230
Year 3	235
Year 4	240
Year 5	245

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

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

◉ **Not applicable. The state does not reserve capacity.**

○ **The State reserves capacity for the following purpose(s).**

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 must:
- Be Medicaid eligible;
- Meet SDMI criteria;
- Be age 18 or older;
- Meet nursing facility level of care;
- Choose to receive waiver services; and
- Reside in an area within the state where the HCBS waiver is available and there' is capacity within the waiver.

Entrance into the waiver will be on a first-come, first-served basis for those who meet the above-listed criteria. Once a waiting list has been established, the case management teams will use the Wait List Criteria Tool within 45 days of the referral and then every 90 days. The Wait List Criteria Tool scores individuals eligible for the waiver according to criteria, including cognitive impairment, risk of medical and/psychiatric deterioration without services, risk of institutional placement or death, need for supervision, need for formal paid services, assessment of informal supports, assessment of relief needed for primary caregiver, need for adaptive aides, and assessment of health and safety issue that place the individual at risk. The case managers will manage the waitlist, which will be reviewed by the Addictive and Mental Disorders Division of the Department of Public Health and Human Services through access to their electronic case management program.

On a quarterly basis, the CPOs will monitor waiting lists in the geographic area where the waiver is available. The Program Manager who will review the waiting list and discuss with CPOS when to reallocate unused capacity to areas where additional capacity may be needed. Any unused slots will be reallocated based on the prioritized need as established by the criteria in the Waiting List Criteria Tool. The tool scores individuals eligible for the waiver according to eleven criteria, including risk of psychiatric deterioration without services, cognitive impairment, risk of institutional placement, need to obtain/maintain stable residence, need for more formal services, need for adaptive aids, and health and safety issues that place the individual at risk.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ◉ **§1634 State**
   - ○ **SSI Criteria State**
   - ○ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ◉ **No**
   - ○ **Yes**

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

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

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ○ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☑ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

PICKLE, DAC

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 spenddown 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:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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 submit Appendix B-5 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-4 indicate that you do not need to submit Appendix B-5 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.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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 submit Appendix B-5 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).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. **Minimum number of services.**

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

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

◉ **The provision of waiver services at least monthly**

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

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

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By an entity under contract with the Medicaid agency.**

Specify the entity:

Mountain Pacific Quality Health

- ○ **Other**

Specify:

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

Registered Nurse or Licensed Practical Nurse, licensed in the State of Montana and individuals with a bachelor's degree in Social Work.

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.

The Mountain Pacific Quality Health will complete a PASRR Determination including a Functional Assessment to determine if the individual meets level of care requirements for enrollment into the waiver. Preadmission determination and functional assessment involves telephone interviews based on established protocols. A Level I screen will also be completed to determine if the individual has Mental Retardation or Mental Illness as part of PASRR requirements. Community Mental Health Centers will complete Level II screens to determine if an individual with Mental Illness identified through the Level I screen requires active treatment. Active treatment in Montana is provided by inpatient care at:
A) Local community hospitals with psychiatric units; or
B) The Montana State Hospital (MSH); or
C) Montana Mental Health Nursing Care Center (MMHNCC).
MSH and MMHNCC are Institutions for Mental Disease.

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

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

A level of care screening is performed to evaluate the medical, psychological and social needs of an individual. The

Functional Assessment is a review of impairments in walking, bathing, grooming, dressing, toileting, transferring, feeding, bladder incontinence, bowel incontinence, special sense impairments (such as speech or hearing), mental and behavioral dysfunctions. Nursing facility or waiver level of care is authorized if the individual's needs are greater than personal level of care. The reevaluation process is the same.

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:

The reevaluation schedule is every 12 months and when there is significant change within the year.

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 Case Management Teams will use their own internal systems to track participants enrolled in the waiver and alert the Mountain Pacific Quality Health when a participant is due for a reevaluation of level of care. The quality assurance process will include a review by the Community Program Officers to ensure the timeliness of reevaluation in accordance with quality assurance standards.

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:

The Mountain Pacific Quality Health will maintain all evaluations and re-evaluations for a minimum of three years as required in 45 CFR §74.53.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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 of waiver participants who received a LOC determination prior to enrollment Denominator is the number of enrolled participants Numerator is the number of enrolled participants who received an LOC prior to enrollment

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report submitted to AMDD from Mountain Pacific Quality Health.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

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

Performance Measures

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

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

Performance Measure:
The percent of waiver participants whose LOCs are reevaluated at least annually.
Numerator - The number of participants whose LOCs are reevaluated annually.
Denominator - All waiver participants

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

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

		Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

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:
The percent of initial LOC determinations for waiver applicants completed timely by MPQH. Numerator is the number of LOC determinations initiated within three working days. Denominator is the total number of LOC determinations.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report to the AMDD provided by Mountain Pacific Quality Health.

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

☑ **Other** Specify: Mountain Pacific Quality Health	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.
MPQH will submit a management report to MHSB on a monthly basis. This report will capture data on the Level of Care evaluations completed prior to the receipt of waiver services, participants notified of the Level of Care determinations within the state required timeframes and timeframes for redeterminations. CPOs will review Level of Care determinations and re-determinations as part of their annual QA reviews. CPOs will review 100% of LOC denials and take action if an inappropriate denial was made. All persons denied are notified in writing of the denial and process of requesting a Fair Hearing.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
AMDD will review monthly and monitor the MPQH management reports to assure that LOCs occur prior to receipt of waiver services and that participants are notified within the required timeframes. Reports will also be monitored monthly to assure that a re-determination occurs with in the specified timeframes of the

approved waiver. CPOs and Program Manager will review Level of Care determinations and re-determinations as a part of their annual QA reviews. CPOs will review 100% of LOC denials and take action if an inappropriate denial was made. MHSB provides ongoing monitoring of MPQH LOC activities and provides additional training as needed. All individuals must be informed of his/her right to Fair Hearing in writing as part of the waiver entrance process. A request for a Fair Hearing must be in writing within 90 days of the mailing date of notice of denial of LOC.

Level of Care Determinations
Discovery - Mountain Pacific Quality Health (MPQH) will submit a management report to AMDD on a monthly basis. This report will capture data on the Level of Care evaluations completed prior to the receipt of waiver services, participants notified of the Level of Care Determinations within state required timeframes and timeframes for re-determinations. CPOs and Waiver Program Manager will review Level of Care determinations and re-determinations as part of the annual QA reviews.
Remediation - AMDD will review monthly and monitor the MPQH management reports to assure that the LOCs occur prior to receipt of waiver services and participants are notified within the required timeframes. Reports will also be monitored to assure that a re-determination occurs within the specified time frames of the approved waiver. The CPOs and Program Manager will review Level of Care determinations and re-determinations as a part of their annual QA reviews. The CPOs review 100% of LOC denials and take action if an inappropriate denial was made. The AMDD will identify if the inappropriate denials are from a particular reviewer. AMDD will request the reviewer receive further training on LOC determinations. If the problem is not resolved the AMDD can suspend payments until resolved or may terminate contract with MPQH if training and suspension of payments does not resolve the matter.

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

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

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

During the preadmission screening determination, the Mountain Pacific Quality Health will inform eligible individuals of the feasible alternatives available under the waiver and allow individuals to choose either institutional or waiver services, as long as the individuals reside in areas where the waiver is available (the SDMI Waiver will not be available statewide) and there is capacity. The Screening Determination form documenting choice will be maintained on file at MPQH.

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.

The Mountain Pacific Quality Health will maintain the Screening Determination Form, including all documentation regarding freedom of choice, for a minimum of three years.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The State will make reasonable accommodation upon request. Accommodations for foreign translators will be arranged through the local college and university system. Accommodations for consumers who are deaf or hearing impaired will be made through Montana Communications Access Program for the Deaf and Hard of Hearing Services. The State will utilize other resources including, but not limited to, the Special Needs Center through the Qwest phone book. Individuals are notified of the opportunity for reasonable accommodations in the Medicaid application process and in the Medicaid Screening determination letter.

Appendix C: Participant Services

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

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

Service Type	Service	
Statutory Service	Adult Day Health	
Statutory Service	Case Management	
Statutory Service	Homemaker	
Statutory Service	Prevocational Services	
Statutory Service	Residential Habilitation	
Statutory Service	Respite	
Statutory Service	Supported Employment	
Extended State Plan Service	Occupational Therapy	
Other Service	Chore	
Other Service	Community Transition	
Other Service	Consultative Clinical and Therapeutic Services	

Other Service	Dietician/Nutrition/Meals
Other Service	Environmental Accessibility Adaptations
Other Service	Habilitation Aide
Other Service	Health and Wellness
Other Service	Non-Medical Transportation
Other Service	Pain and Symptom Management
Other Service	Peer Support
Other Service	Personal Assistance Service and Specially Trained Attendant Care
Other Service	Personal Emergency Response System
Other Service	Private Duty Nursing (and Registered Nurse Supervision)
Other Service	Specialized Medical Equipment and Supplies
Other Service	Substance Use Related Disorder Services
Other Service	Supported Living

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Adult Day Health provides a broad range of health, nutritional, recreational, and social and habilitation services in licensed settings outside the person's place of residence. Adult Day Health services do not include residential overnight services. Adult day health services are furnished in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the consumer. Meals provided as part of these services will not constitute a "full nutritional regiment" (3 meals per day). The scope of Adult Day Health service will not duplicate State Plan services or habilitation aid services. Transportation between the consumer's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is not duplicative of the transportation services, or the meals under the distinct meals service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:
Agency
Provider Type:
Adult Day Health Provider
Provider Qualifications
License *(specify)*:
Licensed as an Adult Day Center with Department of Public Health and Human Services (Administrative Rules of Montana 37.106.301,et.seq.)
Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.430.
The agency is responsible to hire qualified staff and follow all state and federal labor laws
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services
Frequency of Verification:
Upon enrollment and at renewal of license.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Case Management entails:
Development and review of the Person Centered Recovery Plan with the participant
Reevaluation of the Person Centered Recovery Plan including a functional assessment and appropriateness of services in the recovery plan
Coordination of services
Linking participants to other programs
Monitoring implementation of recovery plan
Ensuring health and safety
Addressing problems with respect to services and providers
Responding to crises
Being financially accountable for waiver expenditures for participants on the waiver

Case management assists participants in gaining access to needed Home and Community Based Services and other State Plan services as well as needed medical, social, educational and other services regardless of the funding source.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency

Provider Type:
Case Management Providers

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.425.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.
Cannot provide any other services to waiver participants other than case management services.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services

Frequency of Verification:
Upon enrollment and annually
Verify RN/LPN License annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Homemaker
Alternate Service Title (if any):

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Homemaker services consist of general household activities. Homemaker services are provided to participants unable to manage their own homes. Homemaker services do not include personal care services available under State Plan Medicaid.
Homemaker activities include tasks related to household management. This may include assisting the participant to find and relocate to other housing, assisting participant with boxing, unpacking and organizing household items. In addition the service provides general housecleaning and meal preparation, as well as teaching services that improve a participant's skills in household management and social functioning.
Social restorative services include activities that will further a participant's involvement with activities and other persons. This may include reimbursement to the homemaker for escort to social functions if the participant's needs require such a service. Social restorative services under Homemaker are different from Socialization under Home and Community Based Services Personal Assistance Service (HCBS PAS). Social restorative services under Homemaker are intended for those participants who do not require assistance with personal care. If a participant can use homemaker services, HCBS PAS should not be utilized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services shall be provided only after other homemaker services through any other entity have been exhausted. Homemaker services are not allowed for a participant residing in an adult residential setting.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	PAS Provider
Agency	Homemaker Provider
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency

Provider Type:
PAS Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.437.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and every two years

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 Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.437.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Medicare Certified
Other Standard *(specify)*:
Administrative Rules of Montana 37.90.437.
The agency is responsible to hire qualified staff and follow state and federal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and license renewal

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Prevocational Services are habilitative activities that foster employability for a HCBS consumer. Prevocational Services:
Are aimed at preparing an individual for paid or unpaid employment;

Include teaching such concepts as compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, attention span, motor skills and safety; and

Are provided to persons who may or may not join the general work force (excluding supported employment programs).

When compensated, consumers are paid at less than 50 percent of the minimum wage. Activities included in this service are generally not directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the participant's person centered recovery plan.

Must not be provided if they are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Education of the Handicapped Act. The Case Management Team must document in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142. This documentation may be obtained from the Rehabilitation Services Program, Department of Public Health and Human Services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency

Provider Type:
Supported Living Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.432.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/ Xerox.

Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Residential Habilitation is provided in a licensed group home, adult foster home, assisted living facility, or residenial hospice. Residential Habilitation is a bundled service that may include personal assistance supports or habilitation to meet the specific needs of each resident; homemaker services; medication oversight; social activities; personal care; recreational activities at least twice a week, transportation; medical escort; and 24-hour on-site awake staff to meet the needs of the residents and provide supervision for safety and security.

Adult residential care is provided in an adult foster home, group home, assisted facility or residential hospice.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Medicaid reimbursement for room and board is prohibited. This service will not duplicate any other services that the waiver consumer receives. The provider may not bill Medicaid for services on days the resident is absent from the facility, unless retainer days have been approved by the CMT. The provider may bill on date of admission and discharge from a hospital or nursing facility. If the resident is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer. Residents in residential habilitation may not receive the following services under the HCBS program: 1) Personal Assistance; 2) Homemaking; 3) Environmental Modifications; 4) Respite; or 5) Meals. These restrictions only apply when the HCBS payment is being made for the residential service.

Retainer days
Providers of this service may be eligible for a retainer payment if authorized by the case management team. Retainer days are days on which the consumer is either in hospital, nursing facility or on vacation and the team has authorized the provider to be reimbursed for services in order to keep their placement in the residential setting. Retainer days are limited to 30 days a year and may not be used for any other service if used for residential habilitation. If a provider rate includes vacancy savings, retainer days are a duplication of services and may not be paid in addition.

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	Assisted Living Facility, Residential Hospice
Agency	Adult Foster Care
Agency	Group Home

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:
Assisted Living Facility, Residential Hospice
Provider Qualifications
License *(specify)*:
Assisted Living Facility
Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 7.90.428 and 37.106.2801 (QAD)
The agency is responsible to hire qualified staff and follow all state and federal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services (Quality Assurance Division)/ Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and renewal of license.

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:
Adult Foster Care
Provider Qualifications
License *(specify)*:
Adult Foster Home
Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.428
The agency is responsible to hire qualified staff and follow all state and federal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/ Quality Assurance Division
State Fiscal Fidiciary Contractor
Frequency of Verification:
Upon enrollment and renewal of license.

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:
Group Home

Provider Qualifications

License *(specify)*:
Group Home License

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.429
The agency is responsible to hire qualified staff and follow all the state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/Quality Assurance Division
State Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and renewal of license.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Respite care is temporary, short-term care provided to consumers in need of supportive care to relieve those persons who normally provide the care. Respite care is only utilized to relieve a non-paid caregiver. Respite care may include payment for room and board in adult residential facilities or nursing homes.
Respite care can be provided in the participant's residence or by placing the participant in another private residence, adult residential setting or licensed nursing facility.

When respite care is provided, the provision of, or payment for other duplicative services under the waiver is precluded (e.g., payment for respite when consumer participant is in Adult Day Care).
If a participant requires assistance with activities of daily living during the respite hours, a personal assistant should be used under State Plan or Home and Community Based Services Personal Assistance Services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	PAS Provider
Agency	Homemaker Provider
Agency	Nursing Facility
Agency	Adult Residential Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
PAS Provider
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.438
The agency is responsible to hire qualified staff and follow all state and federal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Homemaker Provider
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.438.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Nursing Facility
Provider Qualifications
License *(specify)*:
Licensed in the State of Montana
Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.438
The agency is responsible to hire qualified staff and to follow all state and federal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and renewal of license

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Adult Residential Facility

Provider Qualifications

License *(specify)*:
Licensed in the State of Montana

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.438.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and renewal of license

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Supported employment includes activities needed to sustain paid work by participants; including supervision and training for persons for whom unsupported or competitive employment at or above the minimum wage is unlikely. Supported employment is conducted in a variety of settings. Supported employment may include group community employment such as crews, enclaves or individual community employment.

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

Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142. This documentation may be obtained from with the Rehabilitation Services Program, Department of Public Health and Human Services.
Transportation may be provided between the participant's place of residence and the job site or between job sites (in cases where the participant is working in more than one place) as a component of supported employment services.
Use of community transportation, including specialized transportation is encouraged.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is not duplicative of the transportation service.

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Supported Living Provider
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.432
The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Extended state plan occupation therapy services provided when the limits of Occupational Therapy Services under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from Occupational Therapy Services furnished under the State plan, except that palliative therapies are allowed. The provider qualifications specified in the State plan apply.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
State Plan Occupational Therapy Services will be utilized prior to HCBS.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Hospital/Home Health Agency
Individual	Licensed Occupational Therapist

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:
Hospital/Home Health Agency

Provider Qualifications

License *(specify)*:
As required by Montana law and regulations

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.440.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and renewal of license

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Licensed Occupational Therapist

Provider Qualifications

License *(specify)*:

As required by Montana law and regulations
Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.440 and meets the state's definition as an independent contractor.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and upon renewal of license

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Chore

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Chore services are provided to participants unable to manage their own homes.
Chore activities include extensive cleaning beyond the scope of general household cleaning under the waiver service, Homemaker Services. Chore services may include but are not limited to heavy cleaning; washing windows or walls; yard care; walkway maintenance; minor home repairs; wood chopping and stacking.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services shall be provided only after other homemaker services through any other entity have been exhausted. Chore services are not allowed for a resident in an adult residential setting.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	PAS Provider
Agency	Homemaker Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Medicare Certified
Other Standard *(specify)*:
Administrative Rules of Montana 37.90.437.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore

Provider Category:
Agency
Provider Type:
PAS Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Administrative Rules of Montana 37.90.437.

The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore

Provider Category:

Agency

Provider Type:

Homemaker Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Administrative Rules of Montana 37.90.437.

The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Community Transition services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household and are not limited to but may include: security deposits that are required to obtain a lease on an apartment or home; essential household furnishings required, including furniture, window coverings, food preparation items and bed/bath linens; moving expenses; usual and customary set up fees or deposits for utility or service access, including telephone, electricity, heating and water; activities to assess need, arrange for and procure resources.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Community Transition Services do not include monthly rental or mortgage expenses, regular utility charges, and/or household appliances or items that are intended for purely diversion/recreational purposes. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dependent upon specific service/support required

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:
Agency
Provider Type:
Dependent upon specific service/support required
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Dependent upon specific provider 37.90.46
Verification of Provider Qualifications
Entity Responsible for Verification:
State/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Consultative Clinical and Therapeutic Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
These are services that assist unpaid and/or paid caregivers in carrying out individual person centered recovery plans and are necessary to improve the individual's independence and inclusion in the community. This service is geared towards individuals with more complex disabilities that require a more clinical approach and specialized interventions. Consultation activities are provided by professionals in psychiatry, psychology, neuro-psychology, behavior management, or others specializing in specific intervention modalities.
This service may include:
1) Clinical evaluations by these professionals;
2) Development by a supplemental home/community treatment plan which is incorporated into the individual's person centered recovery plan;
3) Training and technical assistance to implement the treatment;
4) Monitoring the treatment and interventions; and
5) One-on-One consultation and support for paid and non-paid caregivers.
Professionals will work closely with case managers to ensure treatment plans are implemented and followed.
An entity, inclusive of its staff, providing consultative clinical and therapeutic services must be qualified generally to provide the services and specifically to meet each participant's defined needs.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Psychiatrist, Psychologist, Neuro-Psychiatrist, Rehabilitation Counselor, Professional Counselor
Individual	Psychiatrist, Psychologist, Neuro-Psychiatrist, Rehabilitation Counselor, Professional Counselor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Services

Provider Category:
Agency
Provider Type:
Psychiatrist, Psychologist, Neuro-Psychiatrist, Rehabilitation Counselor, Professional Counselor
Provider Qualifications
License *(specify)*:
As required by state law by the Board of Medical Examiners or the Professional Licensing Bureau
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
State/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and renewal of license

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Services

Provider Category:
Individual

Provider Type:
Psychiatrist, Psychologist, Neuro-Psychiatrist, Rehabilitation Counselor, Professional Counselor

Provider Qualifications

License *(specify)*:
As required by state law by the Board of Medical Examiners or the Professional Licensing Bureau

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
State/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and renewal of license

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Dietician/Nutrition/Meals

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◎ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Services which consist of the provision of hot or other appropriate meals once or twice a day, up to seven days a week. In keeping with the exclusion of room and board as covered services, a full nutritional regimen of three meals per day will not be provided. In addition, nutrition/dietician consists of education and meal planning services provided by a registered dietitian or a licensed nutritionist for participants who have medically restricted diets or for participants who do not eat appropriately to maintain health.

Dietitian Services mean services related to the management of a recipient's nutritional needs and include the following: evaluation and monitoring of nutritional status; nutrition counseling; therapy; and education and research.
Dietitian services must be provided by a registered dietitian or a licensed nutritionist. Registered dietitians must meet the qualifications in 37-21-302 MCA and licensed nutritionists must meet the licensing requirements in 37-25-302, MCA.
Nutrition services include the provision of meals in a congregate setting or home-delivered meals. Nutrition services can also include, but are not limited to, meals from restaurants, hospitals and meal service in a residential setting that is not considered room and board (e.g. apartment that offers meal service separate from room and board).
Congregate or home delivered meals must be provided as defined in Administrative Rules of Montana Proposed Rule XXII.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
No more than two meals a day shall be provided to participants through congregate or home-delivered meals. Providing more than two meals a day constitutes a full nutritional regimen or "board", which is not reimbursable under the Home and Community Based Services Program. These services are not available to waiver residents in adult residential care.

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	Retirement Homes
Individual	Licensed Nutritionist
Agency	Restaurants
Agency	Area Agency on Aging
Individual	Registered Dietician

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietician/Nutrition/Meals

Provider Category:
Agency
Provider Type:
Retirement Homes
Provider Qualifications
License *(specify)*:
Retirement Homes License
Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.445 and 37.90.446
The agency is responsible to hire qualified staff and follow all state and federal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services
State Fiscal Fiduciary Contractor
Frequency of Verification:
Upon enrollment and renewal of license.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietician/Nutrition/Meals

Provider Category:
Individual
Provider Type:
Licensed Nutritionist
Provider Qualifications
License *(specify)*:
37-25-302, MCA
Certificate *(specify)*:

Other Standard *(specify)*:
meets the state's definition as an independent contractor.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and upon renewal of license

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietician/Nutrition/Meals

Provider Category:
Agency
Provider Type:
Restaurants
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.445 and 37.90.446.
The agency is responsible to hire qualified staff and follow all state and federal labor laws
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietician/Nutrition/Meals

Provider Category:
Agency
Provider Type:
Area Agency on Aging
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.445 and 37.90.446.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/Fiscal Intermediary Contractor
Frequency of Verification:
upon enrollment and two years afterwards

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietician/Nutrition/Meals

Provider Category:
Individual

Provider Type:
Registered Dietician

Provider Qualifications

License *(specify)*:
37-21-302 MCA

Certificate *(specify)*:

Other Standard *(specify)*:
meets the state's definition as an independent contractor.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and upon renewal of license

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

◎ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Those physical adaptations to the home required for the individual's person centered recovery plan, which are necessary to ensure the health, safety and welfare of the individual; or which enable the individual to function with greater independence in the home and without which the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver participant, such as carpeting, roof repair, central air conditioning, etc. All services shall be provided in accordance with applicable state and local building codes.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services are limited to a one-time purchase. The Division, at its discretion, may authorize an exception to this limit. This service is not duplicative of those services provided under specialized medical equipment.

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

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:
☑ **Legally Responsible Person**
☑ **Relative**
☑ **Legal Guardian**
Provider Specifications:

Provider Category	Provider Type Title
Agency	Construction Company, Building Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Construction Company, Building Contractor
Provider Qualifications
License *(specify)*:
Contractor License through business and labor
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
State/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and every two years after that.

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:

Habilitation Aide

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Habilitation aide provides assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, which takes place in a non-residential setting, separate from the home or facility in which the participant resides. Habilitation aides must be physically and mentally able to perform the duties required and able to follow written orders. The habilitation aide is utilized when imparting a skill unto a participant whereas a personal assistance may perform the task for the participant. The participant and the Case Management Team will evaluate when to utilize the services of the habilitation aide.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider
Agency	PAS Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Habilitation Aide

Provider Category:
Agency

Provider Type:
Supported Living Provider

Provider Qualifications

License ***(specify)*****:**

Certificate ***(specify)*****:**

Other Standard ***(specify)*****:**
Administrative Rules of Montana 37.90.432.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Habilitation Aide

Provider Category:
Agency

Provider Type:
PAS Provider

Provider Qualifications

License ***(specify)*****:**

Certificate ***(specify)*****:**

Other Standard ***(specify)*****:**
Administrative Rules of Montana 37.90.432, 37.90.430, and 37.90.436.

The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:

Health and Wellness

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Health and wellness offers consumers opportunities to engage in recreational, health promoting and wellness/recover activities within their community.

The service includes:

1. Classes on weight loss, smoking cessation, and healthy lifestyles;
2. Health club memberships;
3. Art Therapy; and
4. Costs associated with adaptive activities such as skiing, horseback riding, and swimming.
5. Wellness Recovery Action Plan
6. Classes on managing disabilities such as Illness Management and Recovery and Living Well with a Disability

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Any activities provided under this service must be tied to recovery goals in the person centered recovery plan and necessary to avoid institutionalization.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dependent upon specific service provided.
Agency	Wellness/Recovery Classes/Health Clubs/Fitness Centers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:
Agency
Provider Type:
Dependent upon specific service provided.
Provider Qualifications
License *(specify)*:
As required by state law.
Certificate *(specify)*:

Other Standard *(specify)*:
Dependent upon specific provider.
Verification of Provider Qualifications
Entity Responsible for Verification:
State/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:
Agency
Provider Type:
Wellness/Recovery Classes/Health Clubs/Fitness Centers
Provider Qualifications
License *(specify)*:

As required by state law.
Certificate *(specify)*:
As required by specific service
Other Standard *(specify)*:
Dependent upon specific provider.
Verification of Provider Qualifications
Entity Responsible for Verification:
State/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Non-Medical Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Transportation means travel furnished by common carrier or private vehicle for non-medical reasons as defined in the person centered recovery plan. Medical transportation is available under the State Plan Medicaid Program.
Transportation Services must meet the following criteria:
Be provided only after volunteer, state plan or other publicly funded transportation programs have been exhausted or determined to be inappropriate; and

Be provided by the most cost effective mode.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	PAS Providers
Agency	Accessible Transportation Providers
Agency	Private Ambulance Service Providers and Hospital Ambulance Service Providers
Individual	Taxi Cabs

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency

Provider Type:
PAS Providers

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative rules of Montana 37.90.450.
Transportation providers must provide proof of a valid Montana's driver's license; adequate automobile insurance; and assurance that the vehicle is in compliance with all applicable federal, state and local laws and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
Accessible Transportation Providers
Provider Qualifications
License *(specify)*:
Must meet all pertinent state laws and regulations.
Certificate *(specify)*:

Other Standard *(specify)*:
Administrative rules of Montana 37.90.450.
Transportation providers must provide proof of a valid Montana's driver's license; adequate automobile insurance; and assurance that the vehicle is in compliance with all applicable federal, state and local laws and regulations.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
State/Fiscal Intermediary Contractor
Frequency of Verification:
As required by law; Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
Private Ambulance Service Providers and Hospital Ambulance Service Providers
Provider Qualifications
License *(specify)*:
Must meet all pertinent state laws and regulations
Certificate *(specify)*:

Other Standard *(specify)*:
Administrative rules of Montana 37.90.450.
Transportation providers must provide proof of a valid Montana's driver's license; adequate automobile insurance; and assurance that the vehicle is in compliance with all applicable federal, state and local laws and regulations.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
State/Fiscal Intermediary Contractor
Frequency of Verification:
As Required by law; Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Individual
Provider Type:
Taxi Cabs
Provider Qualifications
License *(specify)*:
Must meet all pertinent state laws and regulations
Certificate *(specify)*:

Other Standard *(specify)*:
Administrative rules of Montana 37.90.450.
Transportation providers must provide proof of a valid Montana's driver's license; adequate automobile insurance; and assurance that the vehicle is in compliance with all applicable federal, state and local laws and regulations.
The agency is responsible to hire qualified staff and follow all state and federal labor laws and meet the state's definition as an independent contractor.
Verification of Provider Qualifications
Entity Responsible for Verification:
State/Fiscal Intermediary Contractor
Frequency of Verification:
As required by law; Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Pain and Symptom Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

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

○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
This service allows for the provision of traditional and non-traditional methods of pain management. Treatments include but are not limited to: acupuncture; reflexology; massage therapy; craniosacral therapy; hyperbaric oxygen therapy; mind-body therapies such as biofeedback and hypnosis; coaching; chiropractic therapy; and nursing services by a nurse specializing in pain and symptom management.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

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

☑ **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Massage Therapists, Chiropractors, Acupuncturists, Specialized RN
Agency	Hospitals
Agency	Psychologist, Counselor, Life Coach, Hypnotist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pain and Symptom Management

Provider Category:
Agency

Provider Type:
Massage Therapists, Chiropractors, Acupuncturists, Specialized RN

Provider Qualifications

License *(specify)*:
Montana Board of Massage Therapy
Montana Board of Chiropractors
Montana Board of Medical Examiners
Montana Board of Nursing

Certificate *(specify)*:

Other Standard *(specify)*:
ARM 37.90.406

Verification of Provider Qualifications

Entity Responsible for Verification:
State/Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and upon license renewal

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pain and Symptom Management

Provider Category:
Agency
Provider Type:
Hospitals
Provider Qualifications
License *(specify)*:
Montana Licensed Hospital
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
State/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and license or certification renewal.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pain and Symptom Management

Provider Category:
Agency
Provider Type:
Psychologist, Counselor, Life Coach, Hypnotist
Provider Qualifications
License *(specify)*:
Montana Board of Social Work and Professional Counselors
Montana Board of Psychologists
Certificate *(specify)*:
Certified Life Coach
Certified Hypnotist
Other Standard *(specify)*:
ARM 37.90.406
Verification of Provider Qualifications
Entity Responsible for Verification:
State/Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Peer Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10050 peer specialist
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Peer Support Services are person centered, recovery focused services that promote empowerment, self-determination, and improved coping skills through recovery coaching, mentoring, and other supports that allow a person with severe disabling mental illness to achieve their goals for personal wellness and recovery. Individuals who provide peer support services have lived experience with mental illness and mental health services, are well grounded in their recovery process and have completed a Peer certification course approved by the Department. Peer services are multi-faceted and include activities such as self-advocacy, education, support of meaningful activities of the individual's choosing, crisis management, effective use of mental health and other community services, and coordination and linkage with community supports and providers. The activities provided by this service promote the development and enhancement of positive coping skills; facilitate use of natural resources and community supports; and enhance recovery-oriented elements such as hope and self-efficacy. The services are coordinated within the context of a comprehensive, Person-Centered Recovery Plan that includes specific individualized goals and delineates activities intended to achieve the identified goals.

Peer services must be provided by an agency or entity approved by the Department.

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

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	PAS Provider
Agency	Mental Health Centers
Agency	Other Entities Approved by Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Support

Provider Category:
Agency

Provider Type:
PAS Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules 37.90.437

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services / Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Support

Provider Category:
Agency

Provider Type:
Mental Health Centers

Provider Qualifications

License *(specify)*:
Licensed by Department of Public Health and Human Services / Quality Assurance Division

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and renewal of license

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Support

Provider Category:
Agency
Provider Type:
Other Entities Approved by Department
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Certification of Peer Support Training as approved by Department
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and renewal of certification

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Personal Assistance Service and Specially Trained Attendant Care

HCBS Taxonomy:

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

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

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

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Personal assistance services under the Home and Community Based Services (HCBS) Program may include supervision for health and safety reasons, socialization, escort and transportation for non-medical reasons, specially trained attendants for participants with mental health needs, or an extension of State Plan personal assistance services. Socialization under personal assistance is different from social restorative services under homemaker services. Socialization is available to those participants who require personal assistance to access the community, rather than just assistance with the access (social restorative). Specially trained personal assistance services are provided by attendants who have been specially trained to meet the unique needs of the HCBS participant. The service is more clearly defined as a tier of personal assistance and provides increased training and higher rate of reimbursement. It is the responsibility of the provider agency to ensure that assistants are appropriately trained under agency based services. Areas of special training include knowledge and understanding of serious mental illness and the needs of consumers with mental illness. All personal assistance service attendants are supervised by registered nurses.
Senior and Long Term Care Division, Department of Public Health and Human Services, has developed a manual for personal assistance provider agencies that outlines all policies and procedures relating to the Personal Assistance Services Program. This manual should be referred to for policy information.

Personal Assistance "per diem" is considered a shared delivery system which is defined as:
Shared service delivery is possible in accessible space apartment living complexes, however, not all of them provide this service at this time. These complexes are currently in the following communities: Missoula, Great Falls, Helena and Billings.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services provided under the waiver exceed or differ in scope from those available under the State Plan. State Plan services must be accessed first.
Personal assistance services are not allowed for a resident residing in adult residential setting.
Services under this definition are not duplicative of the transportation service.

Retainer Days
Providers of this service may be eligible for a retainer payment if authorized by the case management team. Retainers are days on which the particpant is either in the hosptial, nursing facility or on vacation and the team has authorized the provider to be reimbursed for services. Retainer days may not be used for any other HCBS services when they are utilized for PAS. If a provider rate includes vacancy savings, retainer days are a duplication of services and may not be paid in addition. Retainer days are limited to 30 days per year.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	PAS Provider
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Assistance Service and Specially Trained Attendant Care

Provider Category:
Agency

Provider Type:
PAS Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.431 and 37.90.436.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Assistance Service and Specially Trained Attendant Care

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Medicare Certified

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.431 and 37.90.436.
The agency is responsible to hire qualifed staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Personal Emergency Response System (PERS) is an electronic device which enables a participant to secure help in the event of an emergency. The participant may choose to wear a portable "help" button to allow for increased independence and mobility. The system is connected to the participant's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those participants who live alone, or who are alone for significant parts of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision.

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

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	PERS Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency

Provider Type:
PERS Provider

Provider Qualifications

License ***(specify)*****:**

Certificate ***(specify)*****:**

Other Standard ***(specify)*****:**
Administrative Rules of Montana 37.90.448.
the agency is responsible to hire qualified staff and follow all the state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Private Duty Nursing (and Registered Nurse Supervision)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Private Duty Nursing Services are services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) licensed to practice in Montana. These services are provided to a participant at home. Private duty nursing services are medically necessary services provided to participants who require continuous in-home nursing care that is not available from a home health agency. Private duty nursing service provided by an LPN must be supervised by an RN, physician, dentist, osteopath or podiatrist authorized by State law to prescribe medication and treatment. Private Duty Nursing may be prescribed only when Home Health Agency Services, as provided in ARM 37.40.701, are not appropriate or available and must comply with the Montana Nurse Practice Act. Services are provided according to the participant's service and support plan, which documents the participant's specific health-related need for nursing. Use of a nurse to routinely check skin condition, review medication use or perform other nursing duties in the absence of a specific identified problem, is not allowable. General statements such a "monitor health needs" are not considered sufficient documentation for the service. Private duty nursing is not a state plan service for adults.

RN Supervision is a service that provides supervision of an LPN who renders private duty nursing services under the Home and Community Based Services program.

RN Supervision services must be provided by a registered nurse who meets the licensure and certification requirements provided in ARM 8.32.401.

The registered nurse can be from a home health agency or an independent agency. The consumer and the case management team will have input in the amount and degree of supervision required and the projected cost.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Registered Nurse and Licensed Practical Nurse
Agency	Home Health Agency or Private Duty Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing (and Registered Nurse Supervision)

Provider Category:
Individual

Provider Type:
Licensed Registered Nurse and Licensed Practical Nurse

Provider Qualifications

License *(specify)*:
Registered Nurse or Licensed Practical Nurse according to ARM 8.32.401 et. Seq.

Certificate *(specify)*:

Other Standard *(specify)*:
Meets the state's definition as an independent contractor.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and upon license renewal

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing (and Registered Nurse Supervision)

Provider Category:
Agency

Provider Type:
Home Health Agency or Private Duty Nursing Agency

Provider Qualifications

License *(specify)*:
Registered Nurse or Licensed Practical Nurse according to ARM 8.32.401 et. Seq.

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.3447.
The agency is responsible to hire qualified staff and follow all the state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:
Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the person centered recovery plan, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Specialized medical equipment and supplies include the provision of service animals as well as items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the state plan and shall exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

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

Specialized Medical Equipment and Supplies will be limited to a one-time purchase with the exception of supplies not covered by State plan services. The Addictive and Mental Disorders Division, at its discretion, may authorize an exception to this. Purchases in excess of $5,000 must receive prior authorization from the Community Program Officer.

Specialized Medical Equipment and Supplies will not pay for vehicles, vehicle licenses or insurance.

Any equipment or supply covered under the State Plan must be used prior to the waiver.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Durable Medical Equipment Providers/Retailers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency

Provider Type:
Durable Medical Equipment Providers/Retailers

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
All services are provided in accordance with applicable Federal, State or local building codes and requirements (i.e., obtain permits), meet applicable standards of manufacture, design and installed requirements (i.e., obtaining permits) and comply with Administrative Rules of Montana 37.90.449. The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:
State during permit process; Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
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:
Substance Use Related Disorder Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Services that provide individual and/or group counseling in an outpatient setting for participants who have a substance abuse problem to meet the goals set forth in the individual's person centered recovery plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Addiction Counselor
Agency	Chemical Dependency Counseling Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Substance Use Related Disorder Services

Provider Category:
Individual

Provider Type:
Licensed Addiction Counselor
Provider Qualifications
License *(specify)*:
Licensed by Department of Labor and Industry
Certificate *(specify)*:

Other Standard *(specify)*:
Meets independent contractor requirements
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and renewal of license

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Substance Use Related Disorder Services

Provider Category:
Agency
Provider Type:
Chemical Dependency Counseling Providers
Provider Qualifications
License *(specify)*:
Licensed by Department of Public Health and Human Services/ Quality Assurance Division
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and renewal of license

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Supported Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Supported Living is the provision of supportive services to a participant residing in an individual residence or in a group living situation.
Supported Living is a bundled service which includes: independent living evaluation, homemaking, habilitation aides, non-medical transportation, specially trained attendants, prevocational training, supported employment, 24-hour availability of staff for supervision and safety, and service coordination to coordinate supported living services. A case management team may decide not to use a bundled service but instead oversee separate services.

Supported Living providers must have two years experience in providing the following services to persons with mental illness: integrated living; congregate living; personal social and community services; community employment services; and work services.

Waiver participants using this service must have identifiable Home and Community Based Services goals that are reviewed by the Case Management Team every 6 months or more frequently if necessary. Supported Living providers must show progress in the achievement of these goals. If progress is not apparent, the case management team must renegotiate the rate to reflect diminished goals.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Any individual in supported living may not receive other waiver services that would be duplicative to those included in the supported living plan. These include: adult day health, day habilitation, homemaker, homemaker chore, personal assistance, prevocational services, residential habilitation, respite, non-medical transportation, and supported employment.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living

Provider Category:
Agency
Provider Type:
Supported Living Provider
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Administrative Rules of Montana 37.90.429.
The agency is responsible to hire qualified staff and follow all state and fedeal labor laws.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services/ Fiscal Intermediary Contractor
Frequency of Verification:
Upon enrollment and every two years thereafter

Appendix C: Participant Services

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

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

◉ **No. Criminal history and/or background investigations are not required.**

○ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

◉ **No. The State does not conduct abuse registry screening.**

○ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The larger facilities are included in the activities outlined in the transition plan. They will be given a provider self assessment. The waiver residents will be given an opportunity to provide information to AMDD regarding their setting. Many of the larger facilities have attempted to provide a home-like environment through measures such as: being located in the community, allowing individuals to bring in personal belongings and decorate their living spaces, providing easy access to resources and activities in the community, providing access to cooking facilities and small dining areas, providing for private family

dinners, providing for individual differences in schedules and providing for privacy. All individuals will be allowed opportunities to access socialization activities according to individual choices. The waiver participant, family, and/or others, and Case Management Team work closely to determine the most appropriate facility for the waiver participant. The Case Management Teams have regular visits to ensure the participant is not isolated. The Community Program Officer will also complete annual visits and ensure the participant's needs are being met, including socialization.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Case Management	☐
Substance Use Related Disorder Services	☐
Occupational Therapy	☐
Non-Medical Transportation	☐
Specialized Medical Equipment and Supplies	☐
Private Duty Nursing (and Registered Nurse Supervision)	☐
Residential Habilitation	☑
Chore	☐
Homemaker	☐
Supported Living	☐
Community Transition	☐
Health and Wellness	☐
Supported Employment	☐
Pain and Symptom Management	☐
Respite	☑
Prevocational Services	☐
Adult Day Health	☐
Consultative Clinical and Therapeutic Services	☐
Personal Assistance Service and Specially Trained Attendant Care	☐
Peer Support	☐
Personal Emergency Response System	☐
Dietician/Nutrition/Meals	☐
Environmental Accessibility Adaptations	☐
Habilitation Aide	☐

Facility Capacity Limit:

Space dependent. No limit for assisted living facilities

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

All standards are based on licensure requirements in accordance with the Administrative Rules of Montana. Those not checked do not apply to the type of facility listed and are therefore not reviewed by the Licensing Bureau, Quality Assurance Division, Department of Public Health and Human Services, as part of their compliance reviews. Facilities are inspected to ensure adherence to those requirements which are checked above. Staff ratios are not addressed in the state regulations other than to indicate a need for sufficient staff to meet consumer needs. Services to waiver consumers are routinely monitored by Case Management Teams who ensure health and safety of waiver recipients in the facilities. Any concerns from the Case Management Teams will be brought to the attention of the Community Program Officers who will address these issues with the Quality Management Committee defined in Appendix H, Quality Management Strategy.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar**

services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

◉ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **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:

All potential SDMI waiver providers may become Medicaid providers as long as they meet the provider qualifications and are capable of providing services in the area in the state where the SDMI waiver is available. Providers meeting all the provider requirements are encouraged to enroll as Medicaid providers. All requests for enrollment in the Medicaid Program must be made through the State's fiscal intermediary Contractor. The Contractor will provide interested providers with enrollment information. There is a continuous, open enrollment of waiver service providers. Additionally, the State has established an on-line process ted for potential providers to access information electronically. The on-line process allows potential providers to access the provider application as well as applicable provider manuals for specific services at any time. The web sites for this electronic process are:
http://medicaidprovider.hhs.mt.gov/enrollmenttutorial/CONTENTS.html
https://mtaccesstohealth.acs-shc.com/mt/general/providerEnrollmentHome.do

The enrollment application must be completed in its entirety before the Contractor is able to process the enrollment application. This is the same process for enrollment of any Montana Medicaid provider. As specified in the contract

between the Department and the Contractor, Contractor will forward all completed enrollment applications to the Addictive and Mental Disorders Division, Department of Public Health and Human Services, for approval, procedure codes and rates. AMDD will act upon the completed enrollment application within five working days of receipt and return it to ACS for action.

The Case Management Teams will be responsible for waiver provider outreach to ensure there is an adequate listing of willing, available and qualified waiver providers from which the consumers may choose. There is information on the Department's web site to assist potential providers who are seeking information about Montana Medicaid and programs.

An advantage for the SDMI Waiver is the existing network of providers of services for enrollees in the Elderly and Physically Disabled Waiver and the Developmental Disability Waiver. It is anticipated many of these providers will be interested in providing services to enrollees in the SDMI Waiver. Concurrently, the network of mental health professionals has been provided information about the SDMI Waiver application and it is anticipated many of these providers will be ready and willing to provide services to enrollees in the SDMI Waiver.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Ensure providers continually adhere to required licensing standards. Numerator: number of waiver providers that have corrective plans by type of agency and infraction. Denominator: all waiver providers

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

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

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Quality Assurance Div. Program manager meets with Quality Assurance Division, Senior and Long Term Care waiver program manager, and Long term care Ombudsman office monthly to discuss providers.	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Quality Assurance Division - Licensing Bureau Review for compliance of Licensing Standards.	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other**

	Specify: SLTC Division reviews every three years or sooner if concerns were identified in previous review. AMDD will receive written summary of review, including corrective action requested.

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:
Percent of non-licensed/non certified providers that meet waiver provider requirements. Numerator: # of non-licensed/non certified providers that meet waiver requirements. Denominator: # of all non-licensed/non certified waiver providers.

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

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

	☐ Other Specify:	

Data Aggregation and Analysis:

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

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:
Percent of waiver providers that meet state training requirements Numerator is the number of providers who meet training requirements Denominator is all waiver 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 =
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
CPO will ensure that agencies are informed of relevant changes in state and federal policy and procedures and to assist in the training of new agency oversight staff around program policy and procedures (at agency request). The CPOs will provide a provider training report to MHSB central office that captures training dates, attendees and the materials provided. The MHSB central office will use the CPO training report to assure that appropriate training is provided to participating providers.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 Program Manager and CPOs will conduct a review of providers. The review will verify that providers meet relevant qualifications. Data collected in the review will be provided in a report to the MHSB. The CPO and MHSB will communicate the issue to the provider for response and resolution. The providers will be required annually to send in their copy of current certification and trainings, relating to their field of expertise, they have received. In addition, for those WRAP and IMR trainers will be required to send a list of the number of trainings they have provided to waiver recipients. This will be reviewed by the Program Manager and CPOs.

If it is determined that a provider is not in compliance with the qualification standards the provider will be issued a letter stipulating a corrective action plan. Their provider number will be inactivated until the provider demonstrates compliance.

SLTC will conduct onsite review of personal assistance agencies every three years. The summary of the results of review will be sent to Program Manager of MHSB for review. The review of the summary will be on an ongoing basis but at a minimum quarterly. Quality Assurance Division reviews licensed facilites. The Program Manager will meet with monthly with the Quality Assurance Division and Senior and Long Term Division to discuss the results of the license reviews and any corrective action plans requested.

Discovery - The Department does not do criminal background checks; however, ACS (fiduciary agent) checks with licensing entities within the Department of Labor and Industries, the Excluded Individual and Entities List, and Medicare exclusion lists prior to enrolling the provider. The hardcopy of the Licensee Lookup System indicates any adverse action or information regarding the enrolled provider and may prevent that individual or agency from being enrolled as a SDMI waiver provider. When a provider's license is renewed ACS will once again check the Excluded Individual and Entities List, Medicare Exclusion list and the Licensee Lookup System prior to re-enrollment of provider. All contracts issued by the Department go through a review process to insure the potential contractor is not on the Federal Debarment List.

The CPOs provide a quarterly provider training report to the Waiver Program Manager that captures training dates, attendees and the material provided. The CPOs will provide ongoing training to agencies, as necessary, to ensure that agencies are informed of relevant changes in state and federal policy and procedure and to assist in the training of new agency oversight staff around program policy and procedure (at agency request). The Waiver Program Manager will use the CPO training report to assure that appropriate training is provided to participating providers.

Remediation - AMDD will participate in a review of every provider at enrollment and re-enrollment. The review will include: service providers meet relevant qualifications; services are provided according to prior authorizations; and interviews with waiver consumers regarding their providers. Providers will be reviewed no more than three years dependent on their license status. If there are limited deficiencies the review may be every three years, and if there are a number of deficiencies the review may be as few as 6 months. When deficiencies are noted a letter is sent to the provider requesting a plan of correction. The plan of corrections is due 30 days from receipt of letter. The CPOs and Waiver Program Manager review and either approve or determine the plan of correction is not acceptable. If the plan of correction is unacceptable the provider must respond within 2 weeks with additional requested compliance. If the responsible is still unacceptable the Department will suspend the provider from receiving new referrals or cease all program operations. The provider will no longer provide services until the matter has been resolved. The Department can remove a provider when the provider continuously does not meet the standards. Based on the compliance issues AMDD will either return within six months or as much as three years for only enrolled providers.

ii. **Remediation Data Aggregation**

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

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

Specify:

☑ **Continuously and Ongoing**

☐ **Other**
Specify:

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

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

1) AMDD has completed a high level assessment of the settings. AMDD believes the majority of the settings will meet compliance with some modifications. The settings being utilized and reviewed in the waiver are: Residential Habilitation including respite care, Supported Living, prevocational and supported employment. We will be meeting with our specific providers to discuss the HCB setting rule and the possible implications they may have. In addition, it will be an opportunity to hear their concerns. The Program Manager and CPOs will meet in March 2015 to discuss the avenues we can utilize to educate providers and waiver participants. AMDD is working collaboratively with the other DPHHS Divisions to develop a provider and member experience survey. The draft will be put on the website for review and comment. We will hold meetings with providers, stakeholders and members to discuss the survey and receive their comments. After completion of the public comment period we will finalize the surveys based on the comments received.
2) AMDD and Department will review the provider self-assessments and the member experience assessments. The member experience assessments will help validate the provider assessments. A random selection of providers will be selected for on-site reviews. The Department will have this process be as transparent as possible with opportunity to comment on the process and documents. The Department has begun discussions with Quality Assurance Division on the new HCB settings and how we can work together on educating current providers as well as agencies applying as a new provider. We will also meet with fiscal intermediary contractor for the Department, to discuss the regulations and the part that they may play in providing education to new providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Person Centered Recovery Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   ☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

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.

Waiver participants will develop the Person Centered Recovery Plan with their Case Management Team (CMT). Family, friends, and anyone of the participants' choosing may provide support during the Person Centered Recovery Plan development. The CMT will maximize the extent to which the person participates by explaining the person-centered recovery planning process; assisting the participant to explore and identify his/her preferences, desired outcomes, goals, and the services and supports that will assist him/her in achieving desired outcomes; identifying and reviewing with the participant issues to be discussed during the planning process; and giving each person an opportunity to determine the location and time of planning meetings, participants attending the meetings, and frequency and length of the meetings. The waiver participant will have the authority to determine who is included in the process of person centered recovery plan development. The participant signs off on the person centered recovery plan once it is completed.

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) A person centered recovery plan is a written plan developed by the waiver participant and the Case Management Team (CMT) to assess the individual's status and needs. The recovery plan outlines the services that will be provided to meet his/her identified needs as well as the cost of those services. An initial plan must be developed at the time of the person's enrollment. The initial enrollment date is the date the individual begins receiving services under the Home and Community Based Services Waiver. This date will be entered in the upper left corner of the Plan of Care form and will be entered into the case notes. The CMT will notify Eligibility Staff of the Department of Public Health and Human Services (Department) whenever a Medicaid member is being admitted in the HCBS Waiver Program. The waiver participant must sign the recovery plan. The Community Program Officer (CPO) must approve the initial person centered recovery plan and each annual recovery plan.

(b)(c) The CMT will use an assessment tool to record the consumer's strengths, capacities, needs, preferences and desired outcomes along with his/her health status and risk factors. As needed, the CMT will consult with the individual and/or their representative and other health care professionals. The CMT may also consult family members, relatives, psychologists, medical personnel and other consultants as necessary, with approval. The recovery plan development includes a choice of providers. The CMT will provide a list of waiver providers from which the person chooses for the identified needs. The person will sign the recovery plan and receive a copy for his/her files, thus documenting his/her participation in the selection of providers and his/her direct involvement in the recovery plan development.

(d)(e) Each person centered recovery plan shall include at least the following components:
Diagnosis, symptoms, complaints and complications indicating the need for services;
A description of the functional level;
Specific short-term objectives and long-term goals, including discharge potential or plan;
Person's desired outcome;
A description of risk factors and special procedures recommended for the health and safety of the individual;
Discharge plan;
Any orders for the following:
Medication;
Treatments, Including Mental Health Regime;
Restorative and Rehabilitative Services;
Activities;
Therapies;
Social services;
Diet; and
The specific services to be provided, the frequency of services and the types of providers;
A psychosocial summary describing the person's social, emotional, mental and financial situation attached to the initial recovery plan;
Formal and informal supports; and a crisis plan;
A cost sheet which projects the annualized costs of HCBS; and
Signatures of all individuals who participated in development of the person centered recovery plan including the individual and/or representative and CMT (CMTs will maintain the listing of waiver providers from which the consumer chooses for his/her identified needs. Signatures by the individual on the recovery plan acknowledges freedom of choice providers. This is an area the Community Program Officers monitor during their annual quality assurance reviews, furthered detailed in Appendix H).

(f) All person centered recovery plans are subject to review by the Department of Public Health and Human Services (Department). The Department has delegated the review function to the Community Program Officer (CPO). The

CPO is responsible for reviewing all portions of the plan utilizing the criteria outlined below. Review of the person centered recovery plan will be based on the following:
• Completeness of plan which includes all necessary services being listed in terms of amount, frequency and planned provider(s) including assurances of freedom of choice of waiver providers (from the listing of waiver providers maintained by the CMT in the geographic area in the state where the SDMI waiver is available and may vary per geographic area);
• Consistency of the plan with screening information regarding needs; thoroughness of the crisis plan;
• Presence of appropriate signatures; and
• Cost-effectiveness of plan.

The recovery plan must provide documentation of the plan's costs. It will include all Home and Community Based Services to be provided, the frequency, amount and projected annualized cost of the services. The recovery plan will list the non-waiver services to be utilized by the consumer. The CMT will make all necessary referrals for non-waiver services for the consumer and the consumer has free choice of providers. The CMT will prepare the cost sheet after the recovery plan has been developed. The CMT must explain the cost sheet to the participant and/or representative. CMT will complete final cost plan upon return to office and document mailing of form to the participant and/or representative. The person centered recovery plan and cost sheet will be updated as needs change throughout the plan year. A new cost sheet must also be completed at each annual review and update of the person centered recovery plan. The CMT will review the recovery plan and cost sheet with the participant during the three-month plan review.

(g) Subsequent person centered recovery plans must be completed at least annually or when the participant's condition warrants it. The recovery plan is reviewed every three months with the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Training and information will be provided to every participant to prepare them for playing a greater role in the support and service planning and delivery process. The training and information will cover health and safety factors, emergency back up planning, and risk identification, assessment, and management. Participants will conduct a self-assessment as part of the planning and implementation process. If the participant's mental condition has decompensated, family members and other supports will be afforded the opportunity for training and information, if approved by the participant, and allowed to participate with the self assessment. Back up plans and risk identification and management are included in the person centered recovery plan. Emergency back up plans will be defined and planned for on an individual basis. The emergency back up plan may include an assessment of critical services and a back up strategy for each identified critical service. Back up may include:
1. Participant backup incorporated into the plan;
2. Informal backup (for example, family, friends, and neighbors);
3. Enrolled Medicaid provider network (for example, personal assistant agencies); and
4. System level (local emergency response). Back up services may be included and paid for by the waiver program.

As part of the quality assurance reviews, the Community Program Officer reviews every service and support plan to assure that it meets health care needs and there is proper documentation for emergency back up and risk management procedures.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the development of the plan, the participant will select providers from a list prepared by the Case Management Team (CMT). The CMT will maintain the list of waiver providers in the geographic area of the state where the SDMI waiver is available and the lists may vary per geographic area. The participant will choose providers from the list and

signatures by the participant on the person centered recovery plan acknowledging freedom of choice of waiver providers. The Community Program Officers monitor during the annual quality assurance reviews, further detailed in Appendix H. If the participant is dissatisfied with the list of available agencies, the CMT will solicit other providers for services.

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):

The Case Management Team is responsible for the development of the person centered recovery plans with waiver participants. All person centered recovery plans are subject to review by the Department of Public Health and Human Services (Department). The Department has delegated the review function to the Community Program Officers (CPOs). CPOs will be charged with the role of regular review and monitoring of planning, documentation, quality, and delivery of services to HCBS Waiver service participants. The CPO will approve the initial recovery plans for persons enrolling into the SDMI Waiver. Annually, the CPOs will attend 50% of the person centered recovery plan reviews and updates. Every two years, the CPOs will interview HCBS Waiver participants to ensure they feel they are in charge of their person centered recovery plan development; they agreed to all the services outlined in their recovery plans ; they had freedom of choice of services providers; and they signed their person centered recovery plans and retained copies for their files.

Appendix H – Quality Management Strategy, provides additional details.

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**
- [x] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Case Management Team (CMT) will monitor the implementation of the person centered recovery plan. The CMT will meet with the participant at least every three months to ensure that selected services are provided as outlined in the recovery plan and any changes needed. These meetings will also address health and welfare of the participant. The monitoring visits will include a review of the participant's service utilization history, a review of usage and effectiveness of the emergency back up plan and an evaluation of the quality and effectiveness of services. The CMT will identify any problems that need to be addressed and document the strategy for resolution. Serious Occurrence Reports are mandated for incidents in which the consumer's health and safety are at risk. These reports are sent to the Community Program Officer (CPO) for review. The CPO will become involved in problem solving strategies, as needed, to assist in resolution of issues beyond the scope of the participant and the case managers.

The recovery plan is subject to a review every three months for any changes needed to the plan. CMT will complete a person centered recovery plan annually. The annual review assesses the appropriateness and adequacy of the services utilized throughout the plan year for the participant. This will include a review of access to non-waivers services identified in the recovery plan.

The CMT and service providers are mandatory reporters of abuse, neglect, and exploitation. The CMT will complete a Serious Occurrence Report, file a report with the appropriate entity, and send a copy of the report to the CPO for quality assurance monitoring. The CPO provides a quarterly summary to Addictive and Mental Disorders Division, Department of Public Health and Human Services (Central Office) staff. In addition, they will consult with Central Office on any serious occurrences not resolved at the local level, patterns that may be reoccurring or necessary system changes as a result of reports.

Additionally, the CPO will be completing annual quality assurance reviews. This includes reviewing recovery plans developed by the CMT. The CPO will be able to ascertain from the waiver participant and family and/or others if there is satisfaction of waiver providers and adequacy of care through the plan reviews with participants and the biannual interviews. If warranted, the CPO will address any concerns with the Program manager. (Appendix H).

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:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Percent of Person Centered Recovery Plans that include services and supports that align with the participant's assessed needs. Numerator is the number of Recovery Plans that include services and supports aligned with the participants assessed needs. Denominator is all Person Centered Recovery Plans

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number of Person Centered Recovery Plans that meets 90% of the principles of charting checklist. Numerator is the number of Person Centered Recovery Plans that meet 90% principles of charting. Denominator is total number of Person Centered Recovery Plans reviewed.

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

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

Specify:		Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's 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:
The percentage of Person Centered Recovery Plans that are reviewed with the participant every three months. Numerator is the number of recovery plans reviewed every three months. Denominator is the number of recovery plans.

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

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

Data Aggregation and Analysis:

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

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:
Percent of waiver participants who receive services in the type, amount, frequency, and duration specified in the Person Centered Recovery Plan. Numerator is the number of participants who receive services in the type, amount, frequency, and duration specified in the Recovery Plan. Denominator is the total number of waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Done primarily through the desk audits by CPO. This will also be discussed at least monthly during staffing with CMT.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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:
Percent of waiver participants who were afforded a choice of provider. Numerator is the number of waiver participants who were afforded a choice of providers. Denominator is the total number of waiver participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Checklist with all providers available included in consumer file documenting providers chosen by consumer and signed

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

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 Community Program Officer (CPO) will conduct a review of 100% of the case files for waiver

participants. The review will:
*determine if the Person Centered Recovery Plan is completed and comprehensively addresses the participant's need for waiver services, health care and other services in accordance with the participant's preference and goals;
* determine if plan development followed person centered planning procedure and if the plan meets program policy;
* included indicators to assess the completeness of participant's records, changes in needs; and involvement in updating the plan as necessary;
* assure documentation of choice between waiver services and institutional care;
* assure documentation of freedom of choice among qualified providers.

Person Centered Recovery Plan reviews will occur as part of the annual file review. The initial Person Centered Recovery Plan approval is required from the CPO with 30 days of signature from participant. Annual plan of care approval is required by the CPO. The MHSB and CPO will utilize the Quality Review checklist to assess for a comprehensive plan that addresses participant's goals and objectives, health and safety, service needs, expenditures that are appropriate and allowable, correct procedure codes, viable emergency backup plan, health care professional sign off, risk assessment and agreement (if necessary), and appropriate signatures for the recovery plan, including the waiver participant. The recovery plan will be strength based and participant choice. The CPO will address any errors or missing information with the case management team prior to approval of the recovery plan.

Completed waiver participant files will be maintained by the case management agency. The file contains: CMT notes, Person Centered Recovery Plan (with amendments and changes), MPQH Level of Care determination, SDMI determination, Level II results (if appropriate), Level of Care reassessment documentation of prior authorization of services and supports, admittance form, serious occurrence reports, health care professional sign off form, and documentation of freedom of choice for qualified providers.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Initial Person Centered Recovery Plan approval is required by the CPO. Annual Person Centered Recovery Plan approval is required by the CPO. The MHSB and CPO will utilize the Quality Review checklist to assess for a comprehensive plan that addresses waiver participant goals and objectives, health and safety, service needs, expenditures that are appropriate and allowable, correct procedure codes, viable emergency backup plan, health care professional sign off, risk assessment and agreement (if necessary), and appropriate signatures for the recovery plan, including the participant. The recovery plan will be strength based and participant choice. The CPO will address any errors or missing information with the participant and case management team prior to approval of the Person Centered Recovery Plan. The CPO, on an ongoing basis, will address any errors or missing information with the case management agency. Data collected in the review will be provided in a report submitted to the MHSB and provider. Providers are required to respond to the report with resolution efforts according to the specified time frames. All responses to the review must be resolved and returned to the MHSB and CPO prior to closure of the review.

Discovery - AMDD will conduct a review of 100% of case files. The review will: determine if the person centered recovery plan is complete and comprehensively addresses the participant's need for services, recovery, health care and other services in accordance with the preferences and personal goals; determine if recovery plan followed AMDD policies and procedures; include indicators to assess the completeness of waiver records, changes in needs, and involvement in the development and update of the recovery plan; assure documentation of choice between waiver services and institutional care; and assure documentation of freedom of choice among qualified providers.
The initial Person Centered Recovery Plan will occur within 10 days of enrollment in waiver program. This timeframe is necessary for persons who have a difficulty trusting a new case management team to share their needs and goals. The annual Person Centered Recovery Plan review must be completed within 30 days after the initial recovery plan. The CPO will review the assessment and recovery plan. The review process will include a review of the biopsychosocial, goals, health and safety, service and recovery needs, expenditures that are appropriate and allowable, correct procedure codes, viable psychiatric and medical emergency plan, health care professional sign off, waiver participant sign off, and other appropriate signatures for recovery plan. The CPO will address any errors or missing information with the participant and Case Management Team (CMT) for correction prior to approval of the plan.
Complete consumer files will be maintained by the CMTs. The files will consist of: CMT notes, Person Centered Recovery Plan (including amendments and updates), MPQH Level of Care determinations and

reassessment documentation, prior authorizations for services and supports, admittance form, serious occurrence reports, and health care professional sign off form.
The CMTs generate a monthly management report to AMDD. Data includes type of housing and estimated monthly utilization of services.
Every two years the CPO will have a face to face with waiver participants for a satisfaction survey. The results will be used for quality assurance.

Remediation – If a person centered recovery plan does not assure that health and safety needs are met, the CPO will work with the CMT and participant to make appropriate adjustments to the recovery plan in order to receive the necessary approval. When a plan is not developed in accordance with program policy and procedure the CPO will work with the CMT and waiver participant to take appropriate corrective action. The CPO will respond to any immediate concerns related to the health and safety of the participant.
Data collected in the review will result in a report that will be submitted to the Case Management Agency (CMT) and to AMDD. The Case Management Team is required to respond to all identified quality assurance recommendations with corrective plan within 30 days from receipt of letter. The provider can request an extension from AMDD if there sufficient reason for the delay. If AMDD does not grant the extension, the provider will be suspended from providing services which could lead to disenrollment and loss of service. All corrective actions from the quality improvement recommendations must be approved by Waiver Program Manager and CPO prior to closure of the review.
Program Manager will meet monthly with the Quality Assurance Division, Senior and Long Term Care (SLTC) Division and Ombudsman Office to discuss results of facility reviews. Corrective action plans will be discussed and reviewed.

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

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

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

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one)*:

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Nature of the opportunities afforded to participants
Individuals may self-direct some of their services as well as access traditional agency based delivered services as needed. They are provided the opportunity to select and manage staff who perform personal assistance type services using employer authority.

How participants may take advantage of these opportunities
Upon intake into the waiver, case managers will inform every applicant about participant directed option. If an individual indicates interest in the program AMDD will provide an orientation guide about self-direct opportunity in the waiver. Waiver participants will have the opportunity to select either the traditional waiver or the self-direct option.

Entities that support individuals who direct their services and the supports that they provide
Participants will be able to choose from several agencies providing personal assistance type services, ensuring they are successful with participant directed experience. The agencies will: 1) advise, train and support the participant, as needed and necessary, 2) assist with recruiting, interviewing, hiring, training and managing, and/or dismissing workers, 3) manage the employee that includes mandatory agency training and payroll, and 4) assist with monitoring health and welfare. The case management teams will: 1) assist to develop an emergency backup plan, 2) identify risks or potential risks and develop a plan to manage those risks, and 3) assist with monitoring health and safety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ◉ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's

representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

MPQH determines the ability of persons to self-direct their state plan personal assistance services. AMDD will use this as entry criteria. In addition, the person choosing to self-direct the waiver personal assistance type services will need to complete the Wellness Recovery Action Plan prior to approval for self-direction.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The most important component of the outreach strategy is developing and disseminating material to inform current and potential participants about the benefits and potential liabilities of self-directing under the self-direction option. AMDD and community partners provide an orientation guide to all waiver participants who indicate an in the waiver. When a participant decides to participate in self-direct provide skill assessment and training related to self-direction. This will be done prior to enrollment in the program.

At any point during the outreach stages a participant is free to opt out of the self-direction and select to receive the

personal assistance type services via the traditional agency based model.

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:

A personal representative will be required for any potential enrollee who has impaired judgment as identified on the assessment tool used by MPQH and/or is unable to:
1) Understand his/her own personal care needs;
2) Make decisions about his/her care;
3) Organize his/her lifestyle and environment by making these choices;
4) Understand how to recruit, hire, train and supervise providers of care;
5) Understand the impact of his/her decisions and assume responsibility for the results; or
6) When circumstances indicate a change of competency or ability to participant direct demonstrated by noncompliance with program objectives.
The potential enrollee, MPQH, a case manager, and AMDD may request a personal representative be appointed. A personal representative may be a legal guardian, or other legally appointed personal representative, an income payee, a family member or friend. The personal representative must be willing and able to fulfill the responsibilities as outlined in the Personal Representative Agreement and must demonstrate:
1) A strong personal commitment to the consumer;
2) Ability to be immediately available to provide or obtain backup services in case of an emergency or when an attendant does not show;
3) Demonstrate knowledge of the participant's preferences;
4) Agree to predetermined frequency of contact with participant;
5) Be willing and capable of complying with all criteria and responsibilities of consumers;
6) Be at least 18 years of age; and
7) Obtain the approval form the potential enrollee and/or a consensus from other family members to serve in this capacity if applicable.
A personal representative may not be paid for this service nor be a paid worker or paid to provide any other waiver services to the participant. The overall management of personal representatives will assist AMDD to assure health and safety of each individual in participant direction. Each personal representative will be required to complete and sign a Personal Representative Agreement and an Authorized Personal Representative Designation Form and participate in Person Centered Recovery Plan development and reviews.

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
Personal Assistance Service and Specially Trained Attendant Care	☑	☐

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*:

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Case Management	☐

Substance Use Related Disorder Services	☐
Occupational Therapy	☐
Non-Medical Transportation	☐
Specialized Medical Equipment and Supplies	☐
Private Duty Nursing (and Registered Nurse Supervision)	☐
Residential Habilitation	☐
Chore	☐
Homemaker	☐
Supported Living	☐
Community Transition	☐
Health and Wellness	☐
Supported Employment	☐
Pain and Symptom Management	☐
Respite	☐
Provocational Services	☐
Adult Day Health	☐
Consultative Clinical and Therapeutic Services	☐
Personal Assistance Service and Specially Trained Attendant Care	☑
Peer Support	☐
Personal Emergency Response System	☐
Dietician/Nutrition/Meals	☐
Environmental Accessibility Adaptations	☐
Habilitation Aide	☐

☐ **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)

l. **Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants may, at any time, return to the traditional provider managed model. The participant will notify the agency of their intention. The case managers and CPO will coordinate services to ensure that no break in vital services and timely revision of the person centered recovery plan occurs. The reason for the voluntary termination will be documented.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. **Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

When the quality management system identifies an instance where the participant-directed option is not in the best interest of the individual and corrective action (additional training, appointment or change of personal representative, etc.) does not ameliorate the situation, the individual will be informed in writing of the plan to transfer to traditional provider managed service delivery. This could occur due to failure to follow the self-direct policies or failure to participate in the planning of their services. AMDD in collaboration with the agency and case managers will ensure that no break in vital services and a timely revision of the person centered recovery plan occurs. The individual may appeal this decision by requesting a fair hearing through the Department of Public Health and Human Service Fair Hearing process.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	10	
Year 2	20	
Year 3	25	

Year 4	30	
Year 5	35	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. **Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The participant (or participant's personal 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 payroll and human resource functions. Supports are available to assist the participant in conducting employer related functions. The Personal Assistance Agencies are the agencies of choice that serve as co-employers of participant selected staff.

☐ **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:

☑ **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.**
☑ **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**

- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [ ] **Discharge staff (common law employer)**
- [x] **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:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. **Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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:

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.

Waiver participants will be notified of the fair hearing process by eligibility staff when they complete the Medicaid application process. Participants will also be notified of the fair hearing process by the Mountain Pacific Quality Health (MPQH) when they receive the choice of waiver or institutional services during level of care assessment process. They will be notified of the fair hearing process by Case Management Teams (CMTs) when information is provided on choice of providers of service or when there is an adverse action such as a denial, reduction, suspension or termination of services. CMTs will also specify that they will continue to receive waiver services during the period while the appeal is under consideration. CMTs will provide information regarding the fair hearing process on an on-going basis through their routine involvement with the waiver participants.

Resources for waiver participants in the fair hearing process include the Mental Health Ombudsman, Montana Disability Rights Program and personal attorneys of the participants and/or families. All documentation that participants were provided notification of the fair hearing process will be kept in the respective agency files.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Addictive and Mental Disorders Division (AMDD) has established a system of reporting and monitoring serious incidents that involve waiver participants served by AMDD in order to identify, manage and mitigate overall risk to the individual.

A "serious occurrence" means a significant event involving a consumer, which affects the health, welfare or safety of the individual served under the circumstances listed below. Many of the individuals accessing waiver services are vulnerable to abuse or neglect. All persons employed by an agency participating in Home & Community Based Services are mandated by law to report any instances or suspected instances of abuse or neglect to Adult and Protection Services (APS). They are also required to complete a Serious Occurrence Report (SOR). The SOR can be electronically submitted. The SOR must be completed anytime an individual's life, health, or safety has been put at risk. This includes all reports for suspected abuse, neglect or exploitation submitted to APS or Child Protective Services (CPS). Following is a partial list of incidents necessitating a Serious Occurrence Report:
1. Suspected or known physical, emotional, sexual or verbal abuse;
2. Allegations of abuse and neglect;
3. Neglect of the consumer, self-neglect or neglect by a paid caregiver;
4. Exhibiting threatening behavior from or toward others;
5. Sexual harassment by an agency employee or consumer;
6. Injuries received while in care of others, i.e. bruises, lacerations, bump;
7. Serious injuries that require hospital emergency room or equivalent level of treatment or hospital admission. Injuries may be either observed or discovered;
8. An unsafe or unsanitary working or living environment which puts the worker and/or consumer at risk;
9. Any event that is reported to APS, CPS, Law Enforcement, the Ombudsman Program or QAD/Licensing, Drug Utilization Review Board;
10. Exhibiting significant behavior, i.e. alcohol or drug abuse;
11. Referrals to the Medicaid Fraud Unit;
12. Medical & Psychiatric Emergency: Admission of an individual to a hospital or psychiatric facility or the

provision of emergency medical services that results in medical care which is unanticipated and/or unscheduled for the individual;

13. Medication Emergency: When there is a discrepancy between what a physician prescribes and what an individual actually takes and these results in hospital emergency room or equivalent level of treatment or hospital admission;
14. Suicide resulting in death, suicide attempt or suicide threat;
15. Death.

•All Case Management Teams (CMTs) and service providers are mandated to immediately refer all suspected abuse, neglect or exploitation to APS or CPS. CMTs and service providers must complete the SOR and notify the Community Program Officer (CPO) within ten working days of their referral to APS or CPS. The provider agency must document cause and effect of the incident and the action plan to correct or prevent incidents from occurring in the future.

The CPO will review the SOR and return it to the provider, with any responses, within 10 working days. The provider completing the report will include the appropriate case management team as the secondary provider on the SOR.

The CPO is responsible for ensuring an appropriate response by the provider agency. The designated state agency (e.g. APS or CPS) will monitor the provider agency to ensure the corrective action plan was activated and identified issues resolved. The CPO will obtain copies of documentation to ensure compliance has occurred. CPO will monitor the corrective plan of action and sign off on the SOR as approval of action plan and closed the SOR as resolved.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information on identifying, addressing, and protecting someone from abuse, neglect, and exploitation and how to notify the appropriate authorities will be provided to waiver participants during the development of the Person Centered Recovery Plan. The Case Management Teams will continue to provide this information at the annual renewal of the recovery plan. Participants can access information on the Department of Public Health and Human Services (Department) website. Information on incident management, abuse, neglect and exploitation and consumer protection will be covered as special training topics by the Mental Health Services Bureau in the Central Office for the Community Program Officers (CPOs). Training and education for the CPOs will occur on an annual basis or as changes in policies are made.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Investigations involving Abuse, Neglect and Exploitation and/or criminal activity:

Reports of abuse, neglect and exploitation are made to APS or CPS for evaluation, reporting, and investigation. APS are emergency intervention activities which may include: investigating complaints, coordinating family and community support resources, strengthening current living situations, developing and protecting personal financial resources and facilitating legal intervention. All reports come through a centralized intake hotline where trained staff assess the situation and send a report to field staff. Local APS or CPS social workers evaluate, assess, prioritize and follow-up on all cases within their jurisdiction.

CPS are provided to children under the age of 18 in the state of Montana. The response timeline for CPS reports depends on the incident. Any report that is assessed at the level of imminent danger is responded to within 24 hours. For all other reports, response time varies depending on the nature of the report, location, and whether local law enforcement is involved. Before a case is closed a safety assessment is conducted to assess whether appropriate action was taken.

APS are provided to persons over the age of 60, physically or mentally disabled adults (as defined by the Department through SSI or vocational rehabilitation) and adults with developmental disabilities who are at risk of physical or mental injury, neglect, sexual abuse or exploitation. APS provides voluntary protective services to any individual in their jurisdiction. However, APS is unable to provide involuntary protective services to physically or mentally disabled adults under the age of 60. All APS reports are assessed by regional supervisors for imminent risk and capacity of the individual. Cases are triaged using social work methodology and serious cases are responded to first. A computer data system has a built in alert system to track cases and open investigations. Any report that is referred

for investigation has 90 days to be closed.

APS, CPS, Medicaid providers and CPOs make referrals, when necessary, to local law enforcement or other entities. Referrals to local law enforcement include illegal activities, theft, embezzlement and incidents involving significant abuse.

Investigations outside the scope of APS, CPS and local law enforcement:

Incidents and events outside the scope of APS, CPS or local law enforcement authority are reported to the pertinent provider agency. The agency investigates the incident and provides follow-up, when needed. The provider agency documents the scope of the incident, the incident's cause and effect, and work with the individual to develop an action plan to correct or prevent the incident from reoccurring in the future. This information is captured on a SOR. A copy of the SOR must be provided to the CPO within 10 days. The CPO will follow up on the SOR to ensure that the incidents are being addressed and resolved as they occur and during the quality assurance reviews. The CPO is responsible for insuring an appropriate and timely response is provided by the provider agency. On the SOR form there is a section where the CPO may comment on the incident and mark any follow-up action taken, including providing training, case conference, and/or sanctions.

All referrals where there is suspected abuse, neglect, exploitation or other unlawful activity will be immediately reported to the appropriate authority. The Case Management Team (CMT) will be made aware of the referrals through their interactions with waiver enrollees and families and provider agencies. The CMT will follow up with the appropriate authority to ensure the health and safety of waiver consumers. The authority responsible for the investigation may not be able to share the investigation results with CMT, however, due to confidentiality of the investigation. The CMT and Community Program Officers (CPOs) will be monitoring the services provided to waiver enrollees and making necessary changes within the plan of care as well as working with the waiver providers, should the investigation involve providers. The Case Management Team will apprize the CPOs of all serious events. The CPO will be responsible for tracking serious events and bringing situations to the attention of the Program Manager and AMDD. The Program Manager will ensure there is adequate training and monitoring of specific providers in the event there appears to be a common pattern being established in any of the waiver sites.

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 Department of Public Health and Human Services, Addictive and Mental Disorders Division (AMDD) Central Office is responsible for overseeing the operation of the serious occurrence incident management system. All critical events or incidents involving a waiver participant warrant a Serious Occurrence Report (SOR) that is sent to the local CPO who oversees the incident management process and ensures appropriate reporting and follow-up occurs at the local level. The Quality Assurance Management System (QAMS) is the system for all SOR reporting. The Program Manager will pull reports from QAMS for the purpose of analyzing and reviewing the SORs.

The Program Manager will have monthly meetings with the CPOs to discuss the management of critical incidents and events. Program Manager will meet more frequently with individual CPOs, as warranted.

At a minimum, AMDD, CMTs and CPOs will meet annually to discuss the management of critical incidents and events. Training from APS, CPS and law enforcement staff may be included in the annual meetings to provide in-services training to CMTs and CPOs.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◎ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Department of Public Health and Human Services/Addictive and Mental Disorders Division is responsible for detecting unauthorized use of restraints or seclusion. AMDD staff performs routine quality assurance reviews that include home visits with waiver participants and standards for participant satisfaction. AMDD staff provides ongoing training with providers and participants to assure health, safety and welfare. AMDD operates a serious occurrence reporting system as a part of the overall quality management of the waiver. Serious occurrence reports (SORs) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the QA reviews of providers to assure appropriate reporting and resolution of incidents. Any unauthorized use of restraints and restrictive interventions will be reported to the Quality Assurance Division for investigation and to AMDD.

○ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. **Use of Restrictive Interventions.** *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Department and AMDD are responsible for detecting unauthorized use of restrictive interventions. AMDD staff performs routine quality assurance reviews that include home visits with waiver participants and standards for participant satisfaction. AMDD staff provides ongoing training with providers and waiver participants to assure health, safety and welfare. The Division operates a serious occurrence reporting system as a part of the quality management of the waiver. Serious Occurrence Reports (SOR) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are reviewed as a standard in the QA reviews of providers to assure appropriate reporting and resolution of incidents. Any unauthorized use of restraints and restrictive interventions will be reported to the Quality Assurance Division for investigation and to AMDD.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Department of Public Health and Human Services/Addictive and Mental Disorders Division is responsible for detecting unauthorized use of seclusion. AMDD staff performs routine quality assurance reviews that include home visits with waiver participants and standards for participant satisfaction. AMDD staff provides ongoing training with providers and participants to assure health, safety and welfare. AMDD operates a serious occurrence reporting system as a part of the overall quality management of the waiver. Serious occurrence reports (SORs) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the QA reviews of providers to assure appropriate reporting and resolution of incidents. Any unauthorized use of restraints and restrictive interventions will be reported to the Quality Assurance Division for investigation and to AMDD.

○ **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.

Staff in licensed assisted living facilities and licensed group homes provide medication management for self-administered medication. They are responsible for keeping track of medication and ensuring the individuals take their medications as prescribed. Medication is kept in a locked box or cabinet thus restricting access by other residents. Assisted living facilities utilize a bubble pack filled by a pharmacy whenever possible. Group homes always utilize a bubble pack system. In addition, group home staff are required to take a test and be certified to manage and assist with self-administered medication. Staff in licensed assisted living facilities and licensed group homes will refer all medication errors to their respective management and complete the Serious Occurrence Report. Management will work with the Case Management Teams where waiver participants are involved.

The Quality Assurance Division, Licensing Bureau, is responsible for the issuance of licenses to assisted living facilities and group homes. Annual reviews are completed to ensure compliance in the area of medication regimens. Reviews may occur more frequently if warranted.

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.

Department of Public Health and Human Services, Quality Assurance Division, Licensing Bureau, ensures the appropriate management of medication during quality assurance reviews. The point-of-sale system used by pharmacy providers has a set of built-in edits to inform the pharmacist of potential contraindicated effects such as drug-to-drug interaction and therapeutic duplications. There is also a prior authorization process based on clinical criteria established the Drug Utilization Review Board for the Department. Through periodic reviews, Case Management Teams (CMTs) will monitor that participants on the waiver receive their medication as prescribed and will report any mismanagement, harmful practices or crimes to the appropriate authorities. CMTs will be required to complete necessary documentation to report any serious occurrences. Oversight and follow-up are the responsibility of the Quality Assurance Division, Licensing Bureau.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. **Medication Administration by Waiver Providers**

i. **Provider Administration of Medications.** *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Licensed practical nurses and registered nurses administer medication as outlined in the Nurse Practice Act of Montana.

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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

◉ **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:

Providers must record medication doses missed or refused by resident and why, and unexpected effects of medication or medication error.

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.

The State Medicaid Agency is responsible for monitoring the performance of waiver providers in the self-administration of medications to participants on the waiver. Licensed facilities are monitored by the Department of Public Health and Human Services Licensing Bureau. CMTs, during their review processes or as necessary, evaluate the self-administration of medication by waiver providers.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Percent of reports of abuse, neglect, and exploitation that were investigated and resolved within stipulated time frames. Numerator is the number of abuse, neglect and exploitation reports that were investigated and resolved within stipulated time frames. Denominator is the total number of reports.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

	☐ Continuously and Ongoing
	☐ Other Specify:

b. ***Sub-assurance: The state 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:
Percentage of Serious Occurrence Reports (report by type of SOR) reported with the required timeframe. Numerator is the number of SORs reported by type within time frame. Denominator is the total number of SORs received.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	☐ Other Specify:	

Data Aggregation and Analysis:

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

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:
The number and percent of unauthorized uses of restrictive interventions that are appropriately reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports

Responsible Party for data collection/generation	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*

(check each that applies):		
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

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:
The number and percent of waiver participants receiving annual physical exam.
Numerator - number of participants who receive physical health care.
Denominator - total number of waiver participants

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

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

Data Aggregation and Analysis:

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

[x] State Medicaid Agency	[ ] Weekly
[ ] Operating Agency	[ ] Monthly
[ ] Sub-State Entity	[ ] Quarterly
[ ] Other Specify:	[x] Annually
	[ ] Continuously and Ongoing
	[ ] Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The CPO will review all serious occurrence reports on an ongoing basis. They will review for incident types, response time and remediation activities. AMDD Central Office staff will review SORs and CPO response on a quarterly basis.

The medication monitoring will be for those persons who self-administer their medications. The Case Management Teams will require a nurse to visit persons who are self-administering their medications and do not have any other persons monitoring their use. They will check on their use of medication. This will be done by reviewing the prescriptions and tallying the amount of medication remaining. The nurse will meet monthly with the Case Management Team to discuss the monthly medication monitoring. Any missing doses or more doses remaining than prescription notes will be documented and the nurse will discuss with Case Management Team, waiver recipient and doctor. If it is determined the person cannot self-administer their medication the nurse will set up a process of distributing medication. If a person has one year without incidence of self-administering their medication the monitoring can discontinue. This can start up again if warranted.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
As part of the ongoing review of Serious Occurrence Reports, the CPO, when necessary, will take immediate and appropriate action to remediate situations when the health, safety or welfare of a waiver participant has not been safeguarded. The quarterly SOR report will be analyzed and reviewed by Program Manager. The Program Manager will review SORs by type, agency and waiver site. This will allow the Program Manager to identify patterns and trends. All SORs are electronic through Quality Assurance Management System (QAMS) and a report is generated through the QAMS. Prevention and training strategies will be developed to respond to patterns and trends identified by the CPOs, CMTs and AMDD. The Program Manager and CPOs meet monthly and review the reports quarterly. As necessary, APS and AMDD will work together to develop and implement strategies for prevention.

Discovery – The CPO will review all serious occurrence reports (SORs) on an ongoing basis. They will review for incident type, response time by CMT and remediation activities. The Waiver Program Manager will receive copies of all serious occurrence reports and the results of the review by CPO. The Waiver Program Manager will review the SOR for response time and resolution by CMT and CPO. The SOR quarterly report, including the breakdown of types of SORs, is available throught the QAMS by the Waiver program manager for the Quality Management Committee to identify any trends. Training for Waiver providers will be identified based on those trends. All CMT will receive program manual detailing the policies and procedures of the programs. Training of providers and CMT will specifically address information on how to identify and report abuse, neglect and exploitation. A crisis manual will be made available to all providers.

Remediation – As part of the ongoing review of Serious Occurrence Reports the CPO, when necessary when there is imminent risk of harm, will take immediate and appropriate action to remediate situations when the health or welfare of a consumer has not been safeguarded. The Waiver Program Manager will track the timeliness and resolution of Serious Occurrence Reports against AMDD policies and procedures. The quarterly report developed by the Waiver Program Manager will be analyzed and reviewed by the AMDD Quality Management Committee. Based on this review, prevention strategies will be developed by AMDD to respond to patterns and trends. As necessary, APS and AMDD will work together to develop and implement strategies for prevention. When the AMDD Quality Management Committee determines the SORs identify systemic issues, the Committee will recommend strategies to AMDD to prevent further incidences. The strategies would be dependent on the issue identified but could involve several responses from AMDD including additional training, rule changes or referral to another agency such as law enforcement, as examples. The Committee would require a follow up report from AMDD describing results of the strategies implemented. If the SORs are provider related issue initially training would be required or disciplinary action requested if the occurrence was imminently jeopardizing and individual's health or safety. The CPO will also be responsible for follow-up with individual providers regarding an SOR related issue. The CPO would request the provider address the issue and comply with recommended follow-up from the SOR. The time frame for compliance would be negotiated with the provider and CPO. If the change in provider behavior is not acceptable, AMDD would stop using the provider and refer to Quality Assurance Division for potential sanctions.
If the SOR is identified as a waiver consumer issue the CMT and CPO will discuss the issue with the consumer and determine a corrective plan for the consumer and the time line. Again, this will be monitored closely for resolution within the time line. Dependent on the issue the plan could be education, counseling or referral to another entity. The waiver consumer will be an active participant in the corrective plan and any decisions determined necessary to resolve the issues. Unfortunately, when a consumer is abusive to providers the behavior does need to change or providers will refuse to serve the consumer. It is imperative that this resolved before it gets to this point, which could result in the waiver unable to serve the individual in the community.

The medication monitoring will be documented in progress notes. Medication monitoring will be added to the annual quality assurance review. The quality assurance review team will receive a list of persons who are self administering their medication and will review the progress notes to ensure monthly visits. If monthly visits are missed the case management team will be written up. They will be required to develop a system to ensure each person is reviewed monthly for medication monitoring. When a person has one year of no difficulty with medication self administering, the medication monitoring will discontinue. If an issue arises the monthly medication monitoring would resume.

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 2)

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;
- 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 QIS* 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 2)

H-1: Systems Improvement

a. **System Improvements**

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Quality Management Strategy for the SDMI waiver is: The Addictive and Mental Disorders Division (AMDD or Division) of the Department of Public Health and Human Services (Department) will conduct comprehensive evaluations of services to Home and Community Based Services (HCBS) consumers to meet the Division's quality assurance requirements. AMDD staff will perform announced quality assurance reviews. The purpose of the review is to ensure that optimal services are being provided to consumers and that program rules and policies are being followed. Quality assurance results will be utilized to improve the programs and services.

In General

The Quality Management (QM) process will involve a strategy to ensure that individual consumers have access to and are receiving the appropriate services to meet their needs. This will require ongoing development and utilization of individual quality standards, and working with case management teams to evaluate individualized personal outcomes and goals.

The QM process will also involve a strategy designed to collect and review data gathered from providers and individual consumers on quality assurance measures. Provider standards and quality indicators are used to ensure that quality assurances are met. At the Division level in the Helena office, the Quality Management Committee will identify trends and systemic issues and provide remediation, as necessary. Each of the Waiver assurances and other federal requirements will be addressed below at varying levels of responsibility, beginning with the field agents (Community Program Officers; CPOs). Their responsibilities will be the utilization of discovery and monitoring methods, through reviews of consumer clinical records, specifically to include service plans, comparison with up-to-date documentation of service claims paid, and interviews with staff and consumers to evaluate areas of strength and weakness in the overall program. A Quality Management Committee will be assembled to serve as an intermediate quality improvement entity. Their role will be to monitor the discovery activities of the CPOs; to evaluate their submitted information; and to participate in policy decisions that address provider or system deficiencies. They, in turn, will report to Division Management staff through formal reports and meetings, and will keep the Division informed regarding the effectiveness with which qualifying providers support Waiver consumers. Recovery markers have been established as performance/outcome indicators. These include the domains of Employment; Level of Symptom Interference; Housing; Substance Abuse (stages of change and level of use). Each domain contains items that will be scored and submitted quarterly through a secure web based application by case managers to the State Mental Health Authority for analysis, review, and distribution to the Quality Management Committee and other invested stakeholders. All reports will contain only summarized data to ensure consumer confidentiality. The State Mental Health Authority currently administers an annual nationally standardized Consumer Satisfaction Survey that measures Access to services; Quality and Appropriateness of services; Consumer Satisfaction with services; consumer perspective on Outcomes; and consumer Participation in Treatment Planning. This survey will be modified where appropriate to obtain optimal feedback from consumers regarding the Waiver service program.

Additionally, all Case Management Team Providers are required to conduct internal audits of their records to ensure the waiver consumers' files include the necessary documentation to support the consumers' indentified needs. The plans of care must be accurate and complete; services must be aligned to address the identified needs; the cost sheet must match the services provided; and all required information must be included in the file. The qualifications of the case management teams will be reviewed to ensure compliance. These internal audits of the case management providers are performed by the case management agency staff; not by the case

management team staff. Information during the internal audits, which are completed annually, will be made available to the Community Program Officers during their annual reviews of the Case Management Teams. Areas of concern that may into suspected overpayments will be referred to the Audit and Compliance Bureau.

SLTC reviews Personal Assistance agencies a minimum of every three years. The summary reports will be shared with AMDD. All corrective action plans from providers will be reviewed by AMDD. Should any of the areas of deficiency involve individuals from the SDMI waiver the appropriate CPO and Program Manager will be contacted to review the deficiency and corrective plan. The Quality Assurance Division reviews all facilities. The SLTC, Ombudsman, AMDD and Quality Assurance meet monthly to discuss concerns with licensing and corrective plans. The SLTC Ombudsman office will contact the appropriate CPO and Program Manager when a concern is registered with their office. The consumer satisfaction surveys will include a section on their waiver services other than the case management teams. This information will be reviewed by the CPO and Program Manager. Should there be any issues related to Health and Safety these will be addressed immediately with the agency. CPOs review all plans of care and the services provided to waiver recipient. The CPO will make monthly contact with each service provider which will include respite, homemaker, supported employment and other services other than just personal care. In addition, these providers are included in the annual satisfaction survey.

Quality Management Committee Roles and Responsibilities

The Quality Management Committee (QMC; currently under development) will include consumers, providers, Division officials, and members of the Mental Health Oversight and Advisory Council. It is expected that the QMC will meet at least quarterly, and presumably more frequently during the strategic planning and mission development phase. The Mental Health Quality Assurance Manager will facilitate the Committee meetings. The Quality Assurance Manager holds a doctorate in psychology program evaluation with an emphasis on public policy. Roles and responsibilities of this committee will include, but will not be limited to:

a) Work with the Division Management team to establish and monitor performance standards;
b) Serve as a liaison between the CPOs and the Division's Management staff;
c) Review information from the discovery methods utilized and documented by CPOs on an ongoing basis, and based upon Departmental policy, issue a corrective action that identifies deficiencies. The Committee will provide remediation where appropriate, monitoring and follow-up of remediation activity; document the final outcome, and issue a report to the provider and the Division's Management staff;
d) Review the information submitted by the CPOs and note any trends, patterns, systemic issues of concern, as well as positive changes and improvements that support the goals and objectives of the Waiver;
e) Develop corrective action plans to remedy all areas of concern identified under d);
f) Monitor corrective action plans to ensure improvements are occurring;
g) Evaluate the CPOs' QA review activities to ensure consistency, comprehensiveness, and quality of the review process. Consumer chart reviews will be conducted on a rotating basis among HCBS waiver case managers; to include all case managers at least annually. In cases of discrepancies between a CPO and case management team review determination the Committee will provide mediation, training, and discussion until resolution is achieved;
h) Track performance indicators on at least a quarterly basis;
i) Respond to issues that arise from the QM database and CPO reports;
j) Review and revise the QM strategy as the program evolves; and
k) Generate performance reports to Division Management staff, Waiver case management teams, Advisory Council, and other invested stakeholders.

ii. **System Improvement Activities**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other**	☐ **Other**

Specify:	Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The review of the effectiveness of the system design changes will take place during the Quality Assurance (QA) Committee meetings. The review will occur as necessary, but at a minimum annually. The Program Manager will gather information for the review using information from the Quality Improvement (QI) Team, information from discovery methods, Community Program Officers (CPOs), waiver participants and provider input. The review will evaluate the effectiveness, efficiency, and appropriateness of the quality management system design changes.
The QA Committee will review summaries of information on trends, patterns and areas of concern. As issues arise they will be prioritized and strategies developed to address them. An evaluation of the quality assurance infrastructure will be part of the QA Committee meetings. This review will occur as necessary, but at least on an annual basis and will evaluate the effectiveness, efficiency and appropriateness of the QA system.
At the local level, the CPO will identify trends and systemic issues and provide assessment information to the AMDD central office on a quarterly basis. The AMDD central office will perform QA functions through ongoing review of discovery information; monitoring the QA onsite reviews and desk audits; quarterly QI Team meetings and working to develop and implement performance indicators. Case management teams will keep state staff informed of effectiveness of design changes at state wide meetings.

The Quality Management Committee includes AMDD central office, provider representatives, waiver participants, and Community Program Officers (CPOs). The Quality Improvement (QI) Team includes the CPOs, Clinical Manager, Quality Assurance Manager, and Program Manager. The CPOs and Program Manager will meet monthly to discuss issues, trends observed, review of policies and procedures, and service utilization. At the local level, the CPOs will meet monthly with providers to discuss any issues with staff, waiver participants and case management teams. The CPOs have weekly or bi-weekly meetings with their case management teams to discuss issues with providers, participants, review person centered recovery plans, cost sheets and any other issues. The AMDD central office will prepare a quarterly report for the Quality Assurance Committee which will include any trends identified and progress on performance measures.

The Quality Assurance Committee includes AMDD central office, provider representatives, waiver participants, and Community Program Officers (CPOs). The Quality Improvement (QI) Team includes the CPOs, Clinical Manager, Quality Assurance Manager, and Program Manager. The CPOs and Program Manager will meet monthly to discuss issues, trends observed, review of policies and procedures, and service utilization. At the local level, the CPOs will meet monthly with providers to discuss any issues with staff, waiver participants and case management teams. The CPOs have weekly or bi-weekly meetings with their case management teams to discuss issues with providers, participants, review person centered recovery plans, cost sheets and any other issues. The AMDD central office will prepare a quarterly report for the Quality Assurance Committee which will include any trends identified and progress on performance measures.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Assurance Committee and Quality Improvement Team are described in b.i. The contact with Program Manager and CPO is monthly. CPOs meet monthly with providers and meet weekly or biweekly with CMTs.
State Roles and Responsibilities
1. Level of Care (LOC) decision monitoring:
The state will monitor LOC decisions and take action to address inappropriate LOC determinations. This function will be the responsibility of the Program Manager and Clinical Manager. Mountain Pacific Quality Health is contracted to perform initial level of care evaluations and annual level of care reevaluations. If a Case Management Team (CMT) has a concern a waiver participant may no longer meet nursing facility level of care criteria, the CMT may contact the MPQH and request a level of care reevaluation. Annually, the CMT will contact MPQH for a LOC reevaluation of the waiver participant. The same screening determination tool is used for the initial level of care determination and subsequent level of care determinations.
2. Person Centered Recovery Plan:

a) Services will be delivered in accordance with the person centered recovery plan, including the type, scope, amount, duration, and frequency specified in the service plan. This task will be monitored by AMDD Staff that matches services reimbursed by Medicaid for Waiver participants with person centered recovery plan goals. CPOs will be provided records of services by participant to compare with recovery plans. Discrepancies will be referred to the QI Team for further review.
b) The CPO will authorize the initial person centered recovery plan for participants enrolling into the waiver. This initial exposure to the recovery plan will familiarize the CPOs with the participants and their needs and provide an opportunity to work directly with the CMTs. CPOs will be available to problem-solve difficult situations as requested by the CMTs.
c) Through annual reviews of the CMTs records, CPOs will determine that recovery plans for waiver participants were updated annually or more frequently as needed.
d) The annual reviews will provide documentation that the participant was afforded the choice between waiver services and institutional care; offered free choice of waiver providers; and was directly involved in the development of their recovery plan.
e) Discrepancies will be reported to the QI Team.
3. Qualified Providers:
a) The Department will verify that providers meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
b) The Department will verify on an annual basis that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards.
c) All HCBS Waiver service providers must be licensed in their field of expertise. Fiscal Intermediary Contractor, the Department's fiscal agent, will verify licenses of service providers on a regular basis. If a provider does not have an active license, Fiscal Intermediary Contractor will inactivate the provider number and notify the provider and the Department.
d) The Department will identify and remediate situations where providers do not meet requirements.
e) The Department will implement policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver.
4. Health and Welfare:
a) There will be continuous monitoring of the health and welfare of waiver participants and remediation actions will be initiated when appropriate.
b) The Department, on an on-going basis, will identify, address and seek to prevent the occurrence of abuse, neglect and exploitation.
c) All suspected occurrences of abuse, neglect and exploitation will be reported to the appropriate agency (please refer to Appendix G-1-c).
d) Annual reviews completed by the CPOs will provide baseline data regarding quality services, adequacy of services, comprehensive review of all serious occurrence reports, and assurance records are in order and follow the principles of charting. Paid claims data will also be reviewed concurrently during the review period. Once data is pulled, there will be an in-depth review to determine if a common pattern is occurring. If there is a common pattern, the Department will develop a corrective action plan to address any and all issues.
e) Any corrective action plans identified to remedy a situation will be documented and results provided to the appropriate State agency. CMTs and waiver providers will cooperate to prevent any further occurrences of abuse, neglect, or exploitation.
f) The Mental Health Services Bureau will ensure training of CPOs and CMTs in the areas of health and welfare of waiver participants.
g) The Case Management teams will do home visits at least quarterly. The teams will review the self-administration of medication with the individual. The teams will contact providers on a monthly basis to ensure medication is administered appropriately. Any inappropriate medication management such as missed doses, missing medication or taking medication more frequently than prescribed will warrant a SOR. The CPO will investigate and contact Agency for resolution. The resolution would be training on medication administering, equipment that controls dosage, written reprimand, or dismissal to name examples.
h) Montana does not allow the use of restraints. Should the Teams, CPOs or others suspect any use of restraints an immediate report will be given to APS and the Ombudsman Office for an investigation.
i) Alcohol and drug abuse, at times, poses additional health and safety issues. The Case Management Teams meet with the providers monthly to review their waiver participants. Alcohol and drug abuse by a waiver participant may warrant a SOR. At the very least, the CMT must address their concerns with the individual and will be closely monitored by more home visits and more frequent contact with the providers going into the home through a risk negotiation process. Training on alcohol and drugs, stages of change, and motivational interviewing will be provided to CMTs, CPOs, and providers.
5. Administrative Authority:
a) The Montana Department of Public Health and Human Services, Addictive and Mental Disorders Division will retain ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions of contracted entities. The Mountain Pacific Quality Health contract

oversight will be shared responsibility between the Senior and Long Term Care Division and the Addictive and Mental Disorders Division.
b) The CPOs will conduct annual reviews of the CMTs records to ensure services were provided to waiver participants in accordance with their identified needs. These annual reviews will encompass interviews with CMT staff; other waiver providers and the participants of the waiver.
c) The Division may request an audit from the Audit and Compliance Bureau if determined necessary by the AMDD through activities completed by the CPOs.
d) The MMIS Contract Manager in the Director's Office directly oversees the Fiscal Intermediary Contractor contract. Fiscal Intermediary Contractor will provide a report card monthly to the Divisions which include the contract requirements. In addition, Fiscal Intermediary Contractor and the department have a monthly status meeting.
6. Financial Accountability:
a) Claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan and properly billed by qualified waiver providers in accordance with the approved waiver.
b) The CPOs will complete a comparison of up-to-date documentation of paid claims data with the participants' plan of care to ensure accurate billing of services occurred in accordance with those services outlined in the plans of care. The Division will have a data base that compiles the paid claims history from Fiscal Intermediary Contractor (fiscal agent) for the waiver participant and allows the CPO to match the information with the plan of care. This review process will occur annually for each waiver participant.
c) The Division will provide ongoing training to each CMT to ensure accuracy of coding and payments. If there is a CMT experiencing issues with billing deficiencies, AMDD central office will meet with the CMT as warranted.
CPO QA Roles and Responsibilities
Community Program Officers (CPOs) will be charged with the role of regular review and monitoring of planning, documentation, quality, and delivery of services to HCBS Waiver service participants. The CPO will approve the initial plans of care for participants enrolling into the SDMI Waiver. The CPO will interview HCBS Waiver participants to ensure the participants are in charge of their plans of care development; they agreed to all of the services outlined in their plans of care; they had freedom of choice of service providers; and they signed their plans of care and retained copies for their files.
1. Level of Care (LOC) determinations will be the function of the Mountain Pacific Quality Health (MPQH). In a situation where the participant may not appear to meet nursing facility level of care criteria as determined by MPQH, the CPO will conduct an on-site review of the participant's needs, situation and status. If there is additional information to warrant a change in the MPQH's initial determination, the CPO will consult with MPQH and a nursing facility LOC decision will be made.
Chart reviews will include an evaluation of the need for and inclusion of a written evaluation for LOC for all applicants for whom there is reasonable indication that services may be needed in the future. Also included in charts will be annual reevaluations of LOC. The Case Management Teams (CMTs) will keep a tickler filing system as an alert when a waiver participant is nearing his/her annual LOC review. The CMT will contact the MPQH in a timely manner and request a reevaluation of the participant's LOC.
2. Annually, CPOs will verify through a review of waiver participant's files at the case management agency, the documentation of selection of waiver services or institutional care by participants; and selection of waiver services and providers, as indicated by the participant's signature. A new person centered recovery plan will be written annually by the CMT. The CPOs will conduct annual comprehensive reviews to ensure full compliance by the CMTs. The CPOs will follow the established quality assurance review process.
3. At least every 90 days (or when warranted by changes in the waiver participant's needs), a person centered recovery plan will be reviewed with the participant by the CMT to ensure the recovery plan addresses all of the participants assessed needs (including health and safety risk factors) and personal goals. The CMT will do the recovery markers review during the 90 day review. The recovery markers measure the level of symptom interference; housing situation; employment/volunteer; substance use: level of use; and substance use: stage of change.
3. The CPO will participate in the person centered recovery plan development or review at least with 50% of the waiver participants. This provides the CPO an opportunity to meet the waiver participant and observe the CMT engaging the waiver participant in their person centered recovery plan.
4. Every two years the CPOs will interview the waiver participants. Historically, AMDD has used the Participant Experience Survey (PES) developed by The Medstat Group for CMS. The QI Team will be reviewing other surveys to either replace with or in addition to the PES.

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).

The Department of Public Health and Human Services (Department) provides financial oversight to assure that claim coding and payment are in line with the waiver reimbursement methodology. The Department does not require waiver providers to secure an independent audit of their financial statements. Paid claims reports will be run by the Addictive and Mental Disorders Division (AMDD) of the Department on at least a monthly basis (or as needed). These reports will depict the services utilized, the number of waiver participants using each service, the number of units utilized, and the total dollar amount paid for each service. As a part of the quality assurance reviews, financial accountability will be assessed. Charts will be reviewed by AMDD staff to ensure that no payments were made for waiver services when a waiver participant was permanently or temporarily discharged from waiver services. The Audit and Compliance Bureau of the Department will conduct financial audits upon request of the AMDD. The Audit and Compliance Bureau 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 SDMI waiver providers without being directly referred by the AMDD. Audits will be conducted in compliance with the single state audit act.

Case Management Providers are required to conduct internal audits of their records to ensure the waiver participant' files include the necessary documentation to support the participants' identified needs. The person centered recovery plans must be accurate and complete; services must be aligned to address the identified needs; the cost sheet must match the services provided; and all required information must be included in the file. The qualifications of the case management teams will be reviewed to ensure compliance. These internal audits of the case management providers are performed by the case management agency staff; not by the case management team staff. Information from the internal audits, which are completed annually, will be made available to the Community Program Officers (CPOs) during their annual reviews of the Case Management Teams. Areas of concern that may fall into suspected overpayments will be referred to the Audit and Compliance Bureau.

The CPOs does desk audits on 100% of the waiver participants during each fiscal year. The desk audits have waiver paid claims by waiver participant and by service. The State Plan expenditures are reviewed to ensure State Plan funds have been used prior to waiver funds. The claims are compared with the cost sheet and person centered recovery plan to ensure the waiver participant is receiving the services identified on the cost sheet. Any discrepancies are discussed with the case management teams and a summary of trends is sent to central office AMDD.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(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 claims that are paid within the individual's Person Centered Recovery Plan authorizations. Numerator is number of claims paid correctly according to Person Centered Recovery Plan. Denominator is the total number of paid claims.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

b. ***Sub-assurance:** The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

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

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

Performance Measure:
Providers are paid in accordance with the rate methodology specified in the approved waiver application. Numerator is the number of paid claims based on the rate methodology in the approved waiver. Denominator is the number of paid claims.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

☐ Continuously and Ongoing	☐ Other Specify:
☐ Other Specify:	

Data Aggregation and Analysis:

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

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 AMDD and CPOs will conduct at least annual audits of participant records to ensure the waiver services are aligned to address the identified needs and the cost sheet matches services provided and paid claims support services authorized and provided.

b. **Methods for Remediation/Fixing Individual Problems**

i. Describe the State's 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.
AMDD will provide ongoing training to all waiver providers identifies as having issues with billing to ensure accuracy of coding and proper billing. If there is a waiver provider experiencing issues with billing deficiency, AMDD will meet with the provider until resolution has occurred. The Department's fiscal agent holds two provider trainings annually where waiver providers have the opportunity to learn proper billing procedures and to discuss any billing issues.

Discovery – AMDD will run a paid claims report monthly (or as needed). These reports will include the services utilized, the number of waiver participants using each service, the number of units utilized, and the total dollar amount paid for each service. As part of the onsite quality assurance reviews, financial accountability will be assessed. The waiver participant files will be reviewed by AMDD to ensure that no payments were made for waiver services when a participant was permanently or temporarily discharged from waiver services. AMDD will also ensure that no payments were made for waiver services that were not

included in the plan.
Case management teams are required to conduct internal audits of their records to ensure the waiver consumer files include the necessary documentation to support the waiver participants identified needs. The person centered recovery plan must be accurate and complete; services must be aligned to address the identified needs; the cost sheet must match the services provided; and all required information must be included in the file. These internal audits of the CMT are performed by the case management agency staff, not by the CMT staff. Information from the internal audits, which are completed annually, are made available to AMDD during the annual reviews of the CMTs. Areas of concern that may fall into suspected overpayments will be referred to the Audit and Compliance Bureau.
CPOs will complete a comparison of up-to-date documentation of paid claims data (desk audit) with the participants' recovery plan to ensure accurate billing of services occurred in accordance with those services outlined in the recovery plans. The CPOs will review 100% of the consumers' plan of care to ensure accurate billing annually. The CPOs will review a selection of recovery plans quarterly with 100% being completed annually.

Remediation – The Program Manager will review the monthly paid claims reports. If there is a discrepancy the CPO and CMT will be notified, requesting more information. If an error is identified training will be provided the appropriate person.
When reviewing the internal audit, areas of concern that may fall into suspected overpayments will be referred to the Audit and Compliance Bureau. The Audit and Compliance Bureau will investigate and send recommendations to the CMT agency and AMDD.
The CPO shares the results of the desk audits with the CMT with any corrections made at that time. The CPO will send a summary of the desk audits to the Waiver Program Manager within 30 days. The summary will be due to AMDD thirty days following the completion of the desk audits. The desk audits will be done quarterly, with 100% participants reviewed each fiscal year. If the desk audits are not completed with the time frame the CPO supervisor will conduct a coaching session with the CPO staff. If there continues to be difficulty in timely submission of reports the supervisor will begin the State of Montana personnel disciplinary process.

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

Payments for waiver services will be consistent with efficiency, economy and quality of care and will be sufficient to enlist enough providers. Services will be reimbursed via fee for service; there will be no interim rates, no prospective payments, and no cost settlements. The Department of Public Health and Human Services (Department) will take into consideration the difficulty of care factors for some of the waiver services. Information regarding the HCBS services, definitions and rates of reimbursement will be available on the Department"s web site and through Fiscal Intermediary, the Department"s fiscal agent. The Case Management Team will have this specific information in hard copy format to provide to waiver enrollees.

The Department"s Senior and Long Term Care (SLTC) Division has operated a home and community based waiver program for elderly and physically disabled consumers since the early 1980's. SDMI HCBS waiver service descriptions that are the same or similar as the SLTC HCBS waiver, will use the established fee schedule. Many of the same service providers provide waiver services to both waivers' participants and having the same fee schedule will ensure uniformity of rates. In addition, the rate setting methodology will be defined in the Administrative Rules of Montana for the HCBS Waiver for Adults with Severe Disabling Mental Illness. The rule process solicits written and oral comments from the public through a formal hearing.
Reimbursement for waiver services is established pursuant to ARM 37.90.408.
ARM 37.90.408 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: REIMBURSEMENT

The services are reimbursed at the lower of the following:
(a) The provider's usual and customary charge for the service; or
(b) The rate negotiated with the provider by the case management team up to the department's maximum allowable fee.

Personal Assistance as provided at ARM 37.40.1105; and Outpatient occupational therapy as provided at ARM 37.86.610; are reimbursed in accordance with the referenced provisions governing reimbursement of those services through the general Medicaid program
Case management services are reimbursed as a per diem rate.
Respite care services provided by a nursing facility are reimbursed at the rate established for the facility in accordance with ARM Title 37, chapter 40, subchapter 3.
Reimbursement is not paid for a service that is otherwise available from another source.
No co-payment is imposed on services provided through the program but recipients are responsible for co-payment on other services reimbursed with Medicaid monies.
Reimbursement is not available for the provision of services to other members of a participant's household or family unless specifically provided for in these rules.*
The Montana State Legislature approves all provider rate increases and is included in HB 2 budget appropriations for the Department.

*The Case Management Team will evaluate the uniqueness of each waiver participants' needs.
If, for example, the waiver participant's home is in need of heavy duty cleaning (chore service),
The service will be provided and the spouse residing in the home will benefit from the chore
Service.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver service providers bill Montana Medicaid through the MMIS. Payments are issued directly to the providers; no funds are retained by the Department or by the State.

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 has a participant eligibility system that verifies eligibility for Medicaid and the waiver. Case managers will prior authorize all waiver services in the participant's Person Centered Recovery Plan. These prior authorizations will be submitted to the state"s fiscal intermediary contractor. The quality assurance plan includes a process to verify that payments for services were made in accordance with the recovery plan and no waiver services were paid for a participant who was discharged from the waiver.

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:

☐ **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:

Nursing facilities that receive county tax dollars may provide respite services to participants who are on the SDMI waiver. Local city-county health departments that receive city or county tax dollars may provide case management services or direct nursing services to participants who are on the SDMI waiver. Community mental health centers that receive county tax dollars may provide professional mental health services to participants who are on the SDMI waiver.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

◉ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

○ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

◉ **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.**

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:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**
Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The Department sets reimbursement for room and board in residential settings. Upon admission, providers are notified that the waiver may not cover the cost of room and board for the waiver participant. The cost calculation sheet utilized by the case managers to determine reimbursement for services has a line item for room and board, which is identified as the responsibility of the participant.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

◉ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver**

participants.

○ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	17828.30	1326.00	19154.30	60571.75	2508.00	63079.75	43925.45
2	17789.56	1352.52	19142.08	61783.18	2558.00	64341.18	45199.10
3	17759.47	1352.52	19111.99	63018.66	2558.00	65576.66	46464.67
4	17735.93	1352.52	19088.45	63018.66	2558.00	65576.66	46488.21
5	17720.68	1352.52	19073.20	63018.66	2633.00	65651.66	46578.46

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	225	225
Year 2	230	230
Year 3	235	235
Year 4	240	240
Year 5	245	245

Appendix J: Cost Neutrality Demonstration

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The FY 2013 has the average length of stay at 276 days. This will be used in each waiver year appendix J.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

State FY 2014 data was used as the base line to determine utilization of services and estimate number of users per services. The FY 2014 average annual cost per waiver participant was used as the base to determine Waiver Year 1 with a 2% provider rate increase. A 2% provider rate increase was factored into waiver years 2. Waiver years 3,4, and 5 were increased by 2% adjusting for growth of numbers served. The legislature meets every two years and the next biennium will determine percentage of provider rate increase for waiver years 3 and 4.

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:

The FY 2012 372 report was used for baseline with an 2% annual provider rate increase factored in for waiver years 1 and 2. Waiver years 3,4, and 5 were increased by 2% adjusting for growth of numbers served. The legislature meets every two years and the next biennium will determine percentage of provider rate increase for waiver years 3 and 4.

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:

FY 2014 was used as the baseline and a 2% annual provider rate increase was factored in for waiver years 1 and 2.

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:

Determined from FY 2014 paid claims. A 2% provider rate increase was factored in for waiver years 1 and 2. An anticipated growth of 2% for waiver years 3,4, and 5 were factored in.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Adult Day Health
Case Management
Homemaker
Prevocational Services
Residential Habilitation
Respite
Supported Employment

Occupational Therapy
Chore
Community Transition
Consultative Clinical and Therapeutic Services
Dietician/Nutrition/Meals
Environmental Accessibility Adaptations
Habilitation Aide
Health and Wellness
Non-Medical Transportation
Pain and Symptom Management
Peer Support
Personal Assistance Service and Specially Trained Attendant Care
Personal Emergency Response System
Private Duty Nursing (and Registered Nurse Supervision)
Specialized Medical Equipment and Supplies
Substance Use Related Disorder Services
Supported Living

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
Adult Day Health Total:						27514.08
Adult Day Health	15 min	6	2123.00	2.16	27514.08	
Case Management Total:						757620.00
Case Management, Daily	day	225	276.00	12.20	757620.00	
Homemaker Total:						34992.00
Homemaker	15 minute	135	60.00	4.32	34992.00	
Prevocational Services Total:						518.49
Prevocational Services	hour	2	33.80	7.67	518.49	
Residential Habilitation Total:						2025977.04
Specialized Residential Habilitation	day	4	156.00	151.71	94667.04	
Residential Habilitation	day	115	225.00	74.64	1931310.00	
Respite Total:						44765.08

Respite	15 minute	2	26.00	4.24	220.48	
Respite Care, Per Diem	day	15	18.00	164.98	44544.60	
Supported Employment Total:						604.80
Supported Employment	15 minute	2	24.00	12.60	604.80	
Occupational Therapy Total:						435.04
Occupational Therapy	visit	2	4.00	54.38	435.04	
Chore Total:						18375.00
Chore	per job	35	2.10	250.00	18375.00	
Community Transition Total:						6000.00
Community Transition	service	3	4.00	500.00	6000.00	
Consultative Clinical and Therapeutic Services Total:						109176.00
Consultative Clinical and Therapeutic Services	service	30	10.00	363.92	109176.00	
Dietician/Nutrition/Meals Total:						19851.44
dietician, nutritional counseling	15 minute	2	5.00	14.98	149.80	
meals	meal	21	155.07	6.05	19701.64	
Environmental Accessibility Adaptations Total:						172500.00
Environmental Accessibility Adaptations	service	23	5.00	1500.00	172500.00	
Habilitation Aide Total:						4575.60
Habilitation Aide	hour	62	4.00	18.45	4575.60	
Health and Wellness Total:						171000.00
Health and Wellness	service	90	19.00	100.00	171000.00	
Non-Medical Transportation Total:						10345.69
Non-Medical Transportation	trip	25	31.00	12.16	9424.00	
Non-Medical Transportation, per mile	mile	133	21.00	0.33	921.69	
Pain and Symptom Management Total:						105000.00
Pain and Symptom Management	service	70	20.00	75.00	105000.00	
Peer Support Total:						60375.00
Peer Support	15 minute	60	80.50	12.50	60375.00	
Personal Assistance Service and Specially Trained Attendant Care Total:						53262.80
Personal Assistance	15 min	110	79.00	5.32	46230.80	
Personal Assistance Service and Specially Trained Attendant Care	15 min	60	20.00	5.86	7032.00	

Personal Emergency Response System Total:						8470.40
PERS, Installation and Testing	visit	18	1.30	100.00	2340.00	
Personal Emergency Response System	item	1	1.00	500.00	500.00	
PERS, Monthly Rental	monthly	80	1.00	70.38	5630.40	
Private Duty Nursing (and Registered Nurse Supervision) Total:						4273.87
RN Supervision	15 min	25	3.88	8.63	837.11	
Private Duty Nursing (and Registered Nurse Supervision)	15 min	119	4.00	7.01	3336.76	
PAS Nurse Supervision	hour	1	2.00	50.00	100.00	
Specialized Medical Equipment and Supplies Total:						123332.75
Specialized Medical Equipment	item	134	4.00	200.00	107200.00	
Specialized Medical Supply	item	47	13.73	25.00	16132.75	
Substance Use Related Disorder Services Total:						287.00
Substance Use Related Disorder Services	15 minute	5	5.00	11.48	287.00	
Supported Living Total:						252114.40
Supported Living	day	20	58.00	217.34	252114.40	
			GRAND TOTAL:			4011366.49
			Total Estimated Unduplicated Participants:			225
			Factor D (Divide total by number of participants):			17828.30
			Average Length of Stay on the Waiver:			276

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
Adult Day Health Total:						28872.10
Adult Day Health	15 min	6	2187.28	2.20	28872.10	
Case Management Total:						789691.20
Case Management, Daily	day	230	276.00	12.44	789691.20	
Homemaker Total:						

						36721.19
Homemaker	15 minute	135	61.68	4.41	36721.19	
Prevocational Services Total:						544.12
Prevocational Services	hour	2	34.79	7.82	544.12	
Residential Habilitation Total:						2025918.16
Specialized Residential Habilitation	day	4	152.94	154.74	94663.74	
Residential Habilitation	day	115	220.59	76.13	1931254.42	
Respite Total:						46979.56
Respite	15 minute	2	26.78	4.32	231.38	
Respite Care, Per Diem	day	15	18.52	168.28	46748.18	
Supported Employment Total:						634.53
Supported Employment	15 minute	2	24.69	12.85	634.53	
Occupational Therapy Total:						455.96
Occupational Therapy	visit	2	4.11	55.47	455.96	
Chore Total:						19278.00
Chore	per job	35	2.16	255.00	19278.00	
Community Transition Total:						6303.60
Community Transition	service	3	4.12	510.00	6303.60	
Consultative Clinical and Therapeutic Services Total:						114589.44
Consultative Clinical and Therapeutic Services	hour	30	10.29	371.20	114589.44	
Dietician/Nutrition/Meals Total:						20830.81
dietician, nutritional counseling	vist	2	5.14	15.28	157.08	
meals	meal	21	160.86	6.12	20673.73	
Environmental Accessibility Adaptations Total:						180876.60
Environmental Accessibility Adaptations	service	23	5.14	1530.00	180876.60	
Habilitation Aide Total:						4795.71
Habilitation Aide	hour	62	4.11	18.82	4795.71	
Health and Wellness Total:						179469.00
Health and Wellness	service	90	19.55	102.00	179469.00	
Non-Medical Transportation Total:						10827.81
Non-Medical Transportation	trip	25	31.90	12.40	9889.00	
Non-Medical						

Transportation, per mile	mile	133	21.39	0.33	938.81	
Pain and Symptom Management Total:						110205.90
Pain and Symptom Management	service	70	20.58	76.50	110205.90	
Peer Support Total:						63357.30
Peer Support	15 minute	60	82.82	12.75	63357.30	
Personal Assistance Service and Specially Trained Attendant Care Total:						55893.22
Personal Assistance	15 min	110	81.22	5.43	48512.71	
Personal Assistance Service and Specially Trained Attendant Care	15 min	60	20.57	5.98	7380.52	
Personal Emergency Response System Total:						8901.04
PERS, Installation and Testing	visit	18	1.34	102.00	2460.24	
Personal Emergency Response System	item	1	1.03	510.00	525.30	
PERS, Monthly Rental	monthly	80	1.03	71.79	5915.50	
Private Duty Nursing (and Registered Nurse Supervision) Total:						4488.36
RN Supervision	15 min	25	3.99	8.80	877.80	
Private Duty Nursing (and Registered Nurse Supervision)	15 min	119	4.12	7.15	3505.50	
PAS Nurse Supervision	15 min	1	2.06	51.00	105.06	
Specialized Medical Equipment and Supplies Total:						129559.12
Specialized Medical Equipment	item	134	4.12	204.00	112624.32	
Specialized Medical Supply	item	47	14.13	25.50	16934.80	
Substance Use Related Disorder Services Total:						300.95
Substance Use Related Disorder Services	15 minute	5	5.14	11.71	300.95	
Supported Living Total:						252105.87
Supported Living	day	20	56.86	221.69	252105.87	
				GRAND TOTAL:		4091599.55
				Total Estimated Unduplicated Participants:		230
				Factor D (Divide total by number of participants):		17789.56
				Average Length of Stay on the Waiver:		276

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
Adult Day Health Total:						30695.68
Adult Day Health	15 min	6	2325.43	2.20	30695.68	
Case Management Total:						806858.40
Case Management, Daily	day	235	276.00	12.44	806858.40	
Homemaker Total:						39037.10
Homemaker	15 minute	135	65.57	4.41	39037.10	
Prevocational Services Total:						578.52
Prevocational Services	hour	2	36.99	7.82	578.52	
Residential Habilitation Total:						2025830.61
Specialized Residential Habilitation	day	4	152.94	154.74	94663.74	
Residential Habilitation	day	115	220.58	76.13	1931166.87	
Respite Total:						49947.48
Respite	15 minute	2	28.47	4.32	245.98	
Respite Care, Per Diem	day	15	19.69	168.28	49701.50	
Supported Employment Total:						674.62
Supported Employment	15 minute	2	26.25	12.85	674.62	
Occupational Therapy Total:						484.81
Occupational Therapy	visit	2	4.37	55.47	484.81	
Chore Total:						20527.50
Chore	per job	35	2.30	255.00	20527.50	
Community Transition Total:						6701.40
Community Transition	service	3	4.38	510.00	6701.40	
Consultative Clinical and Therapeutic Services Total:						121827.84
Consultative Clinical and Therapeutic Services	hour	30	10.94	371.20	121827.84	
Dietician/Nutrition/Meals Total:						22146.65
dietician, nutritional counseling	vist	2	5.47	15.28	167.16	
meals	meal	21	171.02	6.12	21979.49	
Environmental Accessibility Adaptations Total:						192489.30

Environmental Accessibility Adaptations	service	23	5.47	1530.00	192489.30	
Habilitation Aide Total:						5099.09
Habilitation Aide	hour	62	4.37	18.82	5099.09	
Health and Wellness Total:						190760.40
Health and Wellness	service	90	20.78	102.00	190760.40	
Non-Medical Transportation Total:						11513.26
Non-Medical Transportation	trip	25	33.92	12.40	10515.20	
Non-Medical Transportation, per mile	mile	133	22.74	0.33	998.06	
Pain and Symptom Management Total:						117167.40
Pain and Symptom Management	service	70	21.88	76.50	117167.40	
Peer Support Total:						67358.25
Peer Support	15 minute	60	88.05	12.75	67358.25	
Personal Assistance Service and Specially Trained Attendant Care Total:						59420.22
Personal Assistance	15 min	110	86.35	5.43	51576.86	
Personal Assistance Service and Specially Trained Attendant Care	15 min	60	21.86	5.98	7843.37	
Personal Emergency Response System Total:						9423.11
PERS, Installation and Testing	visit	18	1.42	102.00	2607.12	
Personal Emergency Response System	item	1	1.09	510.00	555.90	
PERS, Monthly Rental	monthly	80	1.09	71.79	6260.09	
Private Duty Nursing (and Registered Nurse Supervision) Total:						4773.41
RN Supervision	15 min	25	4.25	8.80	935.00	
Private Duty Nursing (and Registered Nurse Supervision)	15 min	119	4.38	7.15	3726.72	
PAS Nurse Supervision	15 min	1	2.19	51.00	111.69	
Specialized Medical Equipment and Supplies Total:						137733.15
Specialized Medical Equipment	item	134	4.38	204.00	119731.68	
Specialized Medical Supply	item	47	15.02	25.50	18001.47	
Substance Use Related Disorder Services Total:						320.27
Substance Use Related Disorder Services	15 minute	5	5.47	11.71	320.27	
Supported Living Total:						252105.87
Supported Living	day	20	56.86	221.69	252105.87	

GRAND TOTAL:	4173474.35
Total Estimated Unduplicated Participants:	235
Factor D (Divide total by number of participants):	17759.47
Average Length of Stay on the Waiver:	276

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
Adult Day Health Total:						32565.46
Adult Day Health	15 min	6	2467.08	2.20	32565.46	
Case Management Total:						824025.60
Case Management, Daily	day	240	276.00	12.44	824025.60	
Homemaker Total:						41418.50
Homemaker	15 minute	135	69.57	4.41	41418.50	
Prevocational Services Total:						613.71
Prevocational Services	hour	2	39.24	7.82	613.71	
Residential Habilitation Total:						2025830.61
Specialized Residential Habilitation	day	4	152.94	154.74	94663.74	
Residential Habilitation	day	115	220.58	76.13	1931166.87	
Respite Total:						52991.47
Respite	15 minute	2	30.20	4.32	260.93	
Respite Care, Per Diem	day	15	20.89	168.28	52730.54	
Supported Employment Total:						715.75
Supported Employment	15 minute	2	27.85	12.85	715.74	
Occupational Therapy Total:						514.76
Occupational Therapy	visit	2	4.64	55.47	514.76	
Chore Total:						21777.00
Chore	per job	35	2.44	255.00	21777.00	

Community Transition Total:						7099.20
Community Transition	service	3	4.64	510.00	7099.20	
Consultative Clinical and Therapeutic Services Total:						129177.60
Consultative Clinical and Therapeutic Services	hour	30	11.60	371.20	129177.60	
Dietician/Nutrition/Meals Total:						23495.92
dietician, nutritional counseling	15 minute	2	5.80	15.28	177.25	
meals	meal	21	181.44	6.12	23318.67	
Environmental Accessibility Adaptations Total:						204102.00
Environmental Accessibility Adaptations	service	23	5.80	1530.00	204102.00	
Habilitation Aide Total:						5414.14
Habilitation Aide	hour	62	4.64	18.82	5414.14	
Health and Wellness Total:						202419.00
Health and Wellness	service	90	22.05	102.00	202419.00	
Non-Medical Transportation Total:						12212.43
Non-Medical Transportation	trip	25	35.98	12.40	11153.80	
Non-Medical Transportation, per mile	mile	133	24.12	0.33	1058.63	
Pain and Symptom Management Total:						124289.55
Pain and Symptom Management	service	70	23.21	76.50	124289.55	
Peer Support Total:						71458.65
Peer Support	15 minute	60	93.41	12.75	71458.65	
Personal Assistance Service and Specially Trained Attendant Care Total:						63042.81
Personal Assistance	15 min	110	91.61	5.43	54718.65	
Personal Assistance Service and Specially Trained Attendant Care	15 min	60	23.20	5.98	8324.16	
Personal Emergency Response System Total:						10026.07
PERS, Installation and Testing	visit	18	1.51	102.00	2772.36	
Personal Emergency Response System	item	1	1.16	510.00	591.60	
PERS, Monthly Rental	monthly	80	1.16	71.79	6662.11	
Private Duty Nursing (and Registered Nurse Supervision) Total:						5056.26
RN Supervision	15 min	25	4.50	8.80	990.00	
Private Duty Nursing (and Registered Nurse Supervision)	15 min	119	4.64	7.15	3947.94	

PAS Nurse Supervision	15 min	1	2.32	51.00	118.32	
Specialized Medical Equipment and Supplies Total:						145931.14
Specialized Medical Equipment	item	134	4.64	204.00	126839.04	
Specialized Medical Supply	item	47	15.93	25.50	19092.10	
Substance Use Related Disorder Services Total:						339.59
Substance Use Related Disorder Services	15 minute	5	5.80	11.71	339.59	
Supported Living Total:						252105.87
Supported Living	day	20	56.86	221.69	252105.87	
				GRAND TOTAL:		4256623.09
				Total Estimated Unduplicated Participants:		240
				Factor D (Divide total by number of participants):		17735.93
				Average Length of Stay on the Waiver:		276

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
Adult Day Health Total:						34482.23
Adult Day Health	15 min	6	2612.29	2.20	34482.23	
Case Management Total:						841192.80
Case Management, Daily	day	245	276.00	12.44	841192.80	
Homemaker Total:						43853.48
Homemaker	15 minute	135	73.66	4.41	43853.48	
Prevocational Services Total:						649.84
Prevocational Services	hour	2	41.55	7.82	649.84	
Residential Habilitation Total:						2025830.61
Specialized Residential Habilitation	day	4	152.94	154.74	94663.74	
Residential Habilitation	day	115	220.58	76.13	1931166.87	
Respite Total:						56111.61

Respite	15 minute	2	31.98	4.32	276.31	
Respite Care, Per Diem	day	15	22.12	168.28	55835.30	
Supported Employment Total:						757.89
Supported Employment	15 minute	2	29.49	12.85	757.89	
Occupational Therapy Total:						544.72
Occupational Therapy	visit	2	4.91	55.47	544.72	
Chore Total:						23026.50
Chore	per job	35	2.58	255.00	23026.50	
Community Transition Total:						7512.30
Community Transition	service	3	4.91	510.00	7512.30	
Consultative Clinical and Therapeutic Services Total:						136861.44
Consultative Clinical and Therapeutic Services	hour	30	12.29	371.20	136861.44	
Dietician/Nutrition/Meals Total:						24878.90
dietician, nutritional counseling	15 minute	2	6.14	15.28	187.64	
meals	meal	21	192.12	6.12	24691.26	
Environmental Accessibility Adaptations Total:						216066.60
Environmental Accessibility Adaptations	service	23	6.14	1530.00	216066.60	
Habilitation Aide Total:						5729.18
Habilitation Aide	hour	62	4.91	18.82	5729.18	
Health and Wellness Total:						214261.20
Health and Wellness	service	90	23.34	102.00	214261.20	
Non-Medical Transportation Total:						12931.95
Non-Medical Transportation	trip	25	38.10	12.40	11811.00	
Non-Medical Transportation, per mile	mile	133	25.54	0.33	1120.95	
Pain and Symptom Management Total:						131572.35
Pain and Symptom Management	service	70	24.57	76.50	131572.35	
Peer Support Total:						75666.15
Peer Support	15 minute	60	98.91	12.75	75666.15	
Personal Assistance Service and Specially Trained Attendant Care Total:						66750.23
Personal Assistance	15 min	110	97.00	5.43	57938.10	
Personal Assistance Service and Specially Trained Attendant Care	15 min	60	24.56	5.98	8812.13	

Personal Emergency Response System Total:						**10629.04**
PERS, Installation and Testing	visit	18	1.60	102.00	2937.60	
Personal Emergency Response System	item	1	1.23	510.00	627.30	
PERS, Monthly Rental	monthly	80	1.23	71.79	7064.14	
Private Duty Nursing (and Registered Nurse Supervision) Total:						**5352.53**
RN Supervision	15 min	25	4.77	8.80	1049.40	
Private Duty Nursing (and Registered Nurse Supervision)	15 min	119	4.91	7.15	4177.67	
PAS Nurse Supervision	15 min	1	2.46	51.00	125.46	
Specialized Medical Equipment and Supplies Total:						**154438.46**
Specialized Medical Equipment	item	134	4.91	204.00	134219.76	
Specialized Medical Supply	item	47	16.87	25.50	20218.70	
Substance Use Related Disorder Services Total:						**359.50**
Substance Use Related Disorder Services	15 minute	5	6.14	11.71	359.50	
Supported Living Total:						**252105.87**
Supported Living	day	20	56.86	221.69	252105.87	
GRAND TOTAL:						**4341565.38**
Total Estimated Unduplicated Participants:						**245**
Factor D (Divide total by number of participants):						**17720.68**
Average Length of Stay on the Waiver:						276