Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Home and Community-Based Waiver for Individuals with Developmental Disabilities

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

D. Amendment Number:

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

06/29/19

Approved Effective Date of Waiver being Amended: 07/01/18

2. Purpose(s) of Amendment

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

•The DPHHS Developmental Disabilities (DD) Program and representatives from DD providers have had extensive meetings over the last year to discuss ways to improve the current invoicing and rates system. Through these discussions, we came to an agreement that we would request an amendment to transition from an hourly to a daily invoicing for the following services: Supported Employment - Small Group, Residential Habilitation, Day Supports and Activities and Retirement Services.

•Waiver billing is being moved into the Medicaid Management Information System.

•Rate estimates for Waiver Years one through five are being recalculated based on rate changes approved by the Montana Legislature and the changes to the reimbursement for the services identified above.

•Appendix D sub assurance a, updated wording, "personal goals" changed to "assessed needs"

•Appendix D sub assurance d, updated the Confidence Interval

•Appendix D sub assurance e, updated the Confidence Interval

•Appendix G sub assurance c, updated the Confidence Interval

•Appendix G sub assurance d, updated the Confidence Interval

The estimated fiscal impact of the amendment in Waiver Year 1 is an increase of $10,701,136.35. The estimated fiscal impact of the amendment in Waiver Years 2 through 5 is an increase of $11,786,208.69.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A Waiver Administration and Operation**	
☐ **Appendix B Participant Access and Eligibility**	
☐ **Appendix C Participant Services**	
☒ **Appendix D Participant Centered Service Planning and Delivery**	
☐ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant Rights**	

Component of the Approved Waiver	Subsection(s)
☒ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	
☒ Appendix J Cost-Neutrality Demonstration	

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

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☒ **Other**

Specify:

The DPHHS Developmental Disabilities (DD) Program and representatives from DD providers have had extensive meetings over the last year to discuss ways to improve the current invoicing and rates system. Through these discussions, we came to an agreement that we would request an amendment to transition from hourly to daily invoicing for the following services: Supported Employment - Small Group, Residential Habilitation, Day Supports and Activities and Retirement Services.

Waiver billing is being moved into the Medicaid Management Information System

Appendix J estimates for Waiver Years 1-5 have been recalculated based on rate changes approved by the legislature and the changes to the reimbursement for the services identified above.

The following Performance Measures were also updated:

Appendix D sub assurance a, updated wording, "personal goals" changed to "assessed needs"
Appendix D sub assurance d, updated the Confidence Interval
Appendix D sub assurance e, updated the Confidence Interval
Appendix G sub assurance c, updated the Confidence Interval
Appendix G sub assurance d, updated the Confidence Interval

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

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

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

Home and Community-Based Waiver for Individuals with Developmental Disabilities

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MT.0208
Draft ID: MT.004.06.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/18
Approved Effective Date of Waiver being Amended: 07/01/18

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

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

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

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

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to

provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

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

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual

might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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

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

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. 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 notice to inform interested parties of the pending waiver amendment was posted in two major Montana newspapers and on the Department of Public Health and Human Services, Developmental Disabilities Program website on February 13, 2019. The notice contained information regarding the purpose of the amendment, projected annual cost and the proposed major changes, and a provision to request a paper copy of the draft waiver. The public was invited to submit questions or comments through March 14, 2019 via phone or email to identified Department staff. Tribal notice of similar content was provided on February 11, 2019.

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: Cummings

First Name: Melinda

Title: Developmental Disabilities Program DD Waiver Specialist

Agency: Department of Public Health and Human Services

Address: PO Box 4210

Address 2: 111 Sanders

City: Helena

State: **Montana**

Zip: 59604

Phone: (406) 444-2695 **Ext:** ☐ **TTY**

Fax: (406) 444-0230

E-mail: mcummings@mt.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Montana**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Montana**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

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:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The Department of Public Health and Human Services (DPHHS) received initial approval of its statewide transition plan from CMS on December 23, 2016. Montana's transition plan addresses the areas of public input, assessment, member transition plans, remediation, and program administration. DPHHS partners with Medicaid members, providers and provider associations, advocates and other stakeholders to allow for input and to assure that members and providers have access to needed information to assist with transition plan activities. The outcome will be that all Medicaid members are served in a manner that enables them to live and thrive in integrated community settings. Members, providers, other stakeholders, the medical advisory committee and Tribes were informed on 8/16/16; public notice was published on 8/3/16. A revised Statewide Transition Plan was submitted on 9/20/16 to add more detail and clarification based on CMS feedback. The Department of Public Health and Human Services (DPHHS) received initial approval of its statewide Transition plan from CMS on December 23, 2016.

Summary of HCB Settings transition activities:

Public Input
DPHHS held a public meeting in October 2014 for stakeholders. Public comment periods have also been held throughout the development of our statewide transition plan. Information regarding the public meeting and the public comment periods can be found on our website at http://dphhs.mt.gov/hcbs.

Assessment
DPHHS has completed a provider self-assessment and member survey. DPHHS is using an on-site validation tool. DPHHS implemented that tool beginning in February 2016 to conduct on-site visits of a sample of providers to validate their provider self-assessment.
The tools developed addressed questions recommended by CMS as part of the assessment process and, as such, were based on the nature and quality of the experience of individuals supported by that agency/facility. Each of these assessments helped determine which programs/settings were in compliance and which need some changes to come into compliance. As the assessment process was completed for a setting, DPHHS notified the provider of the results.
The provider self-assessment tool and member survey were 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. These tools were public noticed and comment period was open from April 27, 2015, to May 27, 2015. Comments and responses are available on the HCBS website at http://dphhs.mt.gov/hcbs.The state held a public comment period on the Statewide Transition Plan from 10/26/15 to 11/25/15 with a public meeting on 11/20/15. This public notice, Validation Tool, revised statewide transition plan, and other related information for participating in and submitting comments are posted on the DPHHS website at: http://dphhs.mt.gov/hcbs.

Member Transition Planning
DPHHS will identify members who are receiving services from providers/settings that don't meet the HCB settings requirements. A transition plan will be developed and members will be transitioned to a setting of their choice that is compliant with the HCB settings rule.

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

For the settings that were found to be non-compliant, the provider was required to submit a corrective action plan to DPHHS that describes the steps taken and timelines to achieve compliance. Consideration of corrective action plans by the State take into account the scope of the transition to be achieved and the unique circumstances related to the setting in question.

Program Administration
DPHHS conducted a review of the Administrative Rules of Montana (ARM), policy manuals, and documents. A Crosswalk was developed indicating compliance and non-compliance or silence of each article in reference to the settings rule. The Department is in the initial phases of addressing changes needed to ARM, policy manuals and documents that are silent or not in compliance with the settings rule.

If a setting is not in compliance the department works closely with the provider to come into compliance. If a setting is unable to come into compliance members will be transitioned to HCBS compliant settings and services of their choosing in accordance with their person centered plan no later than March 17, 2022. The waiver member and family will have clear communication from the state and case manager/service coordinator to be fully informed throughout.

Montana assures that the settings transition plan included with this waiver renewal will be subject to any provisions or

requirements included in the Statewide Transition Plan. Montana will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Comments regarding the 0208 waiver amendment are below:

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

Appendix A.2. Oversight of Performance
(a) The Developmental Disabilities Program (DDP) is responsible for the design, implementation and monitoring of all activities associated with this waiver.
(b) There is no single document serving to outline the roles and responsibilities of all staff related to waiver operation. There are many documents serving to outline the responsibilities of assigned staff regarding specific aspects of the waiver, including DDP rules and policies relating directly to the operation of the waiver. DDP maintains organizational charts, individual position descriptions, and web based information serving to assist persons who need assistance in accessing information about the waiver, and who within the DDP is responsible for decision making based on the issue at hand. The waiver application is probably the most comprehensive single document in outlining the persons/positions responsible for ensuring all the requirements of the waiver are being met.
(c). The Medicaid Director or designee are ultimately responsible for ensuring that problems in the administration of the waiver are resolved. Typically, the Medicaid Director or designee are not directly involved in the day to day operational decisions of DDP staff.

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

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Financial Management Services (FMS):

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

Case Management Services for individuals in the waiver:

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

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

DISTRIBUTION OF WAIVER OPERATIONAL AND ADMINISTRATIVE FUNCTIONS

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

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

Financial Management Service Contract

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

Appendix A: Waiver Administration and Operation

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	☒	☐

Function	Medicaid Agency	Contracted Entity
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐
Level of care evaluation	☒	☐
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☐
Utilization management	☒	☐
Qualified provider enrollment	☒	☐
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

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**

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

Performance Measure:
Number and percent of individuals whose files maintained by the FMS under self direction were in compliance with the contract; N: Number of individuals who were in compliance with the contract. D: Number of individuals reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMS electronic files

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:

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

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. Remediation Data Aggregation

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

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	0		☒
	☒	Intellectual Disability	0		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

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

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

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

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

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

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

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

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

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

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

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

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the

number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

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

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	2777
Year 2	2777
Year 3	2777
Year 4	2777
Year 5	2777

Appendix B: Participant Access and Eligibility

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

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

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

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

Purpose(s) the state reserves capacity for:

Purposes	
Individuals who require services due to a crisis or emergency	
Individuals transitioning from institutional settings to DD HCBS waiver services	

Purposes	
Child Family Services	

Appendix B: Participant Access and Eligibility

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

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

Individuals who require services due to a crisis or emergency

Purpose *(describe):*

To allow individuals who meet the 0208 waiver eligibility criteria and are on the waiting list to access waiver services due to a crisis or emergency situation that is currently threatening his/her life and/or safety. 0208 HCBS Waiver services shall only be offered when all other resources have been exhausted and if the waiver can meet the identified needs.

Describe how the amount of reserved capacity was determined:

The amount was derived from historical data of individuals with referrals for waiver services that indicated a crisis or emergency situation.

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

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	20
Year 4	20
Year 5	20

Appendix B: Participant Access and Eligibility

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

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

Individuals transitioning from institutional settings to DD HCBS waiver services

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

50 slots, based on historical counts of individual transitioning from institutions.

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

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	50
Year 4	50
Year 5	50

Appendix B: Participant Access and Eligibility

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

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

Child Family Services

Purpose *(describe):*

To reserve capacity for children who meet 0208 waiver eligibility and are aging out of state custody and would require insitutional placement to meet health and safety needs, if not enrolled in waiver.

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ◉ **§1634 State**
- ○ **SSI Criteria State**
- ○ **209(b) State**

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

- ◉ **No**
- ○ **Yes**

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

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

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

Select one:

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

Specify percentage: [ ]

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

Specify:

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

All other mandatory and optional groups under the State Plan.

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- ☐ **A special income level equal to:**

Select one:

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI**

program (42 CFR §435.121)

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

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

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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: 1

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

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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

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

Quality assurance personnel (employed by the State Medicaid Agency): The DDP quality assurance personnel is responsible for completing the LOC evaluations. The quality assurance personnel must possess the following qualifications:
Bachelors degree and three years of job related experience, and preference for two years experience in the field of services for individuals with developmental disabilities.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify

the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

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

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

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

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

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

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

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

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

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

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

The statutory criteria for commitment to the ICF-IID is at Part 1 of Title 53, Chaper 20, MCA. The tool used by the Residential Facility Screening Team in the ICF-IID commitment process is the Determination Regarding Commitment to Residential Facility form. The governing policy for this form is the Manual for the Screening of Persons Being Considered for Civil Commitment to the Montana Development Center or to a Community Treatment Plan found on the DDP website. ICF-IID commitment is based on a person having:
*A diagnosis of developmental disability and;
*Impairment in cognitive functioning and;
*Behaviors that pose an imminent risk of serious harm to self or others, and because of those behaviors cannot safely or effectively be habilitated in community-based services and;
*Placement and habilitation in the ICF-IID are appropriate for the person.

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

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

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

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

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

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

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

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

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

are maintained:

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of initial level of care determinations (eligibility determination worksheet date as compared to completed application date) that were completed within 90 days of the applicant's request for services. N: Number of eligibility determinations completed for new applicants within 90 days of request; D: number of all new applications.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **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 levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of initial level of care determinations that were completed according to the level of care process described in the waiver. N: Number of level of care determinations where the level of care process was completed as required; D: Number of all level of care 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 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.

100% of eligibility determinations are reviewed.

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

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

b. Methods for Remediation/Fixing Individual Problems

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

DDP Staff QA Performance Issues:

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

ii. Remediation Data Aggregation

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

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).

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

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

The form covers:
1. Choice of waiver services, including self-direction
2. Choice of providers of DDP funded services
3. Choice of filing a fair hearing request
4. Choice between wiaver services and Intermediate Care Facilities for the Intellectually Disabled (ICF/IID)

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

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

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

Appendix B: Participant Access and Eligibility

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

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

The Department operates under the Interpreter Services Medicaid Services Bureau policy. The interpreter is reimbursed by submitting the Interpreter Services Invoice Verification form to:

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

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

Appendix C: Participant Services

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

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

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

Service Type	Service		
Other Service	Supported Employment - Small Group Employment Support		
Other Service	Transportation		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Supports and Activities

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

Day Supports and Activities include but are not limited to:

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

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

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

Total hours for a member's attendance shall not include time spent during transporting to/from the member's residence. Day Supports and Activities services will not duplicate or supplant other services provided under IDEA (20 U.S.C. 1401 et seq) and cannot be billed for during the same time frame as Individual or Small Group Employment Support, Follow Along Support, or Co Worker Support.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled DD service provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Supports and Activities

Provider Category:

Agency

Provider Type:

Enrolled DD service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

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

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

Current first aid, CPR, and other training in accordance with DDP requirements.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

HOMEMAKER SERVICES

Homemaker services consist of general household activities provided by a homemaker when the person regularly responsible for these activities is unable to manage the home and care for himself/herself or others in the home, or is engaged in providing habilitation and support services to the member with disabilities.

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

Homemaker services are not available under the State Plan.

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Homemaker entity enrolled as a Montana Medicaid Provider and contracting directly with the DDP
Agency	DD service provider agency under contract with the DDP
Agency	DD service provider agency under contract with the DDP and subcontracting for Homemaker services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Individual
Provider Type:

Homemaker entity enrolled as a Montana Medicaid Provider and contracting directly with the DDP

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Qualifications of the person providing the homemaker service will be reviewed and approved by the contracting agency and the member and family, if applicable.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP and subcontracting for Homemaker services

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Qualifications of the person providing the homemaker service will be reviewed and approved by the contracting agency and the member and family, if applicable.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DDP waiver funded agency subcontracting for homemaker services.
Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

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

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Habilitation- Residential

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

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

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

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

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

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

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

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

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

Retainer payment:

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD service provider agency under contract with the DDP

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:

DD service provider agency under contract with the DDP

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

The staffing rule as outlined in ARM 37.34.2101-37.34.2111.

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

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

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

Current first aid, CPR, and other training in accordance with DDP requirements.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DPHHS Quality Assurance Division (QAD) for compliance with group home licensing standards, if applicable.

Applicable standards are verified by the DD service provider agency.

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

Frequency of Verification:

QAD licensing study is annual.

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

Age appropriate licensed day care is a respite care option for persons of all ages. Licensed day care is a subcomponent of respite and is treated as a discrete service in the plan of care, the individual cost plan and in the Departments billing and payment system. Day care is reported as respite in federal reports.

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

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

Service Limitations:

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

Children from birth through age 17 may be served in licensed childrens day care centers and in licensed family and group day care homes. For children under the age of 13, the waiver will cover the difference in cost between usual and customary rates and the increased rate charged by the provider to serve a child with extraordinary support needs. Children aged 13 through age 17 may be served in licensed children's day care centers and in licensed family and group day care homes, as allowed by the Montana Quality Assurance Division. Individuals aged 18 and older may receive support and supervision services in licensed adult day centers. Under no circumstances will adults be served in settings licensed to serve children. Neither will children be served in settings licensed to serve adults.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Service Provider Agency under contract with the DDP DD service provider agency under contract with the DDP offering agency with choice employer authority
Individual	An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP DD service provider agency under contract with the DDP offering agency with choice employer authority

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

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

Current first aid and CPR certification, and other training in accordance with DDP requirements

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

Current first aid and CPR certification, and other training in accordance with DDP requirements.

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Follow Along Support

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

Supported Employment – Follow Along Support includes habilitation services needed to stabilize and maintain a member in a competitive, customized, or self-employment setting. Examples of stabilization and support may include, but are not limited to, the following situations described below.
1. Job in jeopardy – the member will lose his/her job without additional intervention.
2. Job promotion within same employment setting - it is determined that the new job requires more complex, comprehensive, intensive supports that can be offered under the waiver.

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

REIMBURSABLE ACTIVITIES: Follow Along Support:

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

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

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

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

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

ACTIVITIES NOT REIMBURSABLE: Follow Along Support:

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD service provider agency under contract with the DDP
Individual	An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.
Agency	DD service provider agency under contract with the DDP offering Agency with Choice Employer Authority

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

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

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

Current first aid, CPR certification, and other training in accordance with DDP requirements.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to hire:
*Be at least 17 years of age.
*Screening and a background check of a person prior to an offer of employment as a direct care staff.

Within 30 days of hire receive training in:
*abuse reporting,
*incident reporting,
*client confidentiality,
*service documentation requirements,
*training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

Current first aid certification, and other training in accordance with DDP requirements.

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP offering Agency with Choice Employer Authority

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

Within 30 days of hire receive training in:
*abuse reporting,
*incident reporting,
*client confidentiality,
*service documentation requirements,
*training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

Current first aid certification, and other training in accordance with DDP requirements.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.

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

Frequency of Verification:

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

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Nutritionist Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope)*:

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

Nutritionist Services

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

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

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

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

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

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

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

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

- ☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD service provider agency under contract with the DDP
Individual	Licensed Nutritionist, enrolled as a Montana Medicaid provider and contracting directly with DDP
Agency	DD service provider agency under contract with the DDP and subcontracting for Nutritionist Services.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Nutritionist Services

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Licensed Nutritionist- ARM 24.156.1301 through ARM 24.156.1308

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Nutritionist Services

Provider Category:

Individual

Provider Type:

Licensed Nutritionist, enrolled as a Montana Medicaid provider and contracting directly with DDP

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Licensed Nutritionist- ARM 24.156.1301 through ARM 24.156.1308

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Nutritionist Services

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP and subcontracting for Nutritionist Services.

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Licensed Nutritionist- ARM 24.156.1301 through ARM 24.156.1308

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

OCCUPATIONAL THERAPY SERVICES

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD service provider agency under contract with the DDP and subcontracting for Occupational Therapy.
Agency	DD service provider under contract with DDP
Individual	Licensed Occupational Therapist enrolled as a Montana Medicaid provider and contracting directly with DDP.

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:

DD service provider agency under contract with the DDP and subcontracting for Occupational Therapy.

Provider Qualifications

License *(specify)*:

Licensed in accordance with applicable ARMS 24.165.401 through 24.165.2301

Certificate *(specify)*:

Other Standard *(specify)*:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

DD service provider under contract with DDP

Provider Qualifications
License *(specify):*

Licensed in accordance with applicable ARMs 24.165.401 through 24.165.2301

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications
Entity Responsible for Verification:

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

Licensed Occupational Therapist enrolled as a Montana Medicaid provider and contracting directly with DDP.

Provider Qualifications
License *(specify):*

Licensed in accordance with applicable ARMS 24.165.401 through 24.165.2301

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

PHYSICAL THERAPY SERVICES

These services will be provided through direct contact between therapist and individual as well as between the therapist and other people providing services to the individual. Physical therapists may provide treatment training programs that are designed to:
1. Preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and activities of daily living; and
2. Prevent, insofar as possible, chronic or progressive conditions through means such as the use of orthotic prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

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

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

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

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

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	DD service provider agency under contract with the DDP & subcontracting for PT Services
Individual	Licensed Physical Therapist enrolled as a Montana Medicaid provider and contracting directly with DDP.
Agency	DD service provider agency under contract with DDP

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

DD service provider agency under contract with the DDP & subcontracting for PT Services

Provider Qualifications

License *(specify):*

Licensed in accordance with applicable ARMS 8.42.101 through 8.42.503

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Licensed Physical Therapist enrolled as a Montana Medicaid provider and contracting directly with DDP.

Provider Qualifications

License *(specify):*

Licensed in accordance with applicable ARMS 8.42.101 through 8.42.503

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with DDP

Provider Qualifications

License *(specify):*

Licensed in accordance with applicable ARMs 8.42.101 through 8.42.503

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Private Duty Nursing

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

PRIVATE DUTY NURSING

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

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

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

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	**DD service provider agency under contract with the DDP and subcontracting for Private Duty Nursing services.**
Individual	**An individual providing qualified LPN or RN services and enrolled as a Montana Medicaid provider and contracting directly with DDP**

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP and subcontracting for Private Duty Nursing services.

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

ARMS 8.32.101 through 8.32.507 apply

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

An individual providing qualified LPN or RN services and enrolled as a Montana Medicaid provider and contracting directly with DDP

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

ARMS 8.32.101 through 8.32.507 apply

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech Therapy

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

SPEECH THERAPY SERVICES

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Speech Language Pathologist (Speech Therapist), enrolled as a Montana medicaid provider and contracting directly with the DDP
Agency	DD service provider agency under contract with the DDP.
Agency	DD service provider agency under contract with the DDP subcontracting for Speech Therapy Services

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Licensed Speech Language Pathologist (Speech Therapist), enrolled as a Montana medicaid provider and contracting directly with the DDP

Provider Qualifications

License *(specify):*

Licensed in accordance with applicable ARMs 24.222.101 through 24.222.2407

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP.

Provider Qualifications

License *(specify):*

Licensed in accordance with applicable ARMs 24.222.01 through 24.222.2407

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP subcontracting for Speech Therapy Services

Provider Qualifications

License *(specify):*

Licensed in accordance with applicable ARMs 24.222.101 through 24.222.2407

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Supports Brokerage

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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

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

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

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Service Provider Agency under contract with the DDP. DD service provider agency under contract with the DDP offering agency with choice employer authority
Individual	An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP. DD service provider agency under contract with the DDP offering agency with choice employer authority

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Persons serving as support brokers must achieve initial support broker certification which includes the demonstration of competence in:
*abuse reporting,
*incident reporting,
*client confidentiality,
*fiscal management service forms and billing procedures,
*scheduling of direct support workers,
*on call and emergency back up support models,
*person centered planning,
*individualized budgeting,
*recruitment, hiring and firing of direct support workers,
*the grievance/fair hearing process,
*negotiating service rates,
*DDP funded service options, and
*other skills and competencies as required by the Department.

Ongoing maintenance of certification in accordance with Department requirements.

Other Standard *(specify):*

The staffing rule as outlined in ARM 37.34.2101-37.34.2111.

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency with a DDP contract employing the support broker is responsible for maintaining records verifying compliance with the initial and ongoing support broker certification requirements.

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

Frequency of Verification:

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

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

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

Ongoing maintenance of certification in accordance with Department requirements.

Other Standard *(specify):*

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

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

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

Persons excluded from serving as a supports broker include:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Foster Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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

Payments for adult foster support are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult foster support does not include payments made, directly or indirectly, to members of the individuals immediate family. The methodology by which the costs of room and board are excluded from payments for adult foster support is described in Appendix I.

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

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

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

DDP will reimburse the adult foster care provider for no more than four members. Members with varying supervision needs can be served with Adult Foster Supports, but the Adult Foster Support reimbursement to a single foster home cannot exceed the Adult Foster Supports reimbursement rate for serving one member with intensive support needs.

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Service Provider Agency under contract with the DDP - Residential Training Support Only.
Agency	DD Service Provider Agency under contract with the DDP - Residential Training Support Only.
Agency	DD Service Provider Agency under contract with the DDP - Adult Foster Supports & Residential Training Support.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Foster Support

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP - Residential Training Support Only.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

Current first aid and CPR certification, and other training in accordance with DDP requirements.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Foster Support

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP - Residential Training Support Only.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

Current first aid and CPR certification, and other training in accordance with DDP requirements.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Foster Support

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP - Adult Foster Supports & Residential Training Support.

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

ARM 37.100.101 through 37.100.175

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

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

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

Current first aid and CPR certification, and other training in accordance with DDP requirements.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed by the DD service provider agency, prior to authorization of payment.
Licensure status reviewed annually by Quality Assurance Division of DPHHS
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Assisted Living Facility enrolled as a Montana Medicaid provider and contracting directly with DDP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Licensed Assisted Living Facility enrolled as a Montana Medicaid provider and contracting directly with DDP

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

ARMs 37.106.2801 through 37.106.2908 apply.

Verification of Provider Qualifications

Entity Responsible for Verification:

Quality Assurance Division of DPHHS

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

Frequency of Verification:

Licensure status reviewed annually by Quality Assurance Division of DPHHS

As needed prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Support Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Behavioral Support Services may be provided by:

1. a Board-certified Behavior Analyst (BCBA)or Board-certified Behavior assistant Analyst (BCaBA);
2. a Family Support Specialist with an Autism Endorsement (FSS-AE);
3. a person with an Institute for Applied Behavior Analysis (IABA) consultant certification; or
4. a person with a degree in Applied Behavior Analysis, Psychology, or Special Education who has provided documentation of training and experience in the use of the principles of applied behavior analysis in the habilitation of person(s) with developmental disabilities and the development of behavior support plans to the developmental disabilities program director.

The Behavioral Support Services include the following:

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

In general Behavioral Support Services offer appropriate assessment and intervention methods for use in unfamiliar situations and for a range of cases of all ages. Behavioral Support Services teaches others to carry out ethical and effective behavior interventions based on positive behavior supports. Behavioral Support Services staff may supervise the work of others who implement behavior interventions. All behavior intervention procedures developed by the Behavioral Support Services staff are in compliance with the Administrative Rules of Montana governing the use of Positive Behavioral Supports.

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

Behavioral Support Services will not supplement or supplant services available to children under IDEA, or otherwise available to a school age child.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	An individual enrolled as a Montana Medicaid provider and contracting directly with DDP
Agency	DD service provider agency under contract with the DDP and subcontracting for Behavioral Support Services
Agency	DD Service Provider Agency under contract with the DDP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Individual

Provider Type:

An individual enrolled as a Montana Medicaid provider and contracting directly with DDP

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

A person who meets the requirements of ARM 37.34.1422 (2)

Other Standard *(specify)*:

A Montana Department of Justice background check is required.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP and subcontracting for Behavioral Support Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A person who meets the requirements of ARM 37.34.1422 (2)

Other Standard *(specify):*

A Montana Department of Justice background check is required.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

Frequency of Verification:

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

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A person who meets the requirements of ARM 37.34.1422 (2)

Other Standard *(specify):*

A Montana Department of Justice background check is required.

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Caregiver Training and Support

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD service provider agency under contract with the DDP and subcontracting for CTS services to persons 0 through 15 years of age
Agency	DDP Service Provider Agency under contract with the DDP for CTS services to persons 0 through 15 years. DD provider agency under contract with the DDP offering agency with choice employer authority
Agency	DD service provider agency under contract with the DDP and subcontracting for CTS services to persons 16 years of age and older
Agency	DD Service Provider Agency under contract with the DDP for CTS to persons 16 and older. DD provider agency under contract with the DDP offering agency with choice employer authority

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Caregiver Training and Support

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP and subcontracting for CTS services to persons 0 through 15 years of age

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Family Support Specialist certification in accordance with DDP policies regarding FSS certification for CTS services.

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

Frequency of Verification:

As needed prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Caregiver Training and Support

Provider Category:

Agency

Provider Type:

DDP Service Provider Agency under contract with the DDP for CTS services to persons 0 through 15 years.
DD provider agency under contract with the DDP offering agency with choice employer authority

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Family Support Specialist certification in accordance with DDP policies regarding FSS certification for CT services.

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Caregiver Training and Support

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP and subcontracting for CTS services to persons 16 years of age and older

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

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

This position requires a BA degree in a human services field and a minimum of 3 years of experience in the field of developmental disabilities services.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Caregiver Training and Support

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP for CTS to persons 16 and older. DD provider agency under contract with the DDP offering agency with choice employer authority

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

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

This position requires a BA degree in a human services field and a minimum of 3 years of experience in the field of developmental disabilities services.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Services

HCBS Taxonomy:

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

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

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

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

Service Definition (Scope):

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD service provider agency under contract with the DDP
Individual	An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Companion Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Service Provider Agency under contract with the DDP.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

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

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

Current first aid and CPR certification, and other training in accordance with DDP requirements.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modifications

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Environmental Modifications:

Those physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or which enable the member to function with greater independence in the home, and without which, the member would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment which are necessary for the welfare of the member.

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

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

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

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

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Contractor qualified to perform environmental modifications, enrolled as a Montana Medicaid provider and contracting directly with DDP
Individual	An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.
Agency	DD Service Provider Agency under contract with the DDP - Environmental modifications. DD service provider agency under contract with the DDP and subcontracting for Environmental Mods

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Independent Contractor qualified to perform environmental modifications, enrolled as a Montana Medicaid provider and contracting directly with DDP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A qualified provider designated to either reimburse the individual for the procurement of specialized medical equipment and supplies, or for providing the requested medical equipment and supplies is responsible for meeting all the requirements outlined in the DDP contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP - Environmental modifications. DD service provider agency under contract with the DDP and subcontracting for Environmental Mods

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A qualified provider designated to either reimburse the individual for the procurement of specialized medical equipment and supplies, or for providing the requested medical equipment and supplies is responsible for meeting all the requirements outlined in the DDP contract.

The staffing rule as outlined in ARM 37.34.2101-37.34.2111.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Goods and Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

*Memberships and Fees including but not limited to:

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

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

*Equipment and Supplies including but not limited to:

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

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

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

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

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

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

A. One or more of the following criteria are met:
1. The service, equipment or supply promotes inclusion in the community, and/or
2. The service, equipment or supply increases the person's safety in the home environment, and/or
3. The service, equipment or supply decreases the need for other Medicaid services,

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

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

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

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

Individual goods and services must be approved prior to purchase and reimbursement. In addition, individual goods and services purchased on behalf of the person by legal guardians, legally responsible persons, or other non-employees acting on behalf of the person are reimbursable only if receipts for such purchases are submitted to the agency with a DDP contract. The receipts are reimbursable only if all the requirements listed above have been met.

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	**An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.**
Agency	

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:

Agency

Provider Type:

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Meals

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

MEALS SERVICES

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Meals service provider enrolled as a Montana Medicaid provider and contracting directly with DDP. DD service provider agency under contract with the DDP and subcontracting for Meals
Individual	An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Meals

Provider Category:
Agency
Provider Type:

Meals service provider enrolled as a Montana Medicaid provider and contracting directly with DDP. DD service provider agency under contract with the DDP and subcontracting for Meals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Program authorized as outlined in 42 USC 3030e Subpart b2, Sections 336 and 337

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Meals

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

PERSONAL CARE SERVICES

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD service provider agency under contract with the DDP and subcontracting for Personal Care services
Agency	DD Service Provider Agency under contract with the DDP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:

DD service provider agency under contract with the DDP and subcontracting for Personal Care services

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency contracting with the home health agency providing the service.

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

Frequency of Verification:

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

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

Current first aid and CPR certification, and other training in accordance with DDP requirements.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

PERS services may be appropriate for members who live alone, or who are alone for parts of the day, and have no regular caregiver for periods of time.
Because of the limitations of the PERS service, a cell phone may be a more flexible, cost effective solution in ensuring health and safety for some individuals. Cell phones are not for convenience or general purpose use.

Guidelines for the use of cell phones include:

1. The member requires access to assistance or supports and is frequently beyond the range of coverage of a PERS system.
2. Cell phone plans will be basic plans and will not include features unrelated to health and safety issues, such as web access or music services.
3. Members may elect to add a usage control feature to their basic plan to eliminate the potential for fee overage.
4. Members who do not elect to add a usage control feature and who exceed the fees associated with their plan may require the implementation of a usage control feature to prevent future overages. In all cases of an overage the service coordinator will be notified. If a member goes over their usage limit they are responsible for those charges and the team will evaluate the needs of the member and look at the most cost effective options.
5. Members may elect to add an insurance feature to prevent health and safety concerns should the phone need to be replaced.
6. These cell phone guidelines will be reviewed with the member prior to or at the annual planning meeting.

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Service Provider Agency under contract with the DDP. DD service provider agency under contract with the DDP offering agency with choice employer authority
Individual	An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP. DD service provider agency under contract with the DDP offering agency with choice employer authority

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Supports

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

REIMBURSABLE ACTIVITIES:

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

A member receiving Personal Supports may also receive Respite.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A member receiving personal supports is self-directing this service with employer authority (either common law or agency with choice). Other waiver services that may overlap with the activities of the personal supports worker are prohibited. These include live in care giver services, adult companion, extended personal care services and homemaker.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

While a person may receive both Respite and Personal Supports they can't be billed for during the same timeframe.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	A member or a representative self-directing the service with common law employer authority
Agency	DD service provider agency under contract with the DDP offering agency with choice employer authority

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

A member or a representative self-directing the service with common law employer authority

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Prior to hire:
*Be at least 17 years of age.
*Screening and a background check of a person prior to an offer of employment as a direct care staff.

Within 30 days of hire receive training in:
*abuse reporting,
*incident reporting,
*client confidentiality,
*service documentation requirements,
*training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

Current first aid certification, and other training in accordance with DDP requirements.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

Any other training requirements as outlined by the Department.

Upon hiring of a direct care staff person, the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

In addition, the fiscal agent will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is initially responsible for ensuring that a worker meets the qualified provider standards and the FMS maintains records serving to document the compliance with these standards.

Frequency of Verification:

Annually, the quality assurance personnel reviews compliance of workers during the annual quality assurance review process, based on the requirements of the performance measure sampling process specified.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP offering agency with choice employer authority

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:
*Be at least 17 years of age.

Within 30 days of hire receive training in:
*abuse reporting,
*incident reporting,
*client confidentiality,
*service documentation requirements,
*training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

Current first aid certification and other training in accordance with DDP requirements.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

Any other training requirements as outlined by the Department.
In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.
Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Psychological Evaluation, Counseling and Consultation Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Evaluation, Counseling and Consultation Services

Evaluation, Counseling and Consultation services are those services provided by a licensed psychologist, licensed professional counselor or a licensed clinical social worker within the scope of the practice of the respective professions.

Psychological and counseling services may include individual and group therapy; consultation with providers and care givers directly involved with the member; development and monitoring of behavior programs; participation in the member planning process; and counseling for primary care givers (i.e., family members and foster parents) when their needs are related to problems dealing with the member with the disability. Psychological and counseling services available under the Montana State Plan will be used before invoicing the waiver.

Psychological and counseling services under the State Plan are limited. Under the waiver, this service is available to adults when the service is recommended by a qualified treatment professional, approved by the planning team and written into the plan of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Psychologist, enrolled as a Montana Medicaid provider and contracting directly with the DDP
Individual	Licensed Clinical Social Worker enrolled as a Montana Medicaid provider and contracting directly with

Provider Category	Provider Type Title
	the DDP
Individual	Licensed Professional Counselor, enrolled as a Montana Medicaid provider and contracting directly with the DDP
Agency	DD service provider agency under contract with the DDP
Agency	DD service provider agency under contract with the DDP & subcontracting for Psychological Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Evaluation, Counseling and Consultation Services

Provider Category:

Individual

Provider Type:

Licensed Psychologist, enrolled as a Montana Medicaid provider and contracting directly with the DDP

Provider Qualifications

License *(specify):*

Licensed in accordance with Montana ARM 24.189.601

Certificate *(specify):*

Other Standard *(specify):*

ARM 24.189.101 through 24.189.2401 governing the licensure of persons licensed to practice psychology.
MCA 37-17-101 through 37-17-318 outlining the qualifications of a licensed psychologist

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Evaluation, Counseling and Consultation Services

Provider Category:

Individual

Provider Type:

Licensed Clinical Social Worker enrolled as a Montana Medicaid provider and contracting directly with the DDP

Provider Qualifications

License *(specify):*

Licensed in accordance with Montana ARM
24.219.504

Certificate *(specify):*

Other Standard *(specify):*

ARMS 24.219.101 through 24.219.615 govern the licensure of persons licensed to practice clinical social work
MCA-37.22.101 through 37.22.411 outlining the requirements for licensed clinical social workers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Evaluation, Counseling and Consultation Services

Provider Category:

Individual

Provider Type:

Licensed Professional Counselor, enrolled as a Montana Medicaid provider and contracting directly with the DDP

Provider Qualifications

License *(specify):*

Licensed in accordance with Montana ARM
24.219.504 and 24.219.604

Certificate *(specify):*

Other Standard *(specify):*

ARM 24.219.101 through 24.219.615 governing the licensure of persons practicing professional counseling
MCA 37-23-101 through 37.23.311 outlines the licensure requirements for a licensed professional counselor.

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Evaluation, Counseling and Consultation Services

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP

Provider Qualifications

License *(specify):*

Licensed in accordance with Montana ARM
24.219.504 and 24.219.604

Certificate *(specify):*

Other Standard *(specify):*

In addition, the ARM and MCA site references for these professionals apply.

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed by the provider, prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Evaluation, Counseling and Consultation Services

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP & subcontracting for Psychological Services

Provider Qualifications

License *(specify):*

Licensed in accordance with Montana ARM
24.219.504 and 24.29.604

Certificate *(specify):*

Other Standard *(specify):*

The ARM and MCA site references for these professionals apply.

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Applicable standards are verified by the DD service provider agency.

Frequency of Verification:

Prior to initiating a DDP contract and annually thereafter.

As needed by the provider, prior to authorization of payment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Remote Monitoring Equipment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

The equipment used to operate systems such as live feed video, motion sensing system, radio frequency identification, web-based monitoring system, or other device approved by the DDP. It also refers to the equipment used to engage in live two-way communication with the member being monitored.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Equipment must be leased at a maximum monthly amount of $300. This service allows for the monthly lease of remote monitoring equipment and does not duplicate any equipment purchased under Specialized Medical Equipment and Supplies.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD service provider agency under contract with the DDP. DDP provider agency under contract with with the DDP and subcontracting for Remote Monitoring Equipment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Monitoring Equipment

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP. DDP provider agency under contract with with the DDP and subcontracting for Remote Monitoring Equipment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A qualified provider designated to either reimburse the subcontractor for the procurement of remote monitoring equipment, or for providing the requested remote monitoring equipment is responsible for meeting all the requirements outlined in the DDP contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Remote Monitoring

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

The provision of oversight and monitoring within the residential setting of a member, age 18 and older,through off-site electronic surveillance by staff using one or more of the following systems: live video feed, motion sensing system, radio frequency identification, web-based monitoring system, or other device approved by the DDP. It also allows live two-way communication with the person being monitored as described in the member's plan of care.

Remote monitoring shall be done in real time, not via a recording, by awake staff at a monitoring base using the appropriate connection. When remote monitoring is being provided, the remote monitoring staff shall not have duties other than remote monitoring.

The provider of remote monitoring shall have an effective system for notifying emergency personnel such as police, fire, and back up support staff.

The member who receives the service and each person who lives with the member shall consent in writing after being fully informed of what remote monitoring entails. If the member or a person who lives with the member has a guardian, the guardian shall consent in writing. The member's service coordinator shall keep a copy of each signed consent form with the member's plan of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Remote Monitoring shall only be used in supported living settings and is only used for the purpose of reducing or replacing the amount of residential habilitation needed.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD service provider agency under contract with the DDP. DDP provider agency under contract with with the DDP and subcontracting for Remote Monitoring services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Monitoring

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP. DDP provider agency under contract with with the DDP and subcontracting for Remote Monitoring services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.
Prior to hire:
*Be at least 17 years of age.

Within 30 days of hire receive training in:
*abuse reporting,
*incident reporting,
*client confidentiality, and
*any specialty training relating to the needs of the member served, as outlined in the plan of care.

In addition, the employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency subcontracting for the service.
Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Retirement Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Retirement services are available to a member who is of the typical retirement age (age 62 or older) or is limited due to health and safety issues. Members of this service are no longer able to maintain employment due to health and safety risks OR are of retirement age. Retirement services are structured services consisting of day activities and residential support.

Retirement services may be provided in a provider operated residence (licensed DD group home) or community day activity setting and may be provided as a continuous or intermittent service.

The outcome of Retirement services is to treat each member with dignity and respect, to the maximum extent possible maintain skills and abilities, and to keep the member engaged in their environment and community through optimal care and support. Retirement services are designed to actively stimulate, encourage and enable active participation; develop, maintain, and increase awareness of time, place, weather, persons, and things in the environment; introduce new leisure pursuits; establish new relationships; improve or maintain flexibility, mobility, and strength; develop and maintain the senses; and to maintain and build on previously learned skills.

Retirement services must be furnished in a way which fosters the independence of each member. Strategies for the delivery of Retirement services must be person centered and person directed to the maximum extent possible and is identified in the plan of care.

When Retirement services are delivered in a provider operated residence (licensed DD group home), staff must meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, to provide supervision, safety and security, and to provide activities to keep the member engaged in their environment.

The personal living space and belongings of individuals living at the provider operated residence (licensed DD group home) must not be utilized by those receiving Retirement services at the residence. Only shared living spaces such as the living room, kitchen, bathroom, and recreational areas may be utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payments for Retirement services are not made for room and board.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD service provider agency under contract with the DDP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Retirement Services

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP

Provider Qualifications

License *(specify):*

Retirement services is reimbursable in all community based residential settings, except the provision of this service in DD community group homes is contingent upon State licensure for these facilities. DD group home licensure requirements may be reviewed in ARM 37.100.301 through 37.100.340 and MCA 53-20-301 through 53-20-307.

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:
*Be at least 17 years of age

Within 30 days of hire receive training in:
* abuse reporting,
*incident reporting,
*client confidentiality,
*any specialty training relating to the need of the member served, as outlined in the plan of care.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

Current first aid, and CPR certification, and any other training in accordance with DDP requirements.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPHHS Quality Assurance Division (QAD) for compliance with group home licensing standards, if applicable.

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

QAD licensing study is annual.

As needed by the provider, prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Specialized Medical Equipment and Supplies include:

Devices, controls or appliances, specified in the plan of care, that enable members to increase their ability to perform activities of daily living; devices, controls or appliances that enable the member to perceive, control or communicate with the environment in which they live; items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; such other durable and non-durable medical equipment not available under the State plan that is necessary to address member functional limitations; and necessary medical supplies not available under State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards or manufacture, design and installation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Specialized Medical Equipment and Supplies purchases require prior approval by the DDP Regional Manager.

The following represents a non-inclusive list of non-permissible Specialized Medical Equipment and Supplies:

1. Specialized Medical Equipment and Supplies provided under this definition are not covered under the Individuals with Disabilities Education Act (IDEA), home-based schooling, or Section 110 of the Rehabilitation Act or available through any other public funding mechanism.
2. Specialized medical equipment or supplies benefiting persons other than the member
3. Room and board
4. Personal items and services not related to the disability
5. Gifts, gift certificates, or gift cards for any purpose
6. Items used solely for entertainment or recreational purposes
7. Personal hygiene items
8. Discretionary cash
9. General clothing, food, or beverages (not specialized diet or clothing)
10. Household furnishings
11. Household cleaning supplies
12. Home maintenance

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

The Department requires all other funding sources be utilized, such as Vocational Rehabilitation, or a denial from other funding sources before this service is entered into the cost plan and approved by the Regional Manager.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	**DD Service Provider Agency under contract with the DDP**
Individual	**An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

DD Service Provider Agency under contract with the DDP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A qualified provider designated to either reimburse the member for the procurement of Specialized Medical Equipment and Supplies, or for providing the requested specialized equipment and supplies, is responsible for meeting all the requirements outlined in the DDP contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personell as part of the QA review process.

Frequency of Verification:

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Individual

Provider Type:

An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A member, or their representative, choosing to self-direct with employer authority may elect to purchase specialized medical equipment and supplies, in accordance with the requirements outlined in the service definition, and receive reimbursement from the FMS.

Upon hiring of a person the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for ensuring that equipment and supplies purchased on behalf of the do not exceed individual cost plan allocation for this service, and all documentation requirements have been met prior to issuing reimbursement.

Frequency of Verification:

The DDP quality assurance personnel annually reviews a sample of the service standards with one or more performance measures to ensure that services are in compliance with the QP standards and documentation requirements.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Employment - Co-Worker Support

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition (Scope):

Co-Worker Support allows the DD Program and DD provider agencies to contract with a business to provide co-worker provided job supports as a part of the natural workplace. The supports will be provided directly to the member and may include:
1. the development of positive work-related habits, attitudes, skills,
2. work etiquette directly related to their specific employment,
3. health and safety aspects/requirements of their particular job,
4. assisting the member to become a part of the informal culture of the workplace,
5. job skill maintenance or assistance with incorporating new tasks,
6. facilitation of other supports at the work site such as employer sponsored employee activities beyond job tasks.
7. assistance during breaks and/or lunch.

Members participating in this service are employed by a business and are paid at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. This service differs from Supported Employment – Follow Along Support in that it creates opportunity for services/supports to be provided by the local business' employee where the member is employed. Receiving mentoring from a fellow employee increases opportunities for acceptance into and thus success in the workplace community. This service is intended to provide ongoing Co-Worker Support allowing Follow Along Support to be decreased.

Members may utilize, Individual and Small Group Employment Support, Follow Along Support and Day Supports & Activities in conjunction with Co-Worker Support.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The activities of this service are over and above the obligations an employer has for an employee without a disability, and does not duplicate nor supplant those provided under the provisions of the Individuals with Disabilities Education Improvement Act, or Section 110 of the Rehabilitation Act of 1973, or the Americans with Disabilities Act.

Co-Worker Support and Follow-Along Support cannot be billed for during the same time but could be billed for during the same day.
The Department requires all other funding sources be utilized, such as Vocational Rehabilitation, or a denial from other funding sources before this service is entered into the cost plan and approved by the Regional Manager.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	**An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.**
Agency	**DD service provider agency under contract with the DDP offering agency with choice employer authority.**

Provider Category	Provider Type Title
	DD service provider agency under contract with the DDP subcontracting with employer
Individual	Employer enrolled as a Montana Medicaid provider and contracting directly with DDP

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment - Co-Worker Support

Provider Category:
Individual
Provider Type:

An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The co-worker is a qualified provider of the waiver.

Prior to hire:
*Be at least 17 years of age.
*Screening and a background check of a person prior to an offer of employment as a direct care staff.

Any specialty training relating to the needs of the member served, as outlined in the plan of care.

Upon hiring of a person the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is initially responsible for ensuring that a worker meets the qualified provider standards and the FMS maintains records serving to document the compliance with these standards.

Frequency of Verification:

Annually, the DDP quality assurance personnel reviews compliance of workers during the annual quality assurance review process, based on the requirements of the performance measure sampling process specified.

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment - Co-Worker Support

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP offering agency with choice employer authority.
DD service provider agency under contract with the DDP subcontracting with employer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The co-worker is the person who must meet the qualified provider standards of the waiver while the stipend is reimbursed to the employer.

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:
*Be at least 17 years of age.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Any specialty training relating to the needs of the member served, as outlined in the plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed by the provider, prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment - Co-Worker Support

Provider Category:
Individual
Provider Type:

Employer enrolled as a Montana Medicaid provider and contracting directly with DDP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The co-worker is the person who must meet the qualified provider standards of the waiver while the stipend is reimbursed to the employer.

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:
*Be at least 17 years of age.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Any specialty training relating to the needs of the member served, as outlined in the plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Employment - Individual Employment Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Individual Employment Support consists of habilitation services and staff supports needed by a person to acquire a job/position or career advancement in the general workforce at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Supported Employment - Individual Employment Support is delivered in a competitive, customized, or self-employment setting.

The outcome of this service is paid employment in a competitive, customized, or self-employment setting within the general workforce that meets personal and career goals, as documented in the plan of care. Supported Employment –Individual Employment Support services are person-centered to address the person's employment needs and interests.

REIMBURSABLE ACTIVITIES: Individual Employment Support:

1. Person-centered employment planning (assisting an individual in identifying wants and needs for supports and in developing a plan for achieving integrated employment),
2. Job development,
3. Negotiation with prospective employers,
4. Job carving,
5. Job placement,
6. Career advancement activities,
7. Job analysis,
8. Training, support, coordination and communication in related skills needed to obtain and retain employment such as using community resources and public transportation,
9. Job coaching,
10. Job loss - the person may need to be referred to, or back to, Vocational Rehabilitation for services and reimbursement, in which case, concurrent reimbursement for Supported Employment – Individual Employment Support and Vocational Rehabilitation Services will not be allowed,
11. Benefits planning support,

Members may utilize, Small Group Employment Support, Follow Along Support, Co Worker Support, and Day Supports & Activities in conjunction with Individual Employment Support.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT REIMBURSABLE: Individual Employment Support:
1. Ongoing transportation of a member to and from the job site once the person has been hired.
2. Any service that is otherwise available under the Rehabilitation Act of 1973.
3. Employment activities taking place in a group, i.e., work crews or enclaves.
4. Public relations activities.
5. Staff continuing education - In-service meetings, department meetings, individual staff development.
6. Incentive payments made to an employer to subsidize the employer's participation in a supported employment program.
7. Payments that are passed through to users of supported employment programs.
8. Payments for vocational training that is not directly related to a member's supported employment program.
9. Any other activities that are non-member specific, i.e., the member has the job and can't work their scheduled hours so the job coach is working the job instead of the member.
10. Any activities which are not directly related to the member's career plan.
11. Services furnished to a minor by a parent(s), step-parent(s) or legal guardian.
12. Services furnished to a member by the member's spouse.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore Documentation is required to ensure that the service is not available or is no longer available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Income from customized home-based businesses may not be commensurate with minimum wage requirements with other employment.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

The Department requires all other funding sources be utilized, such as Vocational Rehabilitation, or a denial from other funding sources before this service is entered into the cost plan and approved by the Regional Manager.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	**DD service provider agency under contract with the DDP offering agency with choice employer authority**
Agency	**DD service provider agency under contract with the DDP**
Individual	**An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment - Individual Employment Support

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP offering agency with choice employer authority

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:
*Be at least 17 years of age.

Within 30 days of hire receive training in:
*abuse reporting,
*incident reporting,
*client confidentiality,
*service documentation requirements,
*training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

Current first aid certification, and other training in accordance with DDP requirements.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed by the provider, prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment - Individual Employment Support

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:
*Be at least 17 years of age.

Within 30 days of hire receive training in:
*abuse reporting,
*incident reporting,
*client confidentiality, and
*any specialty training relating to the need of the member served, as outlined in the plan of care, and
*other competencies as required by DDP.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

Current first aid, CPR, and other training in accordance with DDP requirements.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed by the provider, prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment - Individual Employment Support

Provider Category:
Individual
Provider Type:

An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Prior to hire:
*Be at least 17 years of age.
*Screening and a background check of a person prior to an offer of employment as a direct care staff.

Within 30 days of hire receive training in:
*abuse reporting,
*incident reporting,
*client confidentiality,
*service documentation requirements,
*training in areas specific to the needs of the member, as outlined in the training plan included in the Self-Direct with Employer Authority Plan of Care.

Current first aid certification, and other training in accordance with DDP requirements.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

*any other training requirements as outlined by the Department.

Upon hiring of a direct care staff person the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

In addition, the fiscal agent will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is initially responsible for ensuring that a worker meets the qualified provider standards and the FMS maintains records serving to document the compliance with these standards.

Frequency of Verification:

Annually, the quality assurance personnel reviews compliance of workers during the annual quality assurance review process, based on the requirements of the performance measure sampling process specified.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Employment - Small Group Employment Support

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Supported Employment - Small Group Employment Support consists of habilitation services and staff supports needed for groups of two (2) to eight (8) workers with disabilities to maintain a job/position in the general workforce at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small Group Employment examples include enclaves, mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Small Group Employment Support must be provided in a manner that promotes integration into the workplace and interaction between people with and without disabilities in those workplaces. Work occurs in business settings and hours typical for the industry.

REIMBURSABLE ACTIVITIES: Small Group Employment Support:

1. Person-centered employment planning with or on behalf of the member supported,
2. Job development,
3. Negotiation with prospective employers,
4. Job carving,
5. Job placement,
6. Job analysis,
7. Training and support in related skills needed to obtain and retain employment such as using community resources and public transportation,
8. Job coaching,
9. Benefits planning support,
10. Job promotion support,
11. Career advancement support.

People may utilize Job Discovery/Job Preparation, Individual Employment Support, Co Worker Support and Day Supports & Activities in conjunction with Small Group Employment Support.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ACTIVITIES NOT REIMBURSABLE: Small Group Employment Support

1.Transportation of a person to and from the job site.
2.Any service that is otherwise available under the Rehabilitation Act of 1973.
3.Public relations activities.
4.Staff continuing education - In-service meetings, department meetings, individual staff development.
5.Incentive payments made to an employer to subsidize the employer's participation in a supported employment program.
6. Payments that are passed through to members of supported employment programs.
7. Payments for vocational training that is not directly related to a member's supported employment program.
8. Any activities which are not directly related to the member's career plan.
9. Services furnished to a minor by a parent(s), step-parent(s) or legal guardian.
10. Services furnished to a member by the member's spouse.

Total hours for a member's attendance shall not include time spent during transporting to/from the member's residence.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore Documentation is required to ensure that the service is not available or is no longer available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

The Department requires all other funding sources be utilized, such as Vocational Rehabilitation, or a denial from other funding sources before this service is entered into the cost plan and approved by the Regional Manager.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD service provider agency under contract with the DDP. DD service provider agency under contract with the DDP offering agency with choice employer authority

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment - Small Group Employment Support

Provider Category:

Agency

Provider Type:

DD service provider agency under contract with the DDP. DD service provider agency under contract with the DDP offering agency with choice employer authority

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:
*Be at least 17 years of age.

Within 30 days of hire receive training in:
*abuse reporting,
*incident reporting,
*client confidentiality, and
*any specialty training relating to the need of the member served, as outlined in the plan of care.

Persons assisting with meds will be certified in accordance with ARM 37.34.114.

Any training in accordance with Department rules.

In addition, Employer will maintain documentation verifying the person providing direct services has an acceptable criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Applicable standards are verified by the DD service provider agency.

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed by the provider, prior to authorization of payment.

Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

TRANSPORTATION SERVICES

Service offered in order to enable members served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the plan of care. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Legally responsible persons, relatives, legal guardians and other persons who are not employees of agencies with a DDP contract may be reimbursed for the provision of rides. In these cases, reimbursement will be less than or equal to the mileage rate set by the Department for a State employee operating a personal vehicle. The mileage rate is based on the operational expense of a motor vehicle and does not include reimbursement for work performed, or the drivers time. Reimbursement for rides provided by legally responsible persons or others must be related to the specific disability needs of a member, as outlined in the plan of care. Persons providing transportation must be licensed, insured and drive a registered vehicle, in accordance with the motor vehicle laws of the State of Montana.

Reimbursable transportation expenses may also include assistance with reasonable (as determined by the department) costs related to one or more of the following areas: operator training and licensure, insurance, registration or other costs associated with a individual's dependence on the use of a personal vehicle owned by the person in accessing work or other community integration activities as outlined in the plan of care.

Transportation as a self-directed services with employer authority (either common law or agency with choice): Mileage reimbursement at the lowest current state plan rate is available when the member is transported to approved community functions, in accordance with the plan of care and the individual cost plan. Mileage reimbursement paid by the FMS is contingent upon the FMS receiving documentation that transportation was provided in accordance with Montana state requirements for operating a motor vehicle. Reimbursement is contingent upon vehicles being registered and insured, and the operator of the vehicle must have a valid driver's license. Mileage reimbursement does not pay for a person's time, rather, the mileage reimbursement partially offsets the cost of operating a motor vehicle. Mileage reimbursement may also available to the owner of the vehicle when friends and non-employees provide transportation services to the member for approved community functions, when all the requirements for operating a motor vehicle have been met, and the mileage reimbursement provision is approved in the plan of care. Mileage reimbursement is not available for medically necessary transportation reimbursable under the state plan.

Rates for services in residential settings and work/day settings in which paid, on-site primary care givers provide routine, non-medically necessary transportation (community outings, picnics, etc) may include cost of these integrated transportation services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following are excluded:
1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the member;
2) Purchase or lease of a vehicle; and
3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of any modifications.

Transportation services are not reimbursable in residential and work/day settings, if the transportation service is folded into the rates for these residential and/or work/day settings. Under no circumstances will medically necessary transportation (transportation to medical services reimbursed under the State Plan) be reimbursed under the waiver if the service is reimbursable under State Plan transportation.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**
☒ **Relative**
☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDP provider agency under contract with the DDP and/or subcontracting for transportation services.DD service provider agency under contract with the DDP offering Agency with Choice Employer Authority
Agency	Dedicated transportation provider agency enrolled as a Montana Medicaid provider and contracting directly with DDP
Individual	An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

DDP provider agency under contract with the DDP and/or subcontracting for transportation services.DD service provider agency under contract with the DDP offering Agency with Choice Employer Authority

Provider Qualifications

License *(specify):*

Operator will have a valid motor vehicle license,liability insurance and proof of vehicle registration, in accordance with state laws.

Certificate *(specify):*

Other Standard *(specify):*

The staffing rules as outlined in ARM 37.34.2101-37.34.2111.

Prior to hire:
*Be at least 17 years of age.

Payment for escort services may not be made under the transportation category.

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency reimbursing the transportation service is responsible for verifying that the motor vehicle is registered and insured, and the vehicle operator is licensed to operate the vehicle.

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed by the provider, prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Dedicated transportation provider agency enrolled as a Montana Medicaid provider and contracting directly with DDP

Provider Qualifications

License *(specify):*

Operator will have a valid motor vehicle license, liability insurance and proof of vehicle registration, in accordance with state laws.

Certificate *(specify):*

Other Standard *(specify):*

Person providing the service must be 17 or older.

Payment for escort services may not be made under the transportation category.

Terms of minimum liability insurance are outlined in the provider contract, under the section Automobile Liability Insurance Coverage.

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially - The DDP as part of the Qualified Provider Application Process.
Ongoing - The quality assurance personnel as part of the QA review process.

Frequency of Verification:

As needed prior to authorization of payment.
Prior to initiating a DDP contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual
Provider Type:

An individual who works for a member or a respresentative of the member self directing the service with commonl law authority.

Provider Qualifications

License *(specify):*

Operator will have a valid motor vehicle license,liability insurance and proof of vehicle registration, in accordance with state laws

Certificate *(specify):*

Other Standard *(specify):*

Prior to hire:
*Be at least 17 years of age.

Upon hiring of a direct care staff person the FMS must review the list of excluded individuals and entities maintained at the System for Award Management maintained by the federal General Services Administration (GSA) to determine whether the person appears on the list and if the person appears on the list, must report the listing to the department and the employer immediately.

Payment for escort services may not be made under the transportation category.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS is responsible for ensuring that services and supports purchased on behalf of the individual do not exceed individual cost plan allocation for this service, and all documentation requirements have been met prior to issuing reimbursement.

Frequency of Verification:

Annually, the quality assurance personnel reviews compliance of workers during the annual quality assurance review process, based on the requirements of the performance measure sampling process specified.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management is delivered by state employees or contracted entities who complete all case management functions.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a. Name-based criminal background checks from the Montana Department of Justice are required for all DD service provider agency employees who work with individuals funded by the DDP. The background investigation is performed through the State of Montana Department of Justice. The Department of Justice looks for any documentation of criminal activity within the State of Montana. For Homemaker services provided by a non-DD service provider agency employee (i.e. business entity) and Respite services provided as self-direct with employer authority using a fiscal agent a background check is optional. In this case, the member or their representative may choose to request, at no-cost, to the member, criminal background check for workers.

b. Name based criminal background checks are based on criminal records maintained by the Montana Department of Justice. This is a State level repository of criminal records. The background investigation is performed through the State of Montana Department of Justice. The Department of Justice looks for any documentation of criminal activity within the State of Montana.

c. The DDP's performance measure review process requires the DDP quality assurance personnel to annually sample the DDP provider agency employee files for staff working directly with persons to ensure background checks are being completed.

Note- DDP's statewide policy defines acceptable hiring practices related to background check outcomes resulting from QA activities. The policy outlines the steps taken by the DDP and the provider if problems are found during the on-going monitoring of background check outcomes. The policy will preclude the hiring of certain categories of workers who pose a health, safety or financial risk to individuals and others and can be found on the DDP website.

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	
Licensed DD Group Home	
Transitional living apartments, also known as Supported Living, Congregate	
Licensed Adult Foster Home	
Licensed Assisted Living A,B and C Beds	

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.

Required information is contained in Main Module Attachment B Transition Plan or in response to C-5 when all settings are compliant with regulations.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed DD Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Supported Employment - Individual Employment Support	☐
Personal Care	☒
Physical Therapy	☐
Remote Monitoring Equipment	☐
Personal Supports	☐
Specialized Medical Equipment and Supplies	☒
Adult Foster Support	☐
Behavioral Support Services	☒
Respite	☐
Companion Services	☐
Supported Employment - Small Group Employment Support	☐
Supports Brokerage	☐
Assisted Living	☐
Speech Therapy	☐
Individual Goods and Services	☐
Day Supports and Activities	☐
Community Transition Services	☐
Supported Employment - Co-Worker Support	☐
Nutritionist Services	☒
Remote Monitoring	☐
Homemaker	☐
Retirement Services	☒
Psychological Evaluation, Counseling and Consultation Services	☒
Caregiver Training and Support	☐
Private Duty Nursing	☒
Residential Habilitation	☒
Meals	☐
Environmental Modifications	☒
Personal Emergency Response System (PERS)	☐
Occupational Therapy	☐
Transportation	☒
Supported Employment - Follow Along Support	☐

Facility Capacity Limit:

Eight is the maximum.

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:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Transitional living apartments, also known as Supported Living, Congregate

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Supported Employment - Individual Employment Support	☐
Personal Care	☒
Physical Therapy	☐
Remote Monitoring Equipment	☒
Personal Supports	☐
Specialized Medical Equipment and Supplies	☒
Adult Foster Support	☐
Behavioral Support Services	☒

Waiver Service	Provided in Facility
Respite	☐
Companion Services	☒
Supported Employment - Small Group Employment Support	☐
Supports Brokerage	☐
Assisted Living	☐
Speech Therapy	☐
Individual Goods and Services	☐
Day Supports and Activities	☐
Community Transition Services	☒
Supported Employment - Co-Worker Support	☐
Nutritionist Services	☒
Remote Monitoring	☒
Homemaker	☒
Retirement Services	☒
Psychological Evaluation, Counseling and Consultation Services	☒
Caregiver Training and Support	☐
Private Duty Nursing	☒
Residential Habilitation	☒
Meals	☒
Environmental Modifications	☒
Personal Emergency Response System (PERS)	☒
Occupational Therapy	☐
Transportation	☒
Supported Employment - Follow Along Support	☐

Facility Capacity Limit:

Two per apartment or discrete living unit.

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	☒

Standard	Topic Addressed
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:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Adult Foster Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Supported Employment - Individual Employment Support	☐
Personal Care	☐
Physical Therapy	☐
Remote Monitoring Equipment	☐
Personal Supports	☐
Specialized Medical Equipment and Supplies	☒
Adult Foster Support	☒
Behavioral Support Services	☒
Respite	☒
Companion Services	☐
Supported Employment - Small Group Employment Support	☐
Supports Brokerage	☐
Assisted Living	☒
Speech Therapy	☐
Individual Goods and Services	☐

Waiver Service	Provided in Facility
Day Supports and Activities	☐
Community Transition Services	☒
Supported Employment - Co-Worker Support	☐
Nutritionist Services	☒
Remote Monitoring	☐
Homemaker	☐
Retirement Services	☐
Psychological Evaluation, Counseling and Consultation Services	☒
Caregiver Training and Support	☐
Private Duty Nursing	☒
Residential Habilitation	☐
Meals	☐
Environmental Modifications	☒
Personal Emergency Response System (PERS)	☒
Occupational Therapy	☐
Transportation	☒
Supported Employment - Follow Along Support	☐

Facility Capacity Limit:

No more than four persons with DD may reside in an adult foster home.

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:

Staffing Ratios- DDP will not impose a staffing ratio requirement on adult foster care and assisted living placements. The member's planning team and case manager would be involved in matching the member's needs to an appropriate facility. Service Coordinators visit members in these residences, these facilities are licensed by the Quality Assurance Division, service capacity for these facilities is outlined in the licensing standards and in ARM, and these service sites are reviewed during the annual DDP QA review process.

DDP will reimburse a foster home provider of adult foster supports for no more than two members with enhanced supervision/support needs, or, one member with intensive supervision and support needs.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Assisted Living A,B and C Beds

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Supported Employment - Individual Employment Support	☐
Personal Care	☐
Physical Therapy	☐
Remote Monitoring Equipment	☐
Personal Supports	☐
Specialized Medical Equipment and Supplies	☒
Adult Foster Support	☐
Behavioral Support Services	☒
Respite	☐
Companion Services	☐
Supported Employment - Small Group Employment Support	☐
Supports Brokerage	☐
Assisted Living	☒
Speech Therapy	☐
Individual Goods and Services	☐
Day Supports and Activities	☐
Community Transition Services	☐
Supported Employment - Co-Worker Support	☐

Waiver Service	Provided in Facility
Nutritionist Services	☒
Remote Monitoring	☐
Homemaker	☐
Retirement Services	☐
Psychological Evaluation, Counseling and Consultation Services	☒
Caregiver Training and Support	☐
Private Duty Nursing	☐
Residential Habilitation	☐
Meals	☐
Environmental Modifications	☒
Personal Emergency Response System (PERS)	☐
Occupational Therapy	☐
Transportation	☒
Supported Employment - Follow Along Support	☐

Facility Capacity Limit:

Space dependent, no limit on individuals served.

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:

Staffing Ratios- DDP will not impose a staffing ratio requirement on adult foster care and assisted living placements. The member's planning team and service coordinator would be involved in matching the member's needs to an appropriate facility. Service coordinators visit members in these residences, these facilities are licensed by the Quality Assurance Division, service capacity for these facilities is outlined in the licensing standards and in ARM, and these service sites are reviewed during the annual DDP QA review process.

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.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- (●) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

A legal guardian or family member may be reimbursed for the provision of direct services when the guardian is not fiscally responsible for the care of the member as outlined by waiver service category in Appendix C-3. Full legal guardians of DDP-funded members cannot be licensed as foster care providers and unlicensed foster care providers may not receive reimbursement for DDP-funded services.

The controls to ensure that payments are made for services delivered are the same for all providers of waiver services. Private audits, State audits, State SURS reviews, the service coordinator involvement in planning and member contacts, the DDP quality assurance personnel fiscal sampling process and the family and consumer satisfaction surveys regarding the delivery of services are methods by which the delivery of services will be reviewed in support of provider invoices.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Department established an open enrollment policy for all waiver services and developed the initial set of application forms for all waiver-funded services in 2002, following the review of this waiver by the CMS Regional Office in the fall of 2000. The qualified provider enrollment documents, contracting documents and various other application forms have since been revised and updated. The qualified provider enrollment documents, contracting documents and various other application forms are available on the DDP website for all interested parties. The DDP website states that:

To become a new DDP Provider, an entity must determine which services it is able to provide under a particular funding source.

Note: If the provider desires to contract directly with DDP and the service standard (links found on the website) require an individual to have a professional license/certification to provide the service, a DDP contract for licensed professionals is sufficient to become a qualified provider. If the service standard is agency-based and must be delivered by an Organized Health Care Delivery System (OHCDS), a full application to become a new DDP provider must be completed. A licensed/certified individual may also subcontract with an OHCDS-designated DDP qualified provider to provide the service.

Once an entity identified services under one or more of the Waivers that they believe they are able to offer, they should review the Department rules describing what must be provided under each of those services, to determine whether they believe they can meet the requirements for that service.

Once they determine which services they can offer while meeting Department rules, they must:

For services that require an OHCDS agency-based provider: Fill out an application to become a new DDP provider

Or
For services that can be delivered by an individual who is a licensed/certified professional: Complete the contracting process through your local Developmental Disabilities Program Regional Office.

· Complete required criminal background checks as directed in the DDP Background Check Policy.

· Make arrangements to meet liability insurance and bonding requirements.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of provider applicants requiring licensure/certification that met initial qualified provider standards. N: Number of providers requiring licensure/certification who met initial qualified provider standards; D: Number of all provider applicants requiring licensure/certification.

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:

Performance Measure:
Number and percent of current providers requiring licensure/certification that met ongoing qualified provider standards. N: Number of providers requiring licensure/certification that meet qualified provider standards; D: Number of all existing providers requiring licensure/certification (excluding new 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:	☒ **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**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of providers (non-certified/non-licensed) that met DDP ongoing qualified provider standards. N: Number of providers (non-certified/non-licensed) that met ongoing qualified provider standards; D: Number of all providers (non-certified/non-licensed) (excluding new providers).

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:

Performance Measure:
Number and percent of provider applicants (non-certified/non-licensed) that met DDP initial qualified provider standards. N: Number of provider applicants (non-

certified/non-licensed) that met initial standards; D: Number of provider applicants (non-certified/non-licensed) 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of individuals with providers hired under self-direction that met DDP qualified provider standards. N: Number of individuals with providers that met ongoing qualified provider standards; D: Number of all individuals with providers under self-direction.

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 State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of providers in compliance with DDP training requirements. N: Number of providers in compliance with DDP training requirements; D: Number of all 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of service coordinators who meet training requirements. N: Number of service coordinators in compliance with DDP training requirements; D: Number of all service coordinators.

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:	☒ **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.

100% of self-direct recipients are reviewed for sub-assurances a, b and c-2, and stratified sampling approach is used for sub-assurance c-1.

The review of the qualifications of persons providing waiver-funded services occurs annually in the completion of the DDP QA review process. Newly qualified service providers must submit documentation verifying compliance with the qualified provider standards to the DDP as part of the qualified provider application process.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The delivery of direct services by DDP-funded agencies with a DDP contract is subject to annual quality assurance reviews by DDP staff. In general, these problems are resolved via the application of the Quality Assurance Observation Sheet (QAOS). This form generally requires short term turn around times, and includes negotiated timeframes between DDP staff and provider staff in resolution of identified problems. At such time the problem is resolved, the QAOS has been signed and dated by both parties, and the finding is considered closed. Quality assurance personnel monitor the effectiveness of the plan on an ongoing basis. The QAOS becomes a permanent QA record, and is maintained by the provider and in the DDP regional and central offices. The specific protocol used to correct problems resulting from the application of the QA process is outlined in the Quality Assurance and Compliance Policy.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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 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.'

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☒ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Members served in the waiver have individual cost plans based on assessed needs as determined by the Montana Resource Allocation Protocol(MONA), completed by the targeted case manager. Members can choose from the menu of waiver service options, based on assessed needs and identified in the plan of care. The value of the cost plan is largely based on the historical amount awarded to the member with adjustments made based on changing needs as reflected in the MONA. Members and or their families have broad flexibility and choice of services within the limit of the cost plan.

Additional time limited funds are generally available via crisis funds from the DDP regional offices. The rates are fully integrated statewide and the dollar value of cost plans is shared with members and family members.

☐ **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.

Short term (not exceeding one year) and annualized resources may be made available for members from under utilized cost plans.

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.

Provider self assessments and remediation plans for residential and non-residential settings were reviewed showing most settings were already 100% compliant. The setting that were not 100% compliant provided remediation plans to become 100% compliant. At this time on-going random onsite visits have shown that nearly all of the settings are 100% compliant.

One provider self assessment indicated that the setting would meet heightened scrutiny, however it appears this was because the provider made an error in the self assessment.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Personal Support Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

The case manager, also known as the service coordinator, is responsible for the development of the plan of care for each waiver recipient. A case manager/service coordinator must meet the following criteria:

*Possess a bachelor's degree in social work or related field from an accredited college and have one year of experience in human services, or
have provided case management services, comparable in scope and responsibility to that provided by the targeted case managers, to a person
with developmental disabilities for at least five (5) years.
*Have at least one (1) year of experience in the field of developmental disabilities.
*Participate in a on-time new employee training and a minimum of 20 hours of annual training in services to persons with developmental
disabilities each year, including abuse prevention training.

New employee training to be completed within the first three (3) months of hire:
*In accordance with the approved State Pan Amendment

Annual Training:
*In accordance the approved State Pan Amendment

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Upon entry into the waiver, and annually thereafter, the member, family and legal representative if appropriate, receive information on and indicate choices of waiver services, self direction, and qualified provider options via the Freedom of Choice and Consent, and Addendum forms. A detailed explanation of services and options is provided by the case manager/service coordinator.

The plan of care is developed to reflect what is important to the member as designed through outcomes identified in the support plan leading to independence, dignity and personal fulfillment. The person-driven and person-centered plan identifies services and supports that are appropriate to meet the member's assessed needs through completion of the following, results of which are shared with the member: a consumer survey, health and safety risk factor identification form, medical, vision, hearing, and dental examination information
The development of the plan of care reflects a person-centered planning process. The plan belongs to the member and the process helps members achieve their life goals and evolves as the member's life evolves. The plan of care is signed by the member, family and legal representative if appropriate, and participating team members, indicating approval of the plan.

Notification of the planning meeting is sent by the case manager/service coordinator to the member, family and legal representative if applicable, and other invited parties. The member, family and /or legal representative, as appropriate reserve the right to decide who will be attending the planning meeting, except the member does not have the authority to limit attendance by his/her full legal guardian. Plan input and guidance from the member, representatives of agencies providing services, and interested others is actively encouraged by the case manager/service coordinator.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Who develops the plan, who participates in the process, and the timing of the plan:

The participant-centered service plan belongs to the member and the plan of care process helps people achieve his/her life goals, evolving as the member's life evolves. Montana requires that each individual eligible for program supports have a plan of care. The development of the plan of care is facilitated by a case manager/service coordinator, certified in plan of care development and chosen by the member.

Developing a plan of care encourages a team approach to involve the waiver recipient, known as member, and community networks in planning for the future. Whenever possible, members should freely choose their circle of support who may be: family members and/or guardians and/or legal representatives, teachers and paraprofessionals, friends, peers acquaintances, direct support professionals, and other support professionals, and any others who are important to the member and his or her family and those involved in the member's life. In accordance with the Administrative Rules of Montana (ARM) 37.34.1107 the planning team must include: the individual with a developmental disability, if able to participate; member's advocate, if applicable; legal representative of the member, if applicable, the case manager/service coordinator for the member; staff person from each service program; and others who are chosen and approved by the member. The member is also involved in choosing when and where the plan of care meeting occurs.

The plan of care process is designed to be fluid, changing as the member's life changes to include any transitions. The initial plan of care must be developed by the team with participation of the member within 30 calendar days of the member's entry into waiver services. The plan of care is updated at least annually, or more often as needed.

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status:

The case manager/service coordinator is responsible to complete a consumer survey, and the Healthcare Checklist and Risk Worksheet. These documents are completed with the member upon entrance into the waiver, and annually thereafter, and assist in the development of vision statements and outcomes based on the member's needs and desires.

The residential provider agency, or the case manager/service coordinator in the absence of any residentially-based services, supplies the results of the member's annual physical, dental, hearing and vision examinations. Additionally, providers must address the living, employment, educational, developmental, social, and leisure domains according to Department policy and under the direction of the planning team.

The case manager/service coordinator and provider staff may identify additional assessments that will support the team to understand the member, what the member needs, and how best to support those needs while considering the member's wants and the use of natural supports. For members who are employed, additional information may be gathered from the member and from the supported employment coach.

(c) How the participant is informed of the services that are available under the waiver:

Information regarding the services that are available under the waiver is shared with the member upon initial entrance into the waiver, and on an annual basis as part of the planning process. The Freedom of Choice Addendum form lists the available waiver services, and further identifies services which may be self-directed. It is the responsibility of the case manager/service coordinator to present detailed information on the available waiver services and self-direct options, choices between waiver services and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), choices of qualified Home and Community Based Services providers, and information regarding the state of Montana's fair hearings process. The member (guardian or legal representative, if applicable) acknowledges receipt of information and indicates choices on the Freedom of Choice and Consent form. The member (guardian or legal representative, if applicable) may change the choices made at any time. This would be reflected on an updated Freedom of Choice and Consent form, and an amended plan of care as needed.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences:

The plan of care is developed to reflect what is important to, and important for the member as designed through outcomes identified in the support plan leading to independence, dignity, and personal fulfillment. The person-driven and person-centered plan identifies services and supports that are appropriate to meet the member's assessed needs per ARM 37.34.1101

A review of the assessments and other information gathered is conducted prior to the planning meeting in order to facilitate discussion of findings to incorporate into the plan. Assessments lead to valuable information to inform outcomes and goal setting in relationship with the member's goals, needs (including health care needs), and preferences.

(e) how waiver and other services are coordinated:
Developing a PSP encourages a team approach to involve the member and community networks in assisting the member to plan for his/her future. The process involves the member first developing a vision for the future, and identifying all current supports to develop the member's team. This is followed by the case manager/service coordinator being actively engaged in the PSP process to facilitate team members to coordinate the resources and supports available, or for which the member is eligible, to make the member's vision a reality.
The case manager/service coordinator facilitates all plan of care meetings and the pre-plan of care information gathering process. He or she is responsible to gather information and assure coordination of all services, resources and supports. The person–centered process and plan identifies services and supports, including natural supports, private or publicly funded supports, or waiver supports. The plan of care document includes a section to identify people/agencies that support the individual, contact information, and types of services and supports provided. Each action identified in the plan of care to accomplish the member's outcomes also requires the identification of entities responsible to complete the actions, as well as the implementation date.
The process involves the member developing a vision for the future, while facilitating the coordination of resources and supports to make that vision a reality.

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

The Personal Supports Manual delineates responsibilities and timelines of team members responsible to gather, complete, and provide summary information for each assessment completed, or information gathered through formal and informal processes. The summary information is provided to the case manager/service coordinator during the pre-plan of care process.

As part of the plan of care meeting, the team agrees on the assignment of responsibilities to implement actions identified to assist and support the member to achieve his/her outcomes. Each action identified in the plan of care to accomplish the member's outcomes requires the identification of entities responsible to complete the actions, as well as the implementation date.
The entities responsible for the implementation of actions provide updates via a Status/Progress report to the case manager/service coordinator on at least a quarterly basis, or more frequently if needed. The case manager/service coordinator reviews the quarterly status/progress for each action, follows up with the member and other team members as appropriate. This may include scheduling a team meeting to discuss possible revisions to the actions if the status/progress reports indicate the member is not making progress towards his/her desired outcome.
(g) how and when the plan is updated, including when the participant's needs change:

There are several events that could trigger the revision or updating of a member's plan of care. But, minimally the plan is updated annually. Other developments that could result in the update or revision of a plan of care include: lack of progress toward attainment of outcomes as evidenced by Quarterly Report information; change in the member's health or physical support needs; change in the member's behavior; increase in frequency or intensity or types of documented incidents; or a member's desire to change his/her vision, outcomes, services, or supports.

The plan must be reviewed at least quarterly, and revised or amended as warranted. Quarterly reviews include a review of vision statements and outcomes; a summary of progress toward the attainment of each action statement; a summary of any action taken to assure progress; review of current supports and services and identification of any modifications

needed; review of health and medical information; review of assessment information; and review of the services/supports identified in the member's cost plan to determine if they meet the member's assessed needs.

Incidents involving the member are also reported and reviewed regularly by incident management committees, of which case manager/service coordinators are required members. This is in compliance with ARM 37.34.1501, and further described in Montana's Developmental Disabilities Program Incident Management Procedures Manual. Incidents warranting a "high risk review" requires the case manager/service coordinator to schedule a meeting for the team to review the plan of care and determine if a revision is needed to address the incidents.

Any new service/support must be noted in the plan of care therefore, an amendment is necessary to reflect the changes within 30 days of the change. An amendment meeting is held with the team and changes are documented using the amendment form and disseminated among the team members by the case manager/service coordinator in accordance with ARM 37.34.1102(7). Again, the plan of care should change as often as there are changes in the member's life.

The plan of care must be reviewed annually by the team and updated to accurately reflect the person's needs for supports and services. During the annual planning team meeting, the team also reviews the fourth quarterly report. The annual plan of care may not be extended beyond the twelfth month, ensuring no gap in implementation dates.

The case manager/service coordinator posts the completed or amended PSP on the department-approved data management system within 21 calendar days of the plan of care meeting and provides a copy, if requested, to team members who do not have access to the data management system in accordance with ARM 37.34.1102.
Some of the codes, rules and policies governing this section include:

1. Personal Support Planning Policy.
2. ARM 37.86.3301 through 37.86.3306 and 37.86.3601 through 37.86.3607 relate to the provision of services under the State Plan. Other planning meeting references include 37.34.917 and 37.34.918.
3. MCA 53-20-201 through 53-20-205 and 53-20-209.

The case manager/service coordinator is responsible for scheduling and facilitating all team meetings, and it is through these meetings that the plan of care is updated. Any team member may request a meeting to review and/or revise the plan of care, including changing circumstances of the member, such as: lack of progress in completing actions and outcomes identified in the plan of care; waiver expenditures that vary significantly from approved levels; a change in member's assessed needs or visions (goals); and member desire to port to a different service provider(s) or change waiver services. Meetings are scheduled after consultation with the member to determine when and where he/she would like to hold the meeting, and identify who to invite. Any review or revision of the plan of care is documented and disseminated by the case manager/service coordinator.

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.

Assessments of risk are related to two broad areas:

1. Identification of risk factors linked to the increased potential for the abuse, neglect or exploitation of the member.
2. Identification of risk factors, which, if not addressed, could interfere with the member's cognitive, social and physical development, or reduce the potential for independence and/or reduce life choices and options based on behavioral issues or adaptive behavior deficits.

Risk assessment is conducted in the pre-plan of care development process. It consists of the case manager/service coordinator completing a consumer survey in which the member can express needs, health and wellness concerns, and personal lifestyle choices. The case manager/service coordinator also completes the Health Care Checklist and Risk Worksheet with the member and/or with others who know the member's medical, behavioral, environmental, and general safety history, concerns, and needs. These forms are completed at least annually as part of the plan of care development process.

Risk factors may also be identified through the review of recorded incidents involving the member. Case managers/service coordinators participate in weekly incident management committee meetings during which incidents involving members served by the provider are reviewed. In addition to reviewing individual incidents, the committees also review trends which may result in the convening of the member's planning team to conduct a high risk review. These activities are further described in the DDP Incident Management Procedures Manual.

Mitigation of risk factors is addressed by the member and his/her planning team and are documented in the member's plan of care. Training and service objectives related to the mitigation of risk are given a very high priority during the planning process. The plan of care is revised whenever necessitated by a change in the member's health, wellness, or other risk factors.

All service provider staff, and other professionals involved with the member are mandatory reporters of suspected abuse, neglect or exploitation per Montana Code Annotated (MCA) 41-3-201 for children, and MCA 52-3-811 for adults.

Back-up support to members receiving services from agency-based providers in non-congregate settings is available via on call systems linking them to assigned agency staff person. In general, back up plans for persons in congregate settings are less critical and the provider systems and policies to maintain staffing ratios are individualized by service provider agency, based on the needs of each person. Contracted providers are expected to provide the DDP with all emergency back-up or on-call emergency working numbers for all services that they deliver in accordance with Appendix I of the contract for services.

Members choosing to self-direct all or part of his/her services are required to have a back-up plan developed and identified in the member's plan of care.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Upon entry into waiver services, and at least annually thereafter, the member is afforded the choice of a qualified case manager/service coordinator, from amongst those that are available to the member. The member's choice is documented on the Freedom of Choice for Case Management form.

Information regarding the qualified waiver providers that are available is shared with the member upon initial entrance to the waiver, and on an annual basis as part of the planning process. The Freedom of Choice Addendum form lists the available waiver services, and further identifies services which may be self-directed. It is the responsibility of the case manager/service coordinator to present detailed information on the available waiver services, qualified providers of those services, and self-direct options.

The form also requires choices between waiver services and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), choices of qualified Home and Community Based Services providers, and information regarding the state of Montana's fair hearings process.

The member (guardian or legal representative, if applicable) acknowledges receipt of information and indicates choices on the Freedom of Choice and Consent form. The Freedom of Choice and Consent form is completed annually, or more frequently if the member expresses and interest in porting to, or exploring service options offered by other qualified providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

In waiver services, the Plan of Care is approved by the Service Coordinator/Case Manager. These plans are made available to the DDP Quality Assurance Personnel, but the Quality Assurance Personnel does not review these plans as part of the approval process. Because the Service Coordinator/Case Manager is either a state employee or an employee of an agency providing the case management only services to the indiviual, DDP believes there is no conflict in designating the case manager as the Deparment approval authority. The DDP Quality Assurance Personnel monitors a sample of the plans for quality control purposes as part of the annual QA process.

The Medicaid Program Officer/Waiver Specialist generates the sample size by entering the waiver approved unduplicated count into a sample size calculator, Raosoft.com, recommended through technical assistance received by Human Services Research Institute. A confidence interval of 95% is used. Once the sample size is generated, another website, Randomizer.org, is used to create the statistically valid sample, which is increased by 5% to create a cushion.

Plans of care developed by private case management entities for selected members are reviewed by state-employed DDP quality assurance personnel retrospectively as part of the annual performance measure review. The quality assurance personnel review the annual plan of care and any revised/amended plans of care, quarterly reports, associated systems such as the individualized cost plan and invoicing, as well as data and checklists completed by provider staff.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☒ **Other**

  Specify:

  Service providers also maintain copies of the plans.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare:

The case manager/service coordinator is responsible for facilitating the development of, and monitoring the implementation of the plan of care; and is also responsible for the monitoring of the member's health and welfare.

(b) The monitoring and follow-up method(s) that are used:

The entities responsible for the implementation of actions provide updates via a Status/Progress report to the case manager/service coordinator on at least a quarterly basis, or more frequently if needed. The case manager/service coordinator reviews the quarterly status/progress for each action, follows up with the member and other team members as appropriate. This may include scheduling a team meeting to discuss possible revisions to the actions if the status/progress reports indicate the member is not making progress towards his/her desired outcome.

(c) The frequency with which monitoring is performed:
The PSP must be reviewed at least quarterly by the case manager/support coordinator, and revised or amended by the team as warranted. Quarterly reviews include a review of vision statements and outcomes; a summary of progress toward the attainment of each action statement; a summary of any action taken to assure progress; review of current supports and services and identification of any modifications needed; review of health and medical information; review of assessment information; and review of the services/supports identified in the member's cost plan to determine if they meet the member's assessed needs.
Annually, the DDP QIS also reviews a sample of plans of care as part of the Quality Assurance Review, in accordance with the QA review performance measure requirements.

The Medicaid Program Officer/Waiver Specialist generates the sample size by entering the waiver approved unduplicated count into a sample size calculator, Raosoft.com, recommended through technical assistance received byHuman Services Research Institute. A confidence interval of 95% is used. Once the sample size is generated, another website, Randomizer.org, is used to create the statistically valid sample, which is increased by 5% to create a cushion.

Plans of care developed by private case management entities for selected members are reviewed by state-employed DDP quality assurance personnel retrospectively as part of the annual performance measure review. The quality assurance personnel review the annual plan of care and any revised/amended plans of care, quarterly reports, associated systems such as the individualized cost plan and invoicing, as well as data and checklists completed by provider staff.

The plan of care team develops and assesses the effectiveness of back-up plans as part of the annual plan of care process. Contracted providers are required by contract to maintain an emergency back-up plan with the contact phone number listed in the contract. Members choosing to self-direct services are also required to have an emergency back-up plan. These are reviewed, and updated as needed, by the plan of care team at least annually.

b. Monitoring Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of plans of care developed by state service coordinators that address individuals' assessed needs, either by the provision of waiver services or other means. N: Number of plans of care developed by state service coordnators in which all outcomes and actions are based on documented assessed needs; D: Number of plans of care developed by state service coordnators 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 = 95% confidence interval with, +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of plans of care developed by contracted service coordinators that address individuals' assessed needs, either by the provision of waiver services or other means. N: Number of plans of care developed by contracted service coordinators addressing personal goals. D: Number of plans of care developed by contracted service coordinators 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 = 95% confidence interval, +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of plans of care developed by state service coordinators that address individuals' personal goals, either by the provision of waiver services or other means. N: Number of plans of care developed by state service coordinators addressing personal goals. D: Number of plans of care developed by state service coordinators 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 = 95% confidence interval, +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of plans of care developed by contracted service coordinators that address individuals' personal goals, either by the provision of waiver services or other means. N: Number of plans of care developed by contracted service coordinators addressing personal goals. D: Number of plans of care developed by contracted service coordinators reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(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 = 95% confidence interval, +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of plans of care that have been reviewed and updated at least annually by state service coordinators. N: Number of plans of care that have been updated at least annually by state service coordinators. D: Number of plans of care under the responsibility of state service coordinators reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(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 = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of plans of care that have been reviewed and updated at least annually by contracted service coordinators. N: Number of plans of care that have been updated at least annually by contracted service coordinators. D: Number of plans of care under the responsibility of contracted service coordinators 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 = 95% confidence interval, +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of plans of care that were reviewed and revised when warranted by changes in individual needs by state service coordinators. N: Number of plans of care that were reviewed and revised, as needed, to address changing needs by state service coordinators. D: Number of plans of care under the responsibility of state service coordinators reviewed where needs had changed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval, +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of plans of care that were reviewed and revised when warranted by changes in individual needs by contracted service coordinators. N: Number of plans of care that were reviewed and revised, as needed, to address changing needs by contracted service coordinators. D: Number of plans of care under the responsibility of contracted service coordinators reviewed where needs had changed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval, +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	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:
Number and percent of individuals who received the services in their plan of care. N: Number of individuals who received the services identified in their plan of care including type, scope, amount duration and frequency; D: Number of individuals 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 = Confidence Interval = 95% confidence interval, +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of Freedom of Choice forms completed verifying that individuals were afforded choice among qualified providers. N: Number of individual files containing current Freedom of Choice forms; D: Number of individual 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 = Confidence Interval = 95% confidence interval, +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Number and percent of Freedom of Choice forms completed verifying individuals were afforded choice between waiver services and institutional care. N: Number of individual files containing current Freedom of Choice Forms; D: Number of individual 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 = Confidence Interval = 95% confidence interval, +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DDP Waiver Specialist, or designee, is responsible for aggregating the data generated by the DDP quality assurance personnel or Regional Manager in the monitoring of the performance measures, above. Data will be maintained as a percentage of annual compliance with these measures. Performance data will be forwarded electronically by the DDP QIS to the DDP Waiver Specialist at least annually, and the data will be entered onto a spreadsheet. Annual percent compliance with the performance measures will enable reviewers to determine compliance trends. Problem areas would result in the DDP Waiver Specialist notifying the DDP management team.

The identification of problems in the delivery of services is generally the result of the application of the DDP QA review process. The annual QA Review Process is applied by the DDP quality assurance personnel to providers of services. The QA review process is updated as needed to include measures designed to monitor compliance with new waiver requirements, policies, rules, or contracting requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The Department's process for adressing deficits is outlined in the Quality Assurance and Compliance Policy, with standards applying to the providers of children's services and providers of case management services. The outcomes of deficit findings and remediation efforts may be reviewed in QA Reports, the Quality Assurance Observation Sheets, and narratives in the CMS 372 Reports.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(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.

General Description of the Self-Direction Options:

Budget authority allows the individual, based on assessed needs, to identify the services, the amount of services they will purchase, and the provider of the services, as long as the person stays within the allocated amount and uses a provider enrolled in the waiver.

Members living in a natural home or private residence may choose to self-direct some or all of their waiver services via an employer authority using an FMS model or agency with choice employer authority model. There are no age restrictions for persons who may self-direct their services. Parents/legal representatives may choose to self-direct services FOR their children who receive waiver services. Individuals who self-direct exercise increased control of their resource allocation and increased control over the schedule of service delivery and the persons who provide their direct support.

Self-Direct Agency with Choice Employer Authority:

Person's in self-directed agency with choice services participate with the agency with a DDP contract by referring staff to the agency for hiring. Staff providing direct services must be approved by the person and/or designated representative. The agency serves as the legal employer for all staff providing self-directed services in this option. The person supported also partners with the agency with a DDP contract in scheduling the staff, orienting and instructing staff in their duties, in accordance with waiver requirements, supervising the staff, evaluating staff performance, verifying time worked by staff, and discharging staff from providing services. Service agreements between the provider agency with a DDP contract and the individual are required and are designed to be flexible. A family or an individual waiver participant has flexibility in their plan of care to choose the services, from the service array in the Montana approved waiver that best fit their assessed needs. They may utilize their individual cost plan choosing services that help to achieve the outcomes that are important to and important for them and they may choose to return to traditional agency-based services at any time.

Self-Direct Common Law Employer Authority:

Individuals may choose to self-direct their services using common law employer authority. The individual in service may function as the employer, or the employer may be a personal representative or a family member. "Family member" means natural parents, adoptive parents, licensed foster parents, grandparents, step-parents, siblings, aunts, uncles, guardians and individuals who have a legally granted conservatorship or properly executed power of attorney responsibility for overseeing the disabled person's finances or general care. The employer is responsible for hiring, training, supervising, scheduling and terminating their employees.
The employer may purchase support brokerage services to assist with training, scheduling and other agreed-upon functions. The financial management service (FMS) is responsible for providing information to employers on their responsibilities, for processing employer and employee paperwork and for maintaining documentation that staff hired meets the qualified provider requirements.

The FMS reviews the List of Excluded Individuals and Entities (LEIE) and Medicare Exclusion Database (MED) background checks on employees and obtains criminal background checks on direct support staff that require background checks. The FMS processes payroll and reimburses employees according to the submitted timesheet and individual cost plan. The FMS withholds and pays all taxes and arranges for workers' compensation for all employees. The FMS also provides reports to the employer, case manager/service coordinator and state. In all cases, the person who functions as the employer is subject to the initial and ongoing approval of the planning team.

Services available as Agency with Choice Employer Authority:

Respite,
Personal Supports,
Supports Brokerage,
Transportation,
Caregiver Training and Support,
Supported Employment – Individual Employment Support,
Behavioral Support Services,
Supported Employment – Follow Along Support,
Supported Employment – Small Group Employment Support,

Services Available as Common Law Employer Authority:

Meals,
Respite,
Personal Emergency Response System (PERS),
Environmental Modifications,
Specialized Medical Equipment and Supplies,
Personal Supports,
Supports Brokerage,
Community Transition Services,
Transportation,
Supported Employment – Individual Employment Support,
Supported Employment – Follow Along Support,
Supported Employment – Co-Worker Support

Case managers/Service coordinators will play a critical role in the sharing of information to waiver individuals regarding self-directed service options. Case managers/Service coordinators will review the Freedom of Choice form and the supplemental addendum form with every person potentially eligible to self-direct their services, as defined in section E-1:C. This activity occurs annually. Individuals interested in pursuing the self-directed option and needing more information may access more details from their case manager/service coordinator. Information is also available from the DDP website, the FMS website and from DDP staff. Individuals who elect to self-direct their services will be assisted in doing so by their case manager/service coordinator, who will schedule a planning meeting for this purpose. Persons choosing to self-direct will be assisted by their service provider and case manager/service coordinator in establishing the level of individual involvement in self-directing their services.

Services that a member/family may choose to self -direct are indicated in Appendix C and as previously noted in this section. All other waiver services may be purchased through an agency or individual with a DDP contract. The state Medicaid Agency provides the option of entering into a provider agreement as being designated as an OHCDS and for which specific waiver service(s). Agencies that volunteer to affiliate with an OHCDS must meet the requirements of an OHCDS. The state Medicaid Agency also provides the option of entering into a provider agreement with providers that elect not to affiliate with an OHCDS and will be designated as such in their DDP contract. For those contractors who choose to be a qualified OHCDS, it enables the agency to provide third party services from other entities if requested by the service member/family. The rate paid to the member's provider agency for third party services cannot exceed DDP's standardized rate for direct payment for these services. There is no duplication of payment (pass through funding) in the coordination of third party services. The OHCDS function optimizes the ability of the member/family to choose their direct services staff and supports.

The member is not required to use their primary provider agency for the purchase of third party services. If requested by the member, the DDP will reimburse the alternative service provider directly, in accordance with the member's plan of care, individual cost plan and alternative service provider’s DDP contract.

Members choosing to self-direct may opt out of this option at any time, and receive agency based services under the traditional model of service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Persons of all ages may choose to self-direct their services if they meet the residential living requirements as outlined in E-1:c.

Individuals will be granted this option if the following conditions are met:

Self-Direct Agency with Choice Employer Authority:

The individual has identified a provider willing to assist them in self-directing their services. The case manager/service coordinator will assist by explaining the services the person would like to self-direct with the provider of choice. The case manager/service coordinator will review the proposed plan with the provider chosen by the person, to determine the feasibility. If the provider is willing to provide services in accordance with the expressed desires of the person, the case manager/service coordinator will schedule a planning meeting.

Self-Directed Services with Common Law Employer Authority:

The individual and/or their primary caregivers along with the case manager/service coordinator discuss the self direct options. If a decision is made to move forward in gathering more information the case manager/service coordinator gives the individual/primary caregivers the contact information for the financial management service (FMS) and the FMS is contacted to assist the individual and their primary caregivers and/or case manager/service coordinator to review the required paperwork. If they choose this self-direct option the FMS can assist them in enrolling in their FMS services and their case manager/service coordinator helps them in amending their plan of care and the individual cost plan to reflect the changes.

*In both self direct service options the individual's planning team reviews and approves the plan of care incorporating self direction. The individual cost plan (ICP) is based on the plan of care, and approved by the DDP regional manager.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Information Provided to All Waiver Individuals:

The self-directed service options are available to all persons currently enrolled in the waiver, subject to the criteria specified in E-1:c. A persons DDP resource allocation does not change as a function of enrollment in this service option.

The self-directed options are outlined to the person as part of the planning process and is reviewed by the person, representative (if applicable) and case manager/service coordinator prior to the annual planning meeting. A reference to the self-directed service option is included on the Freedom of Choice Form and the supplemental addendum form. This form is completed annually with the person and or their representative by the DDP quality assurance personnel or case manager/service coordinator. The supplemental addendum included with the Waiver 5 Freedom of Choice form includes more in depth, narrative information regarding: ICF-IID SERVICES IN MONTANA, FAIR HEARING RIGHTS and OPPORTUNITIES TO SELF-DIRECT. This information is intended to assist case managers/service coordinators in consistently informing waiver participants about the above mentioned items and to then leave with the waiver participant for future reference.

Individuals, representatives, and/or family members expressing interest in self-directing services may request the FMS contact information from their case manager/service coordinator. The FMS paperwork is also available on their website. The handouts outline the benefits of self-direction, the responsibilities of the individual and others and the guidelines for enrollment, continued participation and dis-enrollment in self-directed services.

DDP also developed a Self-Direct Employer Handbook which provides step by step information describing self direction of waiver services. For more information the handbook can be found on the DDP website.

Individuals and their representatives and/or family members desiring a more active role in the selection of their support workers, and/or increased flexibility in scheduling their supports may be interested in choosing a self directed service option.

The self-directed enrollment requirements and options are briefly described in the freedom of choice addendum form, specific to self direction.

The person's case manager/service coordinator may be asked to provide assistance in any of the following activities:
- scheduling a planning meeting to initiate a self-directed service option.
- helping the person select a willing service provider.
- providing any other requested assistance related to initiating the self-directed option.

The planning document for self-directed services implementation includes a narrative section describing the projected use of the resource allocation, services to be provided, proposed schedule and timeframes, additional training required for each employee, a description of how health and safety issues will be addressed, including back up, emergency and on-call systems, the role of the case manager/service coordinator and support broker if requested, and the responsibilities of the person and/or representative. The planning document must be signed off by the provider agency, case manager/service coordinator, the person and/or representative as applicable. The use of self-directed services with employer authority does not require the FMS to sign off on the plan of care. Once the decision has been made and approved to use this service option by the planning team, the FMS service is contacted for enrollment purposes.

Current providers of services may require the person to give notice of intent to port, in accordance with the requirements of the DDP Porting Policy, found on the DDP website, if the person chooses a new service provider as a primary service delivery agency, or chooses to self-direct some or all of their services with employer authority.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A person may freely choose a non-legal representative. The representative is approved by the planning team and will function as the representative as long as planning team members are in consensus that the representative continues to make decisions in the persons best interest. A representative is not paid for their services.

The personal representative has the same decision making authority as the person, as long as the personal representative continues to serve at the request of, and on behalf of, the person. The person, and/or legal guardian have the right to limit or terminate the authority of a personal representative, or appoint a new personal representative, at any time, for any reason.

The planning team has the right and the obligation to determine if the personal representative continues to function in the best interests of the person. This issue should be reviewed annually as part of the planning process. The team follows the incident management manual to determine if the personal representative is acting in the participant's best interest, in that they look at whether there are concerns of abuse, neglect, or exploitation with the personal representative.

A Waiver Participant or his/her legal representative has the right to file a Fair Hearing request through the Department's Office of Fair Hearing if the planning team does not approve of the person's choice for a non-legal representative. All other planning team members may bring plan of care issues to the Regional Manager for Review as indicated in the Personal Support Planning Policy.

Self-Directed Services with Common Law Employer Authority:

With the common law employer authority, the person or representative become the employer and are responsible for hiring, training, supervising, scheduling, and terminating their employees. In instances where the person is the employer living with a non-paid primary caregiver, the primary caregiver may function as the non-legal representative. The person functioning as the employer is subject to the initial and continued approval of the planning team.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Supported Employment - Individual Employment Support	☒	☒
Personal Care	☐	☒
Physical Therapy	☐	☒
Remote Monitoring Equipment	☐	☒

Waiver Service	Employer Authority	Budget Authority
Personal Supports	☒	☒
Specialized Medical Equipment and Supplies	☒	☒
Adult Foster Support	☐	☒
Behavioral Support Services	☒	☒
Respite	☒	☒
Companion Services	☐	☒
Supported Employment - Small Group Employment Support	☐	☒
Supports Brokerage	☒	☒
Assisted Living	☐	☒
Speech Therapy	☐	☒
Individual Goods and Services	☒	☒
Day Supports and Activities	☐	☒
Community Transition Services	☒	☒
Supported Employment - Co-Worker Support	☒	☒
Nutritionist Services	☐	☒
Remote Monitoring	☐	☒
Homemaker	☐	☒
Retirement Services	☐	☒
Psychological Evaluation, Counseling and Consultation Services	☐	☒
Caregiver Training and Support	☒	☒
Private Duty Nursing	☐	☒
Residential Habilitation	☐	☒
Environmental Modifications	☒	☒
Personal Emergency Response System (PERS)	☒	☒
Occupational Therapy	☐	☒
Transportation	☒	☒
Supported Employment - Follow Along Support	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Acumen under contract with the Department, provides our FMS services. The fiscal management service contractor must: be enrolled as an approved Medicaid provider; retain on staff a Certified Public Accountant (CPA) with at least five (5) years of experience: and be assigned a Federal Employer Identification Number (EIN) and National Provider Identifier (NPI) number. Further, the contractor must: have a basic understanding of developmental disabilities; understand the philosophy and practice of self-directed services in Montana; have sufficient funds necessary to make payroll on behalf of legal guardians at least twice monthly; and ensure staff and employees of members self-directing pass Medicaid required background investigations, including but not limited to the List of Excluded Individuals and Entities (LEIE) and Medicare Exclusion Database (MED). The contractor must also have

capabilities in providing assistance in English and Spanish, and capability to communicate through TTY. The contractor must: possess federal designation as fiscal agent under IRS Rule 3504 (Acts to be Performed by Agents); comply with applicable IRS regulations; possess IRS approval for Agent status; and demonstrate effective internal controls and safeguards over the processing of transactions.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS is compensated by a one time employer enrollment fee for brand new customers only, and a one time employee enrollment fee for each new employee hired per employer. Ongoing fees are based on a per member per month fee that each individual in the FMS system pays regardless of account activity. The FMS also charges check transaction fees based on the number of checks processed each month. The monthly fee includes the processing of 2 checks, an additional fee is charged when the FMS processes more than 2 checks in a month.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-**

related taxes and insurance

☒ **Other**

Specify:

FMS entities are procured using the state of Montana's procurement process.

Provide for workers' compensation insurance for all employees. Conduct background checks, verify service qualified provider standards, monitor appropriate use of Montana Code Annotated 39-3-406(p) which states that certain employers are exempt from paying minimum wage and overtime if an employee is employed in domestic service employment to provide companionship services, as defined in 29 CFR 552.6, or respite care for individuals who, because of age or infirmity, are unable to care for themselves as provided under section 213(a)(15) of the Fair Labor Standards Act, 29 U.S.C. 213, when the person providing the service is employed directly by a family member or an individual who is a legal guardian.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☒ **Other services and supports**

Specify:

Maintain a secure FTP website that allows DD Program staff and case managers to track the person's budget and expenditures.

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The DDP quality assurance personnel will be responsible for monitoring the performance of the FMS through the QA review tool. This will occur on an annual basis.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case Management/Service Coordination activities:

Case Management/Service Coordination is furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Service Coordination includes the following assistance:

- Comprehensive assessment and periodic reassessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:
  - Taking client history;
  - Identifying the individual's needs and completing related documentation;
  - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
  - Conducting MONA (Montana resource allocation tool)assessments for evaluation of service levels in compliance with DDP rate reimbursement requirements using the Developmental Disabilities Program (DDP) web-based MONA system for all consumers in services and referred for services. The MONA will be updated every three years or whenever significant changes in needed services occur.

- Development and periodic revision of a specific care plan that:
  - Is based on the information collected through the assessment or reassessment;
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities:
  - To help an eligible individual obtain needed services including activities that help link an individual with:
    Medical, social, educational providers; or
    Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

- Monitoring and follow-up activities:
  - Activities, and contact, necessary to ensure the personal supports plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:
    Services are being furnished in accordance with the individual's plan of care;
    Services in the plan of care are adequate; and
    If there are changes in the needs or status of the individual, necessary adjustments are made to the plan of care and to service arrangements with providers.

Service Coordination may include:

E. Crisis Intervention:

In assisting an individual through a crisis,

1. If the individual is in a DD funded service, the service coordinator will convene the plan of care team to discuss appropriate action which could include rights restriction, behavior intervention plan, medical review, additional staff, or other response;

2. If the individual does not have a plan of care team, the service coordinator will refer the individual in crisis to an appropriate service provider;

3. If the incident involves suspected abuse, neglect, and/or exploitation of the individual, the service coordinator will immediately report the incident to the Adult Protective Services or Child and Family Services Division and to

the appropriate management staff of the service provider; and DDP.

☒ **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
Supported Employment - Individual Employment Support	☐
Personal Care	☐
Physical Therapy	☐
Remote Monitoring Equipment	☐
Personal Supports	☐
Specialized Medical Equipment and Supplies	☐
Adult Foster Support	☐
Behavioral Support Services	☐
Respite	☐
Companion Services	☐
Supported Employment - Small Group Employment Support	☐
Supports Brokerage	☒
Assisted Living	☐
Speech Therapy	☐
Individual Goods and Services	☐
Day Supports and Activities	☐
Community Transition Services	☐
Supported Employment - Co-Worker Support	☐
Nutritionist Services	☐
Remote Monitoring	☐
Homemaker	☐
Retirement Services	☐
Psychological Evaluation, Counseling and Consultation Services	☐
Caregiver Training and Support	☐
Private Duty Nursing	☐
Residential Habilitation	☐
Meals	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental Modifications	☐
Personal Emergency Response System (PERS)	☐
Occupational Therapy	☐
Transportation	☐
Supported Employment - Follow Along Support	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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:

Dis-enrollment from self-directed services for the purpose of enrollment in traditional services is always an available option for persons choosing to self direct their services. There is flexibility within this service for the person's family members and representatives to choose the level of their involvement in the recruiting, selection and hiring of the direct support staff and/or choose a new service provider, as reviewed annually on the Waiver 5 Freedom of Choice form.

Individuals and/or their representatives, or the employers, choosing to dis-enroll from a self-directed service option would contact the case manager to schedule a planning meeting. This meeting would determine precisely what the individual wants with their resource allocation in a traditional model of service delivery.

Under no circumstances will ongoing waiver-funded services be reduced or terminated if an individual is seeking a new provider, or seeking a traditional waiver service delivery model.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The plan of care document includes a brief section requiring a check off box for persons choosing to self- direct one or more services. The boilerplate plan of care language provides advance notice to the person or representative that participation in self-directed services may be involuntarily terminated, in the event the person or representative does not abide by the Department requirements applicable to self-directed services. The signature page of the plan of care document indicates an understanding of, and agreement with, the need to comply with the Department requirements for participation in self-directed services. The service coordinator will review this section annually with individuals, family members, guardians or representatives who choose to self-direct one or more services.

It is possible that a person or his representative may not cooperate with, abide by, or utilize the services as outlined in the plan of care. In this event, a special planning meeting would be held by the service coordinator to discuss the issues involved with, for example, non-utilization of services. In this event a plan would be developed and implemented, serving to give the person an opportunity to remain in self-directed services for a specified time period, contingent upon the person meeting agreed upon benchmarks written into the approved plan. Boilerplate language in the plan of care serving to address this issue follows:

Failure to abide with the plan of care language in managing self-directed services may result in the involuntary termination of self-directed services. In this event, agency-based services would be made available to the person.

In the event that health/safety issues pose undue risk to the person or others, and immediate intervention is deemed necessary by the team, the individual would be immediately enrolled in traditional services. Additional supports deemed necessary by the planning team to ensure the health and well-being of the person would be provided. For example, the planning team may request crisis grant funds from the DDP to increase the amount of direct care staffing provided to the person. Continued refusal by the person's family to address basic health and safety needs in traditional waiver services could result in the need for the team to initiate referrals to other agencies for the purpose of placement in a more appropriate setting. Waiver services would continue until a more appropriate living arrangement is made available.

A person whose basic health and safety needs cannot be adequately addressed in the opinion of the service coordinator and service provider may not remain in waiver services. In this event, placement in a more restrictive environment may be required.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		350
Year 2		350
Year 3		350
Year 4		350
Year 5		350

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

DDP qualified provider agencies act as the agency with choice

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The costs of such investigations are covered by the FMS entity or the agency with choice.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☒ **Other**

Specify:

The methodology used to authorize payments for services, and to review and approve reimbursements to direct workers based on the delivery of agreed upon services will vary depending on the category of service. The delivery of services is based on the Individual Cost Plan (ICP) and the planning document. All services outlined in the ICP will correspond to a need outlined in the plan of care.

For members choosing to self-direct in family and private settings, self-direction can give the person, representative, or family members acting on the person's behalf additional authority, as desired, to more fully manage the delivery of services.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The value of the individual cost plan for a newly enrolled member is derived from the Montana Resource Allocation Protocol (MONA) tool. The MONA is Montana's cost estimating information tool that is conducted for every newly enrolled waiver member or as the member's needs change. The current MONA methodology, rates and the AWACS detail design is available upon request.

Members or their legal guardian may choose which services they would like to self-direct and the amount allocated for each service, based on assessed needs.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Currently, all individuals and persons acting on their behalf are informed of the details of the person's Individual Cost Plan (ICP). The cost plan details are based on the outcome of the MONA and the planning process, which, in turn, is based on asessments and the expressed desires of the person. The ICP functions as the contractual basis between the person, the provider, and the DDP in the delivery of services.

If the quantity and type of services outlined in the cost plan are not considered adequate in meeting the needs of the person, additional funds may be requested on behalf of the person by the case manager/service coordinator. Requests for additional funding go to the DDP Regional Manager. Funds are available for the purpose of adjusting cost plans with crisis pool funds for short term needs and the urgent needs process addresses long term funding changes based on assessed needs.

Members and team members are able to request budget adjustments by contacting their case manager. If additional funding is needed, the Urgent Needs request is completed by the case manager. This request is reviewed and either approved or denied by the Regional Managers. If the request is denied by the Regional Managers, a letter is sent to the member informing them of this decision and their right to request a fair hearing.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Individuals who self-direct may opt to receive more services in one month or week and fewer services the next week. These changes can be made without prior approval in the plan of care. Quarterly reports submitted by the provider to the case manager/service coordinator would reflect the change in use of services. Quarterly reports become part of the plan of care and are followed up on by the case manager/service coordinator. This flexibility is more available because the individual has had the option to help select their staff who then would likely be working with only that person. The service provider is responsible for monitoring the expenditure of the person's annual ICP and for advising the case manager/service coordinator, person or representative if adjustments are needed in spending patterns to prevent a shortfall prior to the end of the fiscal year.

Generally, if the provider or case manager/service coordinator has concerns regarding health and safety issues stemming from the changing needs of a person, or concerns stemming from changes in spending patterns within the person's budget, a planning meeting would be called and these concerns would be addressed.

The person has the capacity to move funds between services outlined in the cost plan and to request changes in the service categories to be delivered. Both would require team agreement and final approval from the regional manager on the ICP changes.

In situations where a person has chosen to purchase some services directly from another DDP-funded agency changes in the delivery of these services would require team agreement and Regional Manager approval on the ICP change.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The person has the capacity to move funds between services outlined in the cost plan and to make changes in the service categories to be delivered. Both would require team agreement and final approval from the regional manager on the ICP changes.

Self-Directed Agency with Choice Services:

The service provider is responsible for monitoring the expenditure of the person's annual ICP and for advising the case manager/service coordinator, person or representative if adjustments are needed in spending patterns to prevent a shortfall or underutilization prior to the end of the fiscal year.

Self-Directed Services with Common Law Employer Authority:

The employer and the case manager/service coordinator would be responsible for monitoring the expenditure of the person's individual cost plan. The FMS makes available an expenditure report, to the employer, after each payroll that services occur to help in determining if adjustments are needed in spending patterns to prevent a shortfall or underutilization of the cost plan. The case manager/service coordinator can also monitor expenditures via the ICP system.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

As part of the plan of care process, the Service Coordinator is to explain the right to fair hearing in the event the person or family is denied the provider or service of choice. The member is also given the choice of home and community-based services as an alternative to intitutuional care. The member or legal representative acknowledges receipt of this information on the signature page of the plan of care. ARM 37.34.918 outlines the choice of services and choice of provider protections afforded to individuals. ARM 37.34.919 outlines the Fair Hearing process used by the Department. All MCA and ARM references may be reviewed via the State of Montana home page. When an individual is denied services, they are given written notification, which includes the right to request a fair hearing. The written notification will be changed to include language to inform the member of their right to continue receiving waiver services during the fair hearing process. The copies of the fair hearings are maintained in the DDP Central Office.

37.34.918 MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: INFORMING BENEFICIARY OF CHOICE
(1) A person determined by the department to require the level of care provided in an ICF-IID must be given a choice between placement in an ICF-IID or in the medicaid home and community services program.
(2) The person or legal representative must be informed of the feasible alternatives in the community, if any, available under the medicaid home and community services program. (History: Sec. 53-2-201, 53-6-113, 53-6-402 and 53-20-204, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-402 and 53-20-205, MCA; NEW, 1992 MAR p. 1490, Eff. 7/17/92; TRANS, from SRS, 1998 MAR p. 3124.)

37.34.919 MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: NOTICE AND FAIR HEARING (1) The department will provide written notice to applicants for and recipients of medicaid home and community services when determinations are made by the department concerning their status pertaining to level of care and selection or denial for placement.
(a) The department will provide a recipient with notice 10 working days before termination of services due to a determination of ineligibility.
(2) The department will provide a recipient at least 30 calendar days notice before any termination or reduction of services due to limitations upon services or insufficient program funds, as provided in ARM 37.34.902(4).
(3) A person aggrieved by an adverse department determination for a level of care determination finding the person ineligible for services may request a fair hearing as provided in 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.
(4) A person may request a review and a fair hearing as provided in ARM 37.34.335 for a non-selection or denial of a service made by the department. A person may not appeal a termination or reduction in services undertaken by the department in accordance with ARM 37.34.902(4). (History: Sec. 53-2-201, 53-6-113, 53-6-402 and 53-20-204, MCA; IMP, Sec. 53 2-201, 53-6-101, 53-6-402 and 53-20-205, MCA; NEW, 1992 MAR p. 1490, Eff. 7/17/92; AMD, 1995 MAR p. 1136, Eff. 6/30/95; TRANS, from SRS, 1998 MAR p. 3124; AMD, 2000 MAR p. 1653, Eff. 6/30/00.)

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

For persons enrolled in the waiver, the planning process is the general vehicle for settling disputes. Planning meetings may be called for any reason by any team member. Other disputes may be addressed via provider individual grievance procedures. Providers are to maintain internal dispute resolution policies in accordance with ARM 37.34.109. Under no circumstances would an individual forfeit the right to a fair hearing.

37.34.109 CLIENT GRIEVANCE PROCEDURE (1) A provider shall maintain a written grievance procedure by which a client may file a complaint. A current copy of such procedure must be approved by the department.
(2) Upon entry into a program and at least every 6 months thereafter, a client must be advised by the provider of the right to present grievances. The provider shall assist clients, as may be necessary, in utilizing the grievance procedure.
(3) If the outcome of the grievance procedure is adverse to a client, the provider shall notify the person of his or her right to appeal to the department under the department's fair hearing procedure. (History: Sec. 53-20-204, MCA; IMP, Sec. 53-20-205, MCA; NEW, 1979 MAR p. 1711, Eff. 12/28/79; TRANS, from SRS, 1998 MAR p. 3124.)

The types of disputes would vary from provider to provider based on their written grievance procedure. A waiver participant can bypass a provider's grievance process and go straight to a fair hearing request.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Incident Management Policy and the DDP Incident Management Procedures Manual is the reference source providing the following information. Reporting requirements are referenced in Montana Codes Annotated 52-3-811 and the Administrative Rules of Montana 37.34.1501. In accordance with the Developmental Disabilities Program Incident Management Procedures Manual, employees of qualified service providers, Service Coordinators and quality assurance personnel are required to report Critical Incidents.

In accordance with the Developmental Disabilities Program Incident Management Procedures Manual employees of DDP funded Service Providers, DDP Service Coordinators and quality assurance personnel are required to report Critical Incidents by submitting critical incident reports to the DDP Data Management System.

All incidents fall into 3 categories:

CRITICAL INCIDENTS:
A critical incident is one that has compromised the safety and well-being of a person as identified in the incident categories. A critical incident is an event that requires an immediate and appropriate response to protect the person and minimize risk, as well as immediate notification to key people. All critical incidents require an investigation.

REPORTABLE INCIDENTS:
A reportable incident is one that can compromise the safety and well-being of a person as identified in the incident categories. A reportable incident is an event that requires timely and appropriate response to protect the person and minimize risk, as well as timely notification to key people.

INTERNAL INCIDENTS:
All other unusual incidents that are not listed under Critical or Reportable notification level are internal incidents. The discovery of incidents (incidents that occur in the absence of paid staff) can be reported in this category.

NOTIFICATIONS:

CRITICAL INCIDENTS will be reported as soon as possible and within 8 hours. Critical Incidents must be entered into the Data Management System within 48 hours or 2 working days. Provider personnel under contract with the DDP, as well as any DDP-employed staff, who witness or discover an incident or injury, or suspect abuse, neglect, or exploitation are required to report. Critical incidents are required to be reported within 8 hours to quality assurance personnel, case manager, guardian and licensing agent (if applicable). The reports can be made via HIPAA-compliant electronic communication, telephone or direct contact. In addition, the reporter enters the incident into the DDP data management system as soon as reasonably possible, but no longer than 48 hours from the incident being witnessed, discovered, or suspected. The provider’s Incident Management Coordinator, along with the State-employed quality assurance personnel, monitor the time frames to insure deadlines are met.

REPORTABLE AND INTERNAL INCIDENTS will be entered into Data Management System within 48 hours or 2 working days.

Notifications are made to legal representatives, other team members, DDP, advocates and other service provider agencies per Appendix C (Notification Reporting Requirements) as needed or per the plan of care.

All suspected abuse, neglect and exploitation must be reported to Adult Protective Services, Child Protective Services or law enforcement, whichever is applicable. Within 8 hours of incident occurrence or discovery, report must be made to Adult Protective Services (APS), Child Protective Services (CPS), and/or law enforcement. Documentation of contact, including method and time, are entered in the DDP data management system. The provider’s Incident Management Coordinator, along with the State-employed quality assurance personnel, monitor the time frames to insure deadlines are met.

Incident Types:

Incident TYPE ABUSE/NEGLECT/EXPLOITATION/CIVIL RIGHTS VIOLATION are treated as a cause of other events whether witnessed or discovered. Example: A person has a bruise. The event is "Injury" and then you are asked if the injury was a result of suspected abuse or neglect, select abuse/neglect and the notification becomes critical.

Incident TYPE A civil rights violation is defined as any incident that occurs when a person or another person alleges that a civil right of the person has been violated. The incident must be referred to the agency that has jurisdiction to investigate allegations of rights violations. The rights of all persons include the fundamental human, civil, constitutional and statutory rights. This is coded in the ABUSE section as a Civil Rights Violation and therefore is a critical incident. Other rights may be temporarily restricted with plan of care team approval. If a person's rights are restricted as part of a plan of care or an approved behavior support plan, then the plan of care rights restriction must be approved, signed and in place and would not be considered an event for Incident Management reporting purposes.

Incident TYPE Where the reporting staff or supervisor has reasonable cause to suspect that a person receiving DDP funded services has been subjected to abuse, sexual abuse, neglect, or exploitation as defined by the Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act (52-3-801, et. Seq., MCA), and the alleged perpetrator is suspected to be another person receiving services, the incident is required to be reported to the department. These incidents are classified as "Person to Person Altercations" with the cause of abuse. THESE ARE INCIDENTS OF ABUSE and require critical investigations.

Incident TYPE Restraints Related To Behavior

Incident TYPE Death

Incident TYPE Restraint Other (Unauthorized Use Of Restricted Or Prohibited Procedures)

Incident TYPE Hospitalization

Incident TYPE Medication Error

Incident TYPE Accident - No Apparent Injury

Incident TYPE Injury (Self-Injurious Behavior, Pica and Seizure behaviors are causes of injuries and not events and should be clearly marked under "cause" of an injury or suspected injury.)

Incident TYPE Property Damage

Incident TYPE Alcohol/Drug Abuse

Incident TYPE Altercation

Incident TYPE PRN Medication

Incident TYPE Assault

Incident TYPE AWOL/Missing Person (Unaccounted For Absence)

Incident TYPE Possible Criminal Activity/Misconduct

Incident TYPE Fire

Incident TYPE Self-Injurious Behavior (SIB)

Incident TYPE Suicide Threats or Attempt

Incident TYPE Property Damage

Incident TYPE Law Enforcement

Incident TYPE Serious Illness

Incident TYPE	Potential Incident/Near Miss
Incident TYPE	Theft/Larceny Attempt

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.

Adult Services and children residing in group homes:

Information regarding abuse reporting occurs for all members as part of the annual plan of care process. This is completed by asking open ended questions from the consumer survey. Any noted skill deficiencies may result in follow up by the service coordinator including strategies developed in the plan of care. The responsibility of providing information and training to people currently rests with service providers and with service coordinators.

Children in family homes:

Parents are the primary care givers for children enrolled in waiver services. The DDP QA consumer survey used for families was upadated to include questions serving to assess family knowledge of reportable incidents and the process for reporting. If training is needed, follow up would take place via the service coordinator or service provider.

In addition to individual feedback gained during the pre-plan of care and on site DDP QA process, the provider staff will be asked if the corporation provides training to members and their familes regarding issues of abuse, neglect and exploitation and reporting procedures as part of the DDP QA onsite review process. If no formal training is provided, provider follow up will be requested in the QA Report.

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.

Provider Responsibilities:
Review incidents and take action
• Initiate and conduct a critical incident investigation when a critical incident has been reported.
• Promptly assign agency staff to conduct critical incident investigations. All critical incidents must be investigated by agency staff who have been trained in investigations through training approved by the Department.
• Complete the critical incident investigation no later than ten (10) working days from the time the incident occurs. An extension may be granted to the initial 10-working-day period. The extension must be requested of, and approved in writing by, the Developmental Disabilities Regional Manager or designee. Any written request and subsequent approval must be attached to the completed investigative report.
*The provider agency is responsible to notify the Department, the member and/or legal representative of the investigation outcome within five (5) days of its completion.
• Review any IR entered in the data management system regardless of the reporting entity, for example, quality assurance personnel or service coordinator.
• There will be circumstances arising where the critical incident nvestigation will also be conducted by an entity external to the organization or in tandem with another provider where a person is being served jointly by two or more providers. Disability Rights Montana also may conduct an independent investigation and has access to certain records, pursuant to 42 USC Sec.15043.In situations of alleged abuse, neglect or exploitation, APS, CPS, law enforcement, and/or Disability Rights Montana (advocacy group) may conduct an investigation in addition to the Provider(s) Incident Investigator or the DDP Quality Improvement Specialist investigation. Additionally, multiple contracted providers may each conduct an investigation when a member served by multiple providers sustains an injury or reports an incident and it is not known in which environment it occurred.
•
• Cooperate fully with law enforcement, Adult and Child Protective Services, DPHHS Licensure, or any other outside agency which may have statutory jurisdiction over the investigation of an incident. The agency will conduct their own internal review of the incident regardless of the outcome of any outside investigation. The agency is only to review the facts known at the time without impeding outside agency's investigations. The provider agency must make staff available for interviews within reasonable timelines for the investigation. APS and CPS are charged with investigating all allegations of abuse, neglect, or exploitation. Both units use preponderance of evidence as the standard used in determining the substantiation of an allegation of abuse, neglect, or exploitation.

Follow up of review and or action taken by provider:
• Conduct reviews of all incidents and implement action plan requirements and recommendations, which may include personnel action when warranted to prevent the recurrence of similar incidents.
• Establish procedures for data collection through the data management system and conduct trend analysis as a means to develop appropriate support and service plans for the member to prevent more serious incidents from occurring.
• Assure Incident Report and Administrative Review (AR) information are kept in the member's confidential records.
• Assure that policies and procedures were followed during the course of investigations and noted in the administrative review section of the investigation, including removing the employee who is an alleged perpetrator from contact with the person during an investigation of suspected abuse, neglect or exploitation.
• Forward, at the conclusion of the investigation, a copy of the investigation report to the following:
o Agency's Board of Directors;
o Other executive staff, as appropriate; and
o Quality assurance personnel.
• Make the investigation documentation available to the parties listed below:
o DPHHS/DDP executive staff including: Developmental Disabilities Program Bureau Chief, the DDP Community Services Bureau Chief, Regional Manager of the region in which the incident occurred; and
o As appropriate, designated legal staff for the department, and other agencies as required by law or regulation.
• Assure that the person and/or legal representative and service coordinator are notified of the outcome of the investigation by providing a copy of the administrative review for any investigation within 5 days of its completion.

Service Coordinator Responsibilities:
When incidents occur, the service coordinator has the responsibility to assure that the issues/needs of the member are addressed promptly and correctly, and ultimately to reduce the risk of harm to the member. This can be accomplished through the team process. In the incident management system, the service coordinaot is responsible for the following.
• Submit an incident report in data management system if an incident is observed or discovered;
• Review and sign off on incident reports for their caseloads and comment/follow-up if necessary;
• Service coordinator will ensure any significant incident information is documented in the member's social history for

permanency;
• Provide information and if necessary clarification to members and/or legal representative explaining the purpose of incident management in a manner that is easily understood;
• Receive and review incident management weekly minutes & monthly trend data and analyze for possible revision to the plan of care;
• When a high risk review level (as described below under “High Risk Review”) has been identified, the service coordinator will review the plan of care with the team to address the incidents and determine if a revision to the plan is necessary
• Assess the member's level of risk and then address his/her ability to manage the risk with the team;
• Attend weekly incident management committee meetings as assigned;
• Participate in triage review initiated by DDP staff; and
• Receive administrative review information from the provider following an investigation and follow-up if necessary with the team.

Quality assurance personnel:

The quality assurance personnel of DDP have core responsibilities in the receiving, reviewing and evaluating the incident reports that are submitted by provider agencies in the data management system. In addition, the quality assurance personnel will investigate certain critical incidents. The DDP Regional Manager assigns a QIS to attend the weekly provider incident management committee meeting either in person or via phone. Though the QIS may not be able to attend every incident management

meeting, he/she is responsible to review all incident reports and incident management committee meeting minutes. The DDP Regional Manager will assign temporary coverage by another QIS when a prolonged absence of the assigned quality assurance personnel is anticipated.

They are responsible for the following:

• Submit incedent reports in the data management system when incidents are observed or discovered.
• Receive, review, and sign off on all incident reports.
• Receive and review all investigations.
• Participate, when assigned by the Regional Manager, in the provider agency’s Incident Management Committee meetings.
• Participate in triage review, as assigned.
• Receive and review incident management weekly minutes, monthly trend data and high risk reviews.
• Assess the member's level of risk and his/her ability to manage the risk with the team.
• Assess the service provider’s efforts to ensure the health and safety of the member, and make recommendations or take action as appropriate.
• Conduct critical incident investigations for incidents involving emergency/unplanned hospitalization and a member's death, or when assigned by the Regional Manager due to a conflict of interest or a pattern of incidents requiring further review.
• Conduct a procedural review for critical incident investigations involving abuse, neglect or exploitation when the incident is referred to the appropriate agency for their statutory investigation.
• Complete assigned investigations within ten (10) working days. In cases where the ten days cannot be met, an extension to the timeline can be granted by the Regional Manager, or designee. This request must be in writing. Upon completion the quaity assurance personnel will submit the investigation to the Regional Manager for review.
• Complete an investigation review form of all critical investigations submitted by the provider. Any investigatory procedure issues noted in the investigation review form will be addressed with the provider agency.
• The quality assurance personnel has the authority to issue Quality Assurance Observation Sheet (QAOS) to providers as corrective action measures as needed.
• Following the completion of a full investigation, the quality assurance personnel will forward the Quality Assurance Observation Sheets (QAOS) to Central Office for outcome tracking.
• For self-directed services, the quality assurance personnel will:
o Triage/investigate incidents classified as critical.
o Quality assurance personnel will be available through the regional office to provide technical assistance if requested by the person or the family self-directing their services.

Regional Manager Responsibilities:

• Assign the quality assurance personnel to complete critical incident investigations or request other Developmental Disabilities Program (DDP) staff or an additional quality assurance personnel to complete an investigation due to conflicts of interest or other necessary circumstances.
• Participate in a triage review or assign a designee, as warranted.
• Grant extensions, if appropriate, on investigations as requested in writing on a case by case basis.
• Request further follow-up or investigation of an incident.
• Complete the administrative review when the critical incident investigation is conducted by the quality assurance personnel. The administrative review form will be made available to the Bureau Chief along with the supporting documents.
• Based upon this review, DDP may request further follow-up or investigation of the incident.
• Conduct monthly trend analysis meetings with the quality assurance personnel of regional reports generated from data management system or reports from the DDP central office and determine appropriate follow-up on trends.

DDP Central Office Responsibilities:

• The DDP is responsible for developing and revising training materials. This information is then provided to all persons trained to conduct critical incident investigations.
• The medical director reviews medication errors, injury trends and other medical related concerns as needed.
• The medical director reviews all death investigations, including all investigative reports, and participates on the mortality review committee. Findings from the committee are shared with the appropriate field staff.

Responsibilities for Self-Directed Services with a Fiscal Intermediary:

• All staff working for a member receiving self-directed DDP funded services are required to report critical incidents by submitting an incident report following the timelines in the incident management manual.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Developmental Disabilities Program has primary responsiblity for overseeing the reporting of and response to critical incidents that affect members, as identified above.

Investigative and follow-up activities may also be coordinated with licensing personnel and/or Adult or Child Protective Services as appropriate.

Incidents are input into the DDP data management system by agency staff. The provider agency incident management committee, on a weekly basis, uses the information from the system to review incidents. This information is used to take steps to avoid re-occurrence of incidents. DDP quality assurance personnel participate in each provider agency incident management committee.

Incidents are available for review by team members including state staff upon entry into the DDP data management system. Each DDP regional office conducts a monthly trend analysis meeting to review the compiled data.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Administrative Rules of Montana (ARM) outline conditions for the use of restrictive procedures applied to adult services and children's group home settings. Restrictive procedures used by DDP providers in natural homes are based on the desires of the parent and agreed upon by the child's planning team. Restrictive procedures are considered procedures of last resort in the DDP service systems.

The use of restraints and time out is governed in accordance with ARM Title 37, chapter 34, subchapter 14. The use of medications to control behavior is not governed under these rules.

Medications may be used in accordance with the review of the plan of care team and the member's physician or psychiatrist.

Physical and mechanical restraint, and seclusion procedures are considered interventions of last resort. Their use as either emergency procedures or as part of an ongoing behavior program is outlined in the previously referenced ARM.

Physical restraint may only be used as an emergency procedure as described in ARM Title 37, chapter 34, subchapter 14, Positive Behavior Support and all instances of the use of physical restraint must be reported as a critical incident.

Mechanical restraint as described in ARM Title 37, chapter 34, subchapter 14 Positive Behavior Support may only be used upon written order by a licensed physician for medical reasons. It is not necessary to report the use of mechanical restraint ordered by a licensed physician for medical reasons but all other uses of mechanical restraint must be reported as a critical incident.

Restricted or Prohibited Procedures – The unauthorized use of restricted or prohibited procedures as described in ARM Title 37, chapter 34, subchapter 14 Positive Behavior Support must be reported as a critical incident.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Developmental Disabilities Program has primary responsiblity for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed.

Quality assuance personnel and the Behavior Consultation Team provide oversight and guidance through incident review and consultation with plan of care teams as needed.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restricted or Prohibited Procedures – The unauthorized use of restricted or prohibited procedures as described in ARM Title 37, chapter 34, subchapter 14 Positive Behavior Support must be reported as a critical incident.

Compliance with the Positive Behavior Supports rule is monitored continously by the quality assurance personnel.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Developmental Disabilities Program has primary responsiblity for overseeing the use of restrictive intervention and ensuring that state safeguards concerning their use are followed.

Quality assuance personnel and the Behavior Consultation Team provide oversight and guidance through incident review and consultation with plan of care teams as needed.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **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).

Restricted or Prohibited Procedures – The unauthorized use of restricted or prohibited procedures as described in ARM Title 37, chapter 34, subchapter 14 Positive Behavior Support must be reported as a critical incident.

Restricted Procedures:
The following restricted procedures may be used for up to 90 calendar days as part of a behavior support plan that is developed and approved:
(a) physically enforced contingent observation;
(b) contingent access to personal possessions;
(c) contingent access to personal funds;
(d) educational fines;
(e) physically enforced exclusion time out;
(f) physically enforced overcorrection;
(g) physically enforced positive practice overcorrection;
(h) physically enforced restitutional overcorrection;
(i) contingent access to social activities;
(j) response cost; and
(k) physically enforced required relaxation.
(2) A behavior support plan that includes the use of restrictive procedures must be approved by:
(a) a board-certified behavior analyst (BCBA);
(b) a family support specialist with an autism endorsement (FSS-AE);
(c) a person with an Institute for Applied Behavior Analysis (IABA) consultant certification; or
(d) a person with a degree in applied behavior analysis, psychology, or special education who has provided documentation of training and experience in the use of the principles of applied behavior analysis in the habilitation of person(s) with developmental disabilities and the development of behavior support plans to the developmental disabilities program director.
(3) A copy of the behavior support plan incorporating restricted procedures must be sent to the developmental disabilities program director within three working days after approval.
(4) The developmental disabilities program director or their designee must provide prior written authorization for the continued use of the restricted procedures after 90 calendar days and the department designee is responsible for reviewing and monitoring the continued implementation and effectiveness of the behavior support plan.
(5) Restricted procedures may only be used in the delivery of services to a person as authorized by these rules.

Compliance with the Positive Behavior Supports rule is assessed as part of the QA review process.

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:

Restricted Procedures:
The following restricted procedures may be used for up to 90 calendar days as part of a behavior support plan that is developed and approved.

(a) physically enforced contingent observation;
(b) contingent access to personal possessions;
(c) contingent access to personal funds;
(d) educational fines;
(e) physically enforced exclusion time out;
(f) physically enforced overcorrection;
(g) physically enforced positive practice overcorrection;
(h) physically enforced restitutional overcorrection;
(i) contingent access to social activities;
(j) response cost; and
(k) physically enforced required relaxation.

(2) A behavior support plan that includes the use of restrictive procedures must be approved by:
(a) a board-certified behavior analyst (BCBA);
(b) a family support specialist with an autism endorsement (FSS-AE);
(c) a person with an Institute for Applied Behavior Analysis (IABA) consultant certification; or
(d) a person with a degree in applied behavior analysis, psychology, or special education who has provided documentation of training and experience in the use of the principles of applied behavior analysis in the habilitation of person(s) with developmental disabilities and the development of behavior support plans to the developmental disabilities program director.

(3) A copy of the behavior support plan incorporating restricted procedures must be sent to the developmental disabilities program director within three working days after approval.

(4) The developmental disabilities program director or their designee must provide prior written authorization for the continued use of the restricted procedures after 90 calendar days and the department designee is responsible for reviewing and monitoring the continued implementation and effectiveness of the behavior support plan.

(5) Restricted procedures may only be used in the delivery of services to a person as authorized by these rules.

Compliance with the Positive Behavior Supports rule is assessed as part of the QA review process.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Individual medication management and follow up is the responsibility of the physician, clinical nurse specialist, psychiatrist or other prescribing authority. The prescribing physician(s) reviews all prescribed medications, including any behavior modifying medications, at least annually as part of the plan of care process. Medication to reduce or eliminate a behavior is prohibited unless prescribed by a physician for a medical reason. Pro re Nata (PRN), or "as needed" medications also require an approved protocol signed by the physician. Provider agency direct care staff receive information on medication interactions and side-effects, and are to seek medical attention when a member experiences symptoms of concern.

These various healthcare professionals determine the frequency of monitoring and follow up based on the individual's specific circumstances in relation to the type of medication, the length of time the medication is prescribed, any other prescribed medications, height, weight, and other health conditions or issues.

The monitoring of the appropriateness of each medication and the appropriateness of multiple medications is the responsibility of the healthcare professionals who prescribe them and the pharmacist who fills the prescriptions.

DDP providers are required to maintain information about common side effects for each medication prescribed to an individual. Staff who administer medications are required to learn about side effects as part of the mandatory medication administration certification training. Staff are trained to seek medical help should side effects or other symptoms of concern be evidenced. The provider is also required to monitor medication errors as part of the incident management process of which all staff receives training. Incident management committees consist of, at a minimum, an agency incident management coordinator, Quality Improvement Specialist and Case Manager. The Incident Management Manual requires all medication errors to be reported to the Quality Improvement Specialist and case manager within 48 hours or two working days. The legal representative is required to be notified within 8 hours and incident management committees are required to meet weekly when incidents have occurred.
As part of the annual planning process the Healthcare Checklist and Risk Worksheet is completed with each waiver participant and asks questions regarding medications as a specific topic and prompts for any follow up that may be necessary. The plan of care form, which is reviewed and updated at least annually, lists all medications, time of day taken, dosage/route, purpose of medication for the person, start date, prescribing professional and a space for any additional medication information.

In addition, the central office staff including but not limited to DDP director, community supports bureau chief, program support bureau chief, crisis prevention specialist, and state medical director, meet monthly to review trending data and report back to the regional office of any concerns. Central office staff also presents incident management trend summaries to the quality council and the medical director is available to review medication errors as needed.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

DDP requires through the Incident Management rule that providers have an incident management system in place. The requirements for Incident Management are located in the procedural manual referenced in rule which instructs all qualified providers to hold weekly incident management meetings to review all critical, reportable and internal incidents, this includes medication administration and medication error. The DDP Quality Improvement Specialist and a case manager attend the weekly meeting. The DDP Quality Improvement Specialist reviews all incidents before the meeting. The state incident management procedures require a high risk review if a trend is determined at the weekly meeting of provider and state staff.

Documentation of administration of a PRN medication used to reduce or eliminate a behavior is required on the member's medication administration record, and is also recorded as a Reportable Incident to be reviewed by the provider's Incident Management Committee. An incident report is also required when medical attention is sought when a member experiences side-effects or symptoms of concern as a result of a medication. A trend of reportable incidents involving a person over a three (3) month period requires a High Risk Review by the Incident Management Committee and may result in a referral to the POC team to conduct a more thorough review and assessment of the member's needs. Additionally, teams may consult with the DDP contracted psychiatrist, and/or medical doctor to address concerns or questions that arise.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Non- medical professionals may assist and supervise in the administration of medications under a DDP agreement with the Montana State Board of Nursing. Staff providing medication assistance to individuals must be med certified in accordance with the provisions of ARM 37.34.114. Staff are med certified on the basis of passing a written test covering topics such as the purpose and use of various medications, administration dos and donts, requirements for record keeping and proper storage, and responsibilities related to follow up in the event of med errors. The curriculum used to impart skills to staff is Health and Medication Administration Manual for Individuals with Developmental Disabilities: A Self-Paced Instructional Manual written by Dr. William Docktor and updated in 2009 by Dr. Jean Justad. This manual and medication certification process was approved by the Montana Board of Nursing. Staff must demonstrate proficiency in the curriculum by taking and achieving a passing score on the med test every two years. DDP or State of Montana Job Service staff administer the medication tests.

The med rule requires the implementation of a training objective(s) if a person is not independent in the self-administration of meds, and the conditions under which this requirement can be waived.

The med rule applies to all staff in DDP waiver funded services, including those staff providing services to adults and children living with their natural families, and in foster care. There have been numerous requests for interpretations of med rules and DDP policy statements over the years. The answers to these requests for clarification are shared statewide with all providers and copies of these documents are available on the DDP website.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Medication Errors: Incident report is written in Data Management System within 48 hours or 2 working days. Reported to DDP and Case Manager w/in 48 hours of witnessed incident, IR written in Data Management System within 48 hours or 2 working days. Must be reported to the local DPHHS Licensing Office within twenty-four (24) hours of the incident's occurrence. Medication Error will be critical if due to abuse/neglect/exploitation and reporting to DDP and case manager is no later than 8 hours after incident and entered into Data Management System w/in 48 hours or 2 working days

(b) Specify the types of medication errors that providers are required to *record:*

MEDICATION ERROR –
Per the National Coordination Council for Medication Error Reporting and Prevention: “A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or person.” Internal medication errors are physician or pharmacy errors that are discovered but not administered to the person. All other medication errors are considered reportable unless the error causes the outcome of the incident to elevate the incident to a critical notification level. Critical level incidents in this category include: hospitalization, death, or incidents that are caused by suspected abuse or neglect.
Although the Data Management System includes a field for coding medication severity levels, the DDP will not be using that field.
• Charting Error - Medication charted prior to the person taking the medication; medications given to persons and not charted; failure to chart refusals; charting for a co-worker; and/or the use of ditto marks, erasing entries on the Medication Administration Record (MAR), using “white out” on the MAR.
• Omission - Medication not given to person; not obtaining refills on time and/or; sufficient quantities not available. A refusal of medication is also an omission.
• Order Expired - Medication given beyond the “stop order” and/or medication given past an expiration date.
• Transcription errors
o Wrong dose or the dose on the MAR does not match the dose on the prescription and/or pharmacy label;
o Wrong person or the name on the MAR does not match the name on the prescription and/or pharmacy label;
o Wrong medication or the name of the medication on the MAR does not match the medication listed on the prescription and/or pharmacy label;
o Omission or new medication that was prescribed was not written on the MAR;
o MAR entry shows the wrong route or the route for giving the medication does not match the doctor’s order written on the prescription and/or pharmacy label. Ex.: oral route vs. rectal route;
o Wrong time or the time(s) for medication administration is not the same as indicated on the prescription and/or pharmacy label. Examples: Prescription/label states “at bedtime” and MAR indicates 8 am -or- Prescription/label states “twice daily” and MAR indicates only once daily.
• Wrong dose
o Person given the wrong dose of medication. Example: MAR indicates two tablets, person given only one tablet.
Wrong person
o A medication was given to the wrong person.
• Wrong medication
o The wrong medication was given to the person or a medication was prescribed or given to a person with an allergy to that medication.
• Wrong route
o A medication was given by the incorrect route. Examples: Eye drops were placed in the ear or a medication that was to be given orally was given rectally.
• Wrong time
o The medication was actually given at a time that is different than that written on the MAR or outside of the predefined time interval from its scheduled administration time. Examples: An evening medication was given in the morning or a medication that was to be given at 8 am was given at 10 am (outside the window for administration).
• Other
o Physician or pharmacy errors. Examples: A medication was prescribed that was contraindicated in the person due to harmful interactions with other medications or an incorrect dose, dosage form, route, concentration, or quantity was written for or dispensed or the prescription or pharmacy label was illegible.
o Medium/texture/consistency or medication not given in proper form. Examples: Tablets were to be crushed and weren’t, or were to be mixed with applesauce, pudding, etc, and weren’t.
o Position: Medication specifically prescribed to be given to person when sitting upright in wheelchair not when sitting in recliner
o Storage issues: Administration of a drug that has was stored incorrectly or for which the physical or chemical dose (integrity of the drug) has been compromised.

Regardless of whether a person has experienced adverse side effects and/or their health/welfare is in

jeopardy, some types and/or patterns of medication errors emerging from regular trend analysis of all medication errors may raise the incidents to a Critical Incident classification. As a result, service providers should respond as such and initiate investigations into those circumstances (e.g. has possible negligence occurred?).

(c) Specify the types of medication errors that providers must *report* to the state:

All medication errors must be reported to the person's case manager and to the DDP.

Internal medication errors are physician or pharmacy errors that are discovered but not administered to the person. All other medication errors are considered reportable unless the error causes the outcome of the incident to elevate the incident to a critical notification level. Critical level incidents in this category include: hospitalization, death, or incidents that are caused by suspected abuse or neglect.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

In addition to involvement in the investigations involving critical medication errors, the DDP QIS is also involved in monitoring medications as part of the DDP quality assurance process. This includes reviewing medication storage, medication documentation in the med logs, reviewing the qualifications of staff assisting with medications (medication certification must be current). In addition, a sample of direct care staff must demonstrate competence in correctly answering oral interview questions regarding medications and procedures. QIS onsite visits also occur for all adult services residential sites once per year and the adult and childrens congregate living and adult congregate work/day sites are visited once per quarter.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent 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 waiver individuals (or families/legal guardians) who received information on how to report abuse, neglect, exploitation and unexplained death; N: Number of waiver individuals (or families/legal guardians) who received information on how to report abuse, neglect, exploitation and unexplained death; D: Number of waiver individuals' plans of care 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 = 95% Confidence Interval with =/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of abuse, neglect, exploitation and unexplained death incidents reported within the required timeframe; N: Number of abuse, neglect, exploitation and unexplained death incidents reported within the required timeframe; D: Number of all abuse, neglect, exploitation and unexplained death incidents.

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:

Performance Measure:
Number and percent of providers whose sampled staff were able to identify and report suspected abuse, neglect, exploitation and/or other critical incidents in accordance with DDP incident management policy. N: Number of providers whose sampled staff were familiar with signs and symptoms of abuse, neglect and exploitation and knew how to report suspected abuse; D: Number of providers.

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: Four direct care staff randomly selected from each providers payroll, if less than four staff all staff will be reviewed.
	☐ **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:
Number and percent of providers that have a comprehensive incident management system to guide the behavior of staff inclusive of the DPP Incident Management Policy. N: Number of providers with a compliant incident management policy; D: Number of all providers.

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Percent of critical incident trends where systemic intervention was implemented; N: Number of critical incident trends where a systemic intervention was implemented; D: Number of critical incident trends reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval, +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of persons whose behavior support plans that are in compliance with the Administrative Rules of Montana governing the use of restrictive procedures. N: Number of individuals whose behavior support plans meet the requirements specified in the restrictive procedures rule; D: Number of individuals reviewed with behavior support 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 = Confidence Interval = 95% confidence interval, +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of members who have an action in the PSP from the follow-up noted on the Healthcare Checklist and Risk Worksheet. N: Number of members with a PSP action that correspondence to and action on the healthcare checklist and risk worksheet; D: Number of members with a follow-up activity noted on the healthchare checklist and risk worksheet.

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 = Confidence Interval = 95% confidence interval, +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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.

A random-generated statistically valid sample is drawn. 100% of the sample is reviewed.

The QA Review Process is the primary mechanism designed to ensure compliance with the performance measures previously outlined. In addition, the review of incident reports, and the review of reports generated by provider incident management committees result in followup activities by the provider and the assigned DDP QIS to improve services and to reduce the potential for future incidents. The DDP management team also meet monthly to review all incidents reported statewide for trending and followup.

DDP has a Behavior Consultation Team providing crisis response services including on-site assessments, intervention, and training related to individuals (adults and children) experiencing one or more of these crisis risk factors:

- Life threatening safety skills deficits or life threatening issues resulting from behavioral or mental health conditions;
- Loss of family/caregiver support; or
- The individual is not receiving the necessary supports to address their behavioral and/or mental health needs.

The primary goals of crisis services are hospital/institution diversion, in-home stabilization, personal and community safety, and other tasks related to this goal. The provision of crisis prevention and response services allows individuals with developmental disabilities, challenging behavior, and/or mental health disorders to remain in their homes.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The outcomes of the incident management committee meetings are documented in meeting minutes. These minutes are forwarded to the DDP regional offices. The purpose of these meetings is to enable providers to meet with representatives from case management and the DDP to develop solutions serving to reduce or ameliorate the health/safety risks within each agency.

DDP has Crisis and Transition Specialists providing crisis response services including on-site assessments, intervention, and training related to individuals (adults and children) experiencing one or more of these crisis risk factors:

- Life threatening safety skills deficits or life threatening issues resulting from behavioural or mental health conditions;
- Loss of family/caregiver support; or
- The individual is not receiving the necessary supports to address their behavioural and/or mental health needs.

The primary goals of crisis services are hospital/institution diversion, in-home stabilization, personal and community safety, and other tasks related to this goal. The provision of crisis prevention and response services allows individuals with developmental disabilities, challenging behaviour, and/or mental health disorders to remain in their homes.

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 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care

services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

With the assistance of CMS technical assistance provided by HSRI, the DDP is using a QA process based on the performace measures outlined in the Quality Improvement sections of the various Appendices. The DDP updates the QA Review process annually as Department policies and procedures are added or refined.

The DDP quality assurance personnel are responsible for collecting and analyzing data on the performance measures. Deficiencies warrant issuance of a Quality Assurance Observation Sheet (QAOS) requiring the provider to identify remediation activities. The quality assurance personnel analyzes the effectiveness of the remediation and requires further action if necessary.

System improvements emphasize resolving health and safety performance issues first and foremost. When quality assurance personnel note a deficiency (either during the ongoing monitoring of services or during the annual performance measure review), a QAOS is issued. The quality assurance personnel have the authority to assure that corrective action is taken. The provider must respond to the QAOS and demonstrate that they are taking appropriate steps in correcting the issue. The quality assurance personnel will follow up on all QAOSs to assure that corrective action remediates the identified deficiency before the QAOS is accepted as complete. If a situation arises and cannot be resolved, higher level DDP management is consulted to provide additional support in assuring a positive outcome. The Medicaid Program Officer reviews the QAOSs to identify trends that require attention at a statewide level.

The performance measure quality assurance reports are compiled at least annually.

Results of deficiencies or exemplary practices are communicated using the QAOS. These results are communicated at least annually or as needed when issues are identified by quality assurance personnel.

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** Specify:	☐ **Other** 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 DDP has the review elements in place today to ensure the performance measures are adequately monitored. The Department has developed a method for aggregating this information in a statistical format,

Staff to be involved in this activity will include waiver staff, representative regional staff, and DDP management staff in QA for children and adult services.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The QA review process is updated as needed to include measures designed to monitor compliance with new waiver requirements, policies, rules, or contracting requirements.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ○ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

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).*

Contract Audit Requirements:

DDP providers are subject to same auditing requirements as all other Medicaid providers, and are subject to applicable requirements for A-122 and A-133 audits. DDP does not require waiver providers to secure an independent audit of their financial statements,
However, providers frequently have their finances audited, which are sent to our Quality Assurance Division for a desk review.

In addition to enrollment in our Montana Medicaid Information System (MMIS), providers delivering waiver services for the Developmental Disabilities Program are required to engage in a contract directly with the DD Program. The following language from the FY 18 contracting template applies to contractors of DDP waiver funded services:

SECTION 12: ACCOUNTING, COST PRINCIPLES AND AUDIT

A. Accounting Standards
The Contractor must maintain a system of accounting procedures and practices sufficient for the Department to determine to its satisfaction that the system (1) permits timely development of all necessary cost data in the form contemplated by the contract type, (2) is adequate to allocate costs in accordance with Generally Accepted Accounting Principles (GAAP); and (3) complies with any other accounting requirements the Department specifies.

B. Internal Controls
The Contractor must maintain and document an adequate system of internal controls that address: 1) the control environment, 2) the risk environment, 3) the risk assessment, 4) the control activities, 5) information, communications, and monitoring.

C. Separate Accounting of Funding
The Contractor must separately account for and report the source, the receipt, and the expenditure of the different types of program funding received from the Department under this Contract. Except as may be expressly allowed for under this Contract, each different fund must be accounted for separately and may not be diverted or commingled.

D. Audits and Other Investigations
The Contractor must provide authorized state and federal entities, including Montana DPHHS, the U.S. Departments of Health and Human Services, Agriculture, Energy and Education, their auditors, investigators and agents, with timely and unrestricted access to all of the Contractor's records, materials and information including any and all audit reports with supporting materials and work documents related to the delivery of goods and services provided under this Contract for purposes of audit and other administrative activities and investigations. Access must be provided in a format acceptable to those authorized entities, who may record and copy any information and materials necessary for any administrative activity, investigation and audit or other administrative activity or investigation.

E. Corrective Action
If directed by the Department, the Contractor must take corrective action to resolve audit findings. The Contractor must prepare a corrective action plan detailing actions the Contractor proposes to undertake to resolve those audit findings. The Department may direct the Contractor to modify the corrective action plan.

F. Payment for Sums Owing
The Contractor must reimburse or compensate the Department in any other manner as the Department may direct for any sums of monies determined by an audit or other administrative activity or investigation to be owing to the Department.

G. Federal Financial Requirements
1) The Contractor must maintain appropriate financial, accounting and programmatic records necessary to substantiate conformance with federal requirements governing fund expenditures, even if this Contract is not cost / budget based.

2) The Contractor must comply with the federal audit requirements set forth in 2 CFR 200.201 through 200.521

3) The Contractor must comply with the federal cost and accounting principles set forth in 2 CFR 200,400 through 200.475.

H. Expenditures Of Monies To Be In Conformance With Authorities
The monies provided through this Contract must be expended in accordance with the federal and state authorities governing: 1) the delivery of the contracted for services, 2) the receipt and expenditure of the particular types of monies

provided through this Contract, and 3) the conduct of the Contractor as a contractor for the State.

I. Expenditures under $100, may be paid by petty cash. A full accounting, including all receipts, of petty cash expenditures must be available.

J. Accrual accounting is required for year-end financial reports. The Contractor may use the cash method for interim reports if the Contractor accrues the last month of each fiscal year's transactions during the term of the Contract.

The Audit and Compliance Bureau of the Department will conduct financial audits upon request of DDP. If DDP quality assurance personnel find something questionable, we may request a provider audit. Additionally, if the desk review or review of non-audited financial statements (in C below) indicates issues, the Department may ask them to complete a more in depth review. 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 DDP waiver providers without being directly referred by DDP. Audits will be conducted in compliance with the single state audit act. The Audit Compliance staff also conduct limited scope audits or desk reviews for DDP, using agreed upon procedures. The Medicaid PERM processes also provide post-payment analysis of expenditures to identify issues.

The desk review is of providers who receive A-133 Audits (which is limited to those who receive Federal funds non-Medicaid of $750,000 or more) from external auditors. The Audit Compliance staff review the report identifying audit findings which may affect services, to notify enrolled providers of potential problems. However, from the requirements of the A-133, the majority of enrolled providers do not receive audits.

Limited Scope Audits are completed when specifically requested by DDP using agreed-upon procedures. The scope, methods, and frequency would depend on the specific agreed-upon procedures.

As part of the Annual Performance Measures and the Quality Assurance process, DDP incorporated the review of paid claims as part of the reviews. The quality assurance personnel conducts onsite annual audits of paid claim history for a sample person, for a sample month. The same members and months chosen for the other performance measures are used for these reviews. They review the documentation supporting the delivery of waiver services as invoiced by the provide. The percentage varies based on how many members are chosen for performance measures in the statistically valid sample. Problems noted by the quality assurance person will be documented on a Quality Assurance Observation Sheet to ensure a mutual understanding of the auditing issues. The corresponding DDP Regional Manager then reviews the information and the recommended process for remediation. If there is a serious auditing exception, the DDP Regional Manager will notify the DDP Central Office including the DDP Community Services Supervisor, the Division Fiscal Bureau Chief, and the DDP Bureau Chief for guidance. DDP management staff makes the determination whether to expand the audit sample size to determine a possible trend, to request a SURS review, or whether referral to the Medicaid Fraud Control Unit or Department of Justice is appropriate. Consequences for misuse of funds may include repayment, provider corrective action and/or disenrollment.

The Surveillance Utilization Review (SURS) identifies incorrect billing and potential overpayments. When an overpayment is identified, SURS does a provider audit by reviewing records provided by the provider and discusses it with the provider. The provider is sent a letter noting the findings and requesting recoupment of the overpayment, the timelines involved, and notification of fair hearing rights. SURS performs the necessary follow-up to ensure recovery. The Quality Assurance SURS program integrity approach includes sampling new providers' claims in their new provider reviews to ensure the providers are claiming correctly. For ongoing providers they sample a specific provider's claims if their pattern of billing is significantly different than their peers or a referral is received. Samples are drawn in a number of different ways, depending on the number of claims billed. The Quality Assurance SURS Division has an auditor in the Audit Bureau Unit (separate from SURS), conduct a RAT STAT random sample when there are more than 500 claim lines. If there are fewer than 500 claim lines, then a probe or random sample is reviewed. The Quality Assurance SURS Division develops audit plans in which claims are sampled based on previous patterns of errors, the OIG reports, and CERT reviews. If a referral is received, a member's claims or a type of service across members could be reviewed. When an overpayment is identified, SURS issues a notification of the findings with resources used during the review., a request for repayment and the process and timelines for appeal. All overpayments are maintained in the departments Accounts Receivable Management System (ARMS). SURS works with the Business and Financial Service Division to monitor the recovery of funds from the provider. The Business and Financial Services division ensures that CMS is made whole for any remaining outstanding receivables in accordance with the required timelines checks the Fiscal ARMS system monthly to ensure payment is received from the provider. DDP staff monitors the implementation of the corrective action plan if one is implemented by the DDP program.

Depending on the circumstances around the overpayment, DDP may also invoke a corrective action plan to change/monitor/correct processes within the agency to ensure the overpayment does not recur.

In addition to the reviews by quality assurance personal and SURS the department reviews a statistically valid sample of paid claims. These reviews include reviewing claims paid in accordance with the reimbursement methodology specified in the approved waiver, the claims coded as specified in the approved waiver and the claims paid for services as specified in the member's plan of care.

As briefly mentioned prior, if fraud is suspected, the information can be referred to the Medicaid Fraud Control Unit for an investigation. If fraud is verified, the provider can be sanctioned and terminated as a Medicaid or Medicare provider. The findings are sent to the Office of Inspector General (OIG) and the licensing board of the provider (if applicable).

The Montana Legislative Audit Division completes the independent audit as required in the Single Audit Act.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of claims paid in accordance with the reimbursement methodology specified in the approved waiver. N: Number of claims paid according to the reimbursement methodology specified in the approved waiver; D: Number of paid claims.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*

☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence interval, =/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of individuals under self direction with provider timesheets paid by the FMS that match the wage rate agreed upon in the timesheet for a random month N: Number of individuals under self direction with provider timesheets that match the wage rate agreed upon in the timesheet for a random month. D: Number of individuals under self direction 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 =* *95% confidence interval, +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other***	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of claims coded as specified in the approved waiver. N: Number and percent of claims coded as specified in the approved waiver; D: Total number of paid claims.

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence*

		Interval = *95% confidence interval, +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:

Number and percent of individuals whose invoices reviewed for a random month had documentation supporting the delivery of services N: Number of individuals for whom adequate documentation exists to support the delivery of services for a random month; D: Number of individuals (receiving services excluding case management) 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 =* *95% confidence interval, +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of claims paid for services rendered as specified in the member's plan of care; N: Number and percent of claims paid for services rendered as specified in the member's plan of care; D: Total number of paid claims.

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence Interval with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of claims paid at the correct rate. N: Number of claims paid at the correct rate; D: number of claims 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 =* *95% confidence interval, +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

A random-generated statistically valid sample is drawn. 100% of the sample is reviewed.

Members have prior authorization records in MMIS. Units of service can only be billed if they have been prior authorized. Providers may request a Quality Assurance Division (QAD) SURS review for the purpose of helping ensure their documentation efforts are adequate and meet requirements. Montana ARM Title 37, chapter 34, subchapter 30 outlines the invoicing rates and documentation requirements for reimbursement.

The DDP has the quality assurance review elements in place to ensure the annual QA review of a monthly sample of services and supports reimbursed with waiver funds for individuals served in the waiver. In addition to SURS reviews and the DDP annual review process, DDP staff may be contacted by individuals or caregivers, case managers, advocacy groups representing individuals or other persons acting on behalf of the individual if scheduled services are not delivered in accordance with the plan of care, or financial fraud or misuse of funds is suspected.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

The audits conducted by DDP QIS staff are limited to the verification of the delivery of waiver services. More systemic auditing problems that are brought to the DDP central office staff may result in a request for a full program audit conducted by SURS at the Quality Assurance Division or the Medicaid Fraud Unit at the Department of Justice. QAOS forms may be generated in response to findings from SURS audits or Medicaid Fraud Unit investigations.

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 Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The DDP rates methodology system applies to all DDP waiver contracts. The contracts do not change significantly from year to year by provider, any increases/decreases to rates are due to the Legislature and the current practice for rate adjustments do not include provider costs or BLS information. The rate setting process is designed to allow adjustment to any of the 4 cost components exclusive of the others. So we have the ability to specifically adjust the direct care wage, and to adjust other components of the rate if funding allows. Increases/decreases to rates are due to Legislature.

Montana ARM Title 37. chapter 34 subchapter 30 outlines the rates and documentation requirements for reimbursement.

The established methodology is incorporated into DDP rates manual, which is referenced in Montana ARM and is available to the public on the DDP website.

There is no established 'rate' for some services such as Individual Goods and Services, Environmental Modifications, Community Transition Services, Personal Emergency Response Systems, and Specialized Medical Equipment and Supplies where rates do not apply. In these instances, actual cost is used. For others, during the process to implement standardized rates the following was identified:

1.Direct Care Staff Time is the Billable Unit for most HCBS services and it's the basis for daily or monthly billing units. To meet the conditions for payment, the HCBS individual must be Medicaid eligible, enrolled and receive an HCBS Waiver Service as documented by staff. Direct care staff must be actively employed and present to provide the HCBS Waiver Service. The service provided must be consistent with the individual's plan of care.

2.Direct care staff is defined to be those individuals whose primary responsibility is the day to day, hands-on, direct support of people with disabilities, training and instruction, and assistance with and management of activities of daily living.

Standardized Cost Centers per the process creating fee-for-service rates, most provider reimbursement rates consist of four cost centers. These cost centers are:
Direct Care Staff Compensation
Employee-Related Expenses – Mandatory and non-mandatory expenses and benefits.
Program Supervision and Indirect Expenses – Expenses, travel, supervision and indirect costs of running the program.
General & Administrative Expenses – Upper level management and operating costs.

In addition to the standardized cost centers, geographical factors are applied for individualized living such as Supported Living (which is the billing category for a type of residential habilitation) and Residential Training Support. Geographical cost adjustment factors consider the cost of living, employment compensation, cost of housing and labor market trends.

There are a few extended State Plan Services (Private Duty Nursing, Occupational Therapy, Physical Therapy, Psychological, Speech Therapy, Nutritionist) in this waiver which do not use the methodology and components described above and use whatever methodology is established for them through the State Plan.

All waiver services are preauthorized through a service authorization record in MMIS and are based on the person's Plan of Care. The member's cost plan identifies each service, the providers to deliver each service, and either the units identified as necessary or maximum cost allowable. Claims submitted for services that do not have the corresponding authorization record will be denied.

It is specified in the waiver service descriptions that reimbursement should not be sought from the DD waiver if another source (most commonly IDEA or Vocational Rehabilitation) is available to pay for the service. The burden is on the planning teams to potentially identify alternatives, as well as on provider agencies to appropriately seek payment from other potential sources and obtain appropriate documentation. The vast majority of individuals in this waiver have aged out of eligibility for school services. Planning team members and providers have demonstrated due diligence in exploring all potential funding sources for needed services prior to committing waiver cost plan dollars.

There are no co-pays imposed on services provided through the DD waiver, but members may be responsible for co-payment of other services reimbursed with Medicaid monies.

In September 2016, Montana submitted the state's attached Access Monitoring Review Plan (AMRP) to assess Medicaid

member access to medical services and determine if Montana's reimbursement rates are sufficient so medical providers will enroll and participate in Montana Medicaid. Montana also included language within the attached AMRP addendum, submitted to CMS in January 2018, that stated Montana will monitor the number of provider enrollments and compare previous state fiscal year to current year to determine whether there has been a significant reduction of providers. Montana will research trend if the overall provider network decreases by 10 percent.

Finally, in 2016, a JAMA study was completed that showed access to primary care services in Montana is comparable to access for private insurance. This study was provided to CMS on February 13, 2018, after a CMS inquiry was received by Montana related to this question.

Since rate adjustments are the result of the legislative sessions, the rules for public comment and testimony during the legislative process provide opportunity for feedback. In addition, when DDP formalizes the rates based on changes in appropriation, the rule process to implement the new rates is also an avenue for public comments. We do consider comments at other times, including but not limited to: testimony made at interim committee hearings; emails or calls we receive from stakeholders; surveys that DDP sends; and/or workgroups with providers to note possible areas of ongoing concern as we prepare funding proposals for future legislative sessions.

During calendar year 2018, the Developmental Disabilities Program began meeting with 0208 waiver providers with the goal of identifying ways to simplify and increase flexibility for services providers. A key area of concern was the invoicing for those services delivered in a congregate setting, as this is a very complex/non-flexible process. This lead to the creation of a specific workgroup made up of provider and state Developmental Disabilities Program staff. The goal of the workgroup included developing a reimbursement system that allowed the providers more flexibility in meeting the unique and changing needs of the individuals receiving services in a congregate setting. The group also identified eliminating the geographical and scale of economy factors as a goal to assist in simplifying the rates for congregate residential and work/day/retirement.

Tiered Daily rates were developed for congregate residential sites, congregate work sites, congregate day support sites, and congregate retirement sites. The daily rates are identified in tiers based on a range of hours of 1:1 support a person would need in a shared staffing setting

The current waiver methodology uses an hourly reimbursement methodology for residential habilitation and the services are invoiced on an hourly basis by providers. The reimbursement uses four cost centers: 1) Direct Care Staff Compensation; 2) Employee-Related Expenses, both mandatory and non-mandatory expenses and benefits; 3) Program Supervision and Indirect Expenses including travel, supervision and indirect costs of running the program; 4) General and Administrative Expenses which include upper level management and operating costs.

Members served in the waiver have individual cost plans based on assessed needs as determined by the Montana Resource Allocation Protocol (MONA), completed by the case manager. The amount identified in the MONA is used to assist the individual and their team in identifying the services and supports that can be accessed via the waiver to meet the assessed needs. The MONA will continue to be used to identify the appropriate resource allocation for waiver recipients.

The consensus of the workgroup was to move from an hourly reimbursement system to a daily reimbursement system for congregate living and congregate work/day/retirement services. Since the MONA had already identified individual resource allocations for waiver recipients, the workgroup agreed to continue to use the MONA as the assessment tool for identifying the resource allocation. The identification of the resource allocation will remain the same, however, the reimbursement for congregate residential and vocational will move from hourly to daily. Since not every individual requires the maximum hours in the tiers. The reimbursement is based on a percentage of the daily hours in the tier, not the maximum hours in the tier. As individual's needs become more complex, the provider has less flexibility in meeting those supervision and support needs. The payment is not tied to the directly delivery of direct care hours, but rather based upon the provider meeting the plan of care requirements.

Individual plans of care (using assessment tools) will identify the specific outcomes, along with the amount and type of staff supervision and support an individual's needs on a daily basis. In order to qualify for the daily reimbursement, the individual must be present and the provider must meet the required outcomes in the plan of care. To account for changing needs, if a plan of care team identifies the individual's needs have changed, a new MONA will be completed and the planning team will identify what needs the person has that cannot be met with range of hours in the member's

current tier. A request to change tiers must be presented to the DDP regional manager for review and approval.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Flow of Billings

For payment processing, individuals must be Medicaid eligible and enrolled in the states Medicaid Eligibility system under the waiver specific deprivation code. The Medicaid Eligibility system maintains electronic public benefits information, Medicaid enrollment and DDP Waiver enrollment status. The DDP regional staff notify the Office of Public Assistance (OPA) to enter the applicable waiver information in the Eligibility system. Providers can access the Provider Portal in MMIS to check on a member's eligibility before delivering services, or call the local Office of Public Assistance. If a person is not Medicaid eligible for the service date span on a submitted claim, the claim will be denied.

At the time that a claim is submitted for payment, edits in the MMIS system verifies the members' enrollment in the waiver, and Medicaid eligibility. The service authorizations ensure that services pre-authorized can be billed up to, but not exceeding, the annual amount or units approved on the authorization. If a provider attempts to exceed this limit, the claim will only be processed for what's remaining.

Services should be delivered in accordance with a service member's plan of care and service authorizations. Providers of services may subcontract for the delivery of waiver services if the provider has been designated as an Organized Health Care Delivery System in their DDP Contract. In this case, the provider with a DDP contract has the option of reimbursing another provider, at a rate equal to or less than the approved Medicaid rate. The provider with the DDP contract is responsible for processing claims, maintenance of documentation, and the verification of the credentials of the subcontracting entity. The provider with a DDP contract is responsible for ensuring the subcontracted service is delivered in accordance with the plan of care, the service authorization, and the applicable qualified provider standards for the service. The provider with the DDP contract is responsible for maintenance of a "funding and service delivery paper trail", enabling auditors and DDP reviewers to verify the delivery of services in accordance with the aforementioned requirements.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The state's MMIS system has a nightly member interface that verifies eligibility for Medicaid and the waiver. Case managers prior authorize all services that are identified in the member's service plan, which are maintained in the state's MMIS system. If a provider submits a claim that will exceed the limit identified in the service authorization, system edits will decrease the payment and only allow the provider to be reimbursed for amounts/units left in that service authorization. If a provider submits a claim for a service date outside of the dates specified in the service authorization, the claim will be denied. Claims for services to members that are not Medicaid eligible or enrolled in the waiver on the service date will be denied.

The DDP ongoing quality assurance review effort is designed to hold providers accountable for ensuring that services were delivered in accordance with the plan of care and the service authorizations. Additionally if services are not delivered, there is usually a corresponding increase in reportable incidents. The incident management processes are used to address and remediate these situations. Persons who provide case management are responsible for the ongoing monitoring of service delivery per the Plan of care. Reports can be obtained to show services, units, and dollars billed by providers. This can be compared with plans of care to monitor payments vs. services delivered. Additionally, DDP has incorporated performance measures, and also a sample review of paid claims as part of the Performance Measure and our Quality Assurance processes. Inappropriate claims billed will be recouped. The SURS process conducted by the Quality Assurance Division and PERM audits will help ensure the financial integrity of provider billing practices, as described in Section I-1.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The DDP contracts with a financial management service (FMS) to perform fiscal agent duties for self-direct services with employer authority. They educate employers on their responsibilities, process employee and employer paperwork, process employee timesheets according to service authorizations. They provide workers' compensation for all employees and pay employee and employer related taxes. The FMS also generates expense reports for the employer, case manager and the state. The DDP conducts quality assurance reviews of the FMS.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ( ) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- (●) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The only public providers receiving payment from the DDP for waiver services are the public transportation providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- (●) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of***

the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment *(6 of 7)*

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment *(7 of 7)*

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ( ) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ( ) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- (●) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have

free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) Entities are designated as OHCDS. Providers are designated as OHCDS in cases where the enrolled provider with the DD Contract subcontracts with other entities (persons or agencies) for the provision of services not provided by staff employed by the agency. Any person or agency providing services under a subcontract must meet the DDP qualified provider standards for the provision of the service. It is the responsibility of the enrolled DDP provider to ensure the QP standards for the subcontracted service are met and documentation is maintained by the agency with the OHCDS designation to support this requirement.
(b) Providers of waiver services may choose to invoice DDP directly if they are an enrolled DDP provider. The potential service provider would complete an application through MMIS. After the required application and documentation has been reviewed and approved the applicant would achieve qualified provider status.
(c) Individuals are free to request the services of any qualified provider, as outlined in previous sections. Case managers are responsible for providing information to individuals and families regarding available service providers as part of the planning and pre-planning meeting process. Provider agencies currently subcontract with various providers of professional and therapy services, in response to the expressed desires of the individual and/or family.
(d)Invoices break out service categories which allow the reporting of the delivery of all waiver services by waiver service category in the Annual Expenditure Reports (AERs). This information is a critical piece of the paid claims history and audit trail, and is subject to review by independent, state and federal auditors. (e) The provider agency designated as an Organized Health Care Delivery System (OHCDS) is accountable for maintaining documentation verifying the credentials of subcontracted staff. The Performance Measure and Quality Assurance review process reviews the qualified provider documentation for staff providing the services outlined in the plan of care and the service authorization. The DDP quality assurance personnel may choose to verify the professional licensure or certification status at the Montana Department of Labor website, in addition to reviewing the certification or licensure records of subcontracted staff maintained by the provider agency designated as an OHCDS. (f) Financial accountability is maintained as follows: Providers may subcontract for the delivery of waiver services if the enrolled DDP provider has been designated as an Organized Health Care Delivery System in their DDP Contract. In this case, the enrolled DDP provider has the option of reimbursing another waiver service provider, at a rate equal to or less than the approved Medicaid rate. There can be no Medicaid payment made to the provider issuing the subcontract for submitting claims or processing payment, maintenance of documentation, or verification of credentials of the subcontracting entity, when the subcontracted entity bills at the Medicaid rate. The enrolled DDP provider is responsible for ensuring the subcontracted service is delivered in accordance with the plan of care, the service authorization, and the applicable qualified provider standards for the service. The enrolled DDP provider issuing the subcontract is responsible for maintenance of a "funding and service delivery paper trail", enabling auditors and DDP reviewers to verify the delivery of services in accordance with the aforementioned requirements. The DDP QA financial review occurs annually. The additional assurance of individual/unpaid caregiver survey questions linked to the delivery of services outlined in the plan of care, the service authorization and the sampled monthly invoice reduces the potential for fraudulent billing and the misuse of Medicaid funds.

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the

geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

○ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☒ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

In accordance with MCA 53-20-208, counties may access local tax levies for the purpose of supporting local services to persons with developmental disabilities. These funds are not matched with Medicaid.
53-20-208. Contributions of counties and municipalities. (1) The boards of county commissioners of the several counties and the governing bodies of municipalities of this state may contribute to any developmental disabilities facility approved by the department, without regard to whether the facility is within or outside of their respective jurisdictions. Subject to 15-10-420, the boards of county commissioners of the counties may levy a tax on the taxable value of all taxable property within the county. The tax is in addition to all other county tax levies. All proceeds of the tax, if levied, must be used for the sole purpose of support of developmental disabilities services.
(2) For the purpose of carrying out the provisions of this section, boards of county commissioners and governing bodies of municipalities may appropriate out of the general fund of their respective counties or municipalities.
History: En. 80-2619 by Sec. 9, Ch. 325, L. 1974; Sec. 80-2619, R.C.M. 1947; amd. and redes. 71-2408 by Sec. 7, Ch. 239, L. 1975; R.C.M. 1947, 71-2408; amd. Sec. 131, Ch. 584, L. 1999; amd. Sec. 159, Ch. 574, L. 2001.

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

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 cost of room and board is not reimbursable as a waiver expense, in accordance with the waiver service definitions. The amount charged to a person for room and board in a group home setting may leave the individual with insufficient personal funds. State General Fund supplemental payments enable a provider to cover costs associated with room and board expenses above and beyond a person's ability to pay with personal benefits income. In turn, the provider is responsible for ensuring individuals have personal needs money.

Currently, providers are reimbursed for the provision of waiver services under the terms of the provider contract for group home or supported living individuals based on service option codes and the number of individuals to be served. The providers are accountable for the expenditures of waiver funds as outlined in the associated rules, codes, contract and waiver language. Auditing requirements assist in ensuring that funds expended are in accordance with generally accepted accounting principles.

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: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	42253.86	9888.00	52141.86	185454.00	6705.00	192159.00	140017.14
2	42626.61	8776.00	51402.61	189509.00	7336.00	196845.00	145442.39
3	42626.61	9021.00	51647.61	189509.00	7541.00	197050.00	145402.39
4	42626.61	9274.00	51900.61	189509.00	7753.00	197262.00	145361.39
5	42626.61	9534.00	52160.61	189509.00	7908.00	197417.00	145256.39

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	2880	2880
Year 2	2880	2880
Year 3	2880	2880
Year 4	2880	2880
Year 5	2880	2880

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay projections were decreased 329. This average was taken from the length of stay information reported on the 372's submitted in FY 2011, FY 2012, FY 2013, FY 2014 and FY 2015. It is the state's expectation that the length of stay will continue to be consistent with the past information.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

All values approved for year 5 of the 0208.004.06.00 Waiver renewal request were not increased annually for the 5 year waiver renewal period effective 7/1/18 through 6/30/23. Rate changes are determined by the Montana Legislature.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' values were recalculated using the average value of the last 4 years of data for 0208 waiver individuals from Conduent. These data years follow: 7/1/11-6/30/12, 7/1/12-6/30/13, 7/1/13-6/30/14, and 7/1/14-6/30/15. The revised value, $8,828.00, is projected for year 2 (7/1/19-6/30/20) and increased by 2.8% per year for years 3 through 5. This percentage corresponds to the four year average increase from the national Health Care Consumer Price Index (HCI).

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Waiver years 3 through 5 were projected based on the actual value for waiver year 2 (7/1/14-6/30/15). The year two actual value reported by Conduent (from the MMIS extract) is $189,509.00.

All values for years 3 through 5 of the 0208.004.06 Waiver renewal request were not increased for the waiver renewal period effective 7/1/18 through 6/30/23.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is based on the most recent year of actual data for the period from 7/1/14-6/30/15 (waiver year 2). The revised values are based on an increase by 2.8% per year for years 3 through 5.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Day Supports and Activities	
Homemaker	
Residential Habilitation	
Respite	
Supported Employment - Follow Along Support	
Nutritionist Services	
Occupational Therapy	
Physical Therapy	
Private Duty Nursing	
Speech Therapy	
Supports Brokerage	
Adult Foster Support	
Assisted Living	
Behavioral Support Services	
Caregiver Training and Support	
Community Transition Services	
Companion Services	
Environmental Modifications	
Individual Goods and Services	
Meals	
Personal Care	
Personal Emergency Response System (PERS)	
Personal Supports	
Psychological Evaluation, Counseling and Consultation Services	
Remote Monitoring Equipment	
Remote Monitoring	
Retirement Services	
Specialized Medical Equipment and Supplies	
Supported Employment - Co-Worker Support	
Supported Employment - Individual Employment Support	
Supported Employment - Small Group Employment Support	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports and Activities Total:						**23707750.00**
Day Supports and Activities	hour	1375	740.00	23.30	**23707750.00**	
Homemaker Total:						**108918.00**
Homemaker	hour	30	180.00	20.17	**108918.00**	
Residential Habilitation Total:						**76598720.00**
Residential Habilitation	hour	1880	1760.00	23.15	**76598720.00**	
Respite Total:						**2734875.00**
Respite	hour	325	450.00	18.70	**2734875.00**	
Supported Employment - Follow Along Support Total:						**2043626.00**
Supported Employment - Follow Along Support	hour	415	130.00	37.88	**2043626.00**	
Nutritionist Services Total:						**362.64**
Nutritionist Services	hour	3	2.00	60.44	**362.64**	
Occupational Therapy Total:						**557.28**
Occupational Therapy	houe	3	2.00	92.88	**557.28**	
Physical Therapy Total:						**557.28**
Physical Therapy	hour	3	2.00	92.88	**557.28**	
Private Duty Nursing Total:						**1108604.00**
Private Duty Nursing	hour	137	200.00	40.46	**1108604.00**	
Speech Therapy Total:						**341.28**
Speech Therapy	hour	3	2.00	56.88	**341.28**	
Supports Brokerage Total:						**1398.24**
Supports Brokerage	hour	2	24.00	29.13	**1398.24**	
Adult Foster Support Total:						**1623407.00**
adult foster supports	month	49	12.00	2293.85	**1348783.80**	

GRAND TOTAL:	**121691126.20**
Total Estimated Unduplicated Participants:	**2880**
Factor D (Divide total by number of participants):	**42253.86**
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
residential training supports	hour	20	566.00	24.26	274623.20	
Assisted Living Total:						697011.84
Assisted Living	day	12	293.00	198.24	697011.84	
Behavioral Support Services Total:						260850.00
Behavioral Support Services	hour	120	37.00	58.75	260850.00	
Caregiver Training and Support Total:						312426.40
Caregiver Training and Support	hour	220	26.00	54.62	312426.40	
Community Transition Services Total:						6000.00
Community Transition Services	one placement	2	1.00	3000.00	6000.00	
Companion Services Total:						2798985.00
Companion Services	hour	285	460.00	21.35	2798985.00	
Environmental Modifications Total:						121600.00
Environmental Modifications	one mod or item	32	1.00	3800.00	121600.00	
Individual Goods and Services Total:						409277.00
Individual Goods and Services	state fiscal year	550	1.00	744.14	409277.00	
Meals Total:						41543.04
Meals	meal	22	336.00	5.62	41543.04	
Personal Care Total:						43981.00
Personal Care	one hour	1	2060.00	21.35	43981.00	
Personal Emergency Response System (PERS) Total:						4500.00
Personal Emergency Response System (PERS)	month	10	1.00	450.00	4500.00	
Personal Supports Total:						1892357.25
Personal Supports	hour	95	933.00	21.35	1892357.25	
Psychological Evaluation, Counseling and						163908.00

GRAND TOTAL:	121691126.20
Total Estimated Unduplicated Participants:	2880
Factor D (Divide total by number of participants):	42253.86
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultation Services Total:						
Psychological Evaluation, Counseling and Consultation Services	one hour	40	30.00	136.59	163908.00	
Remote Monitoring Equipment Total:						45981.00
Remote Monitoring Equipment	month	25	12.00	153.27	45981.00	
Remote Monitoring Total:						413196.75
Remote Monitoring	hour	25	2043.00	8.09	413196.75	
Retirement Services Total:						2422076.80
Retirement Services	hour	134	790.00	22.88	2422076.80	
Specialized Medical Equipment and Supplies Total:						130400.00
Specialized Medical Equipment and Supplies	year	80	1.00	1630.00	130400.00	
Supported Employment - Co-Worker Support Total:						3276.00
Supported Employment - Co-Worker Support	day	5	63.00	10.40	3276.00	
Supported Employment - Individual Employment Support Total:						60608.00
Supported Employment - Individual Employment Support	hour	40	40.00	37.88	60608.00	
Supported Employment - Small Group Employment Support Total:						359703.00
Supported Employment - Small Group Employment Support	hour	90	170.00	23.51	359703.00	
Transportation Total:						3574328.40
Transportation	one way ride	2293	12.00	129.90	3574328.40	

GRAND TOTAL:	121691126.20
Total Estimated Unduplicated Participants:	2880
Factor D (Divide total by number of participants):	42253.86
Average Length of Stay on the Waiver:	329

Appendix J: Cost Neutrality Demonstration

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
Day Supports and Activities Total:						22872739.30
Day Supports and Activities	daily	1553	155.00	95.02	22872739.30	
Homemaker Total:						108918.00
Homemaker	hour	30	180.00	20.17	108918.00	
Residential Habilitation Total:						77364632.00
Residential Habilitation	daily	1880	335.00	122.84	77364632.00	
Respite Total:						2734875.00
Respite	hour	325	450.00	18.70	2734875.00	
Supported Employment - Follow Along Support Total:						2043626.00
Supported Employment - Follow Along Support	hour	415	130.00	37.88	2043626.00	
Nutritionist Services Total:						362.64
Nutritionist Services	hour	3	2.00	60.44	362.64	
Occupational Therapy Total:						557.28
Occupational Therapy	hour	3	2.00	92.88	557.28	
Physical Therapy Total:						557.28
Physical Therapy	hour	3	2.00	92.88	557.28	
Private Duty Nursing Total:						1108604.00
Private Duty Nursing	hour	137	200.00	40.46	1108604.00	
Speech Therapy Total:						341.28

GRAND TOTAL:	122764644.14
Total Estimated Unduplicated Participants:	2880
Factor D (Divide total by number of participants):	42626.61
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy	hour	3	2.00	56.88	341.28	
Supports Brokerage Total:						1398.24
Supports Brokerage	hour	2	24.00	29.13	1398.24	
Adult Foster Support Total:						1623407.00
adult foster supports	month	49	12.00	2293.85	1348783.80	
residential training supports	day	20	566.00	24.26	274623.20	
Assisted Living Total:						697011.84
Assisted Living	hour	12	293.00	198.24	697011.84	
Behavioral Support Services Total:						260850.00
Behavioral Support Services	hour	120	37.00	58.75	260850.00	
Caregiver Training and Support Total:						312426.40
Caregiver Training and Support	hour	220	26.00	54.62	312426.40	
Community Transition Services Total:						6000.00
Community Transition Services	one placement	2	1.00	3000.00	6000.00	
Companion Services Total:						2798985.00
Companion Services	hour	285	460.00	21.35	2798985.00	
Environmental Modifications Total:						121600.00
Environmental Modifications	one mod or item	32	1.00	3800.00	121600.00	
Individual Goods and Services Total:						409277.00
Individual Goods and Services	state fiscal year	550	1.00	744.14	409277.00	
Meals Total:						41543.04
Meals	meal	22	336.00	5.62	41543.04	
Personal Care Total:						43981.00
Personal Care	hour	1	2060.00	21.35	43981.00	
Personal Emergency Response System						4500.00

GRAND TOTAL:	122764644.14
Total Estimated Unduplicated Participants:	2880
Factor D (Divide total by number of participants):	42626.61
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(PERS) Total:						
Personal Emergency Response System (PERS)	month	10	1.00	450.00	4500.00	
Personal Supports Total:						1892357.25
Personal Supports	hour	95	933.00	21.35	1892357.25	
Psychological Evaluation, Counseling and Consultation Services Total:						163908.00
Psychological Evaluation, Counseling and Consultation Services	hour	40	30.00	136.59	163908.00	
Remote Monitoring Equipment Total:						45981.00
Remote Monitoring Equipment	hour	25	12.00	153.27	45981.00	
Remote Monitoring Total:						413196.75
Remote Monitoring	hour	25	2043.00	8.09	413196.75	
Retirement Services Total:						3098235.00
Retirement Services	daily	125	228.00	108.71	3098235.00	
Specialized Medical Equipment and Supplies Total:						130400.00
Specialized Medical Equipment and Supplies	year	80	1.00	1630.00	130400.00	
Supported Employment - Co-Worker Support Total:						3276.00
Supported Employment - Co-Worker Support	day	5	63.00	10.40	3276.00	
Supported Employment - Individual Employment Support Total:						60608.00
Supported Employment - Individual Employment Support	hour	40	40.00	37.88	60608.00	
Supported Employment - Small Group Employment Support Total:						826161.44

GRAND TOTAL:	122764644.14
Total Estimated Unduplicated Participants:	2880
Factor D (Divide total by number of participants):	42626.61
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Small Group Employment Support	daily	73	208.00	54.41	826161.44	
Transportation Total:						3574328.40
Transportation	one way ride	2293	12.00	129.90	3574328.40	
			GRAND TOTAL:			122764644.14
			Total Estimated Unduplicated Participants:			2880
			Factor D (Divide total by number of participants):			42626.61
			Average Length of Stay on the Waiver:			329

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
Day Supports and Activities Total:						22872739.30
Day Supports and Activities	daily	1553	155.00	95.02	22872739.30	
Homemaker Total:						108918.00
Homemaker	hour	30	180.00	20.17	108918.00	
Residential Habilitation Total:						77364632.00
Residential Habilitation	daily	1880	335.00	122.84	77364632.00	
Respite Total:						2734875.00
Respite	hour	325	450.00	18.70	2734875.00	
Supported Employment - Follow Along Support Total:						2043626.00
Supported Employment - Follow Along Support	hour	415	130.00	37.88	2043626.00	
Nutritionist Services Total:						362.64
			GRAND TOTAL:			122764644.14
			Total Estimated Unduplicated Participants:			2880
			Factor D (Divide total by number of participants):			42626.61
			Average Length of Stay on the Waiver:			329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutritionist Services	hour	3	2.00	60.44	362.64	
Occupational Therapy Total:						557.28
Occupational Therapy	hour	3	2.00	92.88	557.28	
Physical Therapy Total:						557.28
Physical Therapy	hour	3	2.00	92.88	557.28	
Private Duty Nursing Total:						1108604.00
Private Duty Nursing	hour	137	200.00	40.46	1108604.00	
Speech Therapy Total:						341.28
Speech Therapy	hour	3	2.00	56.88	341.28	
Supports Brokerage Total:						1398.24
Supports Brokerage	hour	2	24.00	29.13	1398.24	
Adult Foster Support Total:						1623407.00
adult foster supports	month	49	12.00	2293.85	1348783.80	
residential training supports	hour	20	566.00	24.26	274623.20	
Assisted Living Total:						697011.84
Assisted Living	day	12	293.00	198.24	697011.84	
Behavioral Support Services Total:						260850.00
Behavioral Support Services	daily	120	37.00	58.75	260850.00	
Caregiver Training and Support Total:						312426.40
Caregiver Training and Support	hour	220	26.00	54.62	312426.40	
Community Transition Services Total:						6000.00
Community Transition Services	one placement	2	1.00	3000.00	6000.00	
Companion Services Total:						2798985.00
Companion Services	hour	285	460.00	21.35	2798985.00	
Environmental Modifications Total:						121600.00

GRAND TOTAL:	122764644.14
Total Estimated Unduplicated Participants:	2880
Factor D (Divide total by number of participants):	42626.61
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications	one mod or item	32	1.00	3800.00	121600.00	
Individual Goods and Services Total:						409277.00
Individual Goods and Services	state fiscal year	550	1.00	744.14	409277.00	
Meals Total:						41543.04
Meals	meal	22	336.00	5.62	41543.04	
Personal Care Total:						43981.00
Personal Care	hour	1	2060.00	21.35	43981.00	
Personal Emergency Response System (PERS) Total:						4500.00
Personal Emergency Response System (PERS)	month	10	1.00	450.00	4500.00	
Personal Supports Total:						1892357.25
Personal Supports	hour	95	933.00	21.35	1892357.25	
Psychological Evaluation, Counseling and Consultation Services Total:						163908.00
Psychological Evaluation, Counseling and Consultation Services	hour	40	30.00	136.59	163908.00	
Remote Monitoring Equipment Total:						45981.00
Remote Monitoring Equipment	month	25	12.00	153.27	45981.00	
Remote Monitoring Total:						413196.75
Remote Monitoring	hour	25	2043.00	8.09	413196.75	
Retirement Services Total:						3098235.00
Retirement Services	daily	125	228.00	108.71	3098235.00	
Specialized Medical Equipment and Supplies Total:						130400.00
Specialized Medical Equipment and Supplies	year	80	1.00	1630.00	130400.00	
Supported						3276.00

GRAND TOTAL:	122764644.14
Total Estimated Unduplicated Participants:	2880
Factor D (Divide total by number of participants):	42626.61
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment - Co-Worker Support Total:						
Supported Employment - Co-Worker Support	day	5	63.00	10.40	3276.00	
Supported Employment - Individual Employment Support Total:						60608.00
Supported Employment - Individual Employment Support	hour	40	40.00	37.88	60608.00	
Supported Employment - Small Group Employment Support Total:						826161.44
Supported Employment - Small Group Employment Support	daily	73	208.00	54.41	826161.44	
Transportation Total:						3574328.40
Transportation	one way ride	2293	12.00	129.90	3574328.40	
				GRAND TOTAL:		122764644.14
				Total Estimated Unduplicated Participants:		2880
				Factor D (Divide total by number of participants):		42626.61
				Average Length of Stay on the Waiver:		329

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
Day Supports and Activities Total:						22872739.30
Day Supports and Activities	daily	1553	155.00	95.02	22872739.30	
Homemaker Total:						108918.00
Homemaker	hour				108918.00	
				GRAND TOTAL:		122764644.14
				Total Estimated Unduplicated Participants:		2880
				Factor D (Divide total by number of participants):		42626.61
				Average Length of Stay on the Waiver:		345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		30	180.00	20.17		
Residential Habilitation Total:						77364632.00
Residential Habilitation	daily	1880	335.00	122.84	77364632.00	
Respite Total:						2734875.00
Respite	hour	325	450.00	18.70	2734875.00	
Supported Employment - Follow Along Support Total:						2043626.00
Supported Employment - Follow Along Support	hour	415	130.00	37.88	2043626.00	
Nutritionist Services Total:						362.64
Nutritionist Services	hour	3	2.00	60.44	362.64	
Occupational Therapy Total:						557.28
Occupational Therapy	hour	3	2.00	92.88	557.28	
Physical Therapy Total:						557.28
Physical Therapy	hour	3	2.00	92.88	557.28	
Private Duty Nursing Total:						1108604.00
Private Duty Nursing	hour	137	200.00	40.46	1108604.00	
Speech Therapy Total:						341.28
Speech Therapy	hour	3	2.00	56.88	341.28	
Supports Brokerage Total:						1398.24
Supports Brokerage	hour	2	24.00	29.13	1398.24	
Adult Foster Support Total:						1623407.00
adult foster supports	month	49	12.00	2293.85	1348783.80	
residential training supports	q	20	566.00	24.26	274623.20	
Assisted Living Total:						697011.84
Assisted Living	day	12	293.00	198.24	697011.84	

GRAND TOTAL:	122764644.14
Total Estimated Unduplicated Participants:	2880
Factor D (Divide total by number of participants):	42626.61
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Support Services Total:						**260850.00**
Behavioral Support Services	hour	120	37.00	58.75	**260850.00**	
Caregiver Training and Support Total:						**312426.40**
Caregiver Training and Support	hour	220	26.00	54.62	**312426.40**	
Community Transition Services Total:						**6000.00**
Community Transition Services	one placement	2	1.00	3000.00	**6000.00**	
Companion Services Total:						**2798985.00**
Companion Services	hour	285	460.00	21.35	**2798985.00**	
Environmental Modifications Total:						**121600.00**
Environmental Modifications	one mod or item	32	1.00	3800.00	**121600.00**	
Individual Goods and Services Total:						**409277.00**
Individual Goods and Services	state fiscal year	550	1.00	744.14	**409277.00**	
Meals Total:						**41543.04**
Meals	meal	22	336.00	5.62	**41543.04**	
Personal Care Total:						**43981.00**
Personal Care	hour	1	2060.00	21.35	**43981.00**	
Personal Emergency Response System (PERS) Total:						**4500.00**
Personal Emergency Response System (PERS)	month	10	1.00	450.00	**4500.00**	
Personal Supports Total:						**1892357.25**
Personal Supports	hour	95	933.00	21.35	**1892357.25**	
Psychological Evaluation, Counseling and Consultation Services Total:						**163908.00**
Psychological Evaluation, Counseling and Consultation Services	hour	40	30.00	136.59	**163908.00**	

GRAND TOTAL:	**122764644.14**
Total Estimated Unduplicated Participants:	**2880**
Factor D (Divide total by number of participants):	**42626.61**
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Monitoring Equipment Total:						**45981.00**
Remote Monitoring Equipment	month	25	12.00	153.27	**45981.00**	
Remote Monitoring Total:						**413196.75**
Remote Monitoring	hour	25	2043.00	8.09	**413196.75**	
Retirement Services Total:						**3098235.00**
Retirement Services	daily	125	228.00	108.71	**3098235.00**	
Specialized Medical Equipment and Supplies Total:						**130400.00**
Specialized Medical Equipment and Supplies	year	80	1.00	1630.00	**130400.00**	
Supported Employment - Co-Worker Support Total:						**3276.00**
Supported Employment - Co-Worker Support	daily	5	63.00	10.40	**3276.00**	
Supported Employment - Individual Employment Support Total:						**60608.00**
Supported Employment - Individual Employment Support	hour	40	40.00	37.88	**60608.00**	
Supported Employment - Small Group Employment Support Total:						**826161.44**
Supported Employment - Small Group Employment Support	daily	73	208.00	54.41	**826161.44**	
Transportation Total:						**3574328.40**
Transportation	one way ride	2293	12.00	129.90	**3574328.40**	
				GRAND TOTAL:		**122764644.14**
				Total Estimated Unduplicated Participants:		**2880**
				Factor D (Divide total by number of participants):		**42626.61**
				Average Length of Stay on the Waiver:		345

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
Day Supports and Activities Total:						22872739.30
Day Supports and Activities	daily	1553	155.00	95.02	22872739.30	
Homemaker Total:						108918.00
Homemaker	hour	30	180.00	20.17	108918.00	
Residential Habilitation Total:						77364632.00
Residential Habilitation	daily	1880	335.00	122.84	77364632.00	
Respite Total:						2734875.00
Respite	hour	325	450.00	18.70	2734875.00	
Supported Employment - Follow Along Support Total:						2043626.00
Supported Employment - Follow Along Support	hour	415	130.00	37.88	2043626.00	
Nutritionist Services Total:						362.64
Nutritionist Services	hour	3	2.00	60.44	362.64	
Occupational Therapy Total:						557.28
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Physical Therapy	hour	3	2.00	92.88	557.28	
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Private Duty Nursing	hour	137	200.00	40.46	1108604.00	
Speech Therapy Total:						341.28
Speech Therapy	hour	3	2.00	56.88	341.28	
Supports Brokerage Total:						1398.24
Supports Brokerage	hour	2	24.00	29.13	1398.24	

GRAND TOTAL:	122764644.14
Total Estimated Unduplicated Participants:	2880
Factor D (Divide total by number of participants):	42626.61
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Foster Support Total:						**1623407.00**
adult foster supports	month	49	12.00	2293.85	**1348783.80**	
residential training supports	hour	20	566.00	24.26	**274623.20**	
Assisted Living Total:						**697011.84**
Assisted Living	day	12	293.00	198.24	**697011.84**	
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Companion Services	hour	285	460.00	21.35	**2798985.00**	
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Individual Goods and Services	state fiscal year	550	1.00	744.14	**409277.00**	
Meals Total:						**41543.04**
Meals	meal	22	336.00	5.62	**41543.04**	
Personal Care Total:						**43981.00**
Personal Care	hour	1	2060.00	21.35	**43981.00**	
Personal Emergency Response System (PERS) Total:						**4500.00**
Personal Emergency Response System (PERS)	month	10	1.00	450.00	**4500.00**	
Personal Supports Total:						**1892357.25**

GRAND TOTAL:	**122764644.14**
Total Estimated Unduplicated Participants:	**2880**
Factor D (Divide total by number of participants):	**42626.61**
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Supports	hour	95	933.00	21.35	1892357.25	
Psychological Evaluation, Counseling and Consultation Services Total:						163908.00
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Remote Monitoring Total:						413196.75
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Retirement Services Total:						3098235.00
Retirement Services	daily	125	228.00	108.71	3098235.00	
Specialized Medical Equipment and Supplies Total:						130400.00
Specialized Medical Equipment and Supplies	year	80	1.00	1630.00	130400.00	
Supported Employment - Co-Worker Support Total:						3276.00
Supported Employment - Co-Worker Support	day	5	63.00	10.40	3276.00	
Supported Employment - Individual Employment Support Total:						60608.00
Supported Employment - Individual Employment Support	hour	40	40.00	37.88	60608.00	
Supported Employment - Small Group Employment Support Total:						826161.44
Supported Employment - Small Group Employment Support	daily	73	208.00	54.41	826161.44	
Transportation Total:						3574328.40

GRAND TOTAL:	122764644.14
Total Estimated Unduplicated Participants:	2880
Factor D (Divide total by number of participants):	42626.61
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation	one way ride	2293	12.00	129.90	3574328.40	
			GRAND TOTAL:			122764644.14
			Total Estimated Unduplicated Participants:			2880
			Factor D (Divide total by number of participants):			42626.61
			Average Length of Stay on the Waiver:			329