

# 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:**

**Montana Big Sky**

**C. Waiver Number: MT.0148**

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

**D. Amendment Number:**

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

01/27/21

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

### 2. Purpose(s) of Amendment

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

The Montana Department of Public Health and Human Services (Department) has determined that adult residential assisted living, specialized assisted living (TBI) and group home daily rate increases are required to address, and remedy identified barriers to access and quality service delivery for Montanan's across the state. The congregate care services identified are necessary to serve the high needs of Montana Medicaid residents in a least costly setting.

In partnership with a workgroup of assisted living providers and advocates, it was determined that providers have become, and continue to be, increasingly financially limited in their ability to care for residents in congregate care settings predominantly citing historically low reimbursement rates. As a result, providers have had to face difficult decisions on whether to become a Medicaid provider or limit the admissions of Waiver enrolled individuals into their facility. For example, a provider survey conducted by a third-party advocacy group in January 2017 identified that "Nearly 50% of all providers do not serve Medicaid clients. About 75% of those who do accept Medicaid limit the number of clients they are willing to serve. Many limit participation to a very small number".

In November 2019, the Montana DPHHS Senior and Long Term Care Division facilitated the establishment of an assisted living work group to address identified provider barriers and work collaboratively to resolve and develop solutions to resident access and provider sustainability. Together, the workgroup analyzed the Medicaid population served in assisted living facilities, the number of assisted living providers across the state, the existing market, the costs of providing adult residential services, and comparing the data to costs associated with service delivery within a higher level of care.

Calculations of residential habilitation rate adjustments included the following discussion of: 1) the number of assisted living providers across the state and how the number of providers accepting waiver Medicaid residents impacts access to waiver services, 2) the employment and provider agency costs in addition to salaries, and 4) calculate a rate that would reasonably cover employee wage increases, employing additional staff, and procuring and providing targeted training opportunities. The requested rates are as identified:

Residential Habilitation - Assisted Living Facilities and Adult Foster Homes- \$104.00 per day

Residential Habilitation- TBI/AR- \$165.77 per day

Residential Habilitation- Group Home- \$206.58 per day

The increased rates were calculated by starting with a 'base' rate for assisted living facilities at one-half the average of the state's nursing home rate of \$208 per day. The TBI/AR and Group Home rates were calculated by increasing at the same percentage as the previous base rate to the new base rate of \$104, which was 51%. The calculation is listed below:

Base Rate Calc = 50% of NH Rate:  $\$208 \times 50\% = \$104.00$

TBI/AR Rate Calc = Same increase as Current Base Average Paid Rate of \$69 to new rate of \$104

$\$104 - 69 = 35$ ; 35 divided by 69 = 51%

$\$109.78 \times 51\% = 55.99$ ;  $109.78 + 55.99 = \$165.77$

Group Home Rate Calc = Increase by the difference of the Current Base Average Paid Rate of \$69 and the Current Group Home Rate of \$158.91 or 1.30 ( $158.91 - 69 = 89.91$ ;  $89.91$  divided by  $69 = 1.30$ )

$\$158.91 \times 1.30 = \$206.58$

To compliment the work group's mission to assure maintained access to required services in a least costly setting, it was determined that residents exhibiting adverse behaviors, or in need of enhanced memory care, prompts the need for the establishment a new Big Sky Waiver Service. Adverse behaviors are often compounded by complex diagnoses and unique disease progression. Behavior management intervention within assisted living facilities promotes a Medicaid resident's greater ability to age in place within their preferred setting and community. As well, a resident's ability to age in place maintains consistency, interpersonal relationships, emotional security, and dignity. The requested rate for this is as identified:

Residential Habilitation - Assisted Living Facilities and Adult Foster Homes- Behavior Management - \$141.00 per day

To best support the behavior management rate and demonstrate cost-neutrality, Big Sky Waiver evaluated current adult residential services and rate scales. Furthermore, in September 2020, the Big Sky Waiver program conducted a survey requesting feedback from assisted living facilities. The survey was built to determine if a rate increase would provide at-risk individual's greater access to necessary services isolated to behavioral support and enhanced memory care. Of the respondents, 58.33% indicated the facility provides memory care and 61.54% indicated they provide services to individuals exhibiting difficult behaviors. Collectively, 76.92% of respondents indicated that increased reimbursement rates would prompt the provider to admit additional Medicaid residents within this targeted demographic into their facility. Big Sky Waiver also requested information identifying the provider's average private pay rates. On average, the base is approximately \$3562.00 monthly, median is \$4203.00 monthly, and the maximum is \$4,597.00 monthly. Big sky Waiver also requested the facilities estimate an 'adequate' Medicaid reimbursement rate for serving individuals with difficult behaviors or enhanced memory care needs. This average rate

was determined to be \$4,860.00 monthly or \$162.00 per day. The daily rate provided in the surveys received was a range from \$120.00 to \$200.00 per day. It was determined the rate would be set at mid-point from the low rate to the average rate which calculated to \$141.00 per day.

Historically, it has been found that when residents exhibit adverse behaviors, such as verbal and physical aggression, wandering, elopement, frequent falls, and impulsive behaviors and/or actions, assisted living facilities are often compelled to issue residents an involuntary 30-day eviction notice. If discharges are rendered successful, residents often are inappropriately hospitalized, placed in skilled nursing facilities, or settings specializing in mental health intervention until stabilized.

It is estimated that approximately 10-15% of the Medicaid population, enrolled in the Big Sky Waiver program, would directly benefit from the enhanced behavioral management rate. As indicated previously, the enhanced rate would allow an assisted living provider to secure additional direct care staff, provide regular and ongoing training and education opportunities, and have more incentive to pursue advanced licensure expanding their scope of care.

When an assisted living provider identifies a resident who requires behavioral management, the provider will contact the Big Sky Waiver Adult Residential Program Manager within Senior and Long Term Care Division to begin the review process. The assisted living provider, in collaboration with the Department, will review provider barriers to appropriate person-centered service delivery and determine how the enhanced rate will be applied to meet the health and safety needs of the resident. Prior to approval, the facility will be required to demonstrate past success and or failures to behavior modification practices and provide a resident-centered summary outlining the proposed plan of care in which the enhanced rate will be applied. The behavioral management rate approved by the department may be applied on a temporary or long-term basis depending on the individual resident’s situation or expected outcome.

Behavior modification practices will be assured to always be void of all classes of restraint, retaliation, reprisal, abuse, and neglect. Personal liberties, resident rights, and freedom of movement will be supported by the facility and maintained per state and federal regulation. If rights modifications are identified to be required to meet the health and safety needs of a resident, additional requirements must be met by the resident and their care team. Requirements will include, at a minimum, supporting documentation justifying the need within the resident’s person-centered service plan.

While drafting this amendment, it became known to the department that the Adult Residential service, Group Home, was addressed in Appendix C but was not separately listed in Appendix J. Group Home services is billed with the same procedure code as TBI Residential (T2016) but has a higher rate of reimbursement. It appears in the past Group Home services were included with TBI Residential services in Appendix J. The department will correct this omission with this amendment request.

### 3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	<input type="text"/>
Appendix A Waiver Administration and Operation	<input type="text"/>
Appendix B Participant Access and Eligibility	<input type="text"/>
Appendix C Participant Services	C1/C3/C5
Appendix D Participant Centered	<input type="text"/>

Component of the Approved Waiver	Subsection(s)
Service Planning and Delivery	
Appendix E Participant Direction of Services	<input data-bbox="496 324 1382 371" type="text"/>
Appendix F Participant Rights	<input data-bbox="496 448 1382 495" type="text"/>
Appendix G Participant Safeguards	<input data-bbox="496 555 1382 602" type="text"/>
Appendix H	<input data-bbox="496 633 1382 680" type="text"/>
Appendix I Financial Accountability	<input data-bbox="496 714 1382 761" type="text"/>
Appendix J Cost-Neutrality Demonstration	<input data-bbox="496 822 1382 869" type="text" value="J2"/>

**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:

## 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*):

**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.0148**

**Draft ID: MT.010.06.04**

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

Regular Waiver

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

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

**1. Request Information (2 of 3)**

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

**Hospital**

Select applicable level of care

**Hospital as defined in 42 CFR §440.10**

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

**Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

**Nursing Facility**

Select applicable level of care

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

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

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

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

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

**1. Request Information (3 of 3)**

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

previously approved:

The 1915(b)waiver was approved on July 1, 2011. The renewal has been submitted to CMS with a requested effective date of January 1, 2018. The waiver limits the number of providers of case management.

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

- §1915(b)(1) (mandated enrollment to managed care)**
- §1915(b)(2) (central broker)**
- §1915(b)(3) (employ cost savings to furnish additional services)**
- §1915(b)(4) (selective contracting/limit number of providers)**

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

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

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

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

**A program authorized under §1115 of the Act.**

*Specify the program:*

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

**2. Brief Waiver Description**

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

The waiver provides a vast array of traditional and self-directed services. Services are assessed, prioritized and developed through the completion of a service plan. Each member works with their case management team or independent advisor to individually develop this plan and corresponding budget to successfully meet the identified needs. Representatives are allowed to serve on behalf of a member, if necessary. Legally responsible family members meeting specific criteria may be paid workers.

The goal of providing quality care while maintaining financial accountability will be accomplished by:

1. Conducting quality assurance reviews.
2. Including a robust Financial Accountability component to the quality assurance review.
3. Conducting satisfaction surveys with waiver participants.
4. Providing training/education to all waiver providers.

The Community Services Bureau of the Senior and Long Term Care Division, Department of Public Health and Human Services oversees the waiver. The Division contracts with the Mountain Pacific Quality Health to conduct PASRR activities and disseminate information to members and potential service providers. Applicants receive PASRR screens to ensure that they receive services from the most appropriate waiver. The division contracts with local case management teams that work in conjunction with members to develop a service plan that delineates the services and the cost of those services for each enrollee. The Divisions Regional Program Officers are available at the local level to assist providers and members with the delivery of services and offer training. Community Service Bureau staff conduct quality assurance reviews to ensure that members are satisfied with the services they receive and that providers function within the rules governing the service providers. The Medicaid agency as a whole contracts with Conduent for Montana's MMIS. In those instances in which members utilize a financial manager, the latter submits claims to Conduent for payment.

### 3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

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

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

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

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

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

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

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

#### 4. Waiver(s) Requested

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

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

**Not Applicable**

**No**

**Yes**

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

**No**

**Yes**

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

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

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

#### 5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:
- No public notice was provided for this amendment because it was only changing the service delivery from and administrative service to a waiver service as it was previously.
- 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)**

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

**Last Name:**

Sark

**First Name:**

Jill

**Title:**

Community Services Bureau Chief

**Agency:**

Department of Public Health and Human Services

**Address:**

P.O. Box 4210

**Address 2:**

2030 11th Avenue

**City:**

Helena

**State:**

Montana

**Zip:**

59604

**Phone:**

(406) 444-4544

Ext:

TTY

**Fax:**

(406) 444-7743

**E-mail:**

jsark@mt.gov

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

**Last Name:**

Kulawik

**First Name:**

Mary Eve

**Title:**

Medicaid State Plan Amendment and Waiver Coordinator

**Agency:**

Department of Public Health and Human Services

**Address:**

P.O. Box 4210

**Address 2:**

111 N. Sanders

**City:**

Helena

**State:**

Montana

**Zip:**

59604

**Phone:**

(406) 444-2584

Ext:

TTY

**Fax:**

(406) 444-1970

**E-mail:**

mkulawik@mt.gov

## 8. Authorizing Signature

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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:**

Matthews

**First Name:**

Marie

**Title:**

State Medicaid Director

**Agency:**

Department of Public Health and Human Services

**Address:**

P.O. Box 4210

**Address 2:**

111 N. Sanders

**City:**

Helena

State: Montana

Zip: 59604

Phone: (406) 444-4084 Ext: TTY

Fax: (406) 444-1970

E-mail: Attachments mmatthews@mt.gov

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:

[Empty text box for transition plan specification]

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.

Montana assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Montana will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

The Montana Department of Public Health and Human Services (DPHHS) submitted Montana's Statewide Transition Plan to CMS on December 12, 2014. CMS requested clarification and more detail regarding the Transition Plan on August 26, 2015. Subsequently Montana has resubmitted a revised HCBS Statewide Transition Plan to CMS in December of 2015.

As required by CMS, Montana's transition plan addresses the areas of assessment, remediation and public input. DPHHS will partner with Medicaid members, providers and provider associations, advocates and other stakeholders throughout this process to assure that members and providers have access to needed information to assist with transition activities. Final outcome will be that Medicaid members will be served in a way that will enable them to live and thrive in integrated community settings.

Montana is undertaking a robust public input process related to achieving compliance with HCBS requirements. Notice of all public meetings and opportunities to comment on the transition plan and other documents are provided through newspaper notices as well as direct mail outs to providers, members and other interested parties. The State has held 3 public meetings for the purpose of soliciting comments and feedback relate to the statewide transition plan, the settings validation tool and process, the provider and the member self-assessment tools. The timeline on the statewide transition plan speaks to this transition process being an ongoing process that will occur over several stages and timelines that will provide the opportunity to engage providers and members throughout the process all the way through 2019.

States are required to review and analyze all settings in which Medicaid HCBS are delivered and setting in which individuals receiving Medicaid HCBS services reside. Montana is planning a multi-faceted approach to assessment. High level assessment of the types of settings where HCBS is provided to identify general categories of settings that are likely to be in compliance and settings that are not yet, but could become compliant. A provider self-assessment tool has been developed and distributed to all HCBS setting providers in July 2015 to gather baseline HCBS compliance information. The state will analyze the provider self-assessments and all setting will be assessed through one of three processes. Onsite validations or reviews will be completed on a random sample of the provider settings based on the provider self-assessment surveys that were returned. All settings that did not complete a self-assessment will receive an onsite validation. A matrix for determining HCBS Validation visits from the provider self-assessments received was developed to determine the level of compliance, in a percentage format, for each setting and was used to develop the random sampling process. A validation tool has been developed to be utilized by the individual performing on-site validations for consistent application across all settings. Based on provider self-assessment surveys, 13 settings have been identified as heightened scrutiny. A process for heightened scrutiny is outlined in the statewide transition plan under Heightened Scrutiny. Heightened scrutiny does not necessarily mean the setting is excluded from HCBS services but has a different process for an assessment as to whether the service delivery model meets all of the other HCBS criteria. For any other setting not selected for an onsite validation or considered heightened scrutiny, the state will review the provider self-assessment and any areas identified as non-compliant with the setting regulations will require remediation.

Member surveys were issued in July 2015 to compile setting satisfaction information and to be utilized in the ongoing quality assurance review process.

Remediation will take a series of steps to guide provider in making the transition to full compliance with HCBS settings, such as informational letters, updates to Administrative Rules of Montana and provider manuals, and other targeted communications. For any setting not found in compliance, the provider will be required to submit a corrective action plan to DPHHS that describes the steps to be taken and expected timelines to achieve compliance. Consideration of corrective action plans by the state will take into account the scope of the transition to be achieved and the unique circumstances related to the setting in question. Montana must comply with the settings requirements. If a provider is unable or unwilling to remediate a setting, it may be necessary to transition an individual into a compliant setting. In any instance where an individual would need to move to an alternative setting, the individual will be given timely notice and afforded a choice of alternative providers through the person-centered planning process.

Utilizing the provider self-assessment matrix, we have determined based on responses that there are many facilities that are close to being in compliance with all HCBS settings criteria and would need remediation in one or two areas to be in full compliance. The onsite validations and the state reviews of the provider self-assessments will identify these settings for remediation in order to work to full compliance during the transition timelines. The State has yet to complete any on-site validations or state reviews of provider self-assessments so we have not determined that there are any specific settings that cannot come into or will choose not to come into compliance with the HCBS settings regulations through the remediation process.

Ongoing monitoring process will be established to ensure that a setting that achieves compliance continues to meet HCBS settings requirements. The ongoing monitoring process has not yet been established but may include licensing surveyors or other staff that go onsite, with a checklist, to make sure that settings continue to maintain compliance with the remediation plan that was submitted. The state will meet the federal requirement for continued monitoring of settings and any new providers enrolling in the Medicaid program will be required to meet the setting criteria at the time of enrollment.

The goal of DPHHS is for Medicaid members to live and thrive in integrated community settings. The agency strives for this process to be transparent to the public, including members served through HCBS and their families. The transition web page will become the central hub for information on the transition to fully compliant HCBS settings. It will include stakeholder communications, changes to the transition plan as it is revised, finalized results of onsite assessments and remediation status.

A complete copy of the Montana HCBS Statewide Transition Plan is posted on the Departments website at [www.http://dphhs.mt.gov/hcbs](http://dphhs.mt.gov/hcbs).

### Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

### Appendix A: Waiver Administration and Operation

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

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

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

**The Medical Assistance Unit.**

Specify the unit name:

*(Do not complete item A-2)*

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

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

Senior and Long Term Care Division

*(Complete item A-2-a).*

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

Specify the division/unit name:

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

### Appendix A: Waiver Administration and Operation

## 2. Oversight of Performance.

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

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

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

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

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

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

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

Case management teams will enroll individuals in the Montana Big Sky waiver, provide case management services and conduct annual level of care re-evaluations. Case management teams will work within the communities to identify potential providers of waiver services appropriate to meet the needs of enrollees in the waiver. The enrolled individuals will select their providers of their waiver services.

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

## Appendix A: Waiver Administration and Operation

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

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

The Senior and Long Term Care Division of the Department of Public Health and Human Services is responsible for contract administration and for assessing the performance of Mountain Pacific Quality Health and the Case Management Teams. Contracts for these entities spell out duties and performance requirements for these contractors.

The MMIS Contract Manager in the Director's Office directly oversees the Conduent contract. Conduent provides a report monthly to the Department which includes the contract requirements. In addition, Conduent and the Department have monthly status meetings.

## Appendix A: Waiver Administration and Operation

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

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

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

Fiscal Intermediary contractor - Conduent submits all HCBS provider enrollments to Community Services Bureau Central Office for approval. This includes a report on criminal convictions, whether providers have been sanctioned, debarred or excluded for Medicare and whether there has been an action. Conduent generates a spreadsheet indicating provider enrollment by provider type. Conduent submits a monthly Report Card that summarizes internal monitoring Conduent does over the system and processes (i.e. recipient subsystem, provider enrollment, claims processing and documents, verify changes requested for codes were made appropriately). The MMIS coordinator and senior Medicaid policy analyst meet with Conduent weekly to discuss progress and/or problems with system updates. Monthly status meetings are held between department staff and Conduent staff. In addition, Conduent completes internal audits to review their system processes and effectiveness as a contractor.

## Appendix A: Waiver Administration and Operation

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

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

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		

Function	Medicaid Agency	Contracted Entity
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/percent of monthly reports submitted to the state medicaid agency by Mountain Pacific Quality Health. The numerator is the number of reports submitted to SMA by MPQH. The denominator is the total number of reports mandated by the SMA.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Number/percent of mandated reports submitted to SMA by Conduent to demonstrate compliance with contractual mandates. The numerator is the number of reports submitted by Conduent to SMA. The denominator is the total number of Conduent reports mandated by the SMA.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

**Number/percent of level of care reevaluations completed by the Case Management Teams (CMT) within 12 months of waiver enrollment or previous assessment. The numerator is number of reviewed LOC reevaluations completed by the CMT within 12 months of waiver enrollment or previous assessment. The denominator is the total number of reviewed LOC reevaluations completed by the CMTs.**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

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

		<input type="text"/>
<b>Other</b> Specify:  <input type="text" value="Case Management Teams"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

The CSB Central Office HCBS program managers oversee statewide operation of the waiver. Monthly quality assurance team meetings are the vehicle for continuous statewide oversight of the waiver contractors. During these monthly meetings program managers will review the reports submitted by Conduent and Mountain Pacific Quality Health. At the local level the case management teams are required to both audit with report cards as well as create and implement SMART goals quarterly via the Quality Improvement Project (QIP). The HCBS designated staff person completes Quality Assurance Reviews no less than every three years. Regional Program Officers provide ongoing program oversight of case management teams. Training is implemented by all HCBS staff, as needed, for policy/program changes, Federal Performance Measures and as issues are identified.

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

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

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

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

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

**No**

**Yes**

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

**Appendix B: Participant Access and Eligibility**

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

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

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

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

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

**Not applicable. There is no maximum age limit**

**The following transition planning procedures are employed for participants who will reach the waiver's**

**maximum age limit.**

*Specify:*

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

**Appendix B: Participant Access and Eligibility**

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

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

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

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

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

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

Specify the percentage:

**Other**

*Specify:*

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

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

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

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

**The following dollar amount:**

Specify dollar amount:

**The dollar amount** *(select one)*

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

Specify the formula:

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

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

Specify percent:

**Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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**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	2580
Year 2	2580
Year 3	2580
Year 4	2580
Year 5	2580

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

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

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

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

**Table: B-3-b**

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

**Appendix B: Participant Access and Eligibility**

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

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

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

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

Purpose(s) the state reserves capacity for:

Purposes	
Money Follows the Person Demonstration Grant	

**Appendix B: Participant Access and Eligibility**

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

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

Money Follows the Person Demonstration Grant

**Purpose** (describe):

Create a sustainable system that supports community options as a first choice for individuals needing long term care services. Goals include: 1. increase the use of home and community based services (HCBS); 2. strengthen ability of Medicaid programs to provide HCBS to people who transition out of institutions such as nursing homes; 3. develop community infrastructures that support and promote community placement; and, 4. use procedures to provide quality assurance and improvement of HCBS. There are 54 individuals who will transfer to the Big Sky Waiver at the end of 365 days.

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

Members must meet the following MFP criteria: 1. 90 consecutive days in a qualifying facility; 2. must be Medicaid eligible for at least one day prior to transition; and, 3. must qualify for HCBS waiver services. There are 54 individuals who will transfer to the Big Sky Waiver at the end of 365 days. Reserved capacity is based directly on the benchmarks established in the MFP grant for this population.

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

Waiver Year	Capacity Reserved
Year 1	20
Year 2	0
Year 3	0
Year 4	0
Year 5	0

**Appendix B: Participant Access and Eligibility**

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

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

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

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

**e. Allocation of Waiver Capacity.**

Select one:

**Waiver capacity is allocated/managed on a statewide basis.**

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

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

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

Individuals must:

1. be Medicaid eligible;
2. meet nursing facility level of care;
3. have a need that can only be met through HCBS waiver services; and
4. choose to receive waiver services.

Entry to the waiver is based on prioritized need as established by the statewide criteria on the Wait List Criteria Tool. The Wait List Tool scores members eligible for the waiver according to 10 criteria, including cognitive impairment, risk of medical deterioration without services, risk of institutional placement or death, need for supervision, need for formal paid services, assessment of informal supports, assessment of relief needed for primary caregiver, need for adaptive aids or environmental modifications, assessment of need for spousal impoverishment or waiver of deeming, and health and safety issues that place the member at risk. Case Management Teams (CMTs) are responsible for monitoring and oversight of the waitlist on an on-going basis. Members placed on the waitlist must be assessed within 60 days of the date of the formal referral. The Wait List Tool will be completed on each member awaiting HCBS services. The CMT should assist members in securing needed support or other available services until the member can be admitted to HCBS. Wait List members are contacted on a quarterly basis to update the Wait List Tool.

For those members transitioning from the Money Follows the Person program after a consecutive 365 days, the state has reserved capacity in this waiver to serve those individuals. Reserved Capacity is 14 in year one and 20 in both year 2 and year 3, for a total of 54 individuals.

## 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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

**Working individuals with disabilities who buy into Medicaid (TWWIA 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:*

**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**

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**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**

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**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.

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**Appendix B: Participant Access and Eligibility**

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**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.

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**Appendix B: Participant Access and Eligibility**

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**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**

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**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.

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**Appendix B: Participant Access and Eligibility**

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**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:

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

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

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

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

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

**Directly by the Medicaid agency**

**By the operating agency specified in Appendix A**

**By a government agency under contract with the Medicaid agency.**

*Specify the entity:*

Mountain Pacific Quality Health (QIO) performs the initial evaluations. The case management team conducts an annual reevaluation and when there are significant changes in the member's needs a request to the QIO to perform a new of level of care evaluation.

**Other**

*Specify:*

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

Registered Nurses or Licenses Practical Nurses (LPN) in the State of Montana and individuals with a bachelor's degree in Social Work.

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

Mountain Pacific Quality Health completes a PASRR determination including a Functional Assessment to determine if the member meets level of care requirements for enrollment into the waiver. Preadmission screening determination and functional assessment involves telephone interviews based on established protocol. A level I screen is also completed to determine if the person is an individual with an intellectual disability or mental illness as part of PASRR requirements and whether they would be better served under another waiver.

Placement decisions for individuals applying for home and community based services involve a systemic analysis of the member's medical, functional, and environmental resources and limitations. Primarily these decisions must be anchored by objective boundaries from which clinical judgment, or subjective expertise, is used to interpret the boundaries. This is particularly true in assessing medical and functional issues, as decisions for long-term care must assure that the proposed restrictive preadmission screen is consistent with the member's needs.

Assessment components used to extract information regarding resources and limitations must be guided by an interview and document review to obtain information on medical status, functional capabilities, and available resource options. Preadmission Determination protocols are tools used to direct the data collection process. The specific areas of focus for data collection are as follows:

- a) Identification of specific functional/medical barriers or problems;
- b) Assessment of the status of these issues (particularly as they interface with the member's current living environment and resources) and identification of services, equipment, and/or resources, if any, which currently accommodate those needs; and,
- c) Specification of the types of services, equipment, or resources needed to improve that interface.

Obtained data must next be compared against specific anchors, which reflect services typically required of persons needing institutional care. This decision must be followed by a determination as to, regardless of that "match" in criteria, whether the identified service needs could be provided in a community setting .

For the population identified as meeting criteria for home-based services, the final step would include a process of systematically excluding the availability of any other formal or informal resources that could or should be responsible for meeting those needs.

#### PREADMISSION SCREEN FUNCTIONAL ASSESSMENT/ DETERMINATION

The Preadmission Determination and the Functional Assessment must be used as a guide in determining both the member's medical/functional status and his/her environmental resources and limitations that bear on that status. The member's physical capacity must be measured in conjunction with his/her cognitive ability to determine comprehensive functioning. Although this is the first step in the assessment, the medical assessment is an interactive process which must involve concomitant use of specific boundaries, typically reflecting the needs of individuals requiring institutional level of care.

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

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

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

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

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

For initial evaluations Mountain Pacific Quality Health (MPQH) extracts information from the assessment components regarding resources and limitations based on a phone and/or document review. MPQH also completed a Level I screen to determine if there is an indication of Mental Illness or Intellectual Disability that would require specialized services not available under the Big Sky Waiver.

The case management teams perform annual in-person reevaluations to determine the ongoing need for services and if the member continues to meet level of care.

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

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule**

*Specify the other schedule:*

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

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

**The qualifications are different.**

*Specify the qualifications:*

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

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

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

The QIO maintains records of evaluations for at least 3 years. The case managers can request data from the QIS system but do not have direct access to it.

## 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/percent of new applicants who had a level of care determination indicating need for institutional level of care prior to receipt of services. The numerator is the number of new applicants who had a LOC determination indicating need for institutional level of care prior to receipt of services. The denominator is the total number of new applicants.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		Interval = <input type="text"/>
<b>Other Specify:</b>  <input type="text" value="Case Management Team"/>	<b>Annually</b>	<b>Stratified Describe Group:</b>  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other Specify:</b>  <input type="text"/>
	<b>Other Specify:</b>  <input type="text" value="Upon enrollment"/>	

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**Number/percent of participants who received a LOC reevaluation within 12 months of their last evaluation or more frequently when appropriate. The numerator is the number of participants who received an annual reevaluation within 12 months of their last evaluation. The denominator is the total number of waiver participants who required a screen within the last 12 months.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>

*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/percent of initial level of care determinations made by qualified contractors as specified in the approved waiver. The numerator is the number of initial LOC determinations made by qualified contractor as specified in the approved waiver. The denominator is the total number of initial LOC determinations.**

**Data Source (Select one):**

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<div style="border: 1px solid black; height: 40px; width: 100%;"></div>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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

In addition to the CMTs verification of level of care determination, MPQH will submit a management report to CSB on a monthly basis on the number of screens completed within that time period. To ensure that no one is inappropriately denied LOC by the contractor, CSB staff is available for consultation of level of care denials as necessary for complex situations. All persons denied are notified in writing of the denial and process to request a fair hearing.

**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.

Subassurance a: If a level of care determination has not been made for a new admit, the case management team will immediately make a referral to MPQH to complete the review per level of care protocol. Services will not be prior authorized prior to date of level of care completion. Once the level of care is completed and the individual meets level of care, admission to waiver will proceed. If the individual does not meet level of care he/she will be referred to other programs that could make available necessary support services. If, as a result of long term discovery, trends emerge, the program managers will demand more extensive pertinent remediation - such as mandated training or corrective action items to be completed within a specified time frame.

Subassurance b: If a level of care re-evaluation has not been completed at all, the case management team must immediately schedule a meeting with the member to complete the assessment. In the event that the member no longer meets level of care, discharge will be initiated as outlined in the approved waiver. When the level of care is not completed within the required time frame, the case management team must submit an explanation to the program managers within 30 days of discovery. If, as a result of long term discovery, systemic or provider specific trends emerge, the program managers will evaluate the process and/or demand more extensive pertinent remediation - such as mandated training or corrective action items to be completed within a specified time frame.

Subassurance c: MPQH will submit the names and qualifications of all level of care evaluators to the Department annually. In the event that a reviewer does not meet the Department's requirements, MPQH may no longer utilize that person for level of care determinations and must submit a written explanation to the Department within 30 days of discovery. If a screen was completed by an unqualified individual, the assessment will have to be redone by a qualified screener. In the event that the member does not meet level of care, discharge will be initiated as outlined in the approved waiver.

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="319 521 794 607" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="865 808 1340 893" type="text"/>

**c. Timelines**

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

**No**

**Yes**

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

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

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

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

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

During the preadmission screening determination Mountain Pacific Quality Health (MPQH) informs eligible members of the feasible alternatives available under the waiver and allows members to choose either institutional or waiver services. Freedom of choice is documented on the Screening Determination form (SLTC-61) that is sent to the member from MPQH. During the development of the service plan, members are again informed of their right to choose service settings, service options and service providers and this is documented on the service plan signature page.

**b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice

forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

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

## Appendix B: Participant Access and Eligibility

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

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

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

## Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Adult Day Health
Statutory Service	Case Management
Statutory Service	Community First Choice/Personal Assistance and Specially Trained Attendant Care
Statutory Service	Day Habilitation
Statutory Service	Homemaker
Statutory Service	Prevocational Services
Statutory Service	Residential Habilitation
Statutory Service	Respite
Statutory Service	Supported Employment
Extended State Plan Service	Audiology
Extended State Plan Service	Respiratory Therapy
Supports for Participant Direction	Financial Management Services
Supports for Participant Direction	Independence Advisor
Other Service	Community Supports
Other Service	Community Transition
Other Service	Consultative Clinical and Therapeutic Services
Other Service	Consumer Goods and Services
Other Service	Dietetic Services
Other Service	Environmental Accessibility Adaptations
Other Service	Family Training and Support
Other Service	Health and Wellness
Other Service	Homemaker Chore

Service Type	Service
Other Service	Non-medical Transportation
Other Service	Nutrition
Other Service	Occupational Therapy
Other Service	Pain and Symptom Management
Other Service	Personal Emergency Response Systems
Other Service	Physical Therapy
Other Service	Post Acute Rehabilitation Services
Other Service	Private Duty Nursing
Other Service	Senior Companion
Other Service	Specialized Child Care for Medically Fragile Children
Other Service	Specialized Medical Equipment and Supplies
Other Service	Speech Therapy
Other Service	Supported Living
Other Service	Vehicle Modifications

### Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

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

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04060 adult day services (social model)

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Adult Day Health provides a broad range of health, nutritional, recreational, and social services in settings outside the members place of residence. Adult Day Health services do not include residential overnight services. Adult day health services are furnished in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the member. Meals provided as part of these services shall not constitute a full nutritional regiment (3 meals per day). The scope of Adult Day Health service will not duplicate State Plan services or habilitation aid services. Transportation between the members place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.

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

This service is not duplicative of the transportation service therapies, or the meals provided under the distinct meals service.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult Day Provider

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Adult Day Health**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Provider

**Provider Qualifications**

**License** (specify):

Adult Day License

**Certificate** (specify):

**Other Standard** (specify):

ARM 37.40.1445

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and license renewal.

**Appendix C: Participant Services**

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

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

**Service Type:**

Statutory Service

**Service:**

Case Management

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

**HCBS Taxonomy:**

**Category 1:**

01 Case Management

**Sub-Category 1:**

01010 case management

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Case Management Provider Agencies

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**

Case Management Provider Agencies

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

ARM 37.40.1430

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State

**Frequency of Verification:**

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

**Appendix C: Participant Services**

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

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

**Service Type:**

Statutory Service

**Service:**

Personal Care

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

Community First Choice/Personal Assistance and Specially Trained Attendant Care

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08030 personal care

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Community First Choice/Personal Assistance Services (CFC/PAS) under the Home and Community Based Services Program (HCBS) may include supervision for health and safety reasons, socialization, escort and transportation for non-medical reasons, or an extension of State Plan personal assistance services. Since the provision of personal assistance by legally responsible individuals is not available under State Plan, individuals may use this service for assistance with ADLs by legally responsible individuals.

**CFC/PAS Specially Trained Attendants (STA):**

CFC/PAS STA's provide personal assistance by attendants who have been specially trained to meet the unique needs of the HCBS member. It is the responsibility of the provider agency to ensure that attendants are appropriately trained under agency based services or the member under the self-directed and member-directed programs. Areas of special training may include nursing (RN and LPN), assisting a member with traumatic brain injury, Alzheimers or extensive physical disabilities.

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

**Retainer Days**

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Community First Choice/Personal Assistance and Specially Trained Attendant Care**

**Provider Category:**

Agency

**Provider Type:**

Personal Assistance Agencies, Home Care Agency, Supported Living Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

[Empty text box]

**Other Standard** (specify):

ARM 37.40.1447

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Community First Choice/Personal Assistance and Specially Trained Attendant Care**

**Provider Category:**

Individual

**Provider Type:**

Personal Assistant, Specially Trained Personal Assistant

**Provider Qualifications**

**License** (specify):

If a nurse, must be licensed by the state.

**Certificate** (specify):

[Empty text box]

**Other Standard** (specify):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Member and Independence Advisor/FM

**Frequency of Verification:**

Upon enrollment and as necessary.

**Appendix C: Participant Services**

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

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

**Service Type:**

Statutory Service

**Service:**

Day Habilitation

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

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04060 adult day services (social model)

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Living Provider

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Day Habilitation**

**Provider Category:**

Agency

**Provider Type:**

Supported Living Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

ARM 37.40.1438

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years.

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Homemaker

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

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08050 homemaker

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Homemaker services consist of general household activities. Homemaker services are provided to members who are unable to manage their own home or when the member normally responsible for homemaking is absent. Homemaker services do not include personal care services available under State Plan Medicaid.

Homemaker activities include the following:

Household management necessary for maintaining and operating a home. This may include assisting the member with boxing, unpacking and organizing household items. In addition the service provides general housecleaning and meal preparation. Teaching services to improve a member or family's skills in household management and social functioning.

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

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

### Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Homemaker**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

State License

**Certificate (specify):**

Medicare Certification

**Other Standard (specify):**

ARM 37.40.1450

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and license renewal.

### Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Homemaker**

**Provider Category:**

Agency

**Provider Type:**

Homemaker Agency, Home Care Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

ARM 37.40.1450

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Homemaker**

**Provider Category:**

Agency

**Provider Type:**

Personal Assistance Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

ARM 37.40.1447 and 1450

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Homemaker**

**Provider Category:**

Individual

**Provider Type:**

Homemaker

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Member and Independence Advisor

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

**Frequency of Verification:**

Upon enrollment and as necessary thereafter.

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Prevocational Services

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

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04010 prevocational services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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

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

Are aimed at preparing an individual for paid or unpaid employment;

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

Are provided to members who may or may not join the general work force or participate in a transitional sheltered workshop within one year (excluding sup-ported employment programs).

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

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

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

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

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

**Provider managed**

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

## Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

ARM 37.40.1438

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Xerox

Frequency of Verification:

Upon enrollment and every two years thereafter.

## Appendix C: Participant Services

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

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

Service Type:

Statutory Service

**Service:**

Residential Habilitation

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

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02013 group living, other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Residential habilitation is provided in an adult residential care facility with two separate levels of care including standard care and advanced behavior management care, group home, foster home or a specialized adult residential care facility. Residential habilitation is a bundled service that may include personal assistance supports or habilitation to meet the specific needs of each resident; homemaker services; medication oversight; social activities; personal care; recreational activities, transportation; medical escort; and 24-hour on-site awake staff to meet the needs of the residents and provide supervision for safety and security.

Adult Residential Care is provided in an Adult Foster Home (AFH), Group Home, Assisted Living Facility (ALF) or Residential Hospice.

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

Medicaid reimbursement for room and board is prohibited. 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 CMT. 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 Assistance;
2. Homemaking;
3. Environmental Modifications;
4. Respite; or
6. Meals.

These restrictions apply only when HCBS payment is being made for the residential service.

#### Retainer Days

Providers of this service may be eligible for a retainer payment if authorized by the case management team.

Retainers are days on which the member is either in the hospital, nursing facility or on vacation and the team has authorized the provider to be reimbursed for services in order to keep their placement in the residential setting.

Retainer days are limited to 30 days a year and may not be used for any other service if used for residential habilitation. If a provider rate includes vacancy savings, retainer days are a duplication of services and may not be paid in addition.

The advanced behavior management service provided by assisted living facilities must be prior approved by department staff.

The state will ensure that individuals receive Medicaid HCBS in settings that are integrated, and support full access to, the greater community while providing the opportunity for members to age in place. This includes opportunities to engage in community life, control personal resources, receive services in the community, and, when appropriate, seek employment and work in competitive and integrated settings to the same degree as individuals who do not receive HCBS.

Home and community character is defined by the nature and quality of the member's experiences not the location or physical characteristics of the setting. The setting will be selected by the individual from options that include non-disability specific settings and options for private units. Individuals must have a choice regarding the services they receive and by whom the services are provided. They must be ensured of individual rights of privacy, dignity and respect, and free from coercion and restraint. Additionally, the character must optimize independence and autonomy in making life choices without regimenting such things daily activities, physical environment and with whom the individual interacts.

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

Montana assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Montana will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

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

### 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:

Child Foster Care

Provider Qualifications

License (specify):

State Foster Care License

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Xerox

Frequency of Verification:

Upon Enrollment and renewal of license.

### Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency

**Provider Type:**

Group Home

**Provider Qualifications**

**License** *(specify):*

State Group Home License

**Certificate** *(specify):*

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Xerox

**Frequency of Verification:**

Upon enrollment and renewal of license.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Residential Habilitation**

**Provider Category:**

Agency

**Provider Type:**

Assisted Living Facility, Adult Foster Home, Residential Hospice

**Provider Qualifications**

**License** *(specify):*

State Assisted Living, Adult Foster Home or Residential Hospice License

**Certificate** *(specify):*

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

ARM 37.40.1435

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and renewal of license.

**Appendix C: Participant Services**

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

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

**Service Type:**

Statutory Service

**Service:**

Respite

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

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09011 respite, out-of-home

**Category 2:**

09 Caregiver Support

**Sub-Category 2:**

09012 respite, in-home

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Respite care is short-term, intermittent care provided to members in need of supportive care to relieve those persons who normally provide the care. Respite care is only utilized to relieve a non-paid caregiver. Respite care may include payment for room and board in adult residential facilities, nursing homes, hospitals, group homes or residential hospice facilities. Respite care can be provided in the member's residence or by placing the member in another private residence, adult residential setting or other community setting, hospital, residential hospice, group home, therapeutic camp for children or adults with disabilities or licensed nursing facility.

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

When respite care is provided, the provision of, or payment for other duplicative services under HCBS is precluded (e.g., payment for respite when member is in Adult Day Care).  
 Respite care is limited to no more than 30 consecutive days.

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

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

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

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

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Nursing Facility

**Provider Qualifications**

**License** *(specify):*

State Nursing Facility License

**Certificate** *(specify):*

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

ARM 37.40.1451

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and upon renewal of license.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Assisted Living Facility

**Provider Qualifications**

**License (specify):**

State Assisted Living Facility License

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1451

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and renewal of license.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Homemaker Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

[Empty text box]

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

ARM 37.40.1451

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

Personal Assistant/Homemaker/Specially Trained Attendant/Caregiver

**Provider Qualifications**

**License** (*specify*):

[Empty text box]

**Certificate** (*specify*):

[Empty text box]

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Consumer and Independence Advisor/FM

**Frequency of Verification:**

Upon enrollment and as necessary.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Personal Assistance Agency/Home Care Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1451

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Hospital

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

**Appendix C: Participant Services**

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**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:**

**Service:**

**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:**



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

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

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

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

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Living Provider

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Supported Employment**

**Provider Category:**

**Provider Type:**

Supported Living Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

ARM 37.40.1438

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Audiology

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Continued)**

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

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

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Audiology**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

ARM 37.40.1462

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Audiology**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency or Hospital

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1462

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Xerox/State

**Frequency of Verification:**

Upon enrollment and renewal license/certification.

**Appendix C: Participant Services**

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Respiratory Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11110 respiratory therapy

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Respiratory Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

ARM 37.40.1463

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Respiratory Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency or Hospital

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

ARM 37.40.1463

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and renewal of license/certification.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Respiratory Therapy**

**Provider Category:**

Individual

**Provider Type:**

Respiratory Therapist

**Provider Qualifications**

**License (specify):**

State License

**Certificate (specify):**

**Other Standard (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and renewal of license.

**Appendix C: Participant Services**

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

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

**Service Type:**

Supports for Participant Direction

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

**Support for Participant Direction:**

Financial Management Services

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

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

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

More specifically, the FM will:

**1. Member Enrollment:**

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

**2. Individual Employed to Provide Services:**

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

**3. Payroll and Accounting:**

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

**4. Management:**

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

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

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

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

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

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

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**  
**Service Name: Financial Management Services**

**Provider Category:**

Agency

**Provider Type:**

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

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

## Appendix C: Participant Services

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

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

**Service Type:**

Supports for Participant Direction

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

**Support for Participant Direction:**

Information and Assistance in Support of Participant Direction

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

Independence Advisor

**HCBS Taxonomy:**

**Category 1:**

12 Services Supporting Self-Direction

**Sub-Category 1:**

12020 information and assistance in support of self-direction

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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

An IA can help members or their personal representatives:

- 1) learn how to successfully self-direct services;
- 2) develop a person-centered Service Plan (SP);
- 3) access waiver services, Medicaid State Plan services, and other needed medical, social or educational services regardless of funding source;
- 4) develop, implement, and monitor a monthly spending plan;
- 5) identify risks and develop a plan to manage those risks;
- 6) develop an individualized emergency backup plan;
- 7) make allowable purchases and ensure those purchases are listed in the spending plan;
- 8) negotiate payments for necessary and allowable goods and services;
- 9) work with the Financial Manager (FM) to track expenditures;
- 10) monitor the provision of the services to ensure the member's health and welfare; and
- 11) coordinate with the FM to ensure that members or personal representatives budget appropriately to meet their needs as defined in the SP.

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

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**Service Type: Supports for Participant Direction**

**Service Name: Independence Advisor**

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**Provider Category:**

Agency

**Provider Type:**

Independent Living Center, Personal Assistance Agency, Supportive Living Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

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

**Other Standard (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State

**Frequency of Verification:**

Upon enrollment

## Appendix C: Participant Services

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

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**Service Type: Supports for Participant Direction**

**Service Name: Independence Advisor**

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**Provider Category:**

Individual

**Provider Type:**

Independence Advisor

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State

**Frequency of Verification:**

Upon enrollment

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Community Supports

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17010 goods and services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Community supports is an all inclusive service available for members in the participant-directed Bonanza option. Services include assisting the member with:

- 1) basic living skills such as eating, drinking, toileting, personal hygiene, dressing, transferring and other activities of daily living;
- 2) improving and maintaining mobility and physical functioning;
- 3) maintaining health and personal safety;
- 4) carrying out household chores and preparation with meals and snacks;
- 5) accessing and using transportation (with providers possessing a valid Montana driver's license);
- 6) participating in community experiences and activities;
- 7) relieving unpaid caregivers at those times when such relief is in the best interest of the member or caregiver; and
- 8) receiving daycare for medically fragile children who, because of their disability, cannot be served in traditional child care settings.

Individuals recruited for this service will be selected, hired and managed by the member. This service is offered in lieu of state plan personal assistance which does not allow for participant direction.

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

This service may be used for child care only when it is above and beyond routine child care for which the primary caregiver is responsible. "Above and beyond" is defined as service needs for children who would attend a traditional day care but are unable due to being medically fragile. This service is necessary for high medical acuity children who cannot attend a traditional day care due to need for increased medical/physical supervision.

Members receiving this service may not simultaneously receive non-medical transportation, respite, personal assistance (state plan or waiver), specialized child care, residential habilitation or respite.

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

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

**Provider managed**

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Support Service Provider

### Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Supports

Provider Category:

Individual

Provider Type:

Community Support Service Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The provider must:

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Member/IA/FM

**Frequency of Verification:**

Upon enrollment and as necessary thereafter.

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Community Transition

**HCBS Taxonomy:**

**Category 1:**

16 Community Transition Services

**Sub-Category 1:**

16010 community transition services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the member is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a member to establish a basic household including: security deposits that are required to obtain a lease on an apartment or home; essential household furnishings required, including furniture, window coverings, food preparation items and bed/bath linens; moving expenses; usual and customary set up fees or deposits for utility or service access, including telephone, electricity, heating and water; activities to assess need, arrange for and procure resources.

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

Community Transition Services do not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversion/recreational purposes.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Community Transition**

**Provider Category:**

Agency

**Provider Type:**

Dependent Upon Specific Service/Support Required

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Dependent upon specific provider ARM 37.40.1422

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Consultative Clinical and Therapeutic Services

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11130 other therapies

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

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

**Category 4:**

**Sub-Category 4:**



These are services that assist unpaid and/or paid caregivers in carrying out member service plans and are necessary to improve the member's independence and inclusion in the community. The service is geared towards members with traumatic brain injuries or more complex disabilities that require a more clinical approach and specialized interventions. Consultation activities are provided by professionals in psychiatry, psychology, neuro-psychology, physiatry, behavior management, or others specializing in specific intervention modalities.

The service may include:

- 1) clinical evaluations by these professionals;
- 2) development of a supplemental home/community treatment plan which is incorporated into the individual's service plan;
- 3) training and technical assistance to implement the treatment;
- 4) monitoring the treatment and interventions; and
- 5) one-on-one consultation and support for paid and non-paid caregivers.

Professionals will work closely with case managers to ensure treatment plans are implemented and followed.

An entity, inclusive of its staff, providing consultative clinical and therapeutic services must be qualified generally to provide the services and specifically to meet each member's defined needs.

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Other Service**

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**Service Name: Consultative Clinical and Therapeutic Services**

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**Provider Category:**

Agency

**Provider Type:**

Psychologist, Psychiatrist, Neuro Psychologist, Physiatriist, Rehabilitation Counselor, Professional Counselor

**Provider Qualifications**

**License (specify):**

As Required by State Law by the Board of Meidcal Examiners or the Professional Licensing Bureau.

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1465

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and upon renewal of license.

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**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:**

Consumer Goods and Services

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17010 goods and services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

These are services, supports, supplies or goods not otherwise provided through this waiver or the Medicaid State Plan. These items must address an identified need in the member's person-centered service and support plan and meet the following requirements.

The item or service would:

- 1) decrease the need for other Medicaid services;
- 2) promote inclusion in the community;
- 3) promote the independence of the member;
- 4) fulfill a medical, social, or functional need based on unique cultural approaches; or
- 5) increase the person's safety in the home environment.

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

- 1) meet the member's identified needs and outcomes as outlined in their service plan;
- 2) goods and services collectively must provide an alternative to institutional placement;
- 3) be a cost-effective means of addressing an identified need in the service plan; and
- 4) be of sole benefit to the member.

Department review of the member's service plan, for approval, will determine whether the goods and services address the following outcomes:

- 1) maintain the member's ability to remain in the community;
- 2) enhance the member's community inclusion and family involvement;
- 3) develop or maintain the member's personal, social, physical, or work-related skills; and
- 4) increase the member's independence.

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

This includes any support services or good:

- 1) available through Medicaid State Plan;
- 2) covered by any other third-party payer such as Medicare, the Veteran's Administration, or state educational or vocational agencies;
- 3) used for leisure and recreational purposes only and not determined necessary for the member to remain in the home;
- 4) that is an item or support normally furnished by the member's parents, family or spouse;
- 5) that does not meet an identified need.

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

This service is limited to members in the Bonanza self-managed option. Goods or services in excess of \$2,500 must receive prior authorization from the Community Services Bureau (CSB) designated staff.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Consumer Goods and Services**

**Provider Category:**

Agency

**Provider Type:**

Dependent Upon Service/Support Required

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

Dependent upon specific provider ARM 37.40.1425

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Dietetic Services

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11040 nutrition consultation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Dietician Services are provided in Montana by a licensed nutritionist for member evaluation, monitoring of nutritional status; nutrition counseling; therapy; research, education and meal planning for members who have medically restricted diets or for members who do not eat appropriately to maintain health.

To become a Licensed Nutritionist in Montana, the licensee must be Certified through a National Certifying Organization. The Montana Board of Labor and Industry has deferred license requirements to National Certifying Organizations. Refer to ARM 24.156.1301,24.156.1304 and 37.40.1475. Provider enrollment through Xerox ensures the provider is free of exclusions and criminal activities.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Nutritionist

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Dietetic Services**

**Provider Category:**

Agency

**Provider Type:**

Nutritionist

**Provider Qualifications**

**License (specify):**

A licensed nutritionist must provide dietitian services. Licensed nutritionist must meet the qualifications in MCA 24-156-1301 and 1304.

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1475

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and license renewal.

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Environmental Accessibility Adaptations

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14020 home and/or vehicle accessibility adaptations

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Those physical adaptations to the home, required by the members service plan, 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 and supplies which are necessary for the welfare of the member, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, central air conditioning, etc. All services shall be provided in accordance with applicable state or local building codes.

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

Services are limited to a one-time purchase. The Division, at its discretion, may authorize an exception to this limit. This service is not duplicative of those services provided under specialized medical equipment.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Construction Company, Building Contractor

**Appendix C: Participant Services**

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

**Service Type: Other Service**

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**Service Name: Environmental Accessibility Adaptations**

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**Provider Category:**

Agency

**Provider Type:**

Construction Company, Building Contractor

**Provider Qualifications**

**License (specify):**

Mt. Contractor License

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1485

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

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**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Family Training and Support

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08010 home-based habilitation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**



**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**



Services whereby an employee of a Child and Family Services provider enrolled with the Department is responsible for assisting families with training and support issues associated with their child age 0 through 21 with disabilities and not eligible for Developmental Services Division (DSD) Services. More specifically, Family Training and Support includes:

- 1) Providing training to families and others who work or play with the child. Training would include general orientation about the child's disabling condition as well as training specific to the needs of the child and his or her family and how best to meet those needs.
- 2) Serving as consultant to families in terms of developmental stages and teaching activities that families can do with their child that would help in the developmental process.
- 3) Collaborating with the case managers and families to develop strategies for environmental modifications or adaptations that would be beneficial to the child.
- 4) Periodically assessing the child, including conducting developmental assessments, in order to discover unmet needs, determine progress or lack of progress and identifying areas of strength that can be emphasized.
- 5) Providing emotional support to families, including active listening, problem solving and suggesting resources such as peers and others within the disability community who could offer support.
- 6) Advocating for the family's needs with the case management team and others who may offer supports and services.
- 7) Assisting the family and case management team with transition and referral to special education, including Part B.

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Child and Family Training Services

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Family Training and Support**

**Provider Category:**

Agency

**Provider Type:**

Child and Family Training Services

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Bachelor's Degree with a specialty in child development.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox/Case Manager/IA/FM

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Health and Wellness

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11130 other therapies

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

Each service provides opportunities for members to integrate in an inclusion setting with non-disabled peers for healthy and wellness activities within their community. These services focus on healthy habits thereby preventing or delaying higher cost institutional care.

- o Weight loss - Members who are at a healthy weight are less likely to acquire conditions that increase the risk of institutionalization. (i.e. uncontrolled diabetes) In addition the ability for members to move freely within the community could improve.
- o Smoking Cessation -Members who are able to quit smoking may not acquire severe medical conditions such as COPD, lung cancer, etc. Acquiring these conditions could lead to the use of oxygen, shortness of breath and restrictions in physical activities. Without these conditions the ability for members to move freely within the community improves.
- o Healthy Lifestyles – Members can take classes to address issues regarding living with a disability through the independent living centers. This information increases the capacity of the member to self-advocate, navigate community resources and improve overall health and socialization skills. These skills keep members in the community and out of an institution.
- o Health Club Memberships – Members can participate and utilize health club services to improve overall health and well-being. Since members go to these facilities in the community, they are increasing activities outside of their home and more likely remain in the community. In addition using a private health club gets the member into a non-disability specific exercise program. This service is authorized for individuals with conditions that would benefit from gym activities.
- o Art Therapy – Members have access to art therapy as a means to express themselves and aid in coping with such conditions as depression, memory loss, traumatic brain injury, chronic illness, etc. Participation in this service requires members to access providers in the community. These services can increase the members ability to cope and increase confidence for community living and avoid institutionalization.
- o Cost associated with adaptations and direct support needed to participate in recreational activities such as skiing, horseback riding and swimming- By providing this service; members are outside of their homes and integrated into healthy settings. Members who participate adaptive activities are unlikely to be institutionalized. This cost does not include the fee for the recreational activity, such as ski-lift tickets, horse rentals, swimming pool entrance fees or lessons, professional guide fees and the like.

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

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Dependent Upon Specific Service Provided
Agency	Wellness Classes/Health Clubs/Fitness Centers

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Health and Wellness**

**Provider Category:**

Agency

**Provider Type:**

Dependent Upon Specific Service Provided

**Provider Qualifications**

**License (specify):**

As Required by state Law

**Certificate (specify):**

**Other Standard (specify):**

Dependent upon specific provider

- o Health lifestyle providers include the independent living centers, private providers, local medical facilities.
- o Hippo therapy – horse therapy business or individual providers.
- o Art therapy – eligible art instructors, or therapists.
- o Health Club Memberships – locally owned clubs, YMCAs or medical centers with associated health facilities.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Health and Wellness**

**Provider Category:**

Agency

**Provider Type:**

Wellness Classes/Health Clubs/Fitness Centers

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Dependent upon specific provider

- o Health lifestyle providers include the independent living centers, private providers, local medical facilities.
- o Hippo therapy – horse therapy business or individual providers.
- o Art therapy – eligible art instructors, or therapists.
- o Health Club Memberships – locally owned clubs, YMCAs or medical centers with associated health facilities.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Homemaker Chore

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08060 chore

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Homemaker Chore services are provided to members unable to manage their own home or when the member normally responsible for homemaking is absent. Homemaker Chore activities includes cleaning a home requiring extensive clean-up beyond the scope of general household cleaning available under the Homemaker service; such as heavy cleaning (e.g., washing windows or walls); yard care; walkway maintenance; minor home repairs; wood chopping and stacking.

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

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Personal Assistance Agency
Agency	Homemaker/House Cleaning Agency
Individual	Homemaker

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Homemaker Chore**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Medicare Certification

**Other Standard (specify):**

ARM 37.40.1450

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Homemaker Chore**

**Provider Category:**

Agency

**Provider Type:**

Personal Assistance Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1447 and 1450

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Homemaker Chore**

**Provider Category:**

Agency

**Provider Type:**

Homemaker/House Cleaning Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1450

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Homemaker Chore**

**Provider Category:**

Individual

**Provider Type:**

Homemaker

**Provider Qualifications**

**License (specify):**

[Empty text box]

**Certificate** (specify):

[Empty text box]

**Other Standard** (specify):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Member and IA/FM

**Frequency of Verification:**

At enrollment and as necessary thereafter.

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Non-medical Transportation

**HCBS Taxonomy:**

**Category 1:**

15 Non-Medical Transportation

**Sub-Category 1:**

15010 non-medical transportation

**Category 2:**

[Empty text box]

**Sub-Category 2:**

[Empty text box]

**Category 3:**

**Sub-Category 3:**

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

**Category 4:**

**Sub-Category 4:**



Transportation means travel furnished by common carrier or private vehicle for non-medical reasons as defined in the member service plan. Medical transportation is available under the State Plan Medicaid Program.

Transportation Services must meet the following criteria:

- 1) be provided only after volunteer, State Plan Medicaid or other publicly funded transportation programs have been exhausted or determined to be inappropriate; and
- 2) be provided by the most cost effective mode.

Transportation providers must provide proof of:

- 1) a valid Montana driver's license;
- 2) adequate automobile insurance; and
- 3) assurance that vehicle is in compliance with all applicable federal, state and local laws and regulations.

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

This service may not be used simultaneously with other waiver services that include transportation as an integral part of their rate such as Adult Day Health and Supported Living.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Cabs, Home and Health Care Agencies, Vans & Buses, Ambulance Services

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Non-medical Transportation**

**Provider Category:**

Agency

**Provider Type:**

Cabs, Home and Health Care Agencies, Vans & Buses, Ambulance Services

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

**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:**

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:**

**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:**



Services which consist of the provision of hot or other appropriate meals once or twice a day, up to seven days a week. In keeping with the exclusion of room and board as covered services, a full nutritional regimen of three meals per day will not be provided.

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Meals on Wheels, Area Agencies on Aging, Restaurants, Retirement Homes

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Nutrition**

**Provider Category:**

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Occupational Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11080 occupational therapy

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

The scope and nature of these of these services do not otherwise differ from Occupational Therapy Services furnished under the State plan, except that palliative therapies and maintenance therapy will continue to be provided as previously approved. Montana's HELP Act was implemented January 1, 2016 and includes the removal of the limitations to restorative Occupational Therapy. Maintenance therapies continue to be provided under waiver services.

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

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

A member’s legally responsible individual may provide occupational Therapy or Speech Therapy if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

The service is not available to individuals who are eligible to receive such services through Medicaid State Plan (including EPSDT benefits).

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Care Agency
Agency	Hospital/Home Health Agency
Individual	Occupational Therapist

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Occupational Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

ARM 37.40.1460

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Occupational Therapy**

**Provider Category:**

Agency

**Provider Type:**

Hospital/Home Health Agency

**Provider Qualifications**

**License (specify):**

Licensed as required by Montana law and regulations

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1460

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and license/certification renewal.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Occupational Therapy**

**Provider Category:**

Individual

**Provider Type:**

Occupational Therapist

**Provider Qualifications**

**License (specify):**

State License

**Certificate (specify):**

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

ARM 37.40.1460  
 A member’s legally responsible individual may provide Skilled Nursing, Physical Therapy, Occupational Therapy or Speech Therapy if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and renewal of license

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Pain and Symptom Management

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17990 other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

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

**Category 4:**

**Sub-Category 4:**

This service allows for the provision of traditional and non-traditional methods of pain management. Treatments include but are not limited to: acupuncture; reflexology; massage therapy; craniosacral therapy; hyperbaric oxygen therapy; mind-body therapies such as hypnosis and biofeedback; coaching; chiropractic therapy; and nursing services by a nurse specializing in pain and symptom management.

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Pain and Symptom Management**

**Provider Category:**

Agency

**Provider Type:**

Psychologist, Counselor, Life Coach, Hypnotist

**Provider Qualifications**

**License** (specify):

Montana Board of Social Work Examiners and Professional Counselors  
 Montana Board of Psychologists

**Certificate** (specify):

Certified Life Coach  
 Certified Hypnotist

**Other Standard** (specify):

ARM 37.40.1428

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and upon every two years thereafter

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Pain and Symptom Management**

**Provider Category:**

Agency

**Provider Type:**

Massage Therapists, Chiropractors, Acupuncturists, Specialized RN

**Provider Qualifications**

**License (specify):**

Montana Board of Massage Therapy  
Montana Board of Chiropractors  
Montana Board of Medical Examiners  
Montana Board of Nursing

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1428

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and upon license renewal.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Pain and Symptom Management**

**Provider Category:**

Agency

**Provider Type:**

Hospitals

**Provider Qualifications**

**License (specify):**

Montana Licensed Hospital

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and license or certification renewal.

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Personal Emergency Response Systems

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14010 personal emergency response system (PERS)

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

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

**Category 4:**

**Sub-Category 4:**

The Personal Emergency Response System (PERS) is an electronic, telephonic or mechanical system used to summon assistance in event of an emergency. The system must alert medical professionals, support staff or other designated individuals to respond to a member's emergency. Montana State Plan Community First Choice 1915(k) services provide PERS under State Plan, a waiver PERS device would be available to waiver members only if the State Plan PERS does not meet the member's individual need.

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

Reimbursement is not available for the purchase, installation or routine monthly charges of a telephone or cell phone.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	PERS Provider

### Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Emergency Response Systems**

**Provider Category:**

Agency

**Provider Type:**

PERS Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

ARM 37.40.1486

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Physical Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11090 physical therapy

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

The scope and nature of these of these services do not otherwise differ from Physical Therapy Services furnished under the State plan, except that palliative therapies, and maintenance therapies to prevent deterioration will continue to be provided by this waiver. Maintenance therapy will continue to be provided as previously approved. Montana's HELP Act was implemented January 1, 2016 and includes the removal of the limitations to Physical Therapy. Maintenance therapies continue to be provided under waiver services.

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

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization. A member's legally responsible individual may provide Physical Therapy services if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process. This services is not available to individuals who are eligible to receive such service through Medicaid State Plan (including EPSDT benefits).

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Physical Therapy**

**Provider Category:**

Individual

**Provider Type:**

Physical Therapist

**Provider Qualifications**

**License (specify):**

State license

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1461  
 A member’s legally responsible individual may provide Physical Therapy services if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Xerox/State

**Frequency of Verification:**

Upon enrollment and renewal of license.

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Physical Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1461

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Xerox/State

**Frequency of Verification:**

Upon enrollment and every two years thereafter

### Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Physical Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency or Hospital

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1461

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Xerox/State

**Frequency of Verification:**

Upon enrollment and renewal license/certification

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Post Acute Rehabilitation Services

**HCBS Taxonomy:**

**Category 1:**

10 Other Mental Health and Behavioral Services

**Sub-Category 1:**

10070 psychosocial rehabilitation

**Category 2:**

11 Other Health and Therapeutic Services

**Sub-Category 2:**

11120 cognitive rehabilitative therapy

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Post Acute Rehabilitation is a residential or a non-residential program for persons with a traumatic brain injury, or other severe disability that would benefit from these services. It is intended to maximize functional independence through therapeutic intervention that provides intensive therapies three to five days a week. Members are taught strategies to overcome barriers created by their disability, learn compensatory techniques for memory loss and behavior problems and relearn day-to-day living skills. The goal of this program is to facilitate integration into the community in addition to reducing the level of disability of the member.

Post Acute Rehabilitation is provided by an agency under the direction of an interdisciplinary team consisting of a board certified physiatrist, a licensed neuro-psychologist, or a licensed psychologist, occupational, speech, physical therapists and other appropriate support staff. A provider of this service must be accredited by CARF as a Community Re-Entry Program of Persons with a Traumatic Brain Injury or receive such accreditation within two years of commencement of this service under the HCBS program.

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

Therapies provided under this service are not duplicative of those available under state plan nor will they be provided simultaneously with occupational, speech or physical therapies provided under this waiver.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Health Care Provider, Rehabilitation or Medical

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Post Acute Rehabilitation Services**

**Provider Category:**

Agency

**Provider Type:**

Health Care Provider, Rehabilitation or Medical

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

ARM 37.40.1446

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter or upon license renewal.

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Private Duty Nursing

**HCBS Taxonomy:**

**Category 1:**

05 Nursing

**Sub-Category 1:**

05010 private duty nursing

**Category 2:**

05 Nursing

**Sub-Category 2:**

05020 skilled nursing

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Service provides nursing services by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) licensed to practice in Montana. These services are provided to an member at home or in an adult residential care facility. Private Duty Nursing services are medically necessary services provided to members who require continuous in-home nursing care that is not available from a home health agency. Private Duty Nursing service provided by an LPN must be supervised by an RN, physician, dentist, osteopath or podiatrist authorized by State law to prescribe medication and treatment. Private Duty Nursing may be prescribed only when Home Health Agency Services, as provided in ARM 37.40.701, are not appropriate or available and must comply with the Montana Nurse Practice Act. Services are provided according to the members service and support plan, which documents the members specific health-related need for nursing. Use of a nurse to routinely check skin condition, review medication use or perform other nursing duties in the absence of a specific identified problem, is not allowable. General statements such as monitor health needs are not considered sufficient documentation for the service. Services are not available to individuals who are eligible to receive such service through the Medicaid State Plan(including EPSDT benefits) If Private Duty Nursing is not available under State Plan, i.e., Private Duty Nursing supervision or Private Duty Nursing respite, then waiver Private Duty Nursing is allowable. Private Duty Nursing is not a State Plan service for adults.

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

A member’s legally responsible individual may provide private duty nursing if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Xerox. Xerox verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Care/Health Care Provider
Individual	Licensed Practical Nurse, Registered Nurse

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Private Duty Nursing**

**Provider Category:**

Agency

**Provider Type:**

Home Care/Health Care Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** (specify):

A member’s legally responsible individual may provide nursing services if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Xerox. Xerox verifies the provider is free of exclusions and criminal activity as part of the enrollment process.ARM 47.40.1477

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter or upon license renewal.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Private Duty Nursing**

**Provider Category:**

Individual

**Provider Type:**

Licensed Practical Nurse, Registered Nurse

**Provider Qualifications**

**License** (specify):

State of Montana LPN or RN License

**Certificate** (specify):

**Other Standard** (specify):

ARM 37.40.1477  
A member’s legally responsible individual may provide private duty nursing if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Xerox. Xerox verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/IA/FM

**Frequency of Verification:**

Upon enrollment and license renewal.

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Senior Companion

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08040 companion

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Senior Companion Services are directed at providing companionship and assistance. The service includes: respite, socialization supervision, and homemaking.  
 Providers of this service are Senior Companion Programs that are a part of Senior Corps.

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

This service will not be provided simultaneously with respite or homemaking.

**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:**

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Senior Companion Program

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Senior Companion**

**Provider Category:**

Agency

**Provider Type:**

Senior Companion Program

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Providers of this service are Senior Companion Programs that are a part of Senior Corps.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Specialized Child Care for Medically Fragile Children

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04080 medical day care for children

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

This service provides daycare for medically fragile children who, because of their disability, cannot be served in traditional childcare settings. The need for this service must be verified in writing by the child's health care professional. A provider of this service must be physically and mentally able to perform the duties required, and must be literate and able to follow written orders. This service is limited to medically fragile children and may not be used to provide services that are the responsibility of the parent.

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Caregiver
Agency	Home Care Agency, PAS Provider

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Specialized Child Care for Medically Fragile Children**

**Provider Category:**

Individual

**Provider Type:**

Caregiver

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

ARM 37.40.1452

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/IA/FM

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Specialized Child Care for Medically Fragile Children**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency, PAS Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

ARM 37.40.1452

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Specialized Medical Equipment and Supplies

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14031 equipment and technology

**Category 2:**

14 Equipment, Technology, and Modifications

**Sub-Category 2:**

14032 supplies

**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 service and support plan, which enable members to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live and includes the provision of service animals.

Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under State Plan Medicaid. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan Medicaid and shall exclude those items, which are not of direct medical or remedial benefit to the member. All items shall meet applicable standards of manufacture, design and installation.

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

Specialized Medical Equipment and Supplies will be limited to a one-time purchase with the exception of supplies not covered by State Plan Medicaid services. The Division, at its discretion, may authorize an exception to this policy. Purchases in excess of \$5,000 must receive prior authorization from the Regional Program Officer. This service is not duplicative of those services provided under environmental accessibility adaptations.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supplier of DME and Retailers

**Appendix C: Participant Services**

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

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

**Provider Category:**

Agency

**Provider Type:**

Supplier of DME and Retailers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

ARM 37.40.1487

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Speech Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11100 speech, hearing, and language therapy

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

The scope and nature of these services do not otherwise differ from Speech therapy services furnished under the State plan, except that palliative therapies and maintenance therapy will continue to be provided as previously approved. Montana's HELP Act was implemented January 1, 2016 and includes the removal of the limitations to Speech Therapy. Maintenance therapies continue to be provided under waiver services.

Audiology services have been moved extended state plan service type.

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

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

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

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

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

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

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

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Speech Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1462

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Speech Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency or Hospital

**Provider Qualifications**

**License (specify):**

[Empty text box]

**Certificate** (*specify*):

[Empty text box]

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

ARM 37.40.1462

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and renewal license/certification.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Speech Therapy**

**Provider Category:**

Individual

**Provider Type:**

Speech Therapist

**Provider Qualifications**

**License** (*specify*):

[Empty text box]

**Certificate** (*specify*):

[Empty text box]

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

ARM 37.40.1462  
o A member’s legally responsible individual may provide Speech Therapy if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and renewal of license.

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Supported Living

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02031 in-home residential habilitation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Supported living is a comprehensive habilitation service designed to support members with brain injuries, or other severe disabilities, in the community. Members receiving supported living services may reside in any non-institutional setting.

Supported living is a bundled service which includes: independent living evaluation, homemaking, habilitation aides, behavioral programming, non-medical transportation, specially trained attendants, day habilitation, residential habilitation, prevocational training, supported employment, 24-hour availability of staff for supervision and safety, and service coordination to coordinate supported living services. A Case Management Team (CMT) may decide not to use a bundled service but instead oversee separate services.

Members of this service must have identifiable HCBS goals that are reviewed by the CMT every 6 months or more frequently if necessary. Supported living providers must show progress in the achievement of these goals. If progress is not apparent, the CMT must renegotiate the rate to reflect diminished goals.

In contrast to post acute rehabilitation, which provides short-term rehabilitative treatment, supported living is a long term support service.

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

An individual in supported living may not receive other waiver services that would be duplicative to those included in the supported living plan. These include: adult day health, day habilitation, homemaker, homemaker chore, personal assistance, prevocational services, residential habitation, respite, non medical transportation, community supports, senior companion, and supported employment.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Living Provider

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Supported Living**

**Provider Category:**

Agency

**Provider Type:**

Supported Living Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

ARM 37.40.1438

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Vehicle Modifications

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14020 home and/or vehicle accessibility adaptations

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Vehicle modifications are modifications made to a personal vehicle that will allow the member to be more independent. These modifications would be specified in the service plan as necessary to enable the member to more fully integrate into the community and to ensure their health, safety and welfare. These adaptations would not include regularly scheduled upkeep and maintenance of a vehicle. This service does not include adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the member. This service does not include the purchase or lease of a vehicle and/or partial purchase of vehicle already modified.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

**Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Automotive Repair Shops

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Vehicle Modifications**

**Provider Category:**

Agency

**Provider Type:**

Automotive Repair Shops

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1485

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

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

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

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

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

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

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

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

**As a primary care case management system service under a concurrent managed care authority.** Complete item C-1-c.

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

Case management will be provided under the authority of a 1915(b)(4) waiver to be providers of this service.

Case Management is provided by Medicaid enrolled provider agencies. In order to provide quality services, the agencies must have employees with the education, training and competencies necessary to meet the needs of the individuals they serve. Case management teams must include a nurse licensed to practice in the State of Montana, a BSW social worker and appropriate clerical and support staff.

## Appendix C: Participant Services

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

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

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

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

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

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

**No. The state does not conduct abuse registry screening.**

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

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

## Appendix C: Participant Services

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

- 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	
Residential Hospice	
Retirement Home	
Adult Day	
Foster Home, Assisted Living Facility, Group Home	
Area Agency on Aging	

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

The process for achieving compliance with the HCBS Settings regulations is identified in response to Attachment # 2 and in the Montana HCBS Statewide Transition Plan posted on the Department website at [www.http://dphhs.mt.gov/hcbs](http://dphhs.mt.gov/hcbs).

The state will ensure that individuals receive Medicaid HCBS in settings that are integrated, and support full access to, the greater community while providing the opportunity for members to age in place. This includes opportunities to engage in community life, control personal resources, receive services in the community, and, when appropriate, seek employment and work in competitive and integrated settings to the same degree as individuals who do not receive HCBS.

Home and community character is defined by the nature and quality of the member’s experiences not the location or physical characteristics of the setting. The setting will be selected by the individual from options that include non-disability specific settings and options for private units. Individuals must have a choice regarding the services they receive and by whom the services are provided. They must be ensured of individual rights of privacy, dignity and respect, and free from coercion and restraint. Additionally, the character must optimize independence and autonomy in making life choices without regimenting such things daily activities, physical environment and with whom the individual interacts.

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

Validation tool and process that has been developed by the State and commented on by the providers and stakeholders will be utilized to determine compliance with the HCBS settings characteristics. A remediation plan will be required for any areas of noncompliance before each setting is deemed to be in compliance with the HCBS requirements. The validation tool will address specific areas that would indicate or assure that the setting is HCBS compliant. Validation Tool is posted on the Departments website with the Statewide Transition Plan.

Montana assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the State’s approve 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.

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Residential Hospice

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Post Acute Rehabilitation Services	
Audiology	
Consultative Clinical and Therapeutic Services	

Waiver Service	Provided in Facility
Specialized Child Care for Medically Fragile Children	
Occupational Therapy	
Homemaker	
Community First Choice/Personal Assistance and Specially Trained Attendant Care	
Respite	
Environmental Accessibility Adaptations	
Physical Therapy	
Dietetic Services	
Consumer Goods and Services	
Family Training and Support	
Personal Emergency Response Systems	
Vehicle Modifications	
Homemaker Chore	
Senior Companion	
Nutrition	
Respiratory Therapy	
Financial Management Services	
Supported Employment	
Residential Habilitation	
Pain and Symptom Management	
Private Duty Nursing	
Community Supports	
Community Transition	
Specialized Medical Equipment and Supplies	
Speech Therapy	
Supported Living	
Prevocational Services	
Case Management	
Non-medical Transportation	
Day Habilitation	
Health and Wellness	
Adult Day Health	
Independence Advisor	

**Facility Capacity Limit:**

No Limit

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

<b>Scope of State Facility Standards</b>	
<b>Standard</b>	<b>Topic Addressed</b>
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

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

All standards are based on licensure requirements in accordance with the Administrative Rules of Montana. Those not checked do not apply to the type of facility listed and are therefore not reviewed by the Licensing Bureau as part of their compliance reviews. Facilities are inspected to ensure adherence to those requirements which are checked above. Staff ratios are not addressed in the state regulations other than to indicate a need for sufficient staff to meet member needs. Services to members are routinely monitored by case management teams who ensure health and safety of members in the facilities.

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**

Retirement Home

**Waiver Service(s) Provided in Facility:**

<b>Waiver Service</b>	<b>Provided in Facility</b>
<b>Post Acute Rehabilitation Services</b>	
<b>Audiology</b>	
<b>Consultative Clinical and Therapeutic Services</b>	

Waiver Service	Provided in Facility
Specialized Child Care for Medically Fragile Children	
Occupational Therapy	
Homemaker	
Community First Choice/Personal Assistance and Specially Trained Attendant Care	
Respite	
Environmental Accessibility Adaptations	
Physical Therapy	
Dietetic Services	
Consumer Goods and Services	
Family Training and Support	
Personal Emergency Response Systems	
Vehicle Modifications	
Homemaker Chore	
Senior Companion	
Nutrition	
Respiratory Therapy	
Financial Management Services	
Supported Employment	
Residential Habilitation	
Pain and Symptom Management	
Private Duty Nursing	
Community Supports	
Community Transition	
Specialized Medical Equipment and Supplies	
Speech Therapy	
Supported Living	
Prevocational Services	
Case Management	
Non-medical Transportation	
Day Habilitation	
Health and Wellness	
Adult Day Health	
Independence Advisor	

**Facility Capacity Limit:**

No Limit

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

<b>Scope of State Facility Standards</b>	
<b>Standard</b>	<b>Topic Addressed</b>
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

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

All standards are based on licensure requirements in accordance with the Administrative Rules of Montana. Those not checked do not apply to the type of facility listed and are therefore not reviewed by the Licensing Bureau as part of their compliance reviews. Facilities are inspected to ensure adherence to those requirements which are checked above. Staff ratios are not addressed in the state regulations other than to indicate a need for sufficient staff to meet member needs. Services to members are routinely monitored by case management teams IA/FM who ensure health and safety of members in the facilities.

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**

Adult Day

**Waiver Service(s) Provided in Facility:**

<b>Waiver Service</b>	<b>Provided in Facility</b>
Post Acute Rehabilitation Services	
Audiology	
Consultative Clinical and Therapeutic Services	

Waiver Service	Provided in Facility
Specialized Child Care for Medically Fragile Children	
Occupational Therapy	
Homemaker	
Community First Choice/Personal Assistance and Specially Trained Attendant Care	
Respite	
Environmental Accessibility Adaptations	
Physical Therapy	
Dietetic Services	
Consumer Goods and Services	
Family Training and Support	
Personal Emergency Response Systems	
Vehicle Modifications	
Homemaker Chore	
Senior Companion	
Nutrition	
Respiratory Therapy	
Financial Management Services	
Supported Employment	
Residential Habilitation	
Pain and Symptom Management	
Private Duty Nursing	
Community Supports	
Community Transition	
Specialized Medical Equipment and Supplies	
Speech Therapy	
Supported Living	
Prevocational Services	
Case Management	
Non-medical Transportation	
Day Habilitation	
Health and Wellness	
Adult Day Health	
Independence Advisor	

**Facility Capacity Limit:**

No Limit

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

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

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

All standards are based on licensure requirements in accordance with the Administrative Rules of Montana. Those not checked do not apply to the type of facility listed and are therefore not reviewed by the Licensing Bureau as part of their compliance reviews. Facilities are inspected to ensure adherence to those requirements which are checked above. Staff ratios are not addressed in the state regulations other than to indicate a need for sufficient staff to meet member needs. Services to members are routinely monitored by case management teams or the IA/FM who ensure health and safety of members in the facilities.

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**

Foster Home, Assisted Living Facility, Group Home

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Post Acute Rehabilitation Services	
Audiology	
Consultative Clinical and Therapeutic Services	

Waiver Service	Provided in Facility
Specialized Child Care for Medically Fragile Children	
Occupational Therapy	
Homemaker	
Community First Choice/Personal Assistance and Specially Trained Attendant Care	
Respite	
Environmental Accessibility Adaptations	
Physical Therapy	
Dietetic Services	
Consumer Goods and Services	
Family Training and Support	
Personal Emergency Response Systems	
Vehicle Modifications	
Homemaker Chore	
Senior Companion	
Nutrition	
Respiratory Therapy	
Financial Management Services	
Supported Employment	
Residential Habilitation	
Pain and Symptom Management	
Private Duty Nursing	
Community Supports	
Community Transition	
Specialized Medical Equipment and Supplies	
Speech Therapy	
Supported Living	
Prevocational Services	
Case Management	
Non-medical Transportation	
Day Habilitation	
Health and Wellness	
Adult Day Health	
Independence Advisor	

**Facility Capacity Limit:**

Limit for Group Home is 12. Foster Home limit is 4. No limit for assisted living facilities.

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

<b>Scope of State Facility Standards</b>	
<b>Standard</b>	<b>Topic Addressed</b>
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

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

All standards are based on licensure requirements in accordance with the Administrative Rules of Montana. Those not checked do not apply to the type of facility listed and are therefore not reviewed by the Licensing Bureau as part of their compliance reviews. Facilities are inspected to ensure adherence to those requirements which are checked above. Staff ratios are not addressed in the state regulations other than to indicate a need for sufficient staff to meet consumer needs. Services to waiver individuals are routinely monitored by case management teams who ensure health and safety of waiver recipients in the facilities.

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**

Area Agency on Aging

**Waiver Service(s) Provided in Facility:**

<b>Waiver Service</b>	<b>Provided in Facility</b>
<b>Post Acute Rehabilitation Services</b>	
<b>Audiology</b>	
<b>Consultative Clinical and Therapeutic Services</b>	

Waiver Service	Provided in Facility
Specialized Child Care for Medically Fragile Children	
Occupational Therapy	
Homemaker	
Community First Choice/Personal Assistance and Specially Trained Attendant Care	
Respite	
Environmental Accessibility Adaptations	
Physical Therapy	
Dietetic Services	
Consumer Goods and Services	
Family Training and Support	
Personal Emergency Response Systems	
Vehicle Modifications	
Homemaker Chore	
Senior Companion	
Nutrition	
Respiratory Therapy	
Financial Management Services	
Supported Employment	
Residential Habilitation	
Pain and Symptom Management	
Private Duty Nursing	
Community Supports	
Community Transition	
Specialized Medical Equipment and Supplies	
Speech Therapy	
Supported Living	
Prevocational Services	
Case Management	
Non-medical Transportation	
Day Habilitation	
Health and Wellness	
Adult Day Health	
Independence Advisor	

**Facility Capacity Limit:**

No Limit

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

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

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

All standards are based on licensure requirements in accordance with the Administrative Rules of Montana. Those not checked do not apply to the type of facility listed and are therefore not reviewed by the Licensing Bureau as part of their compliance reviews. Facilities are inspected to ensure adherence to those requirements which are checked above. Staff ratios are not addressed in the state regulations other than to indicate a need for sufficient staff to meet member needs. Services to members are routinely monitored by case management teams IA/FM who ensure health and safety of members in the facilities.

**Appendix C: Participant Services**

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

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

- No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may

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

For a legally responsible individual, including biological and adoptive parents of recipients under 18, spouses of adult recipients, and court appointed guardians to be paid for the provision of HCBS services all of the following authorization criteria and monitoring provisions must be met.

The service must:

- 1) meet the definition of a service/support as outlined in the federally approved waiver plan;
- 2) be necessary to avoid institutionalization;
- 3) be a service/support that is specified in the member service and support plan;
- 4) be provided by a parent or spouse who meets the provider qualifications and training standards specified in the waiver for that service;
- 5) be paid at a rate that does not exceed what is allowed by the department for the payment of similar services; and
- 6) not be an activity that the family would ordinarily perform or is responsible to perform.

The family member who is a service provider will comply with the following:

- 1) for self-directed personal assistance the family member must maintain and submit time sheets and other required documentation for hours paid; and
- 2) married individuals must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the service plan.

**Self-directed**

**Agency-operated**

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

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

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

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

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

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

Relatives may be paid for providing waiver services only if the relative is qualified to provide the service. Legal guardians are considered legally responsible individuals and may be paid for providing waiver services when they meet the criteria specified for legally responsible individuals.

**Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All potential providers can become Medicaid providers as long as they meet the provider qualifications. Providers that meet provider requirements are welcome to enroll as a Medicaid provider. All requests for enrollment in the Medicaid Program must be made to Xerox. Xerox will provide interested providers with enrollment forms. The enrollment form must be completed in its entirety before Xerox can approve and process the enrollment application. Xerox will forward completed enrollment forms to the Division for approval, procedure codes and rates.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

**a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**i. Sub-Assurances:**

**a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

**Performance Measures**

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

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

**Performance Measure:**

**Number/percent of new providers required to be licensed/certified that were verified to initially meet state licensure/certification standards. The numerator is the number of new providers required to be licensed or certified that were verified to initially meet state licensure/certification standards. The denominator is the total number of new providers that require a license or certification.**

**Data Source** (Select one):

**Analyzed collected data (including surveys, focus group, interviews, etc)**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Number/percent of providers required to be licensed or certified that were verified to continually meet state licensure/certification standards. The numerator is the number of providers required to be licensed or certified that were verified to continually meet state licensure/certification standards. The denominator is the total number of providers that require a license or certification.**

**Data Source** (Select one):

**Analyzed collected data (including surveys, focus group, interviews, etc)**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

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

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

**Performance Measure:**

**Number/percent of non licensed/non certified providers that continually meet waiver requirements. The numerator is the number of non licensed/non certified waiver**

**providers that continually meet waiver requirements. The denominator is the total number of on-going non licensed/non certified waiver providers.**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

**Xerox**

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Number/percent of new non licensed/non certified providers that meet waiver requirements. The numerator is the number of new non licensed/non certified waiver providers that meet waiver requirements. The denominator is the total number of new non licensed/non certified waiver providers.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

XEROX		
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  Upon Enrollment	

**Data Aggregation and Analysis:**

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

**c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

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

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

**Performance Measure:**

The number/percent of Financial Managers (FM) who received state approved waiver training. The numerator is the number of new FMs who received state approved waiver training. The denominator is the total number of new FMs.

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Number/percent of new case managers who received state approved waiver training. The numerator is the number of new case managers who received state approved waiver training. The denominator is the total number of new case managers.**

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

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

<b>Case Management Teams</b>		
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:
	<b>Other</b> Specify:	

**Data Aggregation and Analysis:**

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

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

The Department does not do criminal background checks; however, Xerox checks with licensing entities within the Department of Labor and Industries, the Office of Inspector General (OIG), Excluded Individual and Entities List, and Medicare exclusion lists prior to enrolling the provider. The hardcopy of the Licensee Lookup System indicates any adverse action or information regarding the enrolled provider and may prevent that individual or agency from being enrolled as a waiver provider. When a provider's license is renewed Xerox will once again check the Excluded Individual and Entities List, Medicare Exclusion list and the Licensee Lookup System prior to re-enrollment of provider. Non licensed/certified providers will be re-evaluated every two years by Xerox to ensure that they still meet department standards. All contracts issued by the Department go through a review process to insure the potential contractor is not on the Federal Debarment List. The Community Services Bureau staff and/or Xerox provide on-going training to agencies, as necessary, to ensure that agencies are informed of relevant changes in state and federal policy and procedure and to assist in the training of new agency oversight staff around program policy and procedure (at agency request). If providers fail to meet the required qualifications, fail the background check or have had their license/certification revoked, they will either not be enrolled or they will be terminated as a waiver provider.

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

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

Providers that do not have the required qualifications, license, or certification for the specific waiver service cannot be enrolled as a waiver provider for that service. If a providers license/certification has been revoked, that agency/individual will no longer be allowed to provide the service. Repayment procedures will be initiated for payment for services provided after the license/certification expiration date. Members will be given a new choice of providers if available and assisted in the transition process.

Independent Advisors (IA) and Financial Managers (FM) will be trained and certified prior to enrollment as a provider. Case Managers (CM) will be trained within the first year of employment. If an IA/FM/CM failed to go through the appropriate training a Quality Assurance Communication (QAC) will be issued and the provider must respond within 30 days explaining the reason for lack of training. Members will be given a new choice of providers. If the IA/FM/CM want to continue to provide the service they must participate in the next scheduled training.

**ii. Remediation Data Aggregation**

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

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

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

**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**

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**C-3: Waiver Services Specifications**

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

**Appendix C: Participant Services**

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**C-4: Additional Limits on Amount of Waiver Services**

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

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

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

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

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

*Furnish the information specified above.*

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

*Furnish the information specified above.*

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

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

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

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

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

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

The process for achieving compliance with the HCBS Settings regulations is identified in response to Attachment #2 and in the Montana HCBS Statewide Transition Plan posted on the Department website at [www.dphhs.mt.gov/hcbs](http://www.dphhs.mt.gov/hcbs). The plan was resubmitted on 12/04/2016. Department staff have been working internally since the December 2016 submission. A Heightened Scrutiny plan has been submitted receiving initial approval.

1. Big Sky Bonanza (BSB) members traditionally reside in their own homes, not congregate living situations. However, in the off chance that a BSB member chooses to use Adult Residential Services and reside in a congregate living facility, the Independence Advisor would work with the member to ensure the settings criteria is met as a part of the process of selecting a provider.
2. The department staff have conducted a Provider Self Assessment process for all current providers to ensure compliance with federal HCB Setting requirements. All new providers must complete the PSA, it is reviewed for compliance and, if not, any changes must be completed before the provider is authorized to become a BSW Medicaid provider. The department staff are working on a plan to complete ongoing reviews of current providers. These reviews will become part of the state's setting plan.

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**

Service Plan

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

**Registered nurse, licensed to practice in the state**

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

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

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

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

*Specify qualifications:*

**Social Worker**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

Members with support of Independence Advisor (IA) and Financial Manager (FM). The qualifications of the IA and FM are specified in Appendix C.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards.** *Select one:*

**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Montana contracts for Case Management Teams, who are required by proposal response and subsequent state contract, to professionally provide and present non-biased information to members regarding all qualified providers of services without influencing the member decision. The member makes the choice of provider.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (3 of 8)

**c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Members will develop the service plan with their Case Management Team (CMT) or Independence Advisor (IA) and Financial Manager (FM). The member may choose to have a support team present to participate in the plan development. The support team may include family, friends, and anyone else of the member's choosing. The CMT will maximize the extent to which a member participates in the service planning process by explaining the person centered planning process; assisting the member to explore and identify his/her preferences, desired outcomes, goals, and the services and supports that will assist him/her in achieving desired outcomes; identifying and reviewing with the member issues to be discussed during the planning process; and giving each member an opportunity to determine the location and time of planning meetings, participants attending the meetings, and frequency and length of the meetings. The member will have the authority to determine who is included in the process of service plan development. The member or his/her legal representative authorizes the service and support plan once it is completed.

Bonanza members selecting to direct their own care receive information and training to assist in service plan development during the participant-direction training. Members will develop the Support Services and Spending Plan (SSSP) with their IA and a support team. The support team may include family, friends, and anyone else of the member's choosing. The IA will maximize the extent to which a member participates in the service planning process by explaining the person centered planning process; assisting the member to explore and identify his/her preferences, desired outcomes, goals and the services and supports that will assist him/her in achieving desired outcomes; identifying and reviewing with the member issues to be discussed during the planning process; and giving each member an opportunity to determine the location and time of planning meetings, participants attending the meeting and frequency and length of the meetings. The self directing member is responsible for directing the plan development process. The IA will assist the member in the plan development, but will not direct the process. The member will receive a copy of the final SSSP upon approval by the Department.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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 service plan is a written plan for services developed by the Case Management Team (CMT) and members to assess and determine the members status and needs. The service plan also outlines the services that will be provided to the members to meet their identified needs as well as the cost of those services. An initial service plan must be developed prior to the member's enrollment. New service plans must be completed at least annually or when the members condition warrants it. The CMT shall consult with the member and/or the member's representative and the attending health care professional. The CMT may also consult family members, relatives, psychologists, medical personnel and other consultants as necessary, with the members approval. The member signs off on the service plan and receives a copy for his/her files.

Each individual service plan shall include at least the following components:

- 1) Diagnosis, symptoms, complaints and complications indicating the need for services;
- 2) A description of the member's functional level;
- 3) Specific short-term objectives and long-term goals, including discharge potential or plan;
- 4) Discharge plan;
- 5) Any orders for the following:
  - a) Medication;
  - b) Treatments;
  - c) Restorative and rehabilitative services;
  - d) Activities;
  - e) Therapies
  - f) Social services
  - g) Diet; and,
  - h) Other special procedures recommended for the health and safety of the member to meet the objectives of the service plan;
- 6) The specific services to be provided, the frequency of services and the type of provider;
- 7) A psychosocial summary describing member's social,emotional, mental and financial situation attached to the initial service plan;
- 8) A cost sheet which projects the annualized costs of HCBS; and
- 9) Signatures of all individuals who participated in the development of the service plan including the member and/or representative and the CMT.

All plans of care are subject to review by the Department. The Department has delegated the review function to HCBS Program Managers or a designated CSB staff. The reviewer is responsible for reviewing all portions of the plan utilizing the criteria outlined below.

Review of the individual service plan will be based on the following:

- 1) Completeness of plan which includes all necessary services listed in terms of amount, frequency and planned providers;
- 2) Consistency of plan with screening information regarding the member needs;
- 3) Presence of appropriate signatures; and
- 4) Cost-effectiveness of plan.

The initial enrollment date is the date the member begins receiving waiver services. This date should be entered in the upper left corner of the Service Plan form and entered into the case notes. The CMT must notify the Eligibility Staff whenever a Medicaid member is being admitted in the waiver program. The Service Plan must provide documentation of

the member's Service Plan costs. It includes all waiver services to be provided, the frequency, amount and projected annualized cost of the services. The CMT prepares the Service Plan cost sheet after the Service Plan has been developed. The cost sheet is completed to determine initial program eligibility and when amendments are made to the Service Plan. A new cost sheet must also be completed at each annual update of the Service Plan. The CMT must explain the cost sheet to the member and/or representative. CMT may complete final cost plan upon return to office and document mailing of form to the member and/or representative. The CMT should review the cost sheet with the member at the six-month visit. The Department determines the Service Plan cost limit. Members who exceed the Service Plan cost limit are not eligible for waiver services except as prior authorized by the Department.

Members in the participant directed option will receive training in preparation for the greater role they play in the SSSP and delivery process. After the training, the IA will support the member to maximize his/her involvement in the SSSP process. The member will actively participate in the definition of his/her needs through the assessment. The summary of member health status and risk factors, as reported by Mountain Pacific Quality Health during the initial level of care determination, will also be provided to the member and the IA to assist in the planning process. The member and IA will convene a service and support planning meeting with individuals of the members choosing, which may include family members, providers, consultants, advocates and friends. The IA will support the member in directing the meeting to develop and complete the member's Service Plan. The Service Plan will describe the member's goals and outline the individualized supports to meet those goals. IA will assure that the SSSP is complete and meets all of the documentations requirements. Within 14 days following the meeting, the member with assistance from the IA as needed, will complete the SSSP. The member and IA will review and sign off on the plan.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

Risk identification and management, including an emergency backup plan, are included in the member's service plan. Appropriate emergency back up plans will be defined and planned for through the completion of the risk assessment form by the member and case manager. The emergency back up plan may include an assessment of critical services and a back up strategy for each identified critical service.

Back up may include:

1. Member backup incorporated into the plan;
2. Informal backup (family, friends, and neighbors);
3. Enrolled Medicaid provider network (personal assistant agencies); and
4. System level (local emergency response).

Back up services can be included and paid for by the waiver program.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

During the development of the plan, the member selects providers from a list prepared by the Case Management Team (CMT) or the Independent Advisor. If the member is unsatisfied with the available agencies, the CMT or the member may solicit other providers for the service who would be required to enroll as a Medicaid provider.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Case Management Teams as the arms of the Department, approve the Service Plan in conjunction with the member. Service Plans for members who exceed the suggested cost limit are approved by the Community Services Bureau (CSB) for heavy care members.

Plans are reviewed for accuracy by the delegated CSB staff during the on-site quality assurance process.

For member direction, the Support Services and Spending Plans are reviewed and approved by the designated CSB staff.

## Appendix D: Participant-Centered Planning and Service Delivery

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

**Medicaid agency**

**Operating agency**

**Case manager**

**Other**

*Specify:*

Independence Advisors and Financial Managers.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

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

used; and, (c) the frequency with which monitoring is performed.

The Case Management Team (CMT) and Independent Advisor (IA)/Financial Manager (FM) monitor the implementation of the Service Plans. The CMT and IAs/FMs meet with the member at least every six months to ensure that selected services are provided as outlined in the plan of care. These meetings also address health and welfare of the member. The monitoring visits will include a review of the member's service utilization history, a review of usage and effectiveness of the emergency back up plan and an evaluation of the quality and effectiveness of services. The CMT or IA/FM will identify any problems that need to be addressed and document the strategy to attend to the issue and the work on resolution. Serious Occurrence Reports (SOR) are mandated for incidences in which the members health and safety are at risk. These reports are sent to the Regional Program Officers (RPO) for review. The RPO will become involved in problem solving strategies, as needed, to assist in resolution of issues beyond the scope of the member, the CMT and IA/FM. The semi-annual monitoring will also include a review of member access to non-waivers services identified in the service and support plan.

The CMT/IA/FM and service providers are mandatory reporters of abuse, neglect, and exploitation. The CMT/IA/FM will complete an SOR and file a report with the appropriate entity and send a copy of the report to the RPO for quality assurance monitoring. In addition, they consult with Central Office on any SOR that is not resolved at the local level, patterns that may be occurring or needed system changes as a result of reports.

Also see H Quality Assurance Section.

**b. Monitoring Safeguards. *Select one:***

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The entities are monitored by the RPOs on an on-going basis and by the designated CSB staff during the quality assurance process to ensure implementation of plan of care and member health and welfare. When an entity provides Case Management, IA and other waiver services they must assure administrative separateness. Members are to be offered non-biased information of all qualified providers available to provide services to the member. The member's chart must contain documentation that choice of providers procedures were completed.

**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/percent of members who have service plans that address identified needs, including health and safety, as indicated in the assessment. The numerator is the number of participant service plans that addressed all of the participants' identified needs (including health and safety risk factors). The denominator is the total number of service plans reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text" value="10 percent or a minimum of 5 records."/>
	<b>Other</b> Specify:	

	Every Three Years	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

Number/percent of members who sign their service plans indicating that their needs and personal goals, including health and safety, are being met. The numerator is the number of plans that meet member's goals and needs. The denominator is the total number of members.

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		Interval = <input type="text"/>
<b>Other</b> Specify:  <input type="text" value="Case Management Teams IA"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text" value="Plan Development"/>	

**Data Aggregation and Analysis:**

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

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

*procedures.*

**Performance Measures**

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

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

**Performance Measure:**

**Number/percent of members' traditional service plans developed in conjunction with the Case Management Team (CMT). The numerator is the number of members' service plans developed in conjunction with the CMT. The denominator is the total number of service plans.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

	Specify:	
	<input type="text" value="Plan Development"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**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/percent of members' service plans that were updated/revised at least every 180 days or as warranted by changes in the members' needs. The numerator is the number of reviewed members' service plans that were updated/revised within 180 days or sooner if needed. The denominator is the total number of service plans.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**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/percent of members who received services in the type, scope, amount, duration and frequency as specified in the service plan. The numerator is the number of members who received services in the type, scope, amount, duration and frequency as specified in service plan. The denominator is the total number of members.**

**Data Source** (Select one):

**Financial records (including expenditures)**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

*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/percent of new participant records with appropriate documentation that specifies choice was offered between institutional care and waiver services. The numerator is the number of new participant records with appropriate documentation that specified that choice was offered between institutional and waiver services. The denominator is the total number of new participants.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

	Specify:	
	<input type="text" value="Upon enrollment"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

**Number/percent of new participant records with service plan signed by the participant (or personal representative) indicating choice of waiver services and providers. The numerator is the number of new participant records with a service plan signed by the participant (or personal rep) indicating choice of waiver services and providers. The denominator is the total number of new participants.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="Case Management Team IA"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text" value="Upon Enrollment"/>	

**Data Aggregation and Analysis:**

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

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

Designated Community Services Bureau (CSB) staff will conduct on-site review of Case Management Teams (CMT) at least every three years. (However, at any time if a significant issue or deficiency is discovered, a targeted review would be completed and include on-site activities.) Assessing the Service Plan is part of that process. The CSB staff will address any errors or missing information with the CMT for correction. When a plan is not developed in accordance with program policy and procedure the CSB staff work with the CMT to take appropriate corrective action. The CSB staff will respond to any immediate concerns related to the health and safety of the member. Data collected in the review will be entered into the quality assurance database and a report will be submitted to CSB for approval. Issues identified will be shared with CMTs through a Quality Assurance Communication (QAC). CMTs are required to respond to the QACs with resolution efforts according to the specified time frames. All QACs corresponding to a review must be resolved and returned to CSB prior to closure of the review. If a CMT identifies areas of non-compliance during their internal audits, they will take action to immediately rectify the problem and update the Service Plan if necessary. If CSB staff identify a significant discrepancy between scope of services in plan and amount of services actually provided the case will be referred to the Regional Program Officer for follow up with the CMT.

Case Management Teams are required to complete a Quality Improvement Project (QIP) quarterly and submit the QIP to the Regional Program Officer for review. The QIP topic identified must be specific, measurable and relevant to the quality and/or policy implementation of waiver services provided to members participating in the program.

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

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

When plans do not indicate that the following performance measures were met the CMT or the IA will immediately set up a meeting with the member to review the appropriate documentation and/or sign the Service Plan.

The performance measure requires the following:

- 1) Indication that the Service Plan meets personal goals and needs including health and safety;
- 2) Traditional service plans developed in conjunction with the CMT;
- 3) Indication that member received choice between institutional care and waiver home and community based services;
- 4) Indication that member received choice of services and service providers; and
- 5) 180 day service plan re-evaluation

If there appears to be a pattern of failure to do this within an CMT, a written remediation plan will be required within 30 days describing initiated safeguards to ensure plans will meet the performance standards.

If during on-site reviews and meetings with members, the designated CSB staff determine that service plans do not sufficiently address members' needs, they will initiate a Quality Assurance Communication. The CMT will have 30 days to respond with a remediation plan to correct the deficiency. If necessary, the RPO will follow up with training or further instructions for the agency. When the service plan review is not completed within 180 days, the CSB staff will initiate a Quality Assurance Communication. The CMT will have 30 days to respond with a remediation plan to correct the deficiency.

When paid claims indicate that services were not provided in type, scope, amount, duration and frequency as indicated in the service plan, the designated CSB staff will immediately issue a Quality Assurance Communication to the agency requesting an explanation of any discrepancy and remediation plan within 30 days.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

**No**

**Yes**

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

## Appendix E: Participant Direction of Services

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**Applicability** (from Application Section 3, Components of the Waiver Request):

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (select one):

**Yes. The state requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

**Nature of the Opportunity (referred to as the Bonanza option):**

Individuals of all ages (and/or their legal guardians or parents) may self direct some or all of their services as well as accessing traditional agency-based delivered services as needed. They are provided the opportunity: 1) to select and manage staff who perform personal assistant type services under the category of Community Support Services (Employer Authority) and 2) to purchase allowable goods and services using a self-direct budget (Budget Authority). Members may also direct: Member Goods and Services, and Private Duty Nursing.

Members may also access other services, that are available under the traditional provider-managed model. Members may elect to receive traditional services and/or member-directed services but, at a minimum, must select to direct Community Support Services and Member Goods and Services if they have selected the member-directed option.

**How Participants May Take Advantage of the Bonanza Option:**

Upon intake into the waiver, case managers will inform every applicant about member directed option. When an member on the waitlist becomes eligible for a waiver slot the case manager will inform them of the Bonanza option at that time. If a member indicates initial interest in the program designated staff will provide an orientation guide about the self-direct opportunities with the waiver. Waiver members will have the option to select either the traditional elderly/disabled model or the Bonanza option. The member will be given extensive information about unique service offerings available under Bonanza during the member training.

**Entities Who Support Members:**

Members will be able to choose from several agencies and individuals providing support services, ensuring they are successful with the member-directed experience. Once a member receives orientation material and selects Bonanza, they will receive Bonanza training. The Independence Advisor will work with the member to develop a service and support plan (plan of care). Once the service and support plan is developed and approved and the self-direct budget has been authorized the IA and the member will begin implementation. During the implementation and management of the service and support plan, the IA will: 1) advise, train, and support the member, as needed and necessary, 2) assist with the development and execution of the spending plan and negotiate payment rates, 3) assist to develop an emergency back-up plan, 4) identify risks or potential risks and develop a plan to manage those risks, 5) assist with recruiting, interviewing, hiring, training, managing, and/or dismissing workers, and 6) assist with monitoring health and welfare. This position will also serve as an advocate agent to the member and will provide training to promote self-advocacy.

The IA and member will routinely interact with the Financial Manager (FM). The Division will maintain a list of certified FMs. FM entities will have the opportunity to present their services to interested waiver members at the training. Members have an opportunity to ask questions of each entity and select the FM provider of their choice. The FM will: 1) complete all necessary payroll and employment forms, 2) report and pay payroll and employment tasks, 3) monitor and manage the spending plan, 4) certify and enroll the IA, and 5) monitor spending in the services and supports plan.

The designated CSB staff will approve each member's service and support plan, self-direct spending plan, emergency plan, and plan to manage risks to ensure health and welfare are safeguarded.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver.  
*Select one:*

**Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

**Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

**Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

**The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

## Appendix E: Participant Direction of Services

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### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

**Waiver is designed to support only individuals who want to direct their services.**

**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The most important component of the outreach strategy is developing and disseminating material to inform current and potential members about the benefits and potential liabilities of self-directing under the Bonanza option. Member material will include a general overview of the program (HCBS brochure) and comprehensive details specific to self-direction and member responsibilities and liabilities (orientation guide and member manual).

Division and community partners provide a member orientation guide to all waiver members who indicate an interest in HCBS. The orientation guide will describe the member-direct options with HCBS and emphasize rights and responsibilities and potential liabilities associated with self-direction. The orientation guide will be provided prior to entrance to the HCBS waiver.

When a member decides to participate in the Bonanza option, he/she attends a training session and receives a member training manual that outlines program policy and procedures, the member is assigned an Independence Advisor (state staff), provides skill assessment and training related to member-direction, and outlines the person centered planning support and service plan development process. The training will occur prior to entrance into the Bonanza option and development of the service and support plan.

At any time during the outreach stages a member is free to opt out of the Bonanza option and select to receive services via the traditional provider managed model.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

**The state does not provide for the direction of waiver services by a representative.**

**The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: (*check each that applies*):

**Waiver services may be directed by a legal representative of the participant.**

**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A personal representative will be required for any potential enrollee who has impaired judgment as identified on the assessment tool and/or is unable to:

- 1) Understand his/her own personal care needs;
- 2) Make decisions about his/her own care;
- 3) Organize his/her lifestyle and environment by making these choices;
- 4) Understand how to recruit, hire, train, and supervise providers of care;
- 5) Understand the impact of his/her decisions and assume responsibility for the results; or
- 6) When circumstances indicate a change of competency or ability to member-direct demonstrated by non-compliance with program objectives.

The potential enrollee, Mountain Pacific Quality Health, a Case Manager, CSB, the FM or the IA may request a personal representative be appointed. A personal representative may be a legal guardian, or other legally appointed personal representative, an income payee, a family member, or friend. The personal representative must be willing and able to fulfill the responsibilities as outlined in the Personal Representative Agreement and must demonstrate:

- 1) A strong personal commitment to the member;
- 2) Ability to be immediately available to provide or obtain back up services in case of an emergency or when an attendant does not show;
- 3) Demonstrate knowledge of the members preferences;
- 4) Agree to predetermined frequency of contact with the member;
- 5) Be willing and capable of complying with all criteria and responsibilities of members;
- 6) Be at least 18 years of age; and
- 7) Obtain the approval from the potential enrollee and/or a consensus from other family members to serve in this capacity if applicable.

A personal representative may not be paid for this service nor be the member's IA, a paid worker of Community Support-Bonanza Services or paid to provide any other waiver service to the member. The overall management of personal representatives will assist CSB to assure health and welfare of each member in Participant Direction. Each personal representative will be required to complete and sign a Personal Representative Agreement and an Authorized Personal Representative Designation Form and attend the member training.

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Consumer Goods and Services		
Private Duty Nursing		
Community Supports		

Waiver Service	Employer Authority	Budget Authority
Independence Advisor		

**Appendix E: Participant Direction of Services**

**E-1: Overview (7 of 13)**

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

**Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

**Governmental entities**

**Private entities**

**No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

**Appendix E: Participant Direction of Services**

**E-1: Overview (8 of 13)**

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

**FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

Financial Management

**FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services are provided by a variety of entities that meet the provider qualifications for this service. This could include: Independent Living Centers, Self Direct Personal Assistance Service Provider Agencies and Case Management Provider Agencies.

Interested potential providers express their interest to the SLTC Division and begin the process of becoming a FM provider: meeting initial provider qualifications, passing a readiness review, completing required training and receiving certification.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

N/A

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

**Assist participant in verifying support worker citizenship status**

**Collect and process timesheets of support workers**

**Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

**Other**

*Specify:*

Upon request by member, complete criminal background checks on prospective providers/attendants and maintain the results on file.

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Supports furnished when the participant exercises budget authority:

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**Maintain a separate account for each participant's participant-directed budget**

**Track and report participant funds, disbursements and the balance of participant funds**

**Process and pay invoices for goods and services approved in the service plan**

**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

**Other services and supports**

*Specify:*

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Additional functions/activities:

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**Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

**Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

**Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

**Other**

*Specify:*

**iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

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

The designated CSB staff provide Bonanza option program manuals to every provider, train FM providers before they enroll and will provide ongoing training to agencies, as necessary, to ensure that agencies are informed of relevant changes in state and federal policy and procedure and to assist in the training of new agency oversight staff around program policy and procedure (at agency request).

FM providers submit quarterly report cards and utilization reports to the CSB. On-site follow up review are conducted every three years or more frequently if necessary. In between the designated CSB staff monitor FMs on an on-going basis utilizing quality assurance communications.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

**Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

**Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Post Acute Rehabilitation Services	
Audiology	
Consultative Clinical and Therapeutic Services	
Specialized Child Care for Medically Fragile Children	
Occupational Therapy	
Homemaker	
Community First Choice/Personal Assistance and Specially Trained Attendant Care	
Respite	
Environmental Accessibility Adaptations	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Physical Therapy	
Dietetic Services	
Consumer Goods and Services	
Family Training and Support	
Personal Emergency Response Systems	
Vehicle Modifications	
Homemaker Chore	
Senior Companion	
Nutrition	
Respiratory Therapy	
Financial Management Services	
Supported Employment	
Residential Habilitation	
Pain and Symptom Management	
Private Duty Nursing	
Community Supports	
Community Transition	
Specialized Medical Equipment and Supplies	
Speech Therapy	
Supported Living	
Prevocational Services	
Case Management	
Non-medical Transportation	
Day Habilitation	
Health and Wellness	
Adult Day Health	
Independence Advisor	

**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

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### 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:*

Independent Advisors must complete the Department's mandatory training before providing services. IA Agencies must be able to assure that IA employees have no vested interest in who is selected to provide services and that members have the choice of providers and type of services. Before providing BSB services, the IA Agency must provide the Department with a statement describing which BSB services will be provided in addition to the IA services with assurance there are no other providers available to provide the service(s) in the geographical area. The statement should include assurances that the services are included in the member's Support Services Spending Plan.

## Appendix E: Participant Direction of Services

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### E-1: Overview (11 of 13)

**i. Voluntary Termination of Participant Direction.** Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Members in Bonanza participant direction (HCBS) may, at any time, return to the traditional provider managed model. Members will notify their Independence Advisor (IA) of their intention. The IA and the case managers will coordinate services and supports to ensure that no break in vital services and a timely revision of the service plan occurs. The reason for the return will be recorded and information will be entered into the QA database as part of the QA management strategy.

## Appendix E: Participant Direction of Services

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### E-1: Overview (12 of 13)

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

When the quality management system identifies an instance where the participant-directed option is not in the best interest of the member and corrective action (additional training or change of a personal representative, etc.) does not ameliorate the situation, the member will be informed in writing of the plan to transfer to the traditional provider managed service delivery model. This could occur due to failure to follow self-direct policies, mismanagement of the individual budget or failure to participate in the planning of their services. CSB, in collaboration with the IA and case manager will ensure that no break in vital services and a timely revision of the service plan occurs. The member may appeal this decision by requesting a fair hearing through the Department of Public Health and Human Services Fair Hearing process.

## Appendix E: Participant Direction of Services

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**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**

	<b>Employer Authority Only</b>	<b>Budget Authority Only or Budget Authority in Combination with Employer Authority</b>
<b>Waiver Year</b>	<b>Number of Participants</b>	<b>Number of Participants</b>
<b>Year 1</b>	<input type="text"/>	<input type="text" value="32"/>
<b>Year 2</b>	<input type="text"/>	<input type="text" value="32"/>
<b>Year 3</b>	<input type="text"/>	<input type="text" value="33"/>
<b>Year 4</b>	<input type="text"/>	<input type="text" value="34"/>
<b>Year 5</b>	<input type="text"/>	<input type="text" value="35"/>

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant Direction (1 of 6)**

**a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

**Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The Financial Management service entity functions as an agency with choice model.

**Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- Hire staff common law employer**
- Verify staff qualifications**
- Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Costs for criminal background checks will be included in the reimbursement to the FM.

**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:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

#### b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Every member in the Bonanza option has access to a self-direct budget to hire staff and purchase approved services, supports and goods. CSB will manage the overall budget with the intent of maintaining cost neutrality and ensuring that money is allocated according to member need, as outlined in the service and support plan. The self-direct budget will represent a portion of the total budget for the waiver member.

Bonanza members, working with their IA and a support team of their choosing, will assess their needs, develop their goals based on needs, and develop a service and support plan (plan of care) to meet their goals. This plan may include both traditional provider-managed and self-direct services. Once all of the members goals are addressed they are prioritized and the services the member has selected to self-direct are priced-out into a spending plan. The member and IA will receive training on developing an individual self-direct budget to ensure consistency in the budget development process across consumers. Ongoing training will be provided, upon request, by the designated CSB staff.

When CSB approves the service and support plan they authorize traditional service use, which is accessed using the normal procurement process, and authorize services that the member has elected to self-direct, which is the Bonanza budget amount. The Waiver Program Managers will make the final determination on all Bonanza budget amounts. CSB will develop and monitor the members waiver budget using the same methodology in place for the traditional model to ensure consistency across the two and within the self-direct waiver. The process involves a designation from MPQH, assessment to identify needs, development of goals based on needs, and agreement on the type and amount of services and supports needed to meet the goals. Policy and rate methodology are posted on the Division's website and available to the public.

The self-direct budget is calculated over a twelve month time period. The self-direct budget amount is what the member will use to direct all member directed services and supports, as designated in his/her Support Service and Spending Plan. The FM assists the member in managing his/her self-direct budget.

Members have the authority to decide which services, goods or supports to purchase and how much money to pay for each item within the self-direct budget. A suggested range of rates for services is available as a point of reference for the planning stages.

Members will have the ability to designate and allocate dollars within their self-direct budget, during the fiscal year, for larger one-time purchases. These dollars may be used to purchase goods and services outlined in the service and support plan.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

#### b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

CSB will determine a self-direct budget amount and will inform the member of the amount. Each member, with the assistance of his or her IA, will develop a support and service plan and a self-direct spending plan, using this amount, and submit it to CSB for approval. The member and IA will use the self-direct budget amount to finalize the monthly spending plan for self-direct services and submit it to the FM. The member may contact the FM at any time during the month to determine his or her balance and the FM will apprise the member of the budget amount at least monthly through a monthly spending report. During the member training the member is informed of the procedure for requesting an adjustment to the self-direct budget amount. The member is offered the opportunity to request a Fair Hearing when his/her request for an adjustment to the budget is denied or the amount of the budget is decreased.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

#### b. Participant - Budget Authority

- iv. Participant Exercise of Budget Flexibility.** *Select one:*

**Modifications to the participant directed budget must be preceded by a change in the service plan.**

**The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Members have flexibility to manage their services and modify their self-direct budget without requiring the prior preparation of a revised service plan. Self-direct funds may be reallocated when the following criteria are met:

1. the change is within a service category that has been selected for self-direction;
2. the change does not change the total dollars allocated for the member-direct service category; and
3. the change includes only those supports and services that are authorized in the members support and service plan.

Members must notify the FM when they plan to exercise their authority to reallocate funds prior to implementing the changes. Upon making the change the member must meet with the IA to document the changes in the service and support plan.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

#### b. Participant - Budget Authority

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Monitoring oversight of the self-direct budget is the responsibility of the FM and IA. The FM will provide written balances of the members spending plan at least monthly to the member and IA and at the request of the member, the IA or CSB.

The FM will monitor expenditure, flag significant budget variances, and ensure that the purchase of goods and services and submitted timesheets match the members self-direct spending plan. Incidents of over expenditure are handled on an incident-by-incident basis by the FM. The FM will meet with the member on a semi-annual basis to review budget expenses and respond to any concerns.

The IA will track underutilization monthly and contact the member to resolve potential service delivery problems.

The self-direct budget is calculated in twelve-month increments. The member is responsible for developing a monthly self-direct spending plan, which will be utilized to track over and under expenditures.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Members are notified of the fair hearing process when they complete the Medicaid application. They are also notified of the fair hearing process when they are notified of the choice of waiver vs. institutional services during the Mountain Pacific Quality Health level of care assessment. If a member is denied services, disenrolled from the program, have services suspended or reduced, they are again provided fair hearing rights in writing.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

**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

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### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All persons employed by an agency participating in the Medicaid program, pursuant to MCA 52-3-811, are mandatory reporters of suspected abuse, neglect or exploitation of children, elderly, or members with disabilities. They are also required to complete a Serious Occurrence Report (SOR), utilizing the Quality Assurance Management System (QAMS) database, when a situation calls for it. A SOR must be completed anytime an individual's life, health, or safety has been put at risk. This includes all reports that meet the guidelines for suspected abuse, neglect or exploitation (MCA 52-3-803) submitted to Adult Protective Services or Child Protective Services. In addition, circumstances warranting a SOR include:

1. suspected or known physical, sexual, emotional or verbal abuse;
2. neglect of the member, self-neglect or neglect by responsible caregivers;
3. sexual harassment by an agency employee or member;
4. any injury that results in hospital emergency room or equivalent level of treatment. The injury may be either observed or discovered. An SOR would be required for any injury that occurred within the last 90 days;
5. an unsafe or unsanitary working or living environment which puts the worker and/or member at risk;
6. any event which is reported to APS, CPS or Law Enforcement, the Ombudsman or QAD/Licensing;
7. referrals to the Medicaid Fraud Control Unit (MFCU);
8. psychiatric emergencies - admission to a hospital or a mental health facility for a psychiatric emergency;
9. medication emergency when there is a discrepancy between the medication that a physician prescribes and what the individual actually takes and which results in hospital emergency room or equivalent level of treatment or hospital admission; or any medication error occurring during the provision of Medicaid reimbursed nursing services; and
10. suicide, suicide attempt or suicide threat.

All designated service providers are mandated to complete a SOR utilizing the QAMS database within ten working days of receiving information or witnessing the incident. The provider agency must document cause and effect of the incident and the action plan to correct or prevent incidents from occurring in the future. The RPO is responsible for ensuring an appropriate response by the provider agency.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information on identifying, addressing, and protecting someone from abuse, neglect and exploitation and how to notify the appropriate authorities is provided to members upon admission to the waiver and annually thereafter, by the case manager or independence advisor/financial manager. Members can also access information on the Divisions website at [www.http://dphhs.mt.gov/sltc](http://dphhs.mt.gov/sltc). Additional information on incident management, abuse, neglect and exploitation and member protection may be covered as needed at ongoing consumer training sessions and CSB member focus groups.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Investigations involving Abuse, Neglect and Exploitation and/or criminal activity:

Reports of abuse, neglect and exploitation are made to Adult Protective Services (APS) or Child Protective Services (CPS) for evaluation, reporting, and investigation. Adult and Child Protective Services are emergency intervention activities which may include: investigating complaints, coordinating family and community support resources, strengthening current living situations, developing and protecting personal financial resources and facilitating legal intervention. All reports come through a centralized intake hotline where trained staff assess the situation and send a report to field staff. Local APS or CPS social workers evaluate, assess, prioritize and follow-up on all cases within their jurisdiction.

Child Protective Services are provided to children under 18 in the state of Montana. The timeline for response to CPS reports depends on the incident. Any report that is assessed at the level of eminent danger is responded to within 24 hours. For all other reports response time varies depending on the nature of the report, location, and whether local law enforcement is involved. Before a case is closed a safety assessment is conducted to assess whether appropriate action was taken.

Adult Protective Services are provided to persons over the age of 60, physically or mentally disabled adults (as defined by the Department through SSI or vocational rehabilitation) and adults with developmental disabilities who are at risk of physical or mental injury, neglect, sexual abuse or exploitation. APS provides voluntary protective services to any individual in their jurisdiction. However, APS is unable to provide involuntary protective services to physically or mentally disabled adults. All APS reports are assessed by regional supervisors for eminent risk and capacity of the individual. Cases are triaged using social work methodology and serious cases are responded to first. A computer data system has a built in alert system to track cases and open investigations. Any report that is referred for investigation has 90 days to be closed.

The Division coordinates with APS and CPS at their direction and request. Each investigation will be different and we will become involved only to the extent that they direct. APS and CPS notify participants and/or their legal representatives concerning investigative results. Division staff would coordinate and assist at their request.

In situations where APS cannot follow up (i.e. incident is outside scope of APS jurisdiction or the individual doesn't substantiate the report) the RPO is notified and provides necessary referral and follow up (see SOR below).

APS, CPS, Medicaid providers and RPOs make referrals, when necessary, to local law enforcement or other entities. Referrals to local law enforcement include illegal activities, theft, embezzlement and incidents involving significant abuse.

Incidents and events outside the scope of APS, CPS or local law enforcement authority are reported to the pertinent provider agency. The agency investigates the incident and provides follow-up, when needed. The provider agency (or in the case of self-direct services the IA and the member) document the scope of the incident, the incidents cause and effect, and work with the member to develop an action plan to correct or prevent the incident from occurring in the future. This information is captured on a Serious Occurrence Report (SOR), within the QAMS database and must be submitted within 10 days of the incident (or knowledge of the incident). The IA will follow up on SOR outcomes during the monthly member meeting and track follow-up activity in the members file. When needed the IA will assist with modifications to the member Service and Support plan to prevent future incidents. The RPO is responsible for insuring an appropriate and timely response is provided by the provider agency and/or IA and member. On the SOR form there is a section where the RPO may comment on the incident and mark any follow-up action taken, including providing training, case conference, and/or sanctions.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The CSB Central Office is responsible for overseeing the operation of the serious occurrence incident management system. All critical events or incidents involving a member warrant a Serious Occurrence Report (SOR) that is entered into the QAMS database and submitted to the local RPO who oversees the incident management process and ensures that appropriate reporting and follow-up occurs at the local level. The RPO will enter follow up and resolution activities related to the SOR into the QAMS database. The RPO will use the QAMS database to generate a quarterly SOR Report and submit it to the CSB Central Office. The QAMS database and summative reports will capture information on incident type, member characteristics, incident response time, and remediation outcomes and timeliness.

The quarterly SOR report will be analyzed and reviewed at the CSB Central Office QA meetings. Central Office staff will use the reports to track trends and patterns in serious occurrence reporting. During the QA meetings prevention strategies will be developed to respond to patterns and trends. The Central Office staff will also work with the QA Team to establish benchmarks for incident management activity and develop strategies to achieve positive outcomes.

As necessary, APS or CPS and Central Office Staff will work together to develop and implement strategies for prevention using reports from their respective databases.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

**The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Department of Public Health and Human Services/Senior and Long Term Care Division (SLTC) is responsible for detecting unauthorized use of restraints or seclusion. Community Services Bureau (CSB) designated staff perform routine quality assurance reviews that include home visits with members and standards for member satisfaction. CSB staff also provide ongoing training with providers and members to assure health and welfare. The Division operates a serious occurrence reporting system as a part of the overall quality management of the waiver. Serious occurrence reports (SOR) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the QA reviews of providers to assure appropriate reporting and resolution of incidents.

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one):*

**The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Public Health and Human Services/Senior and Long Term Care Division (SLTC) is responsible for detecting unauthorized use of restrictive interventions. Community Services Bureau (CSB) staff perform routine quality assurance reviews that include home visits with members and standards for member satisfaction. CSB staff also provide ongoing training with providers and members to assure health and welfare. The Division operates a serious occurrence reporting system as a part of the overall quality management of the waiver. Serious occurrence reports (SOR) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the QA reviews of providers to assure appropriate reporting and resolution of incidents.

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

**The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Department of Public Health and Human Services/Senior and Long Term Care Division (SLTC) is responsible for detecting unauthorized use of restraints or seclusion. Community Services Bureau (CSB) staff perform routine quality assurance reviews that include home visits with members and standards for member satisfaction. CSB staff also provide ongoing training with providers and members to assure health and welfare. The Division operates a serious occurrence reporting system as a part of the overall quality management of the waiver. Serious Occurrence Reports (SOR) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the QA reviews of providers to assure appropriate reporting and resolution of incidents.

**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

**No. This Appendix is not applicable** (*do not complete the remaining items*)

**Yes. This Appendix applies** (*complete the remaining items*)

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Staff in licensed assisted living facilities and group homes provide medication management. They are responsible for keeping track of medication and ensuring the members take their medication as prescribed. Medication is secured as required by the Department of Labor and Industry to restrict access by residents. In addition group home staff are required to take a test and be licensed to manage and administer medication.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The state Licensing Bureau of the Medicaid Agency ensures appropriate medication management during quality assurance reviews. The reviews are conducted every 1-3 years. Case managers ensure that waiver members receive their medication as prescribed and report any mismanagement, harmful practices or crimes to the appropriate authorities. Case managers are also required to complete a serious occurrence report (SOR) in those instances.

The SOR system is used as a repository for reporting and monitoring serious incidents that involve members. Information is analyzed to assist the member, family and provider agency in the development, implementation and modification of the member's service plan and to assist the Department in program wide quality oversight, accountable and improvement efforts.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

##### i. Provider Administration of Medications. *Select one:*

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

##### ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Licensed practical nurses, registered nurses and licensed medication aides administer medication in accordance with the Montana Nurse Practice Act. Under the self-directed Community First Choice/Personal Assistance Services (CFC/PAS) option the administration of medication by personal assistants is exempt from the Nurse Practice Act. Member requirements to participate in the CFC/PAS self-directed option:

ARM 37.40.1101 - 1135 CFC/PAS, member requirements: To qualify for self-directed CFC/PAS, the member must: have a medical condition which results in the need for personal assistance services; be capable of assuming the management responsibilities of assistants or have an immediately involved representative willing to assume this responsibility; have authorization from a physician or health care professional to participate in the program; and be capable of making choices about activities of daily living, understand the impact of these choices and assume the responsibility of the choices. The member must be capable of acting as though the personal assistant is their employee for the purposes of selection, management and supervision of the personal assistant, although the personal assistant is the employee of a self-directed personal assistance provider. The member has the primary responsibility in the scheduling, training and supervision of the personal assistant. The member has the right to require that a particular assistant discontinue providing services to the member. The member may have an immediately involved representative assume some or all of the responsibilities imposed by this rule. An immediately involved representative is a person who is directly involved in the day to day care of the member. An immediately involved representative must be available to assume the responsibility of managing the member's care, including directing the care as it occurs in the home.

37.40.1007 self-directed personal assistance services, general requirements The member may be authorized to have the personal assistant perform health maintenance activities. These include urinary system management, bowel treatments, administration of medications and wound care.

##### iii. Medication Error Reporting. *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

*Complete the following three items:*

(a) Specify state agency (or agencies) to which errors are reported:

Serious Occurrence Reports must be submitted to the local RPO of the Community Services Bureau whenever there is an issue concerning medication errors or possible mismanagement of medication.

(b) Specify the types of medication errors that providers are required to *record*:

Providers must record medication doses missed or refused by member and why, and unexpected effects of medication or medication error.

(c) Specify the types of medication errors that providers must *report* to the state:

Providers must report a Medication Emergency: When there is a discrepancy between the medication that a physician prescribes and what the member actually takes, and this results in hospital emergency room or equivalent level of treatment or hospital admission; or any medication error occurring during the provision of Medicaid reimbursed nursing (PDN, Home Health or Hospice) services.

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The State Medicaid agency is responsible for monitoring the performance of waiver providers. Licensed facilities are reviewed by the state Licensing Bureau and Xerox. Case managers and IA/FM monitor medication management of their members by outside providers.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

**a. Methods for Discovery: Health and Welfare**

*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

**a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1,*

2014.)

**Performance Measures**

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

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

**Performance Measure:**

**Number/percent of SORs including instances of abuse, neglect and exploitation that received appropriate response and follow up by waiver personnel within the required time frame. The numerator is the number of SORs that received response and follow up by waiver personnel within the required time frame. The denominator is the total number of reported SORs.**

**Data Source** (Select one):

**Analyzed collected data (including surveys, focus group, interviews, etc)**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1442 1262 1525" type="text"/>
Other Specify: <input data-bbox="408 1666 644 1749" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1666 1262 1749" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1890 1262 1973" type="text"/>

	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**Number/percent of serious occurrence reports (SOR), including instances of abuse, neglect and exploitation, that were reported within the required timeframes. The numerator is the number of SORs that were reported within the required timeframe. The denominator is the total number of reported SORs.**

**Data Source (Select one):**

**Analyzed collected data (including surveys, focus group, interviews, etc)**

If 'Other' is selected, specify:

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

<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number/percent of new participants/legal representative who received information/education regarding reporting of abuse, neglect and exploitation. The numerator is the number of new participants/legal representative who received information on reporting abuse, neglect, and exploitation. The denominator is the total number of new participants/legal representative.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number/percent of participants/legal representative who received the annual information/education regarding reporting of abuse, neglect and exploitation. The numerator is the number of participants/legal representative who received the annual information on reporting abuse, neglect, and exploitation. The denominator is the total number of participants/legal representative.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">Case Management Team</div>	<p><b>Annually</b></p>	<p><b>Stratified</b> Describe Group:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">Upon enrollment</div>	

**Data Aggregation and Analysis:**

<p><b>Responsible Party for data aggregation and analysis</b> (<i>check each that applies</i>):</p>	<p><b>Frequency of data aggregation and analysis</b>(<i>check each that applies</i>):</p>
<p><b>State Medicaid Agency</b></p>	<p><b>Weekly</b></p>
<p><b>Operating Agency</b></p>	<p><b>Monthly</b></p>
<p><b>Sub-State Entity</b></p>	<p><b>Quarterly</b></p>
<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>	<p><b>Annually</b></p>
	<p><b>Continuously and Ongoing</b></p>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>

**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 of incidents reported that have been effectively resolved and will the extent possible prevent similar incidents. The numerator is the number of incidents reported that have been effectively resolved and will the extent possible prevent similar incidents. The denominator is the total number of incidents reported.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text" value="At least every three years in conjunction with the Quality Assurance Review."/>

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

**Performance Measures**

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

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

**Performance Measure:**

**Number of members subject to prohibition of restrictive intervention where intervention was applied in accordance with policies/procedures. Numerator is the # of members subject to prohibition of restrictive intervention where the prohibition of restrictive intervention policies/procedures are followed. The denominator is the total# of members subject to prohibition of restrictive intervention.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     At least every three years in conjunction with the Quality Assurance Review.                 </div>

**d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

**Performance Measures**

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

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

**Performance Measure:**

**The numerator is the total number of standards met by all case management teams.  
 The denominator is the total number of standards applied to case management teams.  
 (Calculated as the number of standards multiplied by the number of case management teams.)**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		<input type="text"/>
<b>Other</b> Specify:  <input type="text" value="Case Management Team"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text" value="At least every three years in conjunction with Quality Assurance Reviews."/>

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

The Regional Program Officer (RPO) will review all Serious Occurrence Reports(SORs), entered in the QAMS database, on an ongoing basis. They will review for incident type, response time and remediation activities. CSB Central Office staff will review SORs and RPO responses on a quarterly basis. The QAMS database will generate a SOR report on a quarterly basis. Staff of the CSB will provide information to all members and providers on how to identify and report abuse, neglect and exploitation.

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

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

In instances in which members have not received the appropriate information, Serious Occurrence Reports (SOR) were not responded to in a appropriate time frame or SORs did not receive the appropriate follow-up, the RPO or Program Managers will issue a Quality Assurance Communication to which the provider must respond within a given time frame and action steps.

As part of the ongoing review of SORs, the RPO, when necessary, will take immediate and appropriate action to remediate situations when the health or welfare of a member has not been safeguarded. The quarterly SOR report will be analyzed and reviewed at the Central Office QA team meetings. During the QA team meetings prevention strategies will be developed to respond to patterns and trends. As necessary, APS, CPS and CSB will work together to develop and implement strategies for prevention.

**ii. Remediation Data Aggregation**

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

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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)

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Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 3)

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### H-1: Systems Improvement

**a. System Improvements**

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Community Services Bureau of the Department conducts a comprehensive evaluation of services to HCBS recipients to meet the Bureau's quality assurance requirements. Department staff will perform announced quality assurance reviews. The purpose of the review is to insure that optimal services are being provided to members and that program rules and policies are being followed. Quality assurance results are utilized to improve the programs and services.

The Quality Management (QM) process involves a strategy to ensure that individual members have access to and are receiving the appropriate services to meet their needs. This requires on-going development and utilization of individual quality standards, and working with case management teams, IA/FM and other providers to evaluate individualized personal outcomes and goals. Case management teams and FMs are required to complete Quality Improvement Projects (QIP) and submit findings to designated CSB staff quarterly.

The QM process also involves the CSB Quality Assurance (QA) Reviews. The QA review is a strategy designed to collect and review data gathered from providers and individual members on quality assurance measures. Provider standards and quality indicators are used to ensure that quality assurances are met. In addition, at a regional level the RPO/CMT will identify trends and systemic issues and provide remediation, as necessary.

Finally the QM process involves the Central Office. The Central Office staff will perform five main QM functions: 1. Ongoing review of QM discovery information, 2. Monitoring of QA Review, 3. Review of data during staff meeting, and utilization of data to develop remediation strategies and establish priorities for quality improvement, 4. Evaluate and revise the QM strategy, and 5. work with the CSB staff to develop and implement performance indicators.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify:	<b>Other</b> Specify:
<input style="width: 100%;" type="text" value="Case Management Teams"/>	<input style="width: 100%;" type="text" value="Biennial QI Committee Meetings"/>

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

**Review and Revision of the QM Strategy**

An evaluation of the effectiveness of system changes to the QM infrastructure will take place during the QA team meetings. The review will occur as necessary, but at least on an annual basis. The waiver program manager will gather information for the review using feedback from the CSB staff, information from discovery methods, and provider input. The review will evaluate the effectiveness, efficiency and appropriateness of the QM system design changes.

The QA team will review summaries of discovery information for trends, patterns and areas of concern. As issues arise they will be prioritized and strategies developed to address them. An evaluation of the QA infrastructure will be a part of the QA team meetings. This review will occur as necessary, but at least on an annual basis and will evaluate the effectiveness, efficiency and appropriateness of the QA system.

At the regional level, the RPO/CMT will identify trends and systemic issues and provide assessment information to the CSB on a quarterly basis. The delegated CSB staff will perform QA functions through ongoing review of discovery information; monitoring QA reviews; quarterly QA team meetings and working with the QA team to develop and implement performance indicators. CMT's will keep CSB staff informed of effectiveness of design changes.

**ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.**

Activities for the quality improvement:

1. CMT's will work with RPO's to establish and monitor performance standards;
2. CMT's will conduct a program self-assessment to reflect upon how program structure and policies affect members and their ability to self-direct;
3. CSB staff will assess trends in QA/QM at a state a federal level for best practices; and
4. Make recommendations on quality improvement strategies.

The CSB staff will work with the CMT's to develop Quality Improvement Projects (QIP's) quarterly, which the RPO's will track quarterly. The waiver performance standards will measure quality related to:

1. Independence/Choice;
2. Relationships (between member, workers, and support team);
3. Knowledge and support;
4. Health, Safety, and
5. Financial accountability.

**Appendix H: Quality Improvement Strategy (3 of 3)****H-2: Use of a Patient Experience of Care/Quality of Life Survey****a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):**

No

Yes (*Complete item H.2b*)

**b. Specify the type of survey tool the state uses:**

HCBS CAHPS Survey :

**NCI Survey :**

**NCI AD Survey :**

**Other** (Please provide a description of the survey tool used):

*Big Sky Waiver utilizes a member survey which is a state-developed tool. Member surveys are issued annually. Results are compiled by central office to evaluate setting satisfaction and utilized in the ongoing quality assurance review process.*

## **Appendix I: Financial Accountability**

### **I-1: Financial Integrity and Accountability**

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*The Department of Public Health and Human Services (Department) provides financial oversight to assure that claim coding and payment are in line with the waiver reimbursement methodology. The Department does not require waiver providers to secure an independent audit of their financial statements. Paid claims reports will be run by the Senior and Long Term Care (SLTC) Division of the Department on a monthly basis (or as needed). These reports will depict the services utilized, the number of waiver participants using each service, the number of units utilized, and the total dollar amount paid for each service. As a part of the quality assurance reviews, financial accountability will be assessed. Case managers and financial managers are required to prior authorize waiver services. They inform Xerox of the allowed services and the number of units or dollar amount for which providers are permitted to bill for each member. The Quality Assurance Division (QAD) of the Department will conduct financial audits upon request of the SLTC Division.*

*Case management providers are required to conduct internal audits of their records to ensure the waiver member files include the necessary documentation to support the member's identified needs. The person centered plans must be accurate and complete; services must be aligned to address the identified needs; the cost sheet must match the services provided; and all required information must be included in the file.*

*Community Services Bureau (CSB) staff of the SLTC Division will complete desk audits of case management teams every three years or as necessary. The desk audits include waiver paid claims by waiver member and by service. The State Plan expenditures are reviewed to ensure State Plan funds have been used prior to waiver funds. The claims are compared with the cost sheet and person centered plan to ensure the waiver member is receiving the services identified on the cost sheet. Any discrepancies are discussed with the case management teams and they are provided assistance in the development of a quality improvement plan.*

*The Surveillance Utilization Review (SURS) of the QAD conduct provider audits by reviewing records provided by the provider. When an overpayment is identified through the SURS process, SURS staff discusses the overpayment details with the provider and requests the overpayment by a formal notice. Providers are notified of their fair hearing rights through the notification from SURS staff. If fraud is identified providers can be sanctioned and be discontinued as a Medicaid and Medicare provider. The findings are sent to Office of Inspector General (OIG) and the licensing board of the provider.*

## **Appendix I: Financial Accountability**

### **Quality Improvement: Financial Accountability**

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

**a. Methods for Discovery: Financial Accountability Assurance:**

***The State must demonstrate that it has designed and implemented an adequate system for ensuring financial***

**accountability of the waiver program.** (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

**i. Sub-Assurances:**

**a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

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

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

**Performance Measure:**

Number/percent of claims submitted using the appropriate procedure codes and rates.

The numerator is the number of claims submitted using the appropriate procedure codes and rates. The denominator is the total number of claims submitted.

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

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

		<input type="text"/>
	<p><i>Other Specify:</i></p> <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

*Number/percent of claims that were paid in accordance with the reimbursement methodology on the date that services were provided. The numerator is the number of paid claims that were paid in accordance with the reimbursement methodology on the date that services were provided. The denominator is the total number of paid claims for individuals who receive waiver services.*

**Data Source (Select one):**

*Financial records (including expenditures)*

*If 'Other' is selected, specify:*

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

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Number of claims that are coded and paid only for services rendered. The numerator is the number of claims that are coded and paid only for services rendered. The denominator is the total number of claims coded and paid.**

**Data Source (Select one):**

**Record reviews, on-site**

*If 'Other' is selected, specify:*

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

*Number of claims submitted that are consistent with the participant's service plan. The numerator is the number of claims submitted and paid that are consistent with the participant's service plan. The denominator is the total number of claims submitted and paid.*

**Data Source (Select one):**

**Record reviews, on-site**

*If 'Other' is selected, specify:*

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

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

**Data Aggregation and Analysis:**

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

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number of rates consistent with the approved rate methodology throughout the five year waiver cycle. Numerator is the number of rates consistent with the approved rate methodology. The denominator is the total number of rates throughout the five year waiver cycle.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

The CSB staff will conduct audits of case management teams every three years to perform an audit of participant records to ensure the waiver services are aligned to address the identified needs, the cost sheet matches services provided and paid claims support services authorized.

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

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

Claims that do not have the appropriate procedure codes and/or rates are denied by the MMIS system. Claims that are suspended because of Medicaid eligibility are forwarded to the Department for review and action. Depending upon the number and reasons for denials, training will be made available to providers by Conduent or the Department. CSB staff will always assist providers who encounter on-going problems with the billing system.

In instances in which claims are incorrectly paid, providers will be required reimburse the Department. If the provider fails to do so, the amount owed will be recouped from future claims submitted.

ii. Remediation Data Aggregation

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

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

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

**c. Timelines**

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

**No**

**Yes**

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

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (1 of 3)**

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

*Payments for waiver services will be consistent with efficiency, economy and quality of care and will be enough to enlist enough providers. Services will be reimbursed via fee for service; there will be no interim rates, no prospective payments, and no cost settlements.*

*\*The Department's Senior and Long Term Care (SLTC) Division has operated a home and community based waiver program for elderly and physically disabled consumers since the early 1980s. SDMI HCBS waiver service descriptions that are the same or similar as the SLTC HCBS waiver, will use the established fee schedule. Many of the same service providers provide waiver services to both waivers participants and having the same fee schedule will ensure uniformity of rates. The Senior and Long Term Services Division and the Addictive and Mental Disorders Division waiver programs share the majority of the providers and services. Following is the list of services the two Divisions share: Adult Day Care; Community Transition Services; Consultative Clinic and Therapeutic Services; Environmental Accessibility Modifications; Health and Wellness; Homemaker; Homemaker Chore; Nutrition (Meals); Pain and Symptom Management; Personal Assistance Attendant – Agency Based; Personal Attendant – Self-Direction; Personal Emergency Response System, Rental and Installation; Prevocational Services; Private Duty Nursing; Residential Habilitation; Respite Care; Specialized Medical Equipment and Supplies; Specially Trained Attendant; Supported Employment; and Non-Medical Transportation. These rates were originally determined by surveying current providers.*

*\*Private Duty Nursing rate calculation included the following steps: 1) determine the number of PDN providers across the state and how the number of providers impacts access, 2) review entry level nursing salaries in a cross cutting sample of hospitals across the state, 3) estimate the employment and provider agency costs in addition to salaries, and 4) calculate a rate that would reasonably cover employing nurses at a minimally competitive entry salary level.*

*\*There are three (3) PDN provider agencies enrolled in Montana Medicaid. Analysis of the three PDN provider agencies determined the RN and LPN staffing shortage for PDN services estimates 275 to 670 direct care nursing hours unfilled on a biweekly basis. If the state were to lose one of the three remaining PDN agencies, a total of 3,631 direct care nursing hours offered through SDMI HCBS waiver and Big Sky Waiver would be unfilled monthly. A review of hourly wages for LPNs and RNs gathered from hospitals across the state range from \$24.30 to \$27.39 per hour.*

*\*The department analyzed data from multiple hospitals across the state ensuring the sample represented large, medium, and small hospitals to ensure payments for PDN services are consistent with the 1902(a)30(A) of the social security act and determine the prevailing wage rate for LPNs and RNs.*

*\*Montana analyzed the following data elements to determine the provider agency costs: current staff salaries, benefits, taxes, number of hours approved for current members requiring PDN services, number of members receiving PDN, overhead administrative costs, and total charge for PDN related procedures to determine RVU (relative value unit) and the cost per RVU. Using this information, the state developed an hourly salary calculation based on a weighted hourly rate less 38% to account for benefits and overhead.*

*\*The department estimated the percentage in the response above for employer taxes, benefits and organizational overhead. We determined the desired average starting salary and applied the overhead percentage to the calculation.*

*\*The new rate was calculated by utilizing the estimated taxes and benefits for state government employees' salaries at \$60,000 plus the current state of Montana standard overhead of 10% and determined a 28% increase was required to align with the average starting wage for RNs and LPNs.*

*\*The department used the following data sources in the rate setting process:*

- Wage Study*
- Provider discussions regarding overhead and benefits*
- Projected units of service*
- Additional budget authority of \$400,000*

*\*The proposed hour values are a result of the basic wage study completed by the department. Wage data was collected from five hospitals of different sizes and locals on RN starting wages. The average was calculated for setting the rates*

*\*Currently 80% of private duty nursing is completed by LPNs due to the inability to recruit RNs. This can leave a gap in care due to the licensure/educational differences of the two levels of nursing. This differential adjustment is to attract RNs for in private duty nursing and begin to close the gaps in services. In addition, this split addresses the wage needs to the 3 providers, who are critical to waiver operations and services to children under 19 in both rural and urban areas within the state. Montana believes that access to waiver PDN services is now comparable to access for the general population in the geographic area and comparable to the Medicaid rates in similar state Medicaid programs because of the PDN rate increase.*

*\*As per question a, \$37.52 is the average wage paid plus employer costs base on survey and discussion with providers. The actual calculated rate, \$37.67, is the result of current spend, plus an additional \$400,000 and trended units.*

*\*The providers of private duty nursing are not governmental agencies. Montana does not have a standard overhead rate for non-governmental agencies. The 38% represents taxes, employer benefits and overhead. Our consultation with providers in this instance indicated this overhead is necessary to maintain services in a rural and frontier state*

*\*Although the loss of the first PDN provider agency did not significantly impact SDMI HCBS waiver members, the loss of*

*the second PDN provider agency would have placed a hardship on members being served in the community. Even though Montana Medicaid authorized the direct care worker hours for members, PDN services were either denied or reduced because providers were not able to cover the approved hours due to the growing impact of staffing shortages. If the second PDN provider were to voluntarily terminate their enrollment with Medicaid, the effectiveness of the state's three HCBS waivers would be severely impacted. This precarious situation prompted the state to seriously consider PDN reimbursement rate increases to avoid deterioration of health and safety of enrolled HCBS members and proactively take steps to keep members in their communities to avoid institutionalization.*

*\*Montana solicited feedback from all PDN provider providers using multiple methods including: interested party notification, public notice through Montana Administrative rules process, newspaper, \*posted on the department's website, public hearing, waiver public notice, tribal consultation, Montana Health Coalition notice, and meetings the department held with PDN provider agencies.*

*\*All feedback received from PDN providers was positive. The provider who contemplated exiting the program has committed to providing home and community based services. The department raising the rate demonstrates the commitment to providers and HCBS.*

*\*The department did not receive additional feedback during the rules or waiver comment period for the new LPN and RN rates.*

*\*Montana was not required to seek legislative approval for rate increase as the increase is within legislative appropriations.*

*\*The PDN provider that withdrew as a Medicaid provider did not provide the department with feedback as to why they opted out of the program.*

*The PDN provider agency who reached out to the department to discuss PDN rate concerns has committed to serving the HCBS waiver population as a Medicaid provider if the reimbursement rates are increased.*

*\*The department did not request feedback from all PDN providers between SFY2016 and SFY2017.*

*\*The department did not request provider feedback from the PDN providers. There was not a great impact to SDMI HCBS waiver members when the first PDN provider withdrew.*

*\*The department reviewed feedback by multiple sources identified indicating the struggles PDN agencies have had with staffing.*

*\*AMDD does not have a geographical (rural) differential currently. The Self-direction program may assist waiver participants that live in rural areas to access providers in their areas.*

*\*The Case Management Team and the waiver participant develop the person centered recovery plan. The cost sheet is made available to the waiver participant as the services are identified. The waiver participant is aware of the reimbursement rate for each of their services identified in the person centered recovery plan.*

*\*The SLTC and AMDD review the rates annually to ensure shared services remain consistent and are within our Montana Legislative appropriation. Proposed fee schedules are posted as part of the Administrative Rule of Montana process for public comment when fees are changed, added or deleted. Services are reimbursed according to fee schedule. The fee schedule identifies the maximum allowable rate.*

*\*AMDD and SLTC meet annually to review information received through multiple sources including: number of providers, feedback received from providers and members, member complaints, legislative appropriation, and the state of Montana's Access Plan.*

*\*In addition, AMDD and SLTC will review claim history of all providers for trends in the amount of services utilized and 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.*

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

*Waiver service providers bill Montana Medicaid through the MMIS system. Payments are issued directly to the providers; no funds are retained by the Department. All services are prior authorized by provider and by units.*

*Edits are in place with MMIS to ensure all services are allowable and reimbursed at the appropriate rate. The providers are enrolled as Medicaid waiver providers in the MMIS. Each provider has a charge file of the services (procedure codes) that they are approved to provide. These files are updated annually with the appropriate fiscal year reimbursement rate and the services. Department staff provides the information to the fiscal intermediary for updating.*

*Members are initially entered into the Medicaid eligibility system (CHIMES) as Medicaid and waiver eligible. The eligibility file is transferred nightly to the MMIS.*

*MMIS has edits to ensure the person receiving the service is eligible for the service, and the prior authorization and provider charge file are reviewed. If all is appropriate, the claim is paid. If there is an error anywhere in this process, the claim is denied.*

## **Appendix I: Financial Accountability**

### **I-2: Rates, Billing and Claims (2 of 3)**

#### **c. Certifying Public Expenditures (select one):**

***No. state or local government agencies do not certify expenditures for waiver services.***

***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

**Select at least one:**

#### ***Certified Public Expenditures (CPE) of State Public Agencies.***

*Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)*

#### ***Certified Public Expenditures (CPE) of Local Government Agencies.***

*Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)*

## **Appendix I: Financial Accountability**

### **I-2: Rates, Billing and Claims (3 of 3)**

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The states MMIS (Conduent) has a recipient eligibility system that verifies eligibility for Medicaid and the waiver. Case management teams or financial managers prior authorize all services in the members service plan. These prior authorizations are submitted to the states fiscal intermediary (MMIS). Case managers receive monthly utilization reports from providers documenting units of service provided. These reports are compared to individual service plans, compiled and forwarded to the Community Services Bureau. The data is tabulated and further compared to paid claims data from MMIS.

Utilization reports, cost sheets and service plan for the sampled members are reviewed to determine the date of the claim is within the period authorized by the plan of care, in the amount and type of service as specified in the plan of care. Inappropriate claims billed will be recouped.

- 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:

[Empty text box]

**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:

[Empty text box]

**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:

[Empty text box]

**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:

Financial managers (FM) operate as limited fiscal agents and make payment for the member in the participant directed option (Bonanza option). The FM submits claims to Medicaid for payment and monitors expenditures. Quarterly utilization reports are reviewed by the Community Services Bureau staff.

**Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

**Appendix I: Financial Accountability**

**I-3: Payment (3 of 7)**

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

**No. The state does not make supplemental or enhanced payments for waiver services.**

**Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

**Appendix I: Financial Accountability**

**I-3: Payment (4 of 7)**

**d. Payments to state or Local Government Providers.** Specify whether state or local government providers receive payment for the provision of waiver services.

**No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.**

**Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.**

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

*Nursing facilities that receive county tax dollars may provide respite services to members who are on the waiver. Local city-county health departments that receive city or county tax dollars may provide case management services or direct nursing services to members who are on the waiver. Community mental health centers that receive county tax dollars may provide professional mental health services to members who are on the waiver.*

**Appendix I: Financial Accountability**

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**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**

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**I-3: Payment (6 of 7)**

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

*Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.*

*Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.*

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

**Appendix I: Financial Accountability**

**I-3: Payment (7 of 7)**

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:**

**No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

*Specify the governmental agency (or agencies) to which reassignment may be made.*

**ii. Organized Health Care Delivery System. Select one:**

**No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

*Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:*

**iii. Contracts with MCOs, PIHPs or PAHPs.**

**The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

**The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

*Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

*This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.*

*This waiver is a part of a concurrent §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(c) waiver specifies the types of health plans that are used and how payments to these plans are made.*

*If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.*

*In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (1 of 3)**

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

*Appropriation of State Tax Revenues to the State Medicaid agency*

*Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.*

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

**Other State Level Source(s) of Funds.**

*Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (2 of 3)**

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

*Not Applicable.* There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

Check each that applies:

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**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**

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**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**

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**I-5: Exclusion of Medicaid Payment for Room and Board**

**a. Services Furnished in Residential Settings.** Select one:

*No services under this waiver are furnished in residential settings other than the private residence of the individual.*

*As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.*

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

*The Department sets reimbursement for room and board in residential settings. Upon admission, providers are notified that the waiver will not cover the cost of room and board for the recipient. The cost calculation sheet utilized by the case managers to determine reimbursement for services has a line item for room and board, which is identified as the responsibility of the member.*

**Appendix I: Financial Accountability**

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**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

**No.** *The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.*

**Yes.** *Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.*

*The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*

**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

**a. Co-Payment Requirements.** *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

**No.** *The state does not impose a co-payment or similar charge upon participants for waiver services.*

**Yes.** *The state imposes a co-payment or similar charge upon participants for one or more waiver services.*

**i. Co-Pay Arrangement.**

*Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):*

---

**Charges Associated with the Provision of Waiver Services** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

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*Nominal deductible*

*Coinsurance*

*Co-Payment*

*Other charge*

*Specify:*

--

***Appendix I: Financial Accountability***

***I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)***

***a. Co-Payment Requirements.***

***ii. Participants Subject to Co-pay Charges for Waiver Services.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

***Appendix I: Financial Accountability***

***I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)***

***a. Co-Payment Requirements.***

***iii. Amount of Co-Pay Charges for Waiver Services.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

***Appendix I: Financial Accountability***

***I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)***

***a. Co-Payment Requirements.***

***iv. Cumulative Maximum Charges.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

***Appendix I: Financial Accountability***

***I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)***

***b. Other State Requirement for Cost Sharing.*** *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

*Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:*

**Appendix J: Cost Neutrality Demonstration**

**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	15076.63	13624.00	28700.63	38564.00	2172.00	40736.00	12035.37
2	15076.57	13624.00	28700.57	38564.00	2172.00	40736.00	12035.43
3	17155.26	13624.00	30779.26	38564.00	2172.00	40736.00	9956.74
4	17546.01	13624.00	31170.01	38564.00	2172.00	40736.00	9565.99
5	17545.96	13624.00	31169.96	38564.00	2172.00	40736.00	9566.04

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 9)**

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Nursing Facility	
Year 1	2580		2580
Year 2	2580		2580
Year 3	2580		2580
Year 4	2580		2580
Year 5	2580		2580

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (2 of 9)**

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The FY 2015 average length of stay was 305 days. The assumption was made that the ALOS may not be impacted by the slight increase in enrollment from the Money Follows the Person demonstration grant. The FY 2015 ALOS will be used in each waiver year for Appendix J.

The acuity of the HCBS member has been changing, but it has been offset by members that we serve for a short period of time for a specific set of services. This includes case management, home modifications or specialized equipment not available through state plan Medicaid. The increase in short term members will stabilize the ALOS.

The FY 2015 ALOS will be used in each waiver year for Appendix J.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (3 of 9)**

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

State FY 2015 data was used as the baseline year to determine utilization of services and estimate the number of users per service. There was approximately 2% growth in FY 2016 and FY 2017. There is an anticipated growth of 20 members in FY 2018 from the Money Follows the Person demonstration grant. No annual increase was anticipated for years one through five.

**ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

D' baseline is the number the FY 2015 372 data adding a 2% increase for FY 2016 and FY 2017. No increases were anticipated for years one through five.

**iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was determined using FY 2015 baseline data adding a 2% increase for FY 2016 and FY 2017 and no increases were anticipated for years one through five.

**iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

G' was determined from a FY 2015 baseline date adding a 2% increase for FY 2016 and FY 2017. No increases were anticipated for years one through five.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (4 of 9)**

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Health	
Case Management	
Community First Choice/Personal Assistance and Specially Trained Attendant Care	
Day Habilitation	

<i>Waiver Services</i>	
<i>Homemaker</i>	
<i>Prevocational Services</i>	
<i>Residential Habilitation</i>	
<i>Respite</i>	
<i>Supported Employment</i>	
<i>Audiology</i>	
<i>Respiratory Therapy</i>	
<i>Financial Management Services</i>	
<i>Independence Advisor</i>	
<i>Community Supports</i>	
<i>Community Transition</i>	
<i>Consultative Clinical and Therapeutic Services</i>	
<i>Consumer Goods and Services</i>	
<i>Dietetic Services</i>	
<i>Environmental Accessibility Adaptations</i>	
<i>Family Training and Support</i>	
<i>Health and Wellness</i>	
<i>Homemaker Chore</i>	
<i>Non-medical Transportation</i>	
<i>Nutrition</i>	
<i>Occupational Therapy</i>	
<i>Pain and Symptom Management</i>	
<i>Personal Emergency Response Systems</i>	
<i>Physical Therapy</i>	
<i>Post Acute Rehabilitation Services</i>	
<i>Private Duty Nursing</i>	
<i>Senior Companion</i>	
<i>Specialized Child Care for Medically Fragile Children</i>	
<i>Specialized Medical Equipment and Supplies</i>	
<i>Speech Therapy</i>	
<i>Supported Living</i>	
<i>Vehicle Modifications</i>	

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 9)**

**d. Estimate of Factor D.**

*ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

**Waiver Year: Year 1**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							71129.94
Adult Day Health		15 minutes	23	1405.73	2.20	71129.94	
<b>Case Management Total:</b>							7060444.57
Specialized		day	36	252.22	18.51	168069.32	
Day		day	2544	245.85	11.02	6892375.25	
15 minutes		15 minutes	0	0.00	15.60	0.00	
<b>Community First Choice/Personal Assistance and Specially Trained Attendant Care Total:</b>							9162288.93
CFC/PAS - Specially Trained		15 minutes	396	476.97	5.63	1063395.08	
CFC/PAS - Basic/Social/Supervision		15 minutes	1282	1162.32	4.64	6914037.27	
CFC/PAS - Shared		day	8	310.74	10.51	26127.02	
CFC/PAS - STA LPN		15 minutes	10	10072.56	8.95	901494.12	
CFC/PAS - STA RN		15 minutes	6	3800.76	11.28	257235.44	
<b>Day Habilitation Total:</b>							48557.53
Day Habilitation		day	9	67.34	80.12	48557.53	
<b>Homemaker Total:</b>							942532.21
Homemaker		15 minutes	534	449.12	3.93	942532.21	
<b>Prevocational Services Total:</b>							122521.33
Prevocational Services		hour	25	627.51	7.81	122521.33	
<b>Residential Habilitation Total:</b>							14785632.35
TBI Residential		day	51	315.48	108.79	1750374.53	
Adult Residential		day	864	185.53	76.36	12240349.17	
Child Foster		day	0	0.00	108.79	0.00	
Advanced Behavior Management						0.00	
<b>GRAND TOTAL:</b>							38897695.46
Total: Services included in capitation:							38897695.46
Total: Services not included in capitation:							38897695.46
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							15076.63
Services included in capitation:							15076.63
Services not included in capitation:							15076.63
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		day	0	0.00	141.00		
Group Home		day	16	315.48	157.48	79498.65	
<b>Respite Total:</b>							185945.89
Residential		day	11	9.68	360.00	38332.80	
Individual		15 minutes	47	801.20	3.92	147613.09	
<b>Supported Employment Total:</b>							8352.99
Supported Employment		15 minutes	7	91.16	13.09	8352.99	
<b>Audiology Total:</b>							0.00
Audiology		15 minutes	0	0.00	56.88	0.00	
<b>Respiratory Therapy Total:</b>							38797.16
Therapeutic Procedures		15 minutes	4	847.84	11.44	38797.16	
Visit		visit	0	0.00	25.00	0.00	
<b>Financial Management Services Total:</b>							61828.07
Financial Management Services		month	35	10.23	172.68	61828.07	
<b>Independence Advisor Total:</b>							0.00
Independence Advisor		month	0	0.00	172.68	0.00	
<b>Community Supports Total:</b>							1051498.21
Community Supports		15 minutes	35	5336.20	5.63	1051498.21	
<b>Community Transition Total:</b>							4680.00
Community Transition		service	3	0.78	2000.00	4680.00	
<b>Consultative Clinical and Therapeutic Services Total:</b>							3538.66
Consultative Clinical and Therapeutic Services		service	5	1.91	370.54	3538.66	
<b>Consumer Goods and Services Total:</b>							143790.00
Goods and Services (Goods)		service				52110.00	
<b>GRAND TOTAL:</b>							38897695.46
Total: Services included in capitation:							38897695.46
Total: Services not included in capitation:							2580
Total Estimated Unduplicated Participants:							15076.63
Factor D (Divide total by number of participants):							15076.63
Services included in capitation:							15076.63
Services not included in capitation:							305
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			27	3.86	500.00		
Goods and Services (Services)		service	24	7.64	500.00	91680.00	
<b>Dietetic Services Total:</b>							264.00
Dietetic Services		15 minutes	2	8.65	15.26	264.00	
<b>Environmental Accessibility Adaptations Total:</b>							805920.00
Environmental Accessibility Adaptations		service	146	2.76	2000.00	805920.00	
<b>Family Training and Support Total:</b>							17348.47
Family Training and Support		15 minutes	17	120.20	8.49	17348.47	
<b>Health and Wellness Total:</b>							68345.69
Health and Wellness		service	101	7.00	96.67	68345.69	
<b>Homemaker Chore Total:</b>							73235.00
Homemaker Chore		service	97	3.02	250.00	73235.00	
<b>Non-medical Transportation Total:</b>							370092.78
Trip		service	135	43.60	12.40	72986.40	
Miles		mile	815	1104.69	0.33	297106.38	
<b>Nutrition Total:</b>							490265.96
Nutrition		meal	483	179.02	5.67	490265.96	
<b>Occupational Therapy Total:</b>							112.13
Occupational Therapy		visit	1	1.84	60.94	112.13	
<b>Pain and Symptom Management Total:</b>							165574.49
Pain and Symptom Management		session	135	15.61	78.57	165574.49	
<b>Personal Emergency Response Systems Total:</b>							212810.56
Installation		service	86	0.44	100.00	3784.00	
Monthly							205498.56
<b>GRAND TOTAL:</b>							38897695.46
Total: Services included in capitation:							
Total: Services not included in capitation:							38897695.46
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							15076.63
Services included in capitation:							
Services not included in capitation:							15076.63
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		month	656	4.54	69.00		
Purchase		service	21	0.21	800.00	3528.00	
<b>Physical Therapy Total:</b>							2029.73
Physical Therapy		15 minutes	3	27.15	24.92	2029.73	
<b>Post Acute Rehabilitation Services Total:</b>							215828.02
Post Acute Rehabilitation Services		day	28	9.96	773.91	215828.02	
<b>Private Duty Nursing Total:</b>							913747.09
RN Supervision		15 minutes	15	46.84	15.31	10756.81	
LPN		15 minutes	243	278.96	8.95	606696.16	
RN		15 minutes	149	176.29	11.28	296294.13	
<b>Senior Companion Total:</b>							2465.98
Senior Companion		15 minutes	7	260.95	1.35	2465.98	
<b>Specialized Child Care for Medically Fragile Children Total:</b>							31262.07
Specialized Child Care for Medically Fragile Children		15 minutes	3	1847.64	5.64	31262.07	
<b>Specialized Medical Equipment and Supplies Total:</b>							1416440.00
Equipment		item	874	0.67	2000.00	1171160.00	
Supplies		item	511	0.24	2000.00	245280.00	
<b>Speech Therapy Total:</b>							0.00
Speech Therapy		visit	0	0.00	64.62	0.00	
<b>Supported Living Total:</b>							295135.67
Supported Living		day	7	186.79	225.72	295135.67	
<b>Vehicle Modifications Total:</b>							125280.00
Vehicle Modifications		service	36	1.74	2000.00	125280.00	
<b>GRAND TOTAL:</b>							38897695.46
Total: Services included in capitation:							
Total: Services not included in capitation:							38897695.46
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							15076.63
Services included in capitation:							
Services not included in capitation:							15076.63
Average Length of Stay on the Waiver:							305

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (6 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							<b>71129.94</b>
Adult Day Health	<input type="checkbox"/>	15 minutes	23	1405.73	2.20	71129.94	
<b>Case Management Total:</b>							<b>7060444.57</b>
Specialized	<input type="checkbox"/>	day	36	252.22	18.51	168069.32	
Day	<input type="checkbox"/>	day	2544	245.85	11.02	6892375.25	
15 minutes	<input type="checkbox"/>	15 minutes	0	0.00	15.60	0.00	
<b>Community First Choice/Personal Assistance and Specially Trained Attendant Care Total:</b>							<b>9162288.93</b>
CFC/PAS - Specially Trained	<input type="checkbox"/>	15 minutes	396	476.97	5.63	1063395.08	
CFC/PAS - Basic/Social/Supervision	<input type="checkbox"/>	15 minutes	1282	1162.32	4.64	6914037.27	
CFC/PAS - Shared	<input type="checkbox"/>	day	8	310.74	10.51	26127.02	
CFC/PAS - STA LPN	<input type="checkbox"/>	15 minutes	10	10072.56	8.95	901494.12	
CFC/PAS - STA RN	<input type="checkbox"/>	15 minutes	6	3800.76	11.28	257235.44	
<b>Day Habilitation Total:</b>							<b>48557.53</b>
Day Habilitation	<input type="checkbox"/>	day	9	67.34	80.12	48557.53	
<b>Homemaker Total:</b>							<b>942532.21</b>
Homemaker	<input type="checkbox"/>	15 minutes	534	449.12	3.93	942532.21	
<b>GRAND TOTAL:</b>							<b>38897563.46</b>
<i>Total: Services included in capitation:</i>							<i>38897563.46</i>
<i>Total: Services not included in capitation:</i>							<i>2580</i>
<b>Total Estimated Unduplicated Participants:</b>							<b>15076.57</b>
<i>Factor D (Divide total by number of participants):</i>							<i>Services included in capitation:</i>
<i>Services not included in capitation:</i>							<i>15076.57</i>
<b>Average Length of Stay on the Waiver:</b>							<b>305</b>

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Prevocational Services Total:</b>							122521.33
Prevocational Services		hour	25	627.51	7.81	122521.33	
<b>Residential Habilitation Total:</b>							14785632.35
TBI Residential		day	51	315.48	108.79	1750374.53	
Adult Residential		day	864	185.53	76.36	12240349.17	
Child Foster		day	0	0.00	108.79	0.00	
Advanced Behavior Management		day	0	0.00	141.00	0.00	
Group Home		day	16	315.48	157.48	794908.65	
<b>Respite Total:</b>							185945.89
Residential		day	11	9.68	360.00	38332.80	
Individual		15 minutes	47	801.20	3.92	147613.09	
<b>Supported Employment Total:</b>							8352.99
Supported Employment		15 minutes	7	91.16	13.09	8352.99	
<b>Audiology Total:</b>							0.00
Audiology		15 minutes	0	0.00	56.88	0.00	
<b>Respiratory Therapy Total:</b>							38797.16
Therapeutic Procedures		15 minute	4	847.84	11.44	38797.16	
Visit		visit	0	0.00	25.00	0.00	
<b>Financial Management Services Total:</b>							61828.07
Financial Management Services		month	35	10.23	172.68	61828.07	
<b>Independence Advisor Total:</b>							0.00
Independence Advisor		15 minutes	0	0.00	172.68	0.00	
<b>Community Supports Total:</b>							1051498.21
Community Supports						1051498.21	
<b>GRAND TOTAL:</b>							38897563.46
Total: Services included in capitation:							38897563.46
Total: Services not included in capitation:							2580
Total Estimated Unduplicated Participants:							15076.57
Factor D (Divide total by number of participants):							15076.57
Services included in capitation:							15076.57
Services not included in capitation:							305
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 minutes	35	5336.20	5.63		
<b>Community Transition Total:</b>							4680.00
Community Transition		service	3	0.78	2000.00	4680.00	
<b>Consultative Clinical and Therapeutic Services Total:</b>							3538.66
Consultative Clinical and Therapeutic Services		service	5	1.91	370.54	3538.66	
<b>Consumer Goods and Services Total:</b>							143790.00
Goods and Services (Goods)		service	27	3.86	500.00	52110.00	
Goods and Services (Services)		service	24	7.64	500.00	91680.00	
<b>Dietetic Services Total:</b>							132.00
Dietetic Services		15 minutes	1	8.65	15.26	132.00	
<b>Environmental Accessibility Adaptations Total:</b>							805920.00
Environmental Accessibility Adaptations		service	146	2.76	2000.00	805920.00	
<b>Family Training and Support Total:</b>							17348.47
Family Training and Support		15 minutes	17	120.20	8.49	17348.47	
<b>Health and Wellness Total:</b>							68345.69
Health and Wellness		service	101	7.00	96.67	68345.69	
<b>Homemaker Chore Total:</b>							73235.00
Homemaker Chore		service	97	3.02	250.00	73235.00	
<b>Non-medical Transportation Total:</b>							370092.78
Trip		service	135	43.60	12.40	72986.40	
Miles		mile	815	1104.69	0.33	297106.38	
<b>Nutrition Total:</b>							490265.96
Nutrition		meal	483	179.02	5.67	490265.96	
<b>GRAND TOTAL:</b>							38897563.46
Total: Services included in capitation:							
Total: Services not included in capitation:							38897563.46
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							15076.57
Services included in capitation:							
Services not included in capitation:							15076.57
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Occupational Therapy Total:</b>							112.13
Occupational Therapy		visit	1	1.84	60.94	112.13	
<b>Pain and Symptom Management Total:</b>							165574.49
Pain and Symptom Management		session	135	15.61	78.57	165574.49	
<b>Personal Emergency Response Systems Total:</b>							212810.56
Installation		service	86	0.44	100.00	3784.00	
Monthly		month	656	4.54	69.00	205498.56	
Purchase		service	21	0.21	800.00	3528.00	
<b>Physical Therapy Total:</b>							2029.73
Physical Therapy		15 minutes	3	27.15	24.92	2029.73	
<b>Post Acute Rehabilitation Services Total:</b>							215828.02
Post Acute Rehabilitation Services		day	28	9.96	773.91	215828.02	
<b>Private Duty Nursing Total:</b>							913747.09
RN Supervision		15 minutes	15	46.84	15.31	10756.81	
LPN		15 minutes	243	278.96	8.95	606696.16	
RN		15 minutes	149	176.29	11.28	296294.13	
<b>Senior Companion Total:</b>							2465.98
Senior Companion		15 minutes	7	260.95	1.35	2465.98	
<b>Specialized Child Care for Medically Fragile Children Total:</b>							31262.07
Specialized Child Care for Medically Fragile Children		15 minutes	3	1847.64	5.64	31262.07	
<b>Specialized Medical Equipment and Supplies Total:</b>							1416440.00
Equipment		item	874	0.67	2000.00	1171160.00	
Supplies						245280.00	
<b>GRAND TOTAL:</b>							38897563.46
Total: Services included in capitation:							38897563.46
Total: Services not included in capitation:							2580
Total Estimated Unduplicated Participants:							15076.57
Factor D (Divide total by number of participants):							15076.57
Services included in capitation:							15076.57
Services not included in capitation:							
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		item	511	0.24	2000.00		
<b>Speech Therapy Total:</b>							0.00
Speech Therapy		visit	0	0.00	64.62	0.00	
<b>Supported Living Total:</b>							295135.67
Supported Living		day	7	186.79	225.72	295135.67	
<b>Vehicle Modifications Total:</b>							125280.00
Vehicle Modifications		service	36	1.74	2000.00	125280.00	
<b>GRAND TOTAL:</b>							38897563.46
Total: Services included in capitation:							
Total: Services not included in capitation:							38897563.46
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							15076.57
Services included in capitation:							
Services not included in capitation:							15076.57
Average Length of Stay on the Waiver:							305

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							71129.94
Adult Day Health		15 minutes	23	1405.73	2.20	71129.94	
<b>Case Management Total:</b>							7060444.57
Specialized		day	36	252.22	18.51	168069.32	
Day		day	2544	245.85	11.02	6892375.25	
<b>GRAND TOTAL:</b>							44260580.67
Total: Services included in capitation:							
Total: Services not included in capitation:							44260580.67
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							17155.26
Services included in capitation:							
Services not included in capitation:							17155.26
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
15 minutes		15 minutes	0	0.00	15.60	0.00	
<b>Community First Choice/Personal Assistance and Specially Trained Attendant Care Total:</b>							9162288.93
CFC/PAS - Specially Trained		15 minutes	396	476.97	5.63	1063395.08	
CFC/PAS - Basic/Social/Supervision		15 minutes	1282	1162.32	4.64	6914037.27	
CFC/PAS - Shared		day	8	310.74	10.51	26127.02	
CFC/PAS - STA LPN		15 minutes	10	10072.56	8.95	901494.12	
CFC/PAS - STA RN		15 minutes	6	3800.76	11.28	257235.44	
<b>Day Habilitation Total:</b>							48557.53
Day Habilitation		day	9	67.34	80.12	48557.53	
<b>Homemaker Total:</b>							942532.21
Homemaker		15 minutes	534	449.12	3.93	942532.21	
<b>Prevocational Services Total:</b>							122521.33
Prevocational Services		hour	25	627.51	7.81	122521.33	
<b>Residential Habilitation Total:</b>							20133045.43
TBI Residential		day	51	315.48	165.77	2667153.10	
Adult Residential		day	864	185.53	104.00	16670983.68	
Child Foster		day	0	0.00	111.79	0.00	
Advanced Behavior Management		day	0	0.00	141.00	0.00	
Group Home		day	16	315.48	157.48	794908.65	
<b>Respite Total:</b>							185945.89
Residential		day	11	9.68	360.00	38332.80	
Individual		15 minutes	47	801.20	3.92	147613.09	
<b>GRAND TOTAL:</b>							44260580.67
Total: Services included in capitation:							44260580.67
Total: Services not included in capitation:							2580
Total Estimated Unduplicated Participants:							17155.26
Factor D (Divide total by number of participants):							17155.26
Services included in capitation:							17155.26
Services not included in capitation:							17155.26
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Supported Employment Total:</b>							8352.99
Supported Employment		15 minutes	7	91.16	13.09	8352.99	
<b>Audiology Total:</b>							0.00
Audiology		15 minutes	0	0.00	56.88	0.00	
<b>Respiratory Therapy Total:</b>							38797.16
Therapeutic Procedures		15 minutes	4	847.84	11.44	38797.16	
Visit		15 minutes	0	0.00	25.00	0.00	
<b>Financial Management Services Total:</b>							61828.07
Financial Management Services		month	35	10.23	172.68	61828.07	
<b>Independence Advisor Total:</b>							15472.13
Independence Advisor		month	35	2.56	172.68	15472.13	
<b>Community Supports Total:</b>							1051498.21
Community Supports		15 minutes	35	5336.20	5.63	1051498.21	
<b>Community Transition Total:</b>							4680.00
Community Transition		service	3	0.78	2000.00	4680.00	
<b>Consultative Clinical and Therapeutic Services Total:</b>							3538.66
Consultative Clinical and Therapeutic Services		service	5	1.91	370.54	3538.66	
<b>Consumer Goods and Services Total:</b>							143790.00
Goods and Services (Goods)		service	27	3.86	500.00	52110.00	
Goods and Services (Services)		service	24	7.64	500.00	91680.00	
<b>Dietetic Services Total:</b>							264.00
Dietetic Services		15 minutes	2	8.65	15.26	264.00	
<b>Environmental Accessibility Adaptations Total:</b>							805920.00
<b>GRAND TOTAL:</b>							44260580.67
Total: Services included in capitation:							44260580.67
Total: Services not included in capitation:							2580
Total Estimated Unduplicated Participants:							17155.26
Factor D (Divide total by number of participants):							17155.26
Services included in capitation:							17155.26
Services not included in capitation:							
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations		service	146	2.76	2000.00	805920.00	
<b>Family Training and Support Total:</b>							17348.47
Family Training and Support		15 minutes	17	120.20	8.49	17348.47	
<b>Health and Wellness Total:</b>							68345.69
Health and Wellness		15 minutes	101	7.00	96.67	68345.69	
<b>Homemaker Chore Total:</b>							73235.00
Homemaker Chore		service	97	3.02	250.00	73235.00	
<b>Non-medical Transportation Total:</b>							370092.78
Trip		service	135	43.60	12.40	72986.40	
Miles		mile	815	1104.69	0.33	297106.38	
<b>Nutrition Total:</b>							490265.96
Nutrition		meal	483	179.02	5.67	490265.96	
<b>Occupational Therapy Total:</b>							112.13
Occupational Therapy		visit	1	1.84	60.94	112.13	
<b>Pain and Symptom Management Total:</b>							165574.49
Pain and Symptom Management		visit	135	15.61	78.57	165574.49	
<b>Personal Emergency Response Systems Total:</b>							212810.56
Installation		service	86	0.44	100.00	3784.00	
Monthly		month	656	4.54	69.00	205498.56	
Purchase		service	21	0.21	800.00	3528.00	
<b>Physical Therapy Total:</b>							2029.73
Physical Therapy		service	3	27.15	24.92	2029.73	
<b>Post Acute Rehabilitation Services Total:</b>							215828.02
Post Acute						215828.02	
<b>GRAND TOTAL:</b>							44260580.67
Total: Services included in capitation:							
Total: Services not included in capitation:							44260580.67
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							17155.26
Services included in capitation:							
Services not included in capitation:							17155.26
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Rehabilitation Services		day	28	9.96	773.91		
<b>Private Duty Nursing Total:</b>							913747.09
RN Supervision		15 minutes	15	46.84	15.31	10756.81	
LPN		15 minutes	243	278.96	8.95	606696.16	
RN		15 minutes	149	176.29	11.28	296294.13	
<b>Senior Companion Total:</b>							2465.98
Senior Companion		15 minutes	7	260.95	1.35	2465.98	
<b>Specialized Child Care for Medically Fragile Children Total:</b>							31262.07
Specialized Child Care for Medically Fragile Children		15 minutes	3	1847.64	5.64	31262.07	
<b>Specialized Medical Equipment and Supplies Total:</b>							1416440.00
Equipment		item	874	0.67	2000.00	1171160.00	
Supplies		item	511	0.24	2000.00	245280.00	
<b>Speech Therapy Total:</b>							0.00
Speech Therapy		visit	0	0.00	64.62	0.00	
<b>Supported Living Total:</b>							295135.67
Supported Living		day	7	186.79	225.72	295135.67	
<b>Vehicle Modifications Total:</b>							125280.00
Vehicle Modifications		service	36	1.74	2000.00	125280.00	
<b>GRAND TOTAL:</b>							44260580.67
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							44260580.67
<i>Total Estimated Unduplicated Participants:</i>							2580
<i>Factor D (Divide total by number of participants):</i>							17155.26
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							17155.26
<i>Average Length of Stay on the Waiver:</i>							305

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (8 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields.

All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							71129.94
Adult Day Health		15 minutes	23	1405.73	2.20	71129.94	
<b>Case Management Total:</b>							7060444.57
Specialized		day	36	252.22	18.51	168069.32	
Day		day	2544	245.85	11.02	6892375.25	
15 minutes		15 minutes	0	0.00	15.60	0.00	
<b>Community First Choice/Personal Assistance and Specially Trained Attendant Care Total:</b>							9162288.93
CFC/PAS - Specially Trained		15 minutes	396	476.97	5.63	1063395.08	
CFC/PAS - Basic/Social/Supervision		15 minutes	1282	1162.32	4.64	6914037.27	
CFC/PAS - Shared		day	8	310.74	10.51	26127.02	
CFC/PAS - STA LPN		15 minutes	10	10072.56	8.95	901494.12	
CFC/PAS - STA RN		15 minutes	6	3800.76	11.28	257235.44	
<b>Day Habilitation Total:</b>							48557.53
Day Habilitation		day	9	67.34	80.12	48557.53	
<b>Homemaker Total:</b>							942532.21
Homemaker		15 minutes	534	449.12	3.93	942532.21	
<b>Prevocational Services Total:</b>							122521.33
Prevocational Services		hour	25	627.51	7.81	122521.33	
<b>Residential Habilitation Total:</b>							21094805.95
TBI Residential		day	51	315.48	165.77	2667153.10	
Adult Residential		day	760	185.53	104.00	14664291.20	
<b>GRAND TOTAL:</b>							45268697.14
Total: Services included in capitation:							
Total: Services not included in capitation:							45268697.14
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							17546.01
Services included in capitation:							
Services not included in capitation:							17546.01
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Child Foster		day	0	0.00	111.79	0.00	
Advanced Behavior Management		day	104	185.53	141.00	2720611.92	
Group Home		day	16	315.48	206.58	1042749.73	
<b>Respite Total:</b>							185945.89
Residential		day	11	9.68	360.00	38332.80	
Individual		15 minutes	47	801.20	3.92	147613.09	
<b>Supported Employment Total:</b>							8352.99
Supported Employment		15 minutes	7	91.16	13.09	8352.99	
<b>Audiology Total:</b>							0.00
Audiology		15 minutes	0	0.00	56.88	0.00	
<b>Respiratory Therapy Total:</b>							38797.16
Therapeutic Procedures		15 minutes	4	847.84	11.44	38797.16	
Visit		visit	0	0.00	25.00	0.00	
<b>Financial Management Services Total:</b>							61828.07
Financial Management Services		month	35	10.23	172.68	61828.07	
<b>Independence Advisor Total:</b>							61828.07
Independence Advisor		month	35	10.23	172.68	61828.07	
<b>Community Supports Total:</b>							1051498.21
Community Supports		15 minutes	35	5336.20	5.63	1051498.21	
<b>Community Transition Total:</b>							4680.00
Community Transition		service	3	0.78	2000.00	4680.00	
<b>Consultative Clinical and Therapeutic Services Total:</b>							3538.66
Consultative Clinical and Therapeutic Services		service	5	1.91	370.54	3538.66	
<b>GRAND TOTAL:</b>							45268697.14
Total: Services included in capitation:							
Total: Services not included in capitation:							45268697.14
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							17546.01
Services included in capitation:							
Services not included in capitation:							17546.01
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Consumer Goods and Services Total:</b>							143790.00
Goods and Services (Goods)		service	27	3.86	500.00	52110.00	
Goods and Services (Services)		service	24	7.64	500.00	91680.00	
<b>Dietetic Services Total:</b>							264.00
Dietetic Services		15 minutes	2	8.65	15.26	264.00	
<b>Environmental Accessibility Adaptations Total:</b>							805920.00
Environmental Accessibility Adaptations		visit	146	2.76	2000.00	805920.00	
<b>Family Training and Support Total:</b>							17348.47
Family Training and Support		15 minutes	17	120.20	8.49	17348.47	
<b>Health and Wellness Total:</b>							68345.69
Health and Wellness		service	101	7.00	96.67	68345.69	
<b>Homemaker Chore Total:</b>							73235.00
Homemaker Chore		service	97	3.02	250.00	73235.00	
<b>Non-medical Transportation Total:</b>							370092.78
Trip		service	135	43.60	12.40	72986.40	
Miles		mile	815	1104.69	0.33	297106.38	
<b>Nutrition Total:</b>							490265.96
Nutrition		meal	483	179.02	5.67	490265.96	
<b>Occupational Therapy Total:</b>							112.13
Occupational Therapy		visit	1	1.84	60.94	112.13	
<b>Pain and Symptom Management Total:</b>							165574.49
Pain and Symptom Management		session	135	15.61	78.57	165574.49	
<b>Personal Emergency Response Systems Total:</b>							212810.56
<b>GRAND TOTAL:</b>							45268697.14
Total: Services included in capitation:							
Total: Services not included in capitation:							45268697.14
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							17546.01
Services included in capitation:							
Services not included in capitation:							17546.01
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Installation		service	86	0.44	100.00	3784.00	
Monthly		month	656	4.54	69.00	205498.56	
Purchase		item	21	0.21	800.00	3528.00	
<b>Physical Therapy Total:</b>							2029.73
Physical Therapy		15 minutes	3	27.15	24.92	2029.73	
<b>Post Acute Rehabilitation Services Total:</b>							215828.02
Post Acute Rehabilitation Services		day	28	9.96	773.91	215828.02	
<b>Private Duty Nursing Total:</b>							913747.09
RN Supervision		15 minutes	15	46.84	15.31	10756.81	
LPN		15 minutes	243	278.96	8.95	606696.16	
RN		15 minutes	149	176.29	11.28	296294.13	
<b>Senior Companion Total:</b>							2465.98
Senior Companion		15 minutes	7	260.95	1.35	2465.98	
<b>Specialized Child Care for Medically Fragile Children Total:</b>							31262.07
Specialized Child Care for Medically Fragile Children		15 minutes	3	1847.64	5.64	31262.07	
<b>Specialized Medical Equipment and Supplies Total:</b>							1416440.00
Equipment		item	874	0.67	2000.00	1171160.00	
Supplies		item	511	0.24	2000.00	245280.00	
<b>Speech Therapy Total:</b>							0.00
Speech Therapy		visit	0	0.00	64.62	0.00	
<b>Supported Living Total:</b>							295135.67
Supported Living		day	7	186.79	225.72	295135.67	
<b>Vehicle Modifications</b>							125280.00
<b>GRAND TOTAL:</b>							45268697.14
Total: Services included in capitation:							
Total: Services not included in capitation:							45268697.14
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							17546.01
Services included in capitation:							
Services not included in capitation:							17546.01
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Total:</b>							
Vehicle Modifications		service	36	1.74	2000.00	125280.00	
<b>GRAND TOTAL:</b>							45268697.14
Total: Services included in capitation:							
Total: Services not included in capitation:							45268697.14
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							17546.01
Services included in capitation:							
Services not included in capitation:							17546.01
Average Length of Stay on the Waiver:							305

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (9 of 9)**

**d. Estimate of Factor D.**

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							71129.94
Adult Day Health		15 minutes	23	1405.73	2.20	71129.94	
<b>Case Management Total:</b>							7060444.57
Specialized		day	36	252.22	18.51	168069.32	
Day		day	2544	245.85	11.02	6892375.25	
15 minutes		15 minutes	0	0.00	15.60	0.00	
<b>Community First Choice/Personal Assistance and Specially Trained Attendant Care Total:</b>							9162288.93
CFC/PAS - Specially Trained		15 minutes	396	476.97	5.63	1063395.08	
CFC/PAS - Basic/Social/Supervision		15 minutes	1282	1162.32	4.64	6914037.27	
CFC/PAS - Shared						26127.02	
<b>GRAND TOTAL:</b>							45268565.14
Total: Services included in capitation:							
Total: Services not included in capitation:							45268565.14
Total Estimated Unduplicated Participants:							2580
Factor D (Divide total by number of participants):							17545.96
Services included in capitation:							
Services not included in capitation:							17545.96
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		day	8	310.74	10.51		
CFC/PAS - STA LPN		15 minutes	10	10072.56	8.95	901494.12	
CFC/PAS - STA RN		15 minutes	6	3800.76	11.28	257235.44	
<b>Day Habilitation Total:</b>							48557.53
Day Habilitation		day	9	67.34	80.12	48557.53	
<b>Homemaker Total:</b>							942532.21
Homemaker		15 minutes	534	449.12	3.93	942532.21	
<b>Prevocational Services Total:</b>							122521.33
Prevocational Services		hour	25	627.51	7.81	122521.33	
<b>Residential Habilitation Total:</b>							21094805.95
TBI Residential		day	51	315.48	165.77	2667153.10	
Adult Residential		day	760	185.53	104.00	14664291.20	
Child Foster		day	0	0.00	111.79	0.00	
Advanced Behavior Management		day	104	185.53	141.00	2720611.92	
Group Home		day	16	315.48	206.58	1042749.73	
<b>Respite Total:</b>							185945.89
Residential		day	11	9.68	360.00	38332.80	
Individual		15 minutes	47	801.20	3.92	147613.09	
<b>Supported Employment Total:</b>							8352.99
Supported Employment		15 minutes	7	91.16	13.09	8352.99	
<b>Audiology Total:</b>							0.00
Audiology		15 minutes	0	0.00	56.88	0.00	
<b>Respiratory Therapy Total:</b>							38797.16
Therapeutic Procedures		15 minutes				38797.16	
<b>GRAND TOTAL:</b>							45268565.14
Total: Services included in capitation:							45268565.14
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Total Estimated Unduplicated Participants:							17545.96
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Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			4	847.84	11.44		
Visit		visit	0	0.00	25.00	0.00	
<b>Financial Management Services Total:</b>							61828.07
Financial Management Services		month	35	10.23	172.68	61828.07	
<b>Independence Advisor Total:</b>							61828.07
Independence Advisor		month	35	10.23	172.68	61828.07	
<b>Community Supports Total:</b>							1051498.21
Community Supports		15 minutes	35	5336.20	5.63	1051498.21	
<b>Community Transition Total:</b>							4680.00
Community Transition		service	3	0.78	2000.00	4680.00	
<b>Consultative Clinical and Therapeutic Services Total:</b>							3538.66
Consultative Clinical and Therapeutic Services		service	5	1.91	370.54	3538.66	
<b>Consumer Goods and Services Total:</b>							143790.00
Goods and Services (Goods)		service	27	3.86	500.00	52110.00	
Goods and Services (Services)		service	24	7.64	500.00	91680.00	
<b>Dietetic Services Total:</b>							132.00
Dietetic Services		15 minutes	1	8.65	15.26	132.00	
<b>Environmental Accessibility Adaptations Total:</b>							805920.00
Environmental Accessibility Adaptations		service	146	2.76	2000.00	805920.00	
<b>Family Training and Support Total:</b>							17348.47
Family Training and Support		15 minutes	17	120.20	8.49	17348.47	
<b>Health and Wellness Total:</b>							68345.69
Health and Wellness		service	101	7.00	96.67	68345.69	
<b>GRAND TOTAL:</b>							45268565.14
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Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Homemaker Chore Total:</b>							73235.00
Homemaker Chore		service	97	3.02	250.00	73235.00	
<b>Non-medical Transportation Total:</b>							370092.78
Trip		service	135	43.60	12.40	72986.40	
Miles		mile	815	1104.69	0.33	297106.38	
<b>Nutrition Total:</b>							490265.96
Nutrition		meal	483	179.02	5.67	490265.96	
<b>Occupational Therapy Total:</b>							112.13
Occupational Therapy		visit	1	1.84	60.94	112.13	
<b>Pain and Symptom Management Total:</b>							165574.49
Pain and Symptom Management		session	135	15.61	78.57	165574.49	
<b>Personal Emergency Response Systems Total:</b>							212810.56
Installation		service	86	0.44	100.00	3784.00	
Monthly		month	656	4.54	69.00	205498.56	
Purchase		item	21	0.21	800.00	3528.00	
<b>Physical Therapy Total:</b>							2029.73
Physical Therapy		15 minutes	3	27.15	24.92	2029.73	
<b>Post Acute Rehabilitation Services Total:</b>							215828.02
Post Acute Rehabilitation Services		day	28	9.96	773.91	215828.02	
<b>Private Duty Nursing Total:</b>							913747.09
RN Supervision		15 minutes	15	46.84	15.31	10756.81	
LPN		15 minutes	243	278.96	8.95	606696.16	
RN		15 minutes	149	176.29	11.28	296294.13	
<b>Senior Companion Total:</b>							2465.98
<b>GRAND TOTAL:</b>							45268565.14
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Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Senior Companion		15 minutes	7	260.95	1.35	2465.98	
<b>Specialized Child Care for Medically Fragile Children Total:</b>							31262.07
Specialized Child Care for Medically Fragile Children		15 minutes	3	1847.64	5.64	31262.07	
<b>Specialized Medical Equipment and Supplies Total:</b>							1416440.00
Equipment		item	874	0.67	2000.00	1171160.00	
Supplies		item	511	0.24	2000.00	245280.00	
<b>Speech Therapy Total:</b>							0.00
Speech Therapy		visit	0	0.00	64.62	0.00	
<b>Supported Living Total:</b>							295135.67
Supported Living		day	7	186.79	225.72	295135.67	
<b>Vehicle Modifications Total:</b>							125280.00
Vehicle Modifications		service	36	1.74	2000.00	125280.00	
<b>GRAND TOTAL:</b>							45268565.14
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