Montana Money Follows the Person
Operational Protocol
Version 1.1

Submitted by:
Montana Department of Public Health and Human Services
Montana Senior and Long Term Care Division
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Table of Contents

Table of Contents 2
Table of Tables 5
Table of Figures 5
A. Project Introduction 6
A.1 Organization and Administration 9
System Assessment and Gap Analysis 9
Description of Administrative Structure 22
A.2 Benchmarks 24
B. Demonstration Implementation Policies and Procedures 31
B.1 Participant Recruitment and Enrollment 31
Selecting the Transition Service Provider 33
Participant Selection Mechanism 36
Qualified Institutional Settings from which Individuals will Transition 40
Minimum Residency Requirements 41
Assuring Medicaid Eligibility 41
Transition Assessment Process 42
MFP Re-enrollment Policy 49
Ensuring Consumers and Families Have Information to Make Informed Choices 51
B.2 Informed Consent and Guardianship 54
Informed Consent Procedures 54
Guardianship 55
B.3 Outreach / Marketing / Education 56
Information Communicated to Enrollees, Providers, and State Staff 56
Media Types 59
Targeted Geographic Areas 62
Locations for Information Dissemination 62
Staff Training, State Forum, and Public Educational Seminars 62
Draft Training Schedule 64
Bilingual Materials and Interpretation Services 65
Cost Sharing Responsibilities 66
B.4 Stakeholder Involvement 67
Stakeholder Involvement Chart 68
Consumer and Family Involvement in Demonstration 68
Community and Facility Provider Involvement in Demonstration 70
Consumer and Provider Roles and Responsibilities 70
Consumer and Provider Operational Activities 71
B.5 Benefits and Services 74
Service Delivery System for MFP Participants 74
Service Package Available for MFP Participants 74
B.6 Consumer Supports 107
Description of Educational Materials 107
Description of 24-Hour Back Up Systems 107

Grievance and Resolution Process for Back-Up System Failures 114
Additional Consumer Quality Assurances..... 114
B.7 Self-Direction 116
Voluntary Self-Direction Termination..... 118
State Termination of Self-Direction 119
State Self-Direction Goal..... 119
B.8 Quality 122
1915c Waiver and 1915i State Plan Program Integration 123
1915b, State Plan Amendment, or 1115 Waiver 124
1915c Waiver and 1915i State Plan Assurances 124
Supplemental Demonstration Services Quality Assurances..... 124
Additional MFP Quality Assurance Requirements..... 125
B.9 Housing 126
Process for Documenting Type of Residences to which Participants Transition ... 126
Methods to Ensure Sufficient Supply of Qualified Residences..... 128
B.10 Continuity of Care Post-Demonstration..... 140
Managed Care Participants..... 140
HCBS waiver participants..... 140
Section 1115 Participants 141
HCBS State Plan Program Participants..... 141
C. Project Administration..... 142
C.1 Organizational Chart..... 142
C.2 Staffing Plan 144
The Community Choice Partnership MFP Project Director Is A Full Time Position 144
Number and Title of Dedicated Positions..... 144
Percentage of Time for Each Position is Dedicated 145
Roles and Responsibilities..... 145
Positions Providing In-Kind Support 147
Contracted Individuals Supporting the Grant..... 147
Detailed Staffing Timeline..... 149
Entity Responsible for Staff Performance Assessment 150
C.3 Billing and Reimbursement Procedures 150
D. Evaluation 153
E. Budget..... 154
Attachment 1: Risk Assessments 155
1.1 Risk Prevention Assessment From for Individuals Who Are Elderly or Physically Disabled..... 155
1.2 Risk Negotiation Process for Individuals Who Are Elderly or Physically Disabled 157
1.3 Risk Negotiation Agreement Form for Individuals Who Are Elderly or Physically Disabled..... 160
1.4 Risk Prevention, Assessment, and Management Plan for Individuals with Severe Disabling Mental Illness 161
1.5 Risk Negotiation Process and Agreement for Individuals with Severe Disabling Mental Illness..... 163

1.6 Community Placement Profile Including Risk Assessment for Individuals with Developmental Disabilities 166
1.7 Risk Assessment for Youth with Serious Emotional Disturbance 172
Attachment 2: Other Assessment Tools 175
2.1 Nursing Home Transition Needs Survey 175
2.2 Level of Care Assessment Form 181
2.3 Brief MAST 185
2.4 Housing Checklist 186
Attachment 3: Outreach Materials 188
3.1 HCBS Booklet for MFP 188
3.2 Self-Direct Brochure 208
3.3 MFP Flyer 216

Table of Tables

Table 1: Estimate of Potential MFP Participants 19
Table 2: Estimate of Potential MFP Participants 25
Table 3: Projected Total HCBS Expenditures CY2012 – 2016 27
Table 4: Medicaid Consumers Self-Directing Services..... 28
Table 5: MFP Participants Remaining in Community 29
Table 6: Section 8 Housing Vouchers Used by MFP Participants 30
Table 7: Recruitment and Enrollment Process Narrative 32
Table 8: Outreach, Education, Marketing, and Training Efforts by Stakeholder Group... 56
Table 9: Planning Stakeholder Advisory Council Members 69
Table 10: Montana Big Sky and SDMI 1915c Waivers Benefits and Services..... 75
Table 11: Developmental Disabilities Comprehensive Waiver Benefits and Services 82
Table 12: Youth with SED State Plan Program Benefits and Services 88
Table 13: Local Service Delivery System per Target Population..... 143
Table 14: MFP Key Staff Roles and Responsibilities 145
Table 15: In Kind Staff Roles, Responsibilities, and Time Dedicated 147

Table of Figures

Figure 1: MFP High-Level Organizational Chart 23
Figure 2: High-Level Recruitment and Enrollment Process 31
Figure 3: Stakeholder Involvement in MFP Demonstration Project..... 68
Figure 4: High-level Responsibility for Target Populations..... 142
Figure 5: Detailed MFP Demonstration Project Organizational Chart 144
Figure 6: Staff Timeline 150

A. Project Introduction

Montana is committed to enhancing its long term services and supports (LTSS)[1] system to increase the use of home and community based services (HCBS) and reduce the use of institutional supports. The State faces numerous challenges in achieving this goal – some of which are unique to frontier[2] states, such as insufficient provider and caregiver capacity and accessible housing availability, and many of which are universally faced by states nationwide, including limited funds being balanced between entitlement and non-entitlement (i.e. waiver) expenditures.

Montana is submitting this grant application to the Centers for Medicare and Medicaid Services (CMS) to implement a Money Follows the Person (MFP) demonstration project to augment existing community-based LTSS, and institute a change initiative to rebalance its long term care system. Montana's MFP demonstration project, known as Montana Community Choice Partnership MFP will expand the State's existing transition efforts to individuals of all target populations with more complex needs. Montana will invest the savings garnered through the enhanced Federal Medical Assistance Percentage (FMAP) into increased HCBS services and supports, including diversion activities and waiver expansion.

Montana's vision for its Community Choice Partnership MFP demonstration project is to create a sustainable system that supports community options as a first

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[1] Montana's LTSS population includes consumer who are elderly, physically disabled, developmentally disabled, adults with severe disabling mental illness, and youth with serious emotional disturbance.

[2] 46 out of Montana's 56 counties are considered frontier with an average population of 6 or fewer people per square mile.

choice for individuals needing long term services and supports. This means that:

- Individuals within institutions are supported in making informed choices. Institutional and community-based providers work well together with the common goal of keeping Montanans in the community whenever possible.
- Individuals in facility settings can transition to the community seamlessly without needing to wait for annual enrollment timeframes or wait lists.
- Individuals in the community have a high quality of life. They are connected to their families, community, recreational activities, work, and other needed supports.
- Employment opportunities exist for individuals wishing to work.
- Supportive services exist that keep individuals with complex needs in their communities.
- Consumers are in control – they have had a meaningful part in the definition of the MFP demonstration program and continue to be involved ongoing in the oversight and maintenance of the project.
- Workforce capacity is supplemented to support transitions.
- Housing is coordinated to ensure individuals are efficiently connected with appropriate living arrangements.
- Training opportunities exist for evidence-based or promising practices.
- The public perception of individuals who are elderly and disabled has improved because of outreach to the general population.

- Rebalancing the traditional long term care and institutional system is sustainable beyond the MFP grant – it is based on Montana's needs, values, and realities.

The Department of Public Health and Human Services (DPHHS or Department) collaborated closely with a wide variety of stakeholders, including consumers, family members, advocates, facility providers, and community providers and caregivers to develop this operational protocol. As a result, the partnership between provider networks, advocacy groups, and State agencies has been strengthened and will continue to be nurtured by the MFP project director in order to achieve the goals of the demonstration. Montana is poised to build on the successful work done to create this operational protocol to assure Montanans experience informed choice about the range of service options, including community living options. Ultimately, greater access to choices for service and supports will further reduce the institutional bias in Montana.

Montana has been successfully moving consumers who are elderly or physically disabled from nursing facilities to community settings since 1999. Through the Montana Community Choice Partnership MFP demonstration project, the State will broaden its reach to further target individuals with developmental disabilities, severe disabling mental illness (SDMI), serious emotional disturbance (SED), and other complex needs such as traumatic brain injuries (TBI). The State will work through the MFP demonstration to increase capacity statewide to serve the needs of these populations. Housing and provider/caregiver capacity constraints are both significant barriers in Montana. The Montana Community Choice Partnership MFP stakeholder advisory council and MFP project staff will collaboratively address these issues, looking for

creative solutions including means to promote additional accessible housing meeting MFP residence requirements, and working with nursing facilities and other institutions to repurpose existing resources to enhance the availability of HCBS supports.

The Montana MFP demonstration project will be a five-year, $14,843,807 project. The State will move toward rebalancing with a shift toward HCBS spending over institutional spending.

A.1 Organization and Administration

This section of the operational protocol analyzes Montana's LTSS systems, including work done to increase the availability of HCBS services and obstacles preventing the State from further rebalancing services away from institutional to HCBS-based care. It also includes the empirical measures Montana will use to gauge progress toward transitioning individuals and rebalancing the LTSS system under the Community Choice Partnership MFP demonstration project.

System Assessment and Gap Analysis

Description of current LTSS support systems, past legislative initiatives, and additional State legislative/regulatory changes needed to rebalance the LTSS system

This section contains a description of the current Montana LTSS support systems, prior to the advent of the MFP demonstration program. Montana provides LTSS primarily through four divisions and six bureaus/programs within DPHHS:

1. Senior Long Term Care (SLTC) Division, which includes four bureaus:
    a. Nursing Facilities Bureau
    b. Adult Protective Services Bureau
    c. Aging Services Bureau
    d. Community Services Bureau

2. Developmental Services Division (DSD)
    a. Developmental Disabilities Program (DDP)
    b. Children's Mental Health Bureau (CMHB)
3. Addictive and Mental Disorders Division (AMDD)
4. Disability Employment and Transitions Division

SLTC plans, administers, and provides long term care services to consumers who are elderly or have a physical disability, as well as their families. The Community Services Bureau operates an HCBS waiver, called the Montana Big Sky Waiver, which incorporates traditional HCBS services, specialized services, and assisted living facilities as alternatives to institutional care. This waiver has a participant directed option. The division serves approximately 2,000 individuals on the Big Sky waiver. The Community Services Bureau operates the State's Hospice, Home Health, Personal Assistance Services, and Self-Direct Personal Assistance Services programs. SLTC's Office on Aging develops the State Plan on aging and approves service delivery plans and programs developed by the ten Area Agencies on Aging (AAAs) located across Montana.

SLTC has been operating a transitions program since 1999 within its HCBS waiver. Montana consistently has a waiting list of around 450 individuals for the Big Sky waiver. The Division is able to transition nursing home residents in a set timeframe annually to the waiver regardless of slot capacity. Money follows the individuals transitioning. During the last legislative session, the legislature directed $2.5 million for transition and diversion assistance.

DSD/DDP helps Montanans with developmental disabilities live, work and participate in communities. DDP operates extended State Plan services in addition to three waivers:

1. **Comprehensive waiver** – this is the most complete set of services and benefits available to individuals with developmental disabilities.
2. **Community supports waiver** – this waiver is more limited in nature and is individually capped.
3. **Autism waiver** – this waiver provides benefits and services for children with autism up to eight years old.

The waivers serve a total population of approximately 3,000 individuals. An additional 1,000 individuals receive services through the State Plan, and another 1,000 are on waiver waiting lists. The Montana Developmental Center (MDC) is Montana's intermediate care facility for individuals with mental retardation or developmental disabilities (ICF-MR). Montana previously operated a second ICF-MR, which was closed in 2003, and all residents moved to the community. The State has continually focused on downsizing MDC. There currently are 48 individuals residing there, which is a significant reduction from 160 consumers in 2000. Individuals transitioning from MDC to the community are given expansion slots, so they do not have to wait for a slot to open.

Children's Mental Health Bureau (CMHB) – serves youth with SED and their families. CMHB is one of nine states nationally that operated a psychiatric residential treatment facilities (PRTF) demonstration waiver/grant, which provided benefits and services to allow youth to transition or be diverted from PRTFs and remain at home. The waiver began operating in 2007, and expired on September 30, 2012. CMHB submitted a successful application to CMS for a 1915c HCBS bridge waiver to continue

services to families and youth currently on the PRTF demonstration waiver/grant. CMHB also submitted a successful 1915i HCBS State Plan request to make these HCBS services available statewide. CMS approved the program with an effective date of January 1, 2013. Proposed Administrative Rules of Montana have been filed to support these changes.

AMDD provides chemical dependency and mental health services. AMDD has an HCBS waiver for individuals with SDMI in five geographic areas. Montana is one of only a small number of states (less than five) in the country with a waiver for persons with Severe Disabling Mental Illness. The waiver was approved in 2006 for 125 slots, and has since been expanded to 168. AMDD is hoping to receive legislative approval to further expand the waiver to 298 by the end of 2015. Currently there is a small waitlist for the waiver in the areas where it provides services. AMDD also oversees the Montana State Hospital and the Montana Mental Health Nursing Care Center, both of which are Institutes for Mental Disease (IMDs). Individuals have transitioned from these IMDs as well as nursing facilities to the waiver. There is a disconnect between the SDMI waiver and the nursing facilities, in that SDMI waiver providers do not know who is a candidate for transition because they do not have access to the Minimum Data Set (MDS).

Funding inflexibility impacts the ability of SLTC, DSD, and AMDD to rebalance the system toward HCBS as an ongoing objective. SLTC consumers wanting to transition have to wait for the annual transition period, and then can have the money follow them into the community. DSD and AMDD consumers transitioning from nursing facilities to the community have to wait for a slot. To this point, the State has not allowed money

to follow an individual out of a nursing home into a developmental disabilities (DD) or SDMI waiver. This is primarily a result of division budget separation; meaning money cannot easily transfer across division lines from SLTC to DSD or AMDD. The implementation of the Montana Community Choice Partnership MFP demonstration project will address challenges associated with funding inflexibility, removing the barriers of annual transition periods and slot capacity limitations for MFP participants.

Montana's Disability Employment and Transitions Division promotes employment and independence among Montanans with disabilities through multiple services:

1. **Vocational Rehabilitation** – assists approximately 8,000 Montanans with disabilities each year in securing competitive, integrated employment.
2. **Blind and Low Vision Services** – help blind or visually impaired Montanans secure employment and achieve self-reliance through instruction in alternative techniques and tools.
3. **Independent Living Services** – coordinate independent living services in collaboration with the Statewide Independent Living Council. Four centers for independent living (CILs) (Billings, Great Falls, Helena and Missoula) provide services.
4. **Disability Determination Services** – determine eligibility for the Social Security Administration's Supplemental Security Income and Social Security Disability Insurance programs for approximately 12,000 Montanans each year.
5. **Montana Telecommunications Access Project** – operates the Montana Relay

and provides services and equipment to ensure approximately 1,100 Montanans with disabilities can use the telephone.

6. **Medicaid Infrastructure Grant** – removes barriers to employment and independence among Montanans with disabilities who receive Medicaid. This grant ends in December 2012.
7. **Public Transportation Coordination** – coordinates access to Montana's public transportation programs.
8. **Transition Services** – promote successful transitions from high school to work and/or post-secondary education.

The Disability Employment and Transitions Division's services are generally not categorized as HCBS Medicaid services, however Medicaid clients use them as additional supports for successful community living. The Community Choice Partnership MFP project will collaborate closely with the Disability Employment and Transitions Division in communications with the Statewide Independent Living Council as well as providing employment, transportation, and electronic communication opportunities. Other divisions' services are included in Section B.5, Benefits and Services.

Assessment of Medicaid programs and services working to rebalance the system, current transition processes/programs, and additional programs/services needed for rebalancing work

Montana has been successful in transitioning individuals from nursing facilities to the community, particularly those needing less intensive care. The State has also done a good job transitioning individuals from ICF-MRs over many years, and in-state PRTFs more recently. The State has been less successful with more complex institutionalized

individuals, including those with traumatic brain injuries (TBI), bariatric needs, as well as individuals with dual diagnoses such as mental illness (MI) and DD, or MI and TBI.

The MFP planning stakeholder advisory council assessed Montana's long term services and supports and defined the following obstacles keeping Montana from having a LTSS system balanced in favor of HCBS:

1. **Inadequate consumer control** – despite ongoing efforts to involve consumers, many feel Montana's long term system lacks adequate consumer direction and does not promote or encourage participation by family and friends.
2. **Attitudinal and prejudicial barriers** – there is a need for increased education and awareness regarding disability, aging, and mental illness in Montana to reduce stigma.
3. **Inadequate assessment of the current/as-is state and what progress toward success looks like** – the State needs to assess the consumer population and then define the demonstration project objectives accordingly. The MFP project should be data driven, with standardized outcome definitions and tools to measure and evaluate progress.
4. **Policy problems** – the State should examine federal and State policies, regulations, and statutes to ensure they support MFP goals. In particular, silos between programs/funding sources should be eliminated to support better coordination of systems. The State may also examine limitations within the Nurse Practices Act regarding nursing task delegation that make providing care to high acuity consumers costly and difficult.

5. **Institutional bias and State willingness to appropriate matching funds** – Montana and the federal government are working to alter historical economic bias toward institutions. State leadership needs additional education about LTSS opportunities to promote consistent funding for a rebalanced system.
6. **Lack of access and choice** – timely interventions should occur to prevent institutional placements, when possible, so consumers can live in the least restrictive settings possible. Services and supports should be available in rural/ frontier communities as well as in cities and larger towns.
7. **Lack of certain specialized additional services and supports** – Individuals transitioning from institutions under MFP will generally have more complex needs, and will require additional benefits and services to support them living successfully and happily in community settings.
8. **Lack of healthy workforce development and retention plan** – Montana suffers from a workforce shortage, particularly in rural/frontier areas. The State will need to focus on growing census and quality of the direct service and home care workforce.
9. **Insufficient supply of affordable, accessible housing** – The lack of affordable, accessible housing is one of the largest barriers to keeping people in or transitioning consumers to community settings.

Description of number of potential MFP participants

Montana's MFP program impacts all long term care population types statewide. SLTC wants to build on its existing transition work, allowing transitions to happen any

time in the calendar year and supporting individuals transitioning with more complex needs. The State has historically transitioned 40 to 70 individuals who are elderly or physically disabled from nursing facilities each year. The Department assumes this number will grow as additional consumers are seen as viable transition candidates, support structures and provider capacity are increased, and word spreads of the program. However, many currently transition to assisted living facilities, some of which do not meet qualified residence criteria for MFP, so the number of MFP transitions from SLTC will be smaller until additional housing options become available.

DSD/DDP will transition individuals from MDC as well as nursing facilities. DSD/DDP has placed 15-30 individuals annually from MDC in the community over the last eight years. Many of these placements are to unqualified residences because a significant percentage of Montana's group homes are too large to qualify under MFP. The State hopes to increase the number of smaller group homes over the lifetime of this project, and see the number of consumers with developmental disabilities participating in MFP grow accordingly. According to Pre-Admission Screening and Resident Review (PASRR) level two assessments, Montana has approximately 185 consumers with developmental disabilities living in nursing facilities. The State needs to conduct further assessments to determine how many of these individuals may be viable transition candidates.

As of June 30, 2012, 50 youth were actively enrolled in the PRTF Waiver/Grant. Of this population, 19 were transitioned from PRTFs. In addition to those already being transitioned, CMHB plans to focus on children and youth with higher needs living in out-

of-state PRTFs under the MFP program. In 2011, there were approximately 165 youth in PRTFs (in-state and out-of-state) 90 days or longer; in 2010, there were 159 youth in PRTFs 90 days or longer (per paid claims data). Montana is projecting and tracking youth with SED separately from individuals with mental illness in the "Other" category. Youth who age out during the 365-day MFP period will be assessed for eligibility and referred to the other MFP-related waivers (SDMI, DD, Big Sky Waiver) early in the MFP process. Many youth with SED do not meet SDMI level of care requirements, and will not be eligible to receive HCBS services under the current SDMI waiver criteria once they age out of the SED 1915i HCBS State Plan program. Those not eligible for waivers would be able to receive a reduced package of services under Personal Assistance Services or Community First Choice programs if Medicaid eligible.

AMDD will be focusing on transitioning individuals with SDMI from nursing homes as well as Medicaid eligible individuals (18-21 year olds and individuals 65 and older) in the Montana State Hospital and Montana Mental Health Nursing Care Center. Historically, very few SDMI consumers transition, primarily because they have not been a part of the SLTC nursing facility transition initiative, meaning these consumers have not been targeted for potential community placement. The majority of SDMI waiver clients have been diverted from nursing facilities, rather than transitioned out of them. Under MFP, the State expects this population to grow, but still remain a relatively small portion of the overall MFP universe.

The table below shows Montana's estimated number of transitions by target group from calendar year 2012 through 2016.

Table 1: Estimate of Potential MFP Participants

Year	Elderly	MR/DD	Physically Disabled	Mental Illness	Other*	Total
CY2012	0	0	0	0	0	0
CY2013	5	5	5	3	15	33
CY2014	10	5	10	7	30	62
CY2015	10	5	15	10	30	70
CY2016	10	5	20	10	25	70
Total	35	20	50	30	100	235

*Montana is defining 'other' as youth with SED, transitioning from PRTFs.

Description of existing and future self-direct opportunities

Montana, like most states, is facing a large and growing care gap. The state's population needing care is growing at a much faster rate than those providing it. Because of this, Montana has been, and plans to continue, focusing on self-direction. Self-direction brings people in as caregivers and natural supports because of personal relationships. Many of these individuals would not otherwise enter the workforce.

SLTC has a self-direction option under the Montana Big Sky waiver, called the Bonanza option, which was established in 2006. It is a consumer-directed model where participants plan and direct their own care, and are also responsible for budgeting and spending. Bonanza allows parents of minors and spouses to be paid for care up to 40 hours per week. SLTC is working to increase the number of participants self-directing their care through increased outreach, education, and training. SLTC also offers self-direction in its State Plan Personal Assistance Services, which allows consumers to hire, fire, and train their attendants. This form of self-direction does not permit consumers

to pay a parent of a minor or spouse for care. Both approaches have a provider agency as the legal employer, and the consumer serving as the managing employer.

The waivers for developmental disabilities have self-direct options available for certain services, except for consumers in congregate settings. DSD/DDP does not anticipate that targeted participants will use self-direction under the Community Choice Partnership MFP demonstration.

The PRTF waiver does not include self-direct options per se, but does include High Fidelity Wraparound Facilitation. High Fidelity Wraparound Facilitation services are comprised of a variety of specific tasks and activities designed to carry out the wraparound process whereby the youth and family have voice and choice in service provision.

The waiver for persons with SDMI language does not allow for self-direction or legally responsible caregivers. AMDD would like to implement self-direction and allow consumers to pay legally responsible caregivers, with adequate risk assessment and quality monitoring by 2016. This work will not be done as a part of the Montana Community Choice Partnership MFP demonstration, unless the project continues past 2016.

Stakeholder involvement in Montana's LTSS system

All four divisions involve stakeholders as advisors in their programs to some extent. SLTC mandates that case management teams use a mechanism to gather consumer input, preferably a consumer advisory council. All teams are required to conduct an annual satisfaction survey and address issues raised. SLTC has historically

looked to the Governor's Advisory Council on Aging and more recently to the Long Term Care Coalition as sources of input. SLTC has consistently sought out providers, consumers, and associations for stakeholder input.

DSD/DDP participates in the Montana Council on Developmental Disabilities. This council has a large community presence in terms of consumers (who must make up at least 50% of the council), families, providers, advocates, and other interested parties. DSD/DDP relies heavily on the council for input into Department projects and planning efforts.

AMDD community program officers interview 100% of their HCBS waiver consumers annually to discuss services and what consumers would like to see work differently. Community program officers collaborate very closely with consumers and families, and meet with them as issues arise. Additionally, AMDD works with its three Service Area Authorities, local advisory councils, and the Mental Health Oversight Advisory Council.

CMHB collaborates closely with the Montana Children's Initiative (MCI) as well as the System of Care Committee.

The Disability Employment and Transitions Division works closely with consumers through the Statewide Independent Living Council and the Vocational Rehabilitation Council.

The Montana MFP planning stakeholder advisory council collaborated with the Department to provide input into this draft operational protocol, and will continue to work with the State over the lifetime of the demonstration project. DPHHS is also

seeking broader stakeholder involvement through ongoing community forums or town hall meetings, a public web portal, and increased consumer/family appointments to the council.

Description of Administrative Structure

SLTC will be the lead agency for Montana's MFP demonstration program. SLTC is the division with the most transition expertise and related infrastructure to draw upon for the demonstration project. Additionally, SLTC has a long established connection with nursing facilities, the Montana Health Care Association, and MHA, an association of healthcare providers, which represents nursing facilities.

The SLTC administrator will oversee the Community Choice Partnership MFP demonstration project. The Medicaid Director will keep in close contact with the SLTC administrator as well as the MFP project director over the lifetime of the project.

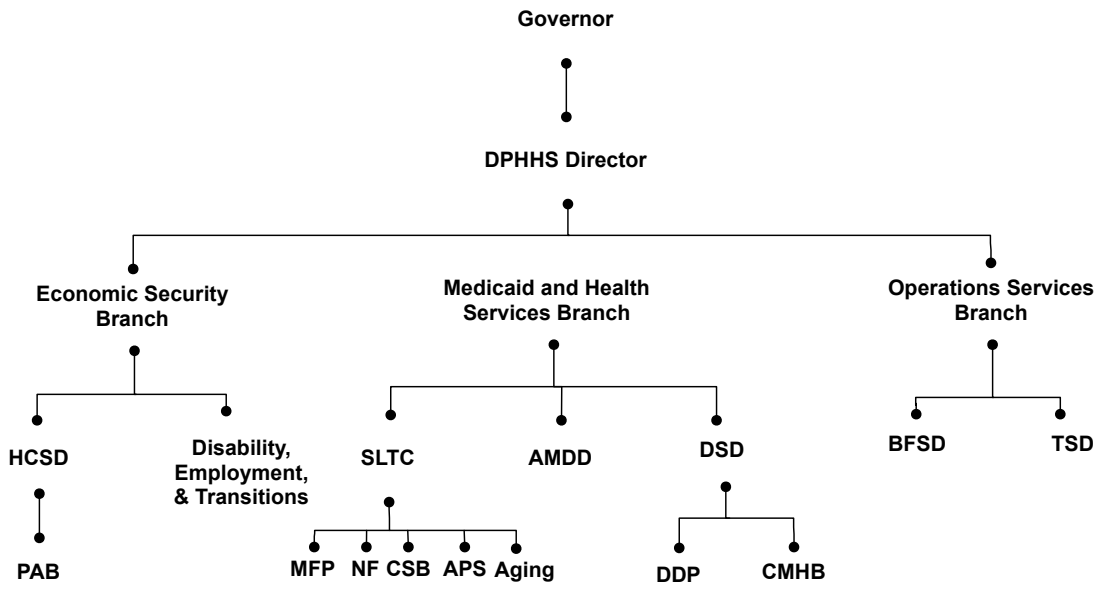
The Department is very committed to having all impacted divisions/bureaus working closely with the MFP demonstration project. AMDD, DSD (DDP and CMHB), and the Disability Employment and Transitions Division will all be closely collaborating to ensure their diverse consumer needs are meaningfully represented.

The Montana Community Choice Partnership MFP demonstration project will also be working closely with the following Divisions in DPHHS:

- **Business and Financial Services Division** (BFSD) in the Department for finance support.

- **Human and Community Services Division** (HCSD), Public Assistance Bureau (PAB). PAB's county offices, called Offices of Public Assistance (OPAs) determine Medicaid financial eligibility.
- **Technology Services Division** (TSD) to support data and information technology development required for project management and reporting.

Figure 1: MFP High-Level Organizational Chart



The MFP demonstration project will additionally be relying on the expertise of Departments external to DPHHS, including:

- **Department of Commerce** will serve as a partner on MFP housing efforts.
- **Department of Labor and Industry** will support employment and workforce-related work within the demonstration as needed.
- **Department of Transportation** will advise and collaborate on transportation-focused work.

A.2 Benchmarks

Montana is committed to furthering its LTSS rebalancing efforts through the Community Choice Partnership MFP demonstration program. The State has been successfully transitioning individuals who are elderly or disabled from nursing facilities for almost 15 years. In addition, the PRTF demonstration waiver/grant has successfully transitioned youth from PRTFs into the demonstration waiver/grant over the past four and a half years. DSD/DDP has reduced the population in Montana's ICF-MRs from over 800 individuals 40 years ago, to 48 today. Montana is excited to increase the scope of this work by providing increased benefits and services and targeting additional populations to make transitioning a viable option to more individuals.

Montana intends to reinvest savings realized through the Community Choice Partnership MFP demonstration project into services and supports to continue rebalancing the State's LTSS system. The State may invest these funds into increased diversion services including demonstration sites for pre-admission counseling, as well as housing supports, transportation services, and provider training or capacity building.

DPHHS will use the following five benchmarks to empirically measure progress toward the State's goals of transitioning individuals to the community and further rebalancing its LTSS system toward increased use of HCBS services and decreased institutional services. The first two are the CMS required benchmarks.

1. *Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.*

Montana plans to transition 235 individuals under the Community Choice Partnership MFP demonstration project from calendar year 2013 through 2016. The State will not transition anyone in 2012 because it will use September through December 2012 to refine the draft operational protocol, hire/move staff, and establish Community Choice Partnership MFP infrastructure. The State is targeting individuals throughout its LTSS system for the MFP project. The table below outlines the number of participants from each target group.

Table 2: Estimate of Potential MFP Participants

Year	Elderly	MR/DD	Physically Disabled	Mental Illness	Other*	Total
CY2012	0	0	0	0	0	0
CY2013	5	5	5	3	15	33
CY2014	10	5	10	7	30	62
CY2015	10	5	15	10	30	70
CY2016	10	5	20	10	25	70
Total	35	20	50	30	100	235

*Montana is defining 'other' as youth with SED, transitioning from PRTFs.

2. *Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program.*

In SFY 2011, Montana's baseline year, authorized expenditures for the target populations totaled $124,284,271. This baseline includes the following expenditures, as reported on the State 901 expenditures report:

- All HCBS 1915c waiver expenditures under the Big Sky Waiver for services provided to physically disabled or elderly consumers.
- All HCBS 1915c waiver expenditures under the waiver for individuals with SDMI.

- All HCBS 1915c waiver expenditures for youth SED transitioning from psychiatric residential treatment facilities (PRTFs). PRTF waiver expenditures include Medicaid expansion expenditures paid with Children's Health Insurance Program (CHIP) funding.
- All HCBS 1915c waiver expenditures for the three waivers under DDP – the comprehensive waiver for individuals with developmental disabilities, the community supports waiver for individuals with developmental disabilities, and the children's autism waiver.

The baseline does not include HCBS 1915(a) expenditures because Montana does not provide HCBS under this authority. The figure also does not include PACE program expenditures because this program was terminated.

The State assumes a 2% annual growth rate the first year, a 2.5% growth rate the second year and a 3% growth rate for each year of the last two years of HCBS expenditures over the lifetime of the demonstration project. The State wants to use an achievable percentage for this benchmark, and will consider increasing it over time.

The table below outlines Montana's projected level of effort for HCBS expenditures throughout the MFP demonstration.

Table 3: Projected Total HCBS Expenditures CY2012 – 2016

	CY12	CY13	CY14	CY15	CY16
Total HCBS Spending	$126,769,956	$129,305,356	$132,537,989	$136,514,129	$140,609,553

3. *Increase the availability of self-directed services.*

Montana is committed to expanding opportunities for Medicaid consumers to self-direct their services and supports.

- DDP, in its waiver renewal effective July 2013, is creating a standalone self-directed waiver, with the intention of increasing the number of consumers with developmental disabilities using self-direction.
- SLTC is working to promote and increase the use of self-direction under the Big Sky Waiver. SLTC anticipates seeing an increase in self-direction under MFP as a result of consumers interacting with independent transition coordinators in addition to case management teams. STLC will evaluate and remediate obstacles to self-direction.
- Montana's SDMI waiver plans to implement a self-direct option in 2016.
- A significant and growing number of Medicaid consumers self-direct services through the Personal Assistance Services (PAS) State Plan program. The majority of PAS consumers will transition to receiving services under the Community First Choice (CFC) State Plan program as of October 2013. Many of these consumers also receive services through one of the 1915(c) HCBS waivers or, once implemented, the 1915(i) State Plan program for youth with SED.

The State will look at MFP participants within the Medicaid self-direction population, comparing the ratio self-directing with statewide (PAS, CFC, and waivers) and waiver-only numbers. The following table outlines the anticipated number of Montana Medicaid self-directed consumers from calendar years 2012 through 2016. Montana anticipates a 5% annual growth of Big Sky Waiver and PAS/CFC consumers self-directing services. The growth rate for the DD self-directed waiver is estimated to be just over 4% on average between calendar years 2013 and 2016.

Table 4: Medicaid Consumers Self-Directing Services

	CY12	CY13	CY14	CY15	CY16
Big Sky Waiver	33	35	36	38	39
Self-Directed Waiver for Individuals with Developmental Disabilities	200	225	230	235	240
Personal Assistance Services/ Community First Choice	1,910	2,006	2,106	2,211	2,322
Total	2,143	2,251	2,362	2,474	2,596

4. *Measure the number of MFP participants remaining in the community throughout their participation in the Community Choice Partnership MFP demonstration project.*

Montana hopes to create a strong network of benefits and services that supports MFP participants to successfully remain in their communities. The State will collect this information through the Quality of Life surveys.

Mathematica's analysis of MFP transitions to date shows that approximately 85% of participants remain in the community for a full year following transition, with about 9% returning to institutional care for 30 consecutive days or longer and 6% deceased. The analysis also reveals that re-institutionalization is most likely to occur within three months of transitioning. Montana will closely monitor re-

institutionalization trends to determine the causes and how to improve services and supports to lessen the rate. The State anticipates seeing a higher number of re-institutionalizations in the first year as capacity is built under the Community Choice Partnership MFP demonstration project and before lessons learned are reflected in services. The table below contains Montana's estimates for the number of participants in each target group remaining in the community for each year of the demonstration project.

Table 5: MFP Participants Remaining in Community

	CY12	CY13	CY14	CY15	CY16	Total
Total MFP Participants	NA	33	62	70	70	235
Consumers Remaining in Community	NA	82% (27)	85% (53)	87% (61)	89% (62)	201

5. *Collaborate with the Department of Commerce, public housing authorities, and HUD to prioritize MFP participants for Section 8 housing vouchers.*

Montana has a limited supply of affordable, accessible housing. Housing is one of the primary barriers keeping individuals living in an institution from being able to transition to a home or community-based setting. DPHHS will work with the Department of Commerce, local and State public housing authorities, and the U.S. Department of Housing and Urban Development (HUD) under the Community Choice Partnership MFP demonstration to prioritize MFP participants for Section 8 housing vouchers. Currently, there is limited collaboration between housing and health and human services in Montana. The State will use the federal guidance requesting

additional interagency coordination to support community-based integration of individuals with disabilities as the foundation for additional collaboration in Montana.

The table below includes Montana's estimates for the number of MFP participants receiving Section 8 housing vouchers throughout the demonstration project. We estimate 0 in 2013 because the agencies will create and implement a memorandum of understanding and develop a protocol for the prioritization process during this calendar year.

Table 6: Section 8 Housing Vouchers Used by MFP Participants

	CY12	CY13	CY14	CY15	CY16	Total
Section 8 Housing Vouchers	0	0	2	4	4	10

B. Demonstration Implementation Policies and Procedures

This section of the operational protocol outlines the specific approach Montana will employ to implement the Community Choice Partnership MFP demonstration project.

B.1 Participant Recruitment and Enrollment

Montana will begin transitioning target populations in the second year (CY2013) of the demonstration. The Community Choice Partnership MFP demonstration project will have a central transition coordinator who will track referrals and their dispositions, and oversee the transition work to ensure quality and consistent processes are occurring statewide. Montana will use a combination of case managers and additional contracted entities to conduct transition work for the Community Choice Partnership MFP demonstration.

Recruitment and enrollment processes may differ between target populations. The following process map outlines the proposed MFP transition process at a high-level.

Figure 2: High-Level Recruitment and Enrollment Process

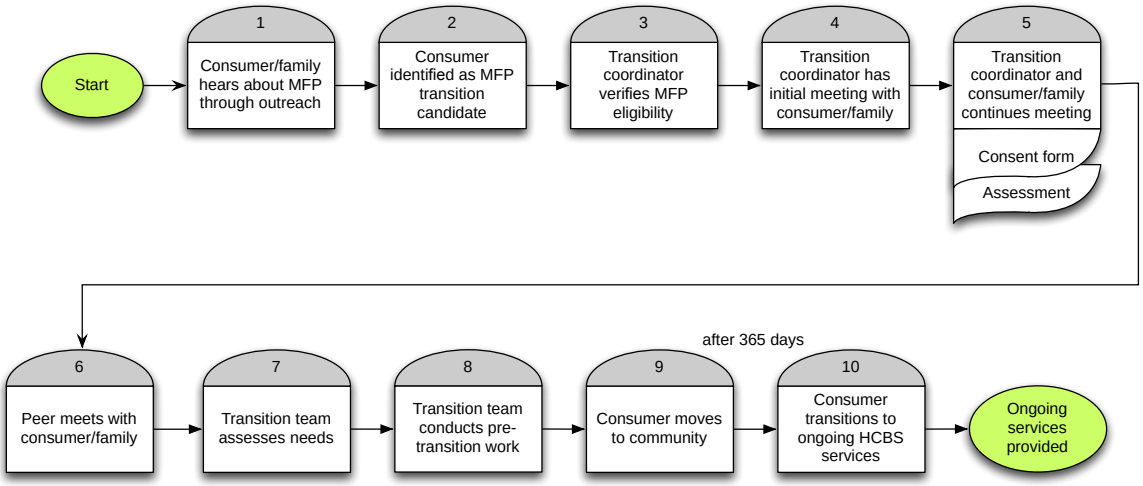


Table 7: Recruitment and Enrollment Process Narrative

Recruitment/Enrollment Process Map Narrative
1. Consumer, family, or institutional provider hears about MFP program through outreach channels. Peers may be involved in outreach. 2. Consumer or family expresses interest or is identified as possible transition candidate through other resources: a. Data analysis (MDS, MMIS, AWACS, CANS) b. Other referral sources (Ombudsmen, providers) c. Waiting list 3. Transition coordinator verifies length of institutional stay and Medicaid eligibility. 4. Transition coordinator has initial meeting with consumer to provide overview of MFP demonstration project. 5. Transition coordinator continues meeting with consumer to conduct assessment, discuss details of transition, provide options counseling. 6. Peers may meet with consumers or families to discuss Community Choice Partnership MFP and options. 7. Transition team assesses transition and community care needs a. Develop plan b. Traditional (HCBS, DD, SDMI, PRTF) case management involved c. Assess community of choice for service availability d. Determine whether additional community services are needed 8. Transition team conducts transition process – pre-work a. Transition services coordination b. Housing/move coordination 9. Consumer moves to community and receives MFP services a. Case management takes over with continued assistance from transition coordinators b. Traditional (HCBS, DD, SDMI, PRTF) services augmented by MFP demonstration and supplemental services – ensuring continuity of care post-MFP 10. Consumer transitions to HCBS 1915c waiver or 1915i State Plan program

The remainder of the Participant and Recruitment Section further details steps 1 through 8 of the process. Steps 9 and 10 are covered in subsequent sections of the operational protocol.

Selecting the Transition Service Provider

The State plans to build on existing transitioning capacity by using transition coordinators, but not supplant current successful transition processes occurring with case management teams. Currently, transition work is done by different entities depending on the target population:

- **Case managers and State staff** (Regional Program Officers (RPOs) and others) implement transition work for SLTC transitions.
- The State Hospital has **community liaison officers (CLOs) or program officers (CPOs)** to prepare individuals to transition to the community and support consumers in connecting to services. AMDD has seen a large reduction in the number of readmissions as a result of having a community liaison work on transitions separately from case managers.
- **Social workers** oversee transitions at the Montana Developmental Center.
- **Facility discharge planners** initially work with youth transitioning home from PRTFs. Facility discharge planners work with CMHB's plan managers, who then refer to wraparound facilitators to develop the plan of care with youth, families, and the wraparound team determined by the family.

Montana recognizes the importance of existing relationships between case managers and LTSS facilities in transition work, while also acknowledging the capacity constraints of case management teams. The State will **use a combination of existing case managers and contracted entities to serve as transition coordinators**. The transition coordinator role will be a separate role from case management in the

demonstration project, however the same entity can fill both roles. Using a combination of existing and new resources to fill the transition coordinator role allows investment and growth in existing resources and the opportunity to increase capacity.

The Department plans to work with Centers for Independent Living, AAAs, and Aging and Disability Resource Centers (ADRCs) to build transition coordination capacity. Montana has four Centers for Independent Living, ten AAAs, and county-based ADRCs.

Montana will require that transition coordinators enroll as Medicaid providers qualified to provide transition services under the MFP demonstration project. This will be done in lieu of creating contracts for services for transition coordinators. The centralized transition coordinator will train and provide oversight to regional transitional coordinators.

Transition coordinators need to have face-to-face contact with transition candidates. These additional resources will help fill this need because of their regional and local presence statewide. Montana is planning to submit a supplemental funding request for the ADRC funding initiative to build ADRC capacity and infrastructure to support MFP transitions. Increasing ADRC capacity will be instrumental in filling the need for face-to-face interaction with consumers and family members.

The Community Choice Partnership MFP demonstration project will have a centralized transition coordinator to oversee the transition work, provide training, and identify/address capacity needs. All referrals will come into the central transition coordinator. The centralized transition coordinator will assign/coordinate transition work with the regional coordinators. Centralized transition coordinators will reach out

to consumers and families to support them in selecting a regional transition coordinator. The centralized coordinator may work with institutional facility social workers. Consumers and family members will have choice in this process.

The central transition coordinator will use data from the quality assurance system being established for this project to track outcomes, provide feedback, and make adjustments to the approach to ensure consistent and high quality transition coordination work is being done statewide.

The State will train regional transition coordinators. As stated in the Outreach, Marketing, and Education section of this operational protocol, all State staff and contractors will receive classroom and practical training. This applies to regional transition coordinators as Medicaid contracted providers. Staff and contractors will be required to thoroughly understand the MFP project by learning the operational protocol and all related project materials and tools. Training sessions will include: 1) presentation of MFP program goals; 2) the State's Community Choice Partnership MFP project; 3) detailed presentation of each tool and element to be used by staff/contractors in administering the program; 4) MFP eligibility policies and available services packages; 5) relevant Montana Medicaid policies and services or supports; 6) Medicaid consumer rights and responsibilities; and 7) Montana's implementation of the ABCs of Transition. The training will include modules specialized in individual roles within the MFP demonstration including transition coordinator, peer advocate/mentor, and housing coordinator. These specialized modules will go into further detail of the

specific roles, responsibilities, tools, assessments, and benefits associated with each MFP role. Training sessions may be recorded and available through the MFP website.

A team led by the local transition coordinator will participate in recruitment and enrollment. The consumer, family members, facility providers, discharge planners, and community providers will also be a part of the transition team. Peer mentors/advocates, as available and appropriate, will be a component of the transition process as desired by the consumer. They will be able to provide peer support by telling their stories to transition candidates and discuss challenges and opportunities awaiting the consumer upon transition. For consumers with developmental disabilities, peer mentoring will also be important for family members. Peer parents will be able to discuss transition issues, opportunities, and challenges from a family member's perspective.

Participant Selection Mechanism

The State believes that many MFP participants will be identified through referrals. Montana plans to conduct outreach, marketing, and education to create a broad awareness of the Community Choice Partnership MFP demonstration project. Outreach efforts will be targeted at institutional residents and their families, institutional administrators and staff, provider and caregiver organizations and associations, hospital discharge planners, health boards, and other advocacy and stakeholder groups as possible referral sources.

Having on-the-ground transition coordinators through ADRCs, AAAs, centers for independent living, and case managers will support the referral process because their representatives will serve as familiar faces to whom institutional staff, consumers,

family members, and others can approach to discuss referrals and related questions. Additionally, these organizations' representatives often know the consumers in institutional settings, and so will themselves be referral sources.

In addition to referrals, Montana will use the following information/data to identify and recruit possible transition candidates. Regional and centralized transition coordinators, as well as other referral sources will be able to use this information.

- MDS Section "Q"
- Pre-Admission Screening and Resident Review (PASRR) PASRR evaluations
- Medicaid Management Information System (MMIS) data
- Agency-Wide Accounting and Client System (AWACS)
- Waiting lists
- Medicaid applications
- Childhood and Adolescent Needs and Strength (CANS) assessment tool (completed in PRTFs)[3]
- Institutional Discharge planners
- Continued Stay Reviews
- Mental Health Ombudsman

MFP outreach, recruitment, and enrollment work will build from existing relationships with nursing facilities. Montana has been working closely with nursing facilities to transition consumers to the community since 1999. Montana's Community Choice Partnership MFP project will conduct outreach with facility providers to create a positive working relationship. Detailed information about outreach efforts is included in Section 3, Outreach, Marketing, and Education of the operational protocol. Community Choice Partnership MFP will also leverage other resources with existing access to facilities to support outreach and referral efforts. These include:

- Oversight/licensing/surveyors
- Mountain Pacific Quality Health – Montana's quality improvement

[3] Montana has not yet implemented the CANS assessment, but plans to in the near future.

organization

- Magellan – Montana's mental health (children and adult) utilization review contractor

These organizations will receive training about the MFP demonstration, eligibility requirements, and the referral process.

Once a consumer or family member has expressed interest in participating in the MFP program, a local transition coordinator, in collaboration with the transition team including the facility discharge planner, will discuss options and the transition process in detail with them. In the first meeting, the transition coordinator will provide an overview of the MFP program's transition process and services, begin to get to know the possible transition candidate, and find out if she/he would like to work with a peer. In subsequent meetings, the transition coordinator will conduct an initial assessment to determine which HCBS waiver or HCBS State Plan program the participant would be eligible for upon exiting the MFP program, provide options counseling, define the composition of the transition team, and have the consumer or representative sign an MFP participation consent form.

The consumer and/or family member will begin working with a peer mentor/advocate, if available and requested, to provide additional perspective throughout the process. The regional housing coordinator will start working with the transition coordinator, once the consumer signs the consent form, to identify viable housing options. The transition team will meet regularly to define the plan of care, back-up plan, risk identification and mitigation plan, and work through transition details.

Traditional waiver case managers or targeted case managers (State Plan program) will work with the transition team once a consumer is screened as needing services from that specialized area. The current case planning process varies by program and target group:

- **SLTC** – if consumer who is elderly or disabled wants to transition from a nursing facility, a referral is made to the case managers in that area.
- **DDP** – Case managers look at service needs for individuals transitioning from MDC. The case managers work closely with consumers and the care team to address these needs, and coordinate a transition to the community.
- **AMDD** – AMDD conducts a strengths-based assessment during the development of consumers' service plans.
- **CMHB** – also conducts a strengths-based assessment for youth transitioning from PRTFs onto the waiver, soon to be replaced by the 1915i State plan. This is part of the high-fidelity wraparound facilitation[4] process used to create the care plan.

[4] Wraparound services are comprehensive services comprised of a variety of specific tasks and activities designed to carry out the wraparound process, including: assembling the wraparound team; facilitating plan of care meetings; working with the department in identifying providers of services and other community resources to meet family and youth needs; making necessary referrals for youth; documenting and maintaining all information regarding the plan of care and the cost plan, including revisions; presenting plan of care and cost plans to the plan manager for approval; providing copies of the plan of care to the youth and family/guardian; monitoring the implementation of the plan of care; maintaining communication between all wraparound team members; consulting with family and other team members to ensure the services the youth and family are receiving continue to meet the youth's needs; educating new team members about the wraparound process; and maintaining team cohesiveness.

Program case management teams know local resources for specific populations, and how best to connect people to needed benefits and services. The team will start creating the plan of care from the established waiver/State Plan program baseline, and then augment with demonstration and supplemental services as needed based on the assessment, retaining an awareness of the importance of continuity of care post-MFP.

Transition coordinators may stay involved following a consumer's transition to the community to support the case management team. In general, this support will last three months post-transition, but can continue if needed throughout the entire year. The transition coordinator may also reengage as consumers leave MFP and transition to a waiver or State Plan program.

Montana will manage the number of MFP participants to the realistic estimates included in the draft operational protocol. The State will continue to reassess this estimate as it learns more about the population transitioning and provider/caregiver/housing/service capacity.

Qualified Institutional Settings from which Individuals will Transition

Montana will target the following facilities/facility types in the MFP program:

- **Nursing facilities** – the State is not targeting specific nursing facilities or geographic areas. Hyperlinked is a list of Montana's nursing facilities.
- **Hospitals** – Individuals qualified for MFP may reside in hospitals. No specific hospitals are being targeted. A list of Montana's hospitals is available online.
- **Montana Developmental Center (MDC)** – this is Montana's sole ICF-MR.

- **Psychiatric Residential Treatment Facilities (PRTFs)** – the Community Choice Partnership MFP demonstration will target out-of-state facilities in addition to Montana PRTFs. A list of Montana's PRTFs is also available online.
- **Montana State Hospital and Montana Mental Health Nursing Care Center** – these are Montana's two Institutes for Mental Disease (IMDs). Medicaid eligible consumers (individuals age 18 to 21 and 65 or older) will be recruited from these facilities.

State facilities will closely review their budgets when consumers are identified for community placement through MFP to identify any funds that can be transferred to help support participants in the community. This step will occur before the State seeks additional funds to support each consumer's services.

Minimum Residency Requirements

Consumers must reside in an institutional setting for a minimum of 90 consecutive days to be eligible for the MFP program. If a potential Community Choice Partnership MFP participant does not meet the 90-day residency requirement at the initial eligibility determination but will meet it during the transition coordination process, the participant will be presumed to meet this requirement for the purposes of receiving transition coordination services. Transition coordinators will verify that consumers meet this requirement through the MDS, Medicaid Management Information System (MMIS), or from other facility records before a transition occurs.

Assuring Medicaid Eligibility

Local transition coordinators will verify with Human and Community Services Division (HCSD) Public Assistance Bureau (PAB), the Montana agency that determines Medicaid eligibility, whether consumers have been, or will be, eligible for Medicaid at least one day before transition. Transition coordinators will verify this upon receiving or creating a referral. If a potential Community Choice Partnership MFP participant does not meet the Medicaid benefits eligibility requirement at the initial eligibility determination but will meet it during the transition coordination process, the participant will be presumed to meet this requirement for the purposes of receiving transition coordination services. The transition coordinator must verify Medicaid eligibility before the consumer transitions.

Local transition coordinators will log eligibility information into the MFP database, which is accessible by the State transition coordinator and State Community Choice Partnership MFP project staff.

Transition Assessment Process

The MFP program will assess level of care needs to determine MFP eligibility. Consumers must meet level of care requirements to be in a nursing facility, other long term care facility, or PRTF.

Montana's transition coordinators, in collaboration with case managers and the transition team, will use an assessment tool to determine a consumer's readiness to transition and identify needed benefits and services. The State will tailor the Nursing Home Transition Needs Survey included in the manual, "ABCs of Nursing Home Transition: an Orientation Manual for New Transition Facilitators," to meet Montana's

needs. Transition coordinators will use this tool in addition to the level of care assessment tool currently used in the State. Montana will also have a subject matter expert modify the Brief MAST assessment tool to screen for alcohol/substance abuse and other addictive disorders. Based on screening outcomes, regional transition coordinators will refer transition candidates for additional assessment. Generally included in the assessment will be:

- **Consumer overview** – the coordinator will collect general information about the consumer including referral source, demographic information, informal support systems, residential information, activities of daily living (ADL) assessment, behavioral health assessment, medical overview, and transition services recommendations.
- **Risk assessment** – the team will analyze risks and define mitigation strategies using the risk assessment checklist as a guide. This assessment looks at physical health, mental health, financial status, insurance coverage, consumer engagement, services and support, housing, legal matters, and provider issues that may negatively impact the welfare and safety of the participant.

For consumers who decide to participate in the Community Choice Partnership MFP demonstration project, the transition team, collaborating closely with the State housing coordinator, will also assess housing. The assessment will analyze:

1. Whether the housing meets the MFP qualified residence criteria.

2. Whether the housing is safe and meet accessibility standards required by the consumer.

Montana developed a housing assessment tool for the demonstration project.

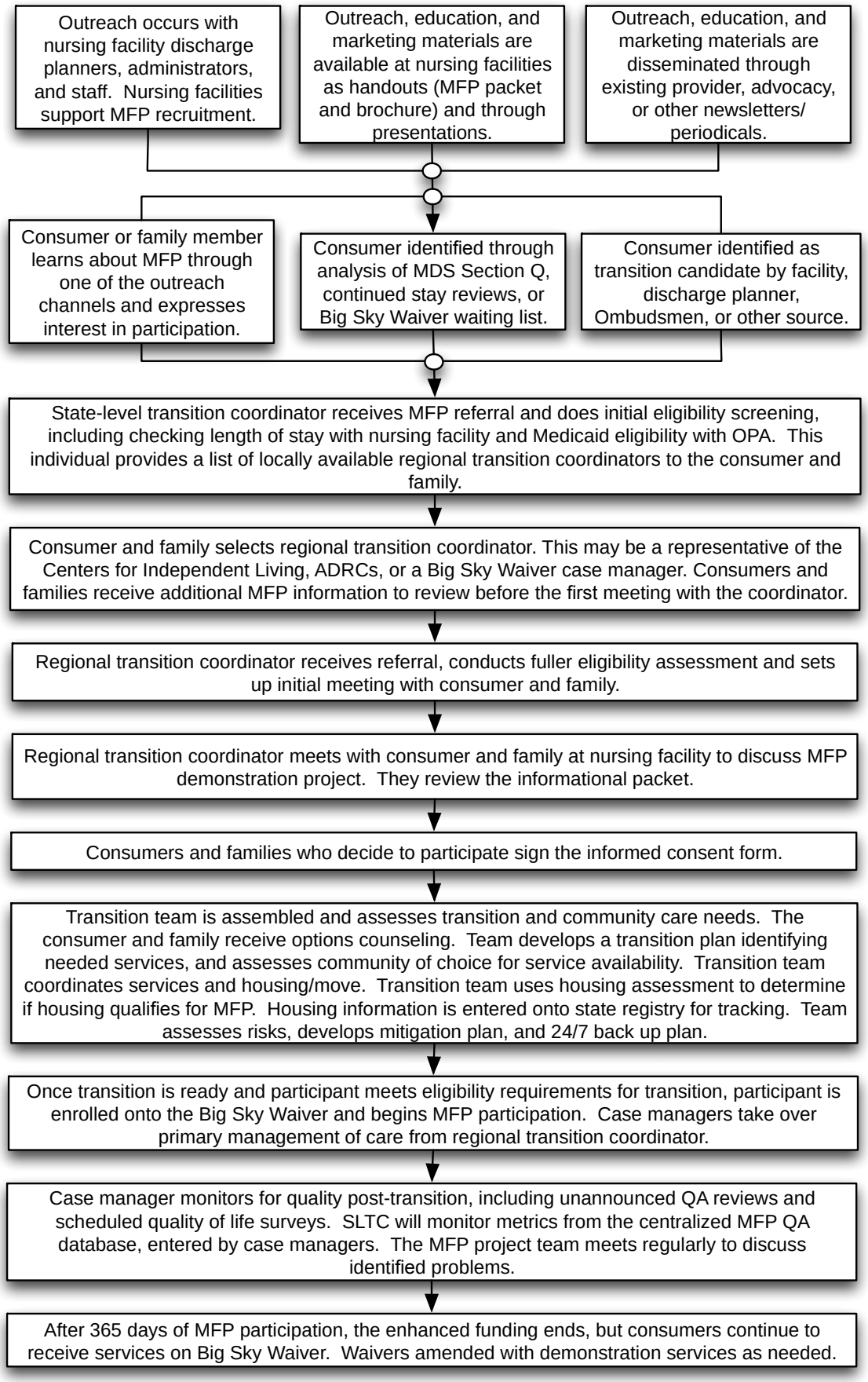
Once a consumer is ready to transition, the team will conduct a readiness review prior to discharge from the institution. This includes ensuring defined transportation, caregiver, medical, and other support services are in place. The local transition coordinator will also make a home visit to assess the consumer's and the home's readiness.

If it appears an individual may no longer meet the HCBS level of care requirement at the end of the 365 MFP days, a referral would be made to the appropriate entity for a formal determination.

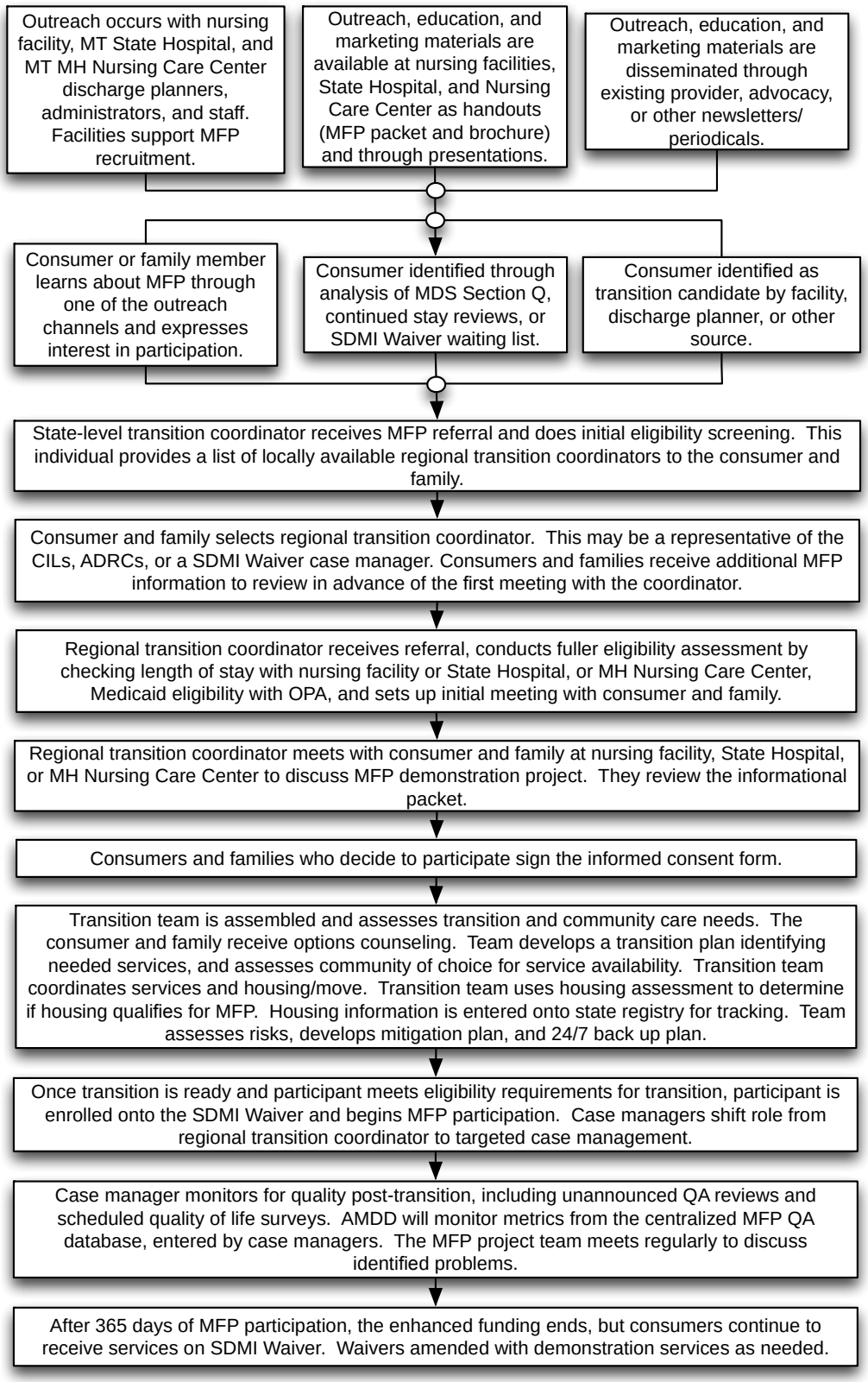
The flowcharts on the following pages outline the transition process for each of the MFP participant populations.

Consumers who are elderly or physically disabled

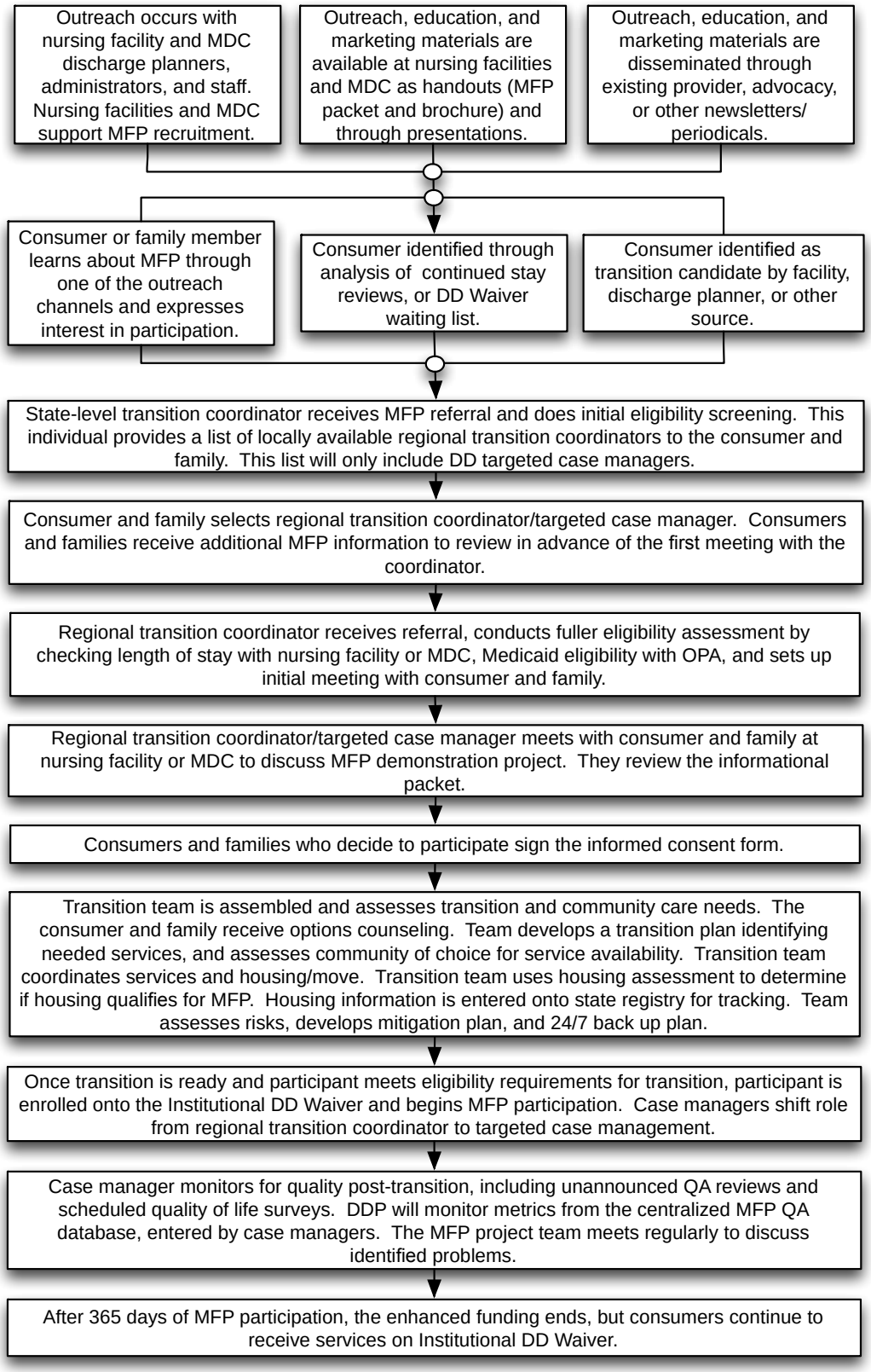
This flowchart is inclusive of both the elderly and physically disabled populations since both receive services through the Big Sky Waiver.


Outreach occurs with nursing facility discharge planners, administrators, and staff. Nursing facilities support MFP recruitment.
Outreach, education, and marketing materials are available at nursing facilities as handouts (MFP packet and brochure) and through presentations.
Outreach, education, and marketing materials are disseminated through existing provider, advocacy, or other newsletters/ periodicals.
Consumer or family member learns about MFP through one of the outreach channels and expresses interest in participation.
Consumer identified through analysis of MDS Section Q, continued stay reviews, or Big Sky Waiver waiting list.
Consumer identified as transition candidate by facility, discharge planner, Ombudsmen, or other source.
State-level transition coordinator receives MFP referral and does initial eligibility screening, including checking length of stay with nursing facility and Medicaid eligibility with OPA. This individual provides a list of locally available regional transition coordinators to the consumer and family.
Consumer and family selects regional transition coordinator. This may be a representative of the Centers for Independent Living, ADRCs, or a Big Sky Waiver case manager. Consumers and families receive additional MFP information to review before the first meeting with the coordinator.
Regional transition coordinator receives referral, conducts fuller eligibility assessment and sets up initial meeting with consumer and family.
Regional transition coordinator meets with consumer and family at nursing facility to discuss MFP demonstration project. They review the informational packet.
Consumers and families who decide to participate sign the informed consent form.
Transition team is assembled and assesses transition and community care needs. The consumer and family receive options counseling. Team develops a transition plan identifying needed services, and assesses community of choice for service availability. Transition team coordinates services and housing/move. Transition team uses housing assessment to determine if housing qualifies for MFP. Housing information is entered onto state registry for tracking. Team assesses risks, develops mitigation plan, and 24/7 back up plan.
Once transition is ready and participant meets eligibility requirements for transition, participant is enrolled onto the Big Sky Waiver and begins MFP participation. Case managers take over primary management of care from regional transition coordinator.
Case manager monitors for quality post-transition, including unannounced QA reviews and scheduled quality of life surveys. SLTC will monitor metrics from the centralized MFP QA database, entered by case managers. The MFP project team meets regularly to discuss identified problems.
After 365 days of MFP participation, the enhanced funding ends, but consumers continue to receive services on Big Sky Waiver. Waivers amended with demonstration services as needed.

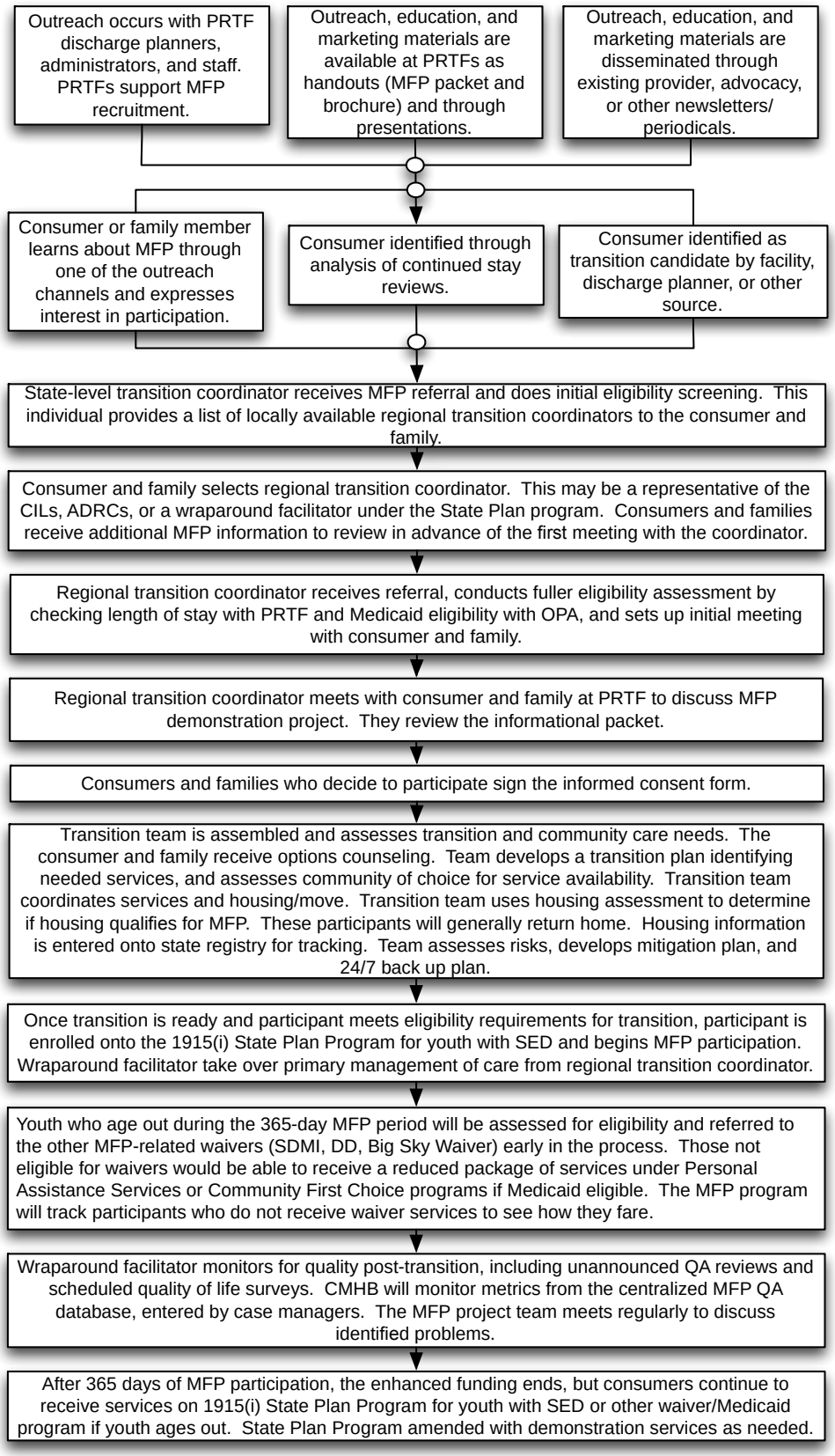
Consumers with Severe Disabling Mental Illness



Consumers with Developmental Disabilities



Consumers with Serious Emotional Disturbance



MFP Re-enrollment Policy

Montana will allow consumers to reenroll in the MFP program if they are re-institutionalized for 90 or more consecutive days following MFP program participation. These individuals previously received 365 days of enhanced FMAP services. These consumers must meet MFP eligibility criteria to reenroll.

Consumers who return to an institution during their 365-day period of MFP eligibility may remain enrolled in the program and resume their participation upon discharge. These consumers are entitled to receive 365 days of services under MFP, even if not consecutive because of re-institutionalization. During the institutional stay, the participant may continue to be enrolled in the MFP Program, although MFP participants are suspended from receiving grant funding while institutionalized. Montana may provide personal assistance retainer payments under the waiver for up to 30 days while an MFP participant is in a hospital or nursing facility (currently an option available under the Big Sky Waiver program).

Participants readmitted to an institution for 30 days or less remain enrolled in Montana's MFP program. MFP participants remaining in an institution for more than 30 days will be suspended from Montana's MFP program. The State will reactivate these suspended participants if they transition back out of the institution into the community. These participants do not need to meet the 90-day residency requirement to be reactivated. At this point, individuals upon discharge from inpatient care resume their status as an MFP participant and are eligible to receive MFP services for any remaining

days up to the 365-day demonstration participation period. No inpatient days are included in the 365-day MFP period of participation.

Montana will arrange for the provision of services deemed necessary by the participant's transition team in advance of the transition of an MFP institutionalized person back into the community in order to ensure the continuity of care for these individuals based on a revised plan of care.

Montana will revise plans of care for participants with interrupted period of MFP eligibility to account for any changes in health and psychosocial status prior to discharge back into the community. The transition coordinator will work closely with the transition team to identify the causes of the re-institutionalization and determine how to design a plan of care to guard against this risk reoccurring. The consumer's risk identification and mitigation plan will also be informed by this incident.

Montana will develop and maintain a process to reevaluate the former MFP participant's plan of care before being re-enrolled back into the MFP demonstration program. The reevaluation will determine the basis for re-institutionalization, such as:

- Medical and/or behavioral changes resulted in the necessity of readmission into an inpatient facility.
- The lack of community services to adequately support the participant originally identified in the original plan of care.
- The plan of care was not supported by the delivery of quality services.

After determining the basis for re-institutionalization, the transition team will make changes in the plan of care that take into consideration the possible causes for a

return to institutional care. At this point, the former MFP former participant may be re-enrolled into the program. Montana will track and trend data regarding MFP reenrollments. The State will incorporate knowledge gained through this process into future training for transition coordinators, additional transition team members, and other MFP staff.

Ensuring Consumers and Families Have Information to Make Informed Choices

Montana realizes the enormity of the decision to move from an institution to the community. Many individuals have lived in institutions for a significant amount of time, and struggle to imagine living more independently. Consumers and families need information to balance the opportunities with the risks and make informed choices.

The Community Choice Partnership MFP demonstration's transition coordinators will educate consumers and families about the services and supports available in the demonstration program. The MFP demonstration mandates options counseling for consumers and families. The State project team will develop options counseling materials collaboratively with the Community Choice Partnership MFP stakeholder advisory council and other stakeholders including the Statewide Independent Living Council (SILC). Options counseling will focus on the voluntary nature of the program, provider versus self-directed services, benefits and services offered in the MFP program, how they compare with institutional and HCBS waiver or State Plan program services, and consumer rights and responsibilities.

Peers will be another important source of information for consumers and family members. Peers can share their experiences transitioning from institutions and living in

the community to provide a consumer perspective to transition candidates. Peers may be a part of options counseling.

Consumers and families will have a voice in the case planning process, and tools to support their decision-making. Under the Community Choice Partnership MFP demonstration project, Montana will create agency quality indicator guides. These guides may include information about whether the agency provides in home care, their wage rate, benefits provided to workers, and staff turnover. The transition coordinator and peer mentor/advocate will provide training to help consumers and families navigate consumer options. Consumers and families will also have the ability to interview potential providers.

Consumers and families will receive information about abuse, neglect, and exploitation prevention, including indicators of possible abuse, neglect, and exploitation, as well as how and when to use adult protective services (APS) and child protective services (CPS) when they enroll in the MFP program. Montana law requires individuals to report abuse, neglect, and exploitation to DPHHS, APS, CPS, the local county attorney where the incident took place, or the local long term care Ombudsmen. Case managers and wraparound facilitators are trained in these issues, and will ensure consumers and families are well informed. The State will require MFP consumers or representatives to sign a form verifying they received this information.

Additionally, the State may provide training and forums regarding:

1. Managing change
2. Managing caregivers – retaining boundaries

3. Living well with a chronic disease/disability
4. Avoiding learned helplessness
5. How to manage stress

These trainings and forums will provide additional information and tools to help consumers and families determine whether and how to approach a transition. The State may offer different trainings and forums as deemed needed and appropriate.

B.2 Informed Consent and Guardianship

Consumers, authorized representatives (power of attorney), or guardians are required to give their consent to participate in the Montana MFP demonstration program.

Informed Consent Procedures

Consumers, authorized representatives, or guardians/legal representatives must provide their consent to participate by signing an informed consent form once they have decided to participate in MFP. Transition coordinators will obtain informed consent as a part of the options counseling process, to ensure consumers/guardians are informed of the transition process, services and supports offered during and after the MFP year, and their rights and responsibilities. Transition coordinators and others on the transition team will discuss these issues in detail throughout the transition process. The consent form includes discussion of:

- **Demonstration benefits** – discussing the transition and ongoing services and supports provided by the MFP demonstration project. This includes qualified, demonstration, and supplemental services.
- **Participation in research** – acknowledging the consumer's information will be a part of the Mathematica MFP research.
- **Confidentiality** – discussing Health Insurance Portability and Accountability Act (HIPAA) requirements.
- **Withdrawal from project** – informing consumers of the voluntary nature of their participation.

- **Grievances** – outlining the process to file a grievance.

The transition team will determine who can provide informed consent. The team will follow State law defining when youth can sign for themselves.

Guardianship

Montana' statute regarding guardianship (MCA 72-5-321, Powers and Duties of Guardian of Incapacitated Person) provides the court appointed guardian of an incapacitated person the same powers, rights, and duties as a parent has with respect to an unemancipated minor child, including the right to give consent or approval to enable the ward to receive medical or other professional care, counsel, treatment, or service. Montana's guardianship and conservatorship policy applies to all MFP target populations, but does not specify the level of interaction required for an individual to serve as a consumer's guardian.

DPHHS is interested in developing a criterion for guardian participation in the MFP demonstration. Montana wants to ensure a baseline frequency of contact for consumers with guardians. When a transition candidate has a guardian, the transition coordinator will verify the guardianship appointment. The transition coordinator will require the guardian's signature on the consent form, to involve her/him from the beginning of the process. The transition coordinator and case manager will encourage maximum participation from the guardian through education/information and inviting the guardian to all assessments and transition team meetings.

B.3 Outreach / Marketing / Education

Montana is committed to conducting outreach, marketing, education, and training to ensure consumers, families, providers, advocacy groups, State staff, and Montanans statewide are aware of the Community Choice Partnership MFP demonstration project. Additionally, this work will be focused on ensuring State staff and contractors are trained to provide high quality support and services for the MFP demonstration project.

Information Communicated to Enrollees, Providers, and State Staff

Montana will provide information targeted to different stakeholder types. The table below defines the audiences for outreach, marketing, education, and training materials, and outlines the types of information the MFP program will communicate to each.

Table 8: Outreach, Education, Marketing, and Training Efforts by Stakeholder Group

Consumers, family members, advocates – family member outreach will be as or more important than consumer outreach for some target groups, particularly individuals with developmental disabilities. Outreach to consumers and families needs to be independent and not reliant on facilities. Montana will target Native American populations in its outreach efforts.
1) MFP project existence – create awareness of the project One page general summary plus additional targeted information relevant to each group 2) Opportunities within the project – transition, independence Ensure that the outreach materials are clear that some services included in MFP are not included in the waivers/State Plan program, and, in that case, will not be available to consumers as they exit MFP 3) Eligibility requirements – 90 days in a facility, receiving Medicaid, and level of care 4) Process to participate – high-level overview – do not want to overwhelm consumers and family members with all the process details at this point 5) Rights, responsibilities, and risks 6) Peers will be involved with initial outreach efforts with consumers and family

members.
Medicaid service providers – not including facility providers.
1) How consumers can participate in MFP 2) Identify possible participants – what tools are available and how do they make referrals 3) Their role in supporting participation – providing information about the program, connecting consumers and family members to transition coordinators, participating in transition teams, risk assessment 4) Enrolling providers – to create HCBS capacity 5) How and where to receive training – about MFP or for provider/caregiver training offered within MFP
Facility providers – facility administrators and admission/discharge planners are the first focus of outreach, with additional outreach and education focused on institutional staff.
1) MFP overview – explaining the program as an additional opportunity available to consumers Build off groundwork from transitions program and MDS Section "Q" work 2) Their role – in supporting outreach efforts, identifying transition candidates, participating in transition teams 3) Expectations – cooperation with outreach and transition coordination work 4) Community service provider possibility – determine if there is any interest in having institutions help fill the need for community service providers
Auxiliary system providers – state and county entities and agents, including Department of Labor, Office of Public Instruction, Human Resources Development Councils, Public Housing Authorities, Women, Infants, and Children, AAAs, and county health departments.
1) Introduction to initiative – one page general summary plus additional targeted information relevant to each group a) Include timelines to set schedule expectations b) Outline opportunities within the project for consumers, families, and their agency 2) Participant needs – discuss in terms of reliance on these auxiliary providers services 3) Eligibility processes – outline how different systems coordinate – e.g. housing and MFP 4) Request for support – explain how this type of systems change relies on broad support to succeed because of the interconnected nature of systems/programs 5) How they can participate in MFP 6) Training opportunities and additional information – on MFP and related work in their specific arena if applicable

MFP Staff and Contractors – including outreach, education, and intake staff
1) Detailed education and training on MFP demonstration project a) Understanding consumers and families b) Develop understanding of all outreach materials c) Develop understanding of consent forms d) Training in assessment tools e) Training in transition process f) Develop understanding of different roles and responsibilities (e.g. transition coordinator, case manager, housing coordinator, peer advocate/mentor) g) Training in MFP benefits and services 2) Participant needs – discuss in terms of reliance on these auxiliary providers services 3) Eligibility processes – outline how different systems coordinate – e.g. housing and MFP 4) Choice – education about the right of choice and dignity of risk People's rights under the Americans with Disabilities Act (ADA) as affirmed by the Olmstead Supreme Court decision to live in the least restrictive environment in the community of their choice
Policymakers – budget office, Governor's office, legislators
1) Synopsis of the MFP program – what it is, funding sources, what it does a) White paper b) Include positive/transformative impacts on lives 2) Choice – education about the right of choice and dignity of risk 3) Impact on the State general fund/budget – short and long term Look at all general committees forming on budget – including housing, revenue, and transportation, in addition to DPHHS 4) Balance and modernize LTSS – demonstrate how this effort is building off work over the last 15 years, and is further rebalancing system toward HCBS 5) Prepares Montana for impending demographic shift
Media – work will be coordinated with DPHHS' public information officer
1) Announcement of MFP program – done with press release, governor's letter to paper, or other vehicles 2) Events – celebrating success, reinforce importance of mission and purpose 3) Share stories of people who transitioned back and the benefits of that transition 4) Connect people to website for more detailed information – include link in all media material

Media Types

Montana's MFP demonstration project will use a variety of media types to maximize the reach and impact of outreach efforts. Media types and specific outreach instruments may include:

1. **MFP informational packet** – the contents may vary by consumer population, but in general the packet may include:
    a. A cover letter clearly and simply defining MFP, how the Community Choice Partnership MFP demonstration project fits within the existing LTSS system in Montana, and the transformational objectives of MFP.
    b. Existing long term services and supports (LTSS) information, including HCBS waiver and State Plan program brochures.
    c. MFP brochure with demonstration overview and eligibility requirements.
    d. MFP fact sheet and frequently asked questions to provide more in depth information on specific topics.
    e. MFP participant consent form that a consumer or family member can complete and give to a transition coordinator at the facility to indicate their desire to move forward in the transition process.
    f. Rights and responsibilities for consumers and families to understand the opportunities, obligations, and risks associated with participation.
    g. MFP transition planning guide with high-level information about the transition and participation process.

2. **MFP brochure** – the brochure will contain an overview of the demonstration, eligibility requirements, and high-level information about how MFP fits within the broader LTSS spectrum.
3. **MFP website** – DPHHS' web designer, with input from the public information officer, will create an MFP webpage, which will be easy to find as a standalone site or through Department programs' and stakeholder organizations' websites. The webpage will contain all of the information from the paper informational packets, and will be updated regularly to ensure it is current.
4. **Newsletters** – The Community Choice Partnership MFP demonstration project will not have its own newsletter, but rather the MFP project director will work with existing provider, advocacy, or other newsletters/periodicals to include MFP content. This includes:

    a. Provider newsletters and magazines
    b. CILs
    c. ADRCs
    d. Aging newsletter
    e. Aging Horizons
    f. AARP website/electronic newsletter
    g. Montana Healthcare Association
    h. MHA, an association of healthcare providers
    i. Network of Care – statewide mental health resources
    j. Parents Let's Unite for Kids (PLUK)
    k. Montana Council on Developmental Disabilities
    l. MCI
    m. Montana Peer Network
    n. Various listservs

5. **Informational letters** – the project director or DPHHS public information officer will distribute informational letters as needed to create awareness or promote MFP.
6. **News releases** – the MFP project team will use news releases to share success stories or other information about MFP.

7. **Facebook** – the MFP project team may use DPHHS' Facebook page to share information about MFP.
8. **Video** – The Community Choice Partnership MFP demonstration may create outreach videos with peer success stories. DPHHS may include the video on the project website, Department Facebook page, and on YouTube. Transition coordinators may use the video as an outreach tool in institutions.
9. **Conference presentations** – the MFP project team will give formal presentations and meet regularly with community groups, providers, and other stakeholders to discuss the program.
10. **Regional meetings** – the Community Choice Partnership MFP project team will facilitate regional meetings with facility providers, Centers for Independent Living, and others to elicit best practices and additional input.
11. **Ombudsmen presentations** – Ombudsmen will add MFP information to the presentations they already conduct at nursing facilities.
12. **Free Media** – the MFP project team may use public radio, public service announcements, and other free media to market the demonstration.
13. **Web-based training** – the project team will create web-based training modules to support ongoing, consistent training on MFP-related topics including self-direction, transition processes, and conducting assessments. These trainings will be directed at consumers, family members, providers, and State staff.

MFP staff will gather materials from other states presented at the 2012 MFP conference and customize for Montana. All outreach, educational, marketing, and

training material will be accessible in multiple formats. Montana will provide outreach materials to CMS prior to use as required.

Targeted Geographic Areas

Outreach efforts will be statewide – Montana will not be targeting specific geographic areas although emphasis will be placed on rural and remote areas.

Locations for Information Dissemination

The MFP project team will use a variety of locations to disseminate outreach, marketing, education, and training materials widely. Locations may include:

1. LTSS facilities
2. Residential senior living facilities
3. PRTFs
4. Senior centers
5. Libraries
6. CILs
7. AAAs/ADRCs
   a. Information assistance counselors
   b. SHIP counselors
8. Community agencies – health clinics
9. MMIS provider system
10. Montana Mental Health Association (MMHA)
11. National Association for Mental Illness (NAMI)
12. OPAs
13. Advocacy groups
14. Hospitals
15. Mental Health Centers
16. Medical associations
17. Mountain Pacific Quality Health
18. Child serving agencies
19. Doctors' offices
20. Tribal health programs
21. School districts – special education programs
22. University schools of nursing

Staff Training, State Forum, and Public Educational Seminars

Montana has already begun public education efforts through community forums held during the writing of the State's operational protocol. As need dictates, the MFP project team will continue hosting community forums throughout the Community

Choice Partnership MFP demonstration implementation to educate the public about MFP, and receive feedback from consumers, family members, and other stakeholders.

MFP staff, contractors, and other stakeholders will receive classroom and practical training. The following groups will be included in training:

1. Referral sources
2. Discharge planners
3. Case managers
4. Transition coordinators
5. Housing coordinator
6. CIL staff
7. Qualified, demonstration, and supplemental service providers
8. ADRC staff
9. Nursing facility (and other institutional) administrators
10. Facility social workers and case managers
11. PRTFs
12. Mental Health Centers
13. State agency staff
14. Consumers and families

Staff and contractors will be required to thoroughly understand the MFP project by learning the operational protocol and all related project materials and tools. Training sessions will include: 1) presentation of MFP program goals; 2) the State's Community Choice Partnership MFP project; 3) detailed presentation of each tool and element to be used by staff/contractors in administering the program; 4) MFP eligibility policies and benefit packages; 5) relevant Montana Medicaid policies and benefits; and 6) Medicaid consumer rights and responsibilities. The training will include modules specialized on individual roles within the MFP demonstration including transition coordinator, peer advocate/mentor, and housing coordinator. These specialized modules will go into further detail of the specific roles, responsibilities, tools, assessments, and benefits

associated with each MFP role. Training sessions may be recorded and available through the MFP website.

Montana will modify the "ABCs of Nursing Home Transition: an Orientation Manual for New Transition Facilitators," a publication by the IL Net National Training and Technical Assistance Program at Independent Living Research Utilization for use as a training manual for the Community Choice Partnership MFP demonstration. The State will also draw from training materials from other states presented at the 2012 MFP conference, modifying them for Montana's use.

Montana will require staff and contractors complete training before working with MFP participants.

Draft Training Schedule

Consumers and family members will receive training as they begin participating in the MFP demonstration, so are not included in the schedule below.

May – June 2013:

- Outreach/marketing will begin to create an awareness of the Montana Community Choice Partnership MFP demonstration project, opportunities within the project, eligibility requirements, and other information to properly set expectations and inform advocates, facility providers, and auxiliary system providers. Montana will continue to use community forums as well as the other medium described in the operational protocol.
- MFP staff and contractors will receive informal training through the same outreach/marketing information used with advocates and providers.

- DPHHS will educate legislators about the demonstration project during the legislative session.

July – September 2013:

- Formal MFP training of staff and contractors will occur in this quarter. Montana will have hired all MFP staff by this point, and transitions should begin soon. Montana will host an intensive training workshop to train contractors and staff as a group.
- Ongoing outreach, marketing and education efforts will continue with providers, advocates, and community members throughout the State.

Ongoing:

- Montana's MFP team will continue to host community forums, present at regional conferences, and work with individual facilities, providers, and advocacy groups regarding the State's MFP project.
- Formal training from MFP staff/contractor conference will have been recorded and available on the web for new staff and contractors joining the project. Web-based modules will be created and available for ongoing training.

Bilingual Materials and Interpretation Services

Montana will provide interpreter services as needed. Historically, this has included primarily sign language, Spanish, Russian, and Hmong interpretation. The State will find additional interpretation services if requested. Many of the county OPAs have bilingual staff who provide interpretation assistance. DPHHS contracts out for additional interpreter services on an as needed basis.

Cost Sharing Responsibilities

Participants are not required to cost share in MFP (other than regular Medicaid cost sharing).

B.4 Stakeholder Involvement

Montana is committed to involving consumers, families, providers, advocacy groups, and other stakeholders throughout the MFP demonstration project. Montana has strong advocacy, consumer, and provider groups in each of the targeted participant areas – DD, MI, SED, elderly, and physically disabled. The Community Choice Partnership MFP demonstration will be unique in that it brings these assorted groups together to work in one unified project, containing a diverse group of participants with varying needs. Many of these individuals and organizations are accustomed to working a specific DPHHS program or bureau – AMDD, Disability Employment and Transitions Division, DSD/DDP, DSD/CMHB, or SLTC. The MFP project director will need to forge relationships across the stakeholder spectrum, while also strengthening existing program relationships. Montana is committed to working with experts across all areas of focus under MFP through the stakeholder advisory council.

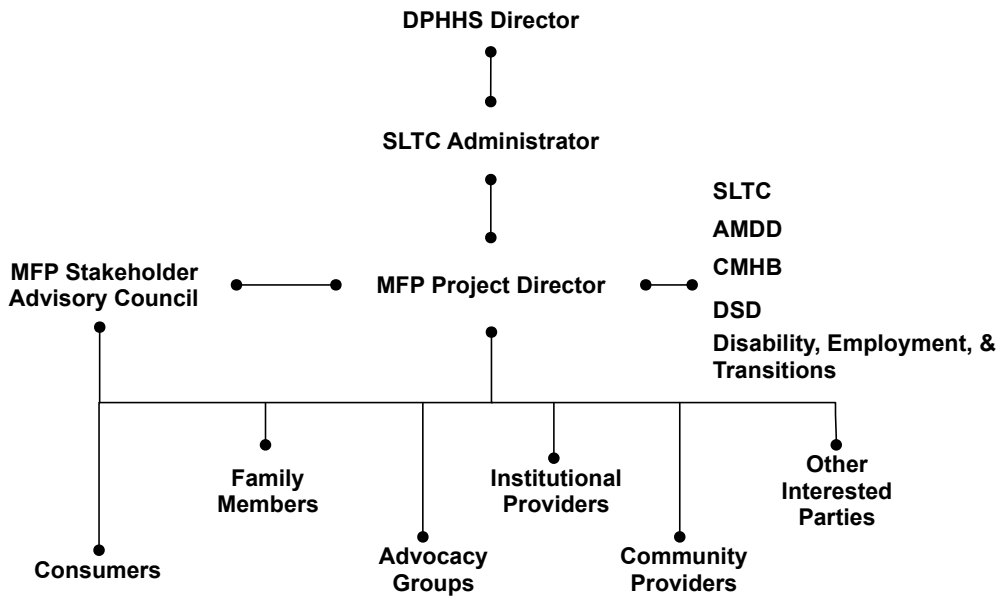
The State plans to augment the stakeholder advisory council established during the planning phase of this grant to include a housing authority representative and additional stakeholder representation as necessary. The Community Choice Partnership MFP stakeholder advisory council will provide feedback guiding the development, implementation, and operations of the Community Choice Partnership MFP demonstration project. This will be the setting for discussing lessons learned from the project and how to adjust the approach to reflect new insights. Additionally, the Community Choice Partnership MFP stakeholder advisory council members will be

instrumental in promoting MFP statewide. The MFP project director will head the MFP advisory council, which will meet regularly throughout the project.

Stakeholder Involvement Chart

The following chart depicts how stakeholders will be involved in the Community Choice Partnership MFP demonstration project.

Figure 3: Stakeholder Involvement in MFP Demonstration Project



Consumer and Family Involvement in Demonstration

Montana views consumers and family member engagement as critical to the success of the Community Choice Partnership MFP demonstration project. The work done through this project very directly impacts their lives, and their voices need to be a part of the planning, implementation, and operations process. The State developed the demonstration project through the planning grant, with most activities occurring in June and July 2012. Consumers and family members participated in the process as members of the MFP planning stakeholder advisory council. The advisory council met five times

during this planning period to discuss the elements of the operational protocol. Although the official council had 11 members, the State opened the meetings and encouraged additional interested parties to participate, supporting broader collaboration with all stakeholder groups.

Table 9: Planning Stakeholder Advisory Council Members

Member	Representation
Mike Mayer	CIL
Quentin Schroeter	NAMI
Mike Hanshew	AARP
Mavis Young Bear	Fort Belknap Agency, Vocational Rehabilitation
Linda Sandman	Son Heaven Assisted Living
David Trost	St. John's Lutheran Ministries
Jan Wenaas	Consumer Family Member
Michael O'Neil	AWARE
Troy Sprang	Chief Dull Knife College
Sheila Thompson	Opportunity Resources Inc.
Mark Boatman	Consumer

The State elicited additional consumer and family involvement through community forums. The MFP planning team went to three cities in June – Missoula, Billings, and Great Falls – to meet with consumers, family members, providers, advocates, and other stakeholders. Over 120 individuals participated in these sessions. Through a facilitated consensus workshop, the forum participants defined MFP benefits and services, housing coordination, and transition processes. The State reimbursed travel expenses for consumers and family members to promote participation from individuals living in rural, outlying areas.

Consumers and family members were provided access to written reports from each of the planning stakeholder advisory council and community forum meetings.

Montana also involved consumers and family members through a planning survey, focused on assessing the current LTSS system – what is working well and where there is need for improvement – and additional services and supports needed to support successful transitions for individuals with more complex needs.

Community and Facility Provider Involvement in Demonstration

Community and facility providers are also critical in the planning, implementation, and operations of the Community Choice Partnership MFP demonstration project. Providers participated in the planning stakeholder advisory council and community forums alongside consumers and family members. Both community and facility providers were represented. Providers were also given access to written reports of the meetings.

Consumer and Provider Roles and Responsibilities

Consumers, family members, and advocates will continue to be central to ongoing stakeholder involvement throughout the implementation and operation phases of the Community Choice Partnership MFP demonstration. Montana will encourage additional consumer and family member participation in MFP demonstration activities. The State wants to ensure that all targeted participant groups are represented on the Community Choice Partnership MFP stakeholder advisory council. Montana will seek to learn from consumers and families as it measures progress toward the project vision and goals, using these lessons learned to adjust benefits, services, and processes to

better meet consumer needs. The State also seeks active involvement from consumers and families in project evaluation.

DPHHS collaborates closely with an active facility provider network. Facility providers have worked closely with the Department to support transitions since 1999. These providers participated extensively in the MFP planning phase, and will be central to successful Community Choice Partnership MFP implementation and operations, as they facilitate choice for institutional consumers and their family members. Facility providers will be a primary referral source. They will also support outreach and education work by providing access to facilities for transition coordinators and peer advocates/mentors. Facility providers will participate in transition teams, assisting with risk assessment and transition planning. Providers will also participate in quality assurance activities, annual surveys, and other forums eliciting feedback. Facility providers may also expand their service scope to include community-based services, helping to address provider and caregiver capacity issues, particularly in rural Montana.

Community providers will also be vital to the Community Choice Partnership MFP demonstration project. Their roles are similar to facility providers. They will participate on the MFP Community Choice Partnership MFP stakeholder advisory council, support education and outreach efforts, serve as referral sources, participate in transition teams, support quality assurance efforts, participate in provider surveys, and attend MFP forums.

Consumer and Provider Operational Activities

Ongoing, the State will use the following mechanisms to secure consumer and provider involvement in the operational activities of the Community Choice Partnership MFP demonstration project:

- **Community Choice Partnership MFP Stakeholder Advisory Council** – the Community Choice Partnership MFP stakeholder advisory council will continue to meet regularly throughout the demonstration project to monitor progress and provide other feedback on the demonstration. The State will augment the group to include wider consumer and family representation as necessary.
- **Outreach and Education** – providers will be an important source of MFP project information for consumers and family members. Consumers and family members will also support this work, particularly those who have previously participated in the MFP demonstration.
- **Referral source** – providers, specifically facility providers, will be an important referral source. Families and consumers will also create referrals.
- **Transition team** – institutional and community providers, including those who have provided services to the participant, will be members of the transition teams, helping to complete risk assessments and plans of care. Consumers and family members will be central to team decision-making processes.
- **Quality assurance** – consumers and providers will support quality assurance work at the State through interviews and feedback.

- **Montana Council on Developmental Disabilities** – the MFP project team will engage the Montana Council on Developmental Disabilities, which is comprised of 50% consumers and family members as a project stakeholder.
- **Statewide Independent Living Council** – the MFP project team will also engage the SILC, which is comprised of a majority of persons with disabilities and reflects the diverse cultural, disability and geographical makeup of Montana.
- **Reporting** – the State will regularly report to consumer/family/advocacy groups to create a feedback loop. Included in this, Montana's MFP project will report on grant progress consistently to Montana Statewide Independent Living Council.
- **Consumer surveys** – the State will initially conduct a comprehensive survey to assess long term services and supports in Montana. After this, the State will periodically survey consumers and families to determine what is working well and where there is room for improvement within the MFP project.
- **Provider surveys** – the State will also survey providers to assess MFP implementation and operations from providers' perspectives.
- **State agency surveys** – the project will solicit feedback on the demonstration from collaborating State agencies.
- **Community forums/focus groups** – the State will periodically travel to communities statewide to elicit feedback on the MFP project and discuss regional topics, such as caregiver or housing capacity.
- **Peer mentoring** – consumers and families will serve as peer mentors in the MFP project.

B.5 Benefits and Services

Montana's MFP participants will be enrolled in an existing waiver or State Plan home and community based program during the MFP year. MFP demonstration and supplemental services will be wrapped around the baseline of services and supports defined within each waiver or State Plan program.

Service Delivery System for MFP Participants

MFP services will be either fee-for-service or cost-based.

Service Package Available for MFP Participants

Transition coordinators/teams will assess MFP participants to determine needs and develop a plan of care. Existing 1915c waivers and the 1915i HCBS State Plan program for youth with SED will be included as qualified services within the MFP demonstration program. Participants will continue to receive ongoing services through waivers or the State Plan program at the termination of their MFP demonstration project participation. However, MFP participants and transition teams may augment these services with demonstration and/or supplemental services if required by the consumer's plan of care and within established cost parameters during their participation in the Community Choice Partnership MFP demonstration project.

Montana Big Sky and SDMI 1915c Waivers

The Montana Big Sky waiver serves persons who are elderly and physically disabled in home and community based settings. This waiver was established in 1983,

and currently serves approximately 2,000 Montanans. Montana Big Sky participants have the option of using self-direct services.

Montana's waiver for persons with SDMI was approved in December 2006. AMDD modeled the services available in this waiver off the Montana Big Sky waiver because of its comprehensive nature. The differences are that Montana does not include self-direct options under its waiver for persons with SDMI, and the waiver offers one additional service – Wellness Recovery Action Plan (WRAP), which lays out specifically what a consumer needs in a crisis.

The benefits and services included in these waivers are listed and defined in the table below. An asterisks denotes a service is only available in the Montana Big Sky waiver. Fee schedules for these services are included as separate attachments with the budget narrative.

Table 10: Montana Big Sky and SDMI 1915c Waivers Benefits and Services

Service	Definition
Adult Day Health	Adult day health provides a broad range of health, nutritional, recreational, and social services in settings outside the person's place of residence in an outpatient setting, and includes transportation to the adult day health provider.
Case Management	Case management provides: • Development and review of the service plan with the consumer • Reevaluation of the service plan including a functional assessment and service delivery • Coordination of services • Linking consumers 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 consumers
Community	Community Supports services include assisting the consumer with:

Service	Definition
Supports – Bonanza Option*	• Basic living skills such as eating, drinking, toileting, personal hygiene, dressing, transferring and other activities of daily living • Improving and maintaining mobility and physical functioning • Maintaining health and personal safety • Carrying out household chores and preparation with meals and snacks • Accessing and using transportation (with providers possessing a valid Montana driver's license) • Participating in community experiences and activities • Relieving unpaid caregivers at those times when such relief is in the best interest of the consumer or caregiver • Receiving day care for medically fragile children who, because of their disability, cannot be served in traditional child care settings
Community Transition	Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.
Consultative Clinical and Therapeutic Services	Consultative Clinical and Therapeutic Services assist caregivers (paid or unpaid) in carrying out individual service plans and are necessary to improve the individual's independence and inclusion in the community. The service is geared toward individuals with traumatic brain injuries or more complex disabilities that require a more clinical approach and specialized interventions. Specific services may include: • Clinical evaluations by these professionals • Development of a supplemental home/community treatment plan which is incorporated into the individual's service plan • Training and technical assistance to implement the treatment • Monitoring the treatment and interventions • One-on-one consultation and support for paid and non-paid caregivers
Consumer Goods and Services – Bonanza Option*	These are services, supports, supplies or goods only available under the self-directed Bonanza Option. These items could include the purchase of appliances and vans, with or without modifications, when criteria and Department approval is in place. These items must address an identified need in the consumer's person-centered service and support plan and meet one of the following: • Decrease the need for other Medicaid services • Promote inclusion in the community • Promote the independence of the consumer • Fulfill a medical, social, or functional need based on unique cultural approaches

Service	Definition
	• Increase the person's safety in the home environment
Day Habilitation	Day habilitation services focus on enabling individuals to attain their maximum functional level. Day Habilitation includes 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 consumer resides. Services are normally provided four or more hours per day on a regularly scheduled basis, for one or more days per week.
Dietetic Services	Dietician Services are those provided by a registered dietitian or a licensed nutritionist for consumer education and meal planning for consumers who have medically restricted diets or for consumers who do not eat appropriately to maintain health. Dietitian Services are related to the management of a recipient's nutritional needs. Dietitian Services include: • Evaluation and monitoring of nutritional status • Nutrition counseling • Therapy • Education and research
Environmental Accessibility Adaptations	Physical adaptations to the home, required by the consumer's service plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which the recipient would require institutionalization.
Family Training and Support	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 aged 0 through 21 with disabilities and not eligible for DD Services. Specifically, Family Training and Support includes: • 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. • 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. • Collaborating with the case managers and families to develop strategies for environmental modifications or adaptations that would be beneficial to the child. • 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.

Service	Definition
	• 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. • Advocating for the family's needs with the case management team and others who may offer supports and services. • Assisting the family and case management team with transition and referral to special education, including Part B.
Financial Management Services – Bonanza Option*	Financial management services provide finance, employer, payroll and related functions for the consumer/personal representative. These services assure that the funds to provide services and supports outlined in the individual service plan are implemented through a self-directed approach and are managed and paid appropriately as authorized. This is a mandatory service for all participant directed waiver participants.
Health and Wellness	Offers consumers opportunities to engage in recreational, health promoting and wellness activities within their community. The service includes: • Classes on weight loss, smoking cessation, and healthy lifestyles such as "Living Well with a Disability" offered by Centers for Independent Living • Health club memberships • Art therapy • Costs associated with adaptive recreation activities such as skiing, horseback riding, and swimming
Homemaker	Homemaker services consist of general household activities provided to consumers unable to manage their own home or when the individual normally responsible for homemaking is absent. Homemaker services do not include personal care services available under State Plan Medicaid.
Homemaker Chore	Homemaker chore services are provided to consumers unable to manage their own home or when the consumer normally responsible for homemaking is absent. Homemaker Chore activities includes cleaning a home requiring extensive cleanup 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.
Independence Advisor – Bonanza Option*	Independence Advisor (IA) services include an array of consumer-directed support activities to ensure the ability of consumers to direct their care successfully. Consumers can choose from any qualified and enrolled provider. This is a mandatory service for consumer-direction.
Non-Medical	Transportation means travel furnished by common carrier or private

Service	Definition
Transportation	vehicle for non-medical reasons as defined in the individual service plan. Transportation Services must meet the following criteria: Be provided only after volunteer, state plan or other publicly funded transportation programs have been exhausted or determined to be inappropriate; and be provided by the most cost effective mode.
Occupational Therapy	Occupational therapists may provide evaluation, consultation, training, and treatment. These services are provided when the limits of Occupational Therapy Services under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from Occupational Therapy Services furnished under the State plan, except that palliative therapies are allowed.
Pain and Symptom Management	Services support traditional and nontraditional approaches to pain and symptom management including, but 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.
Personal Assistance Service	Personal Assistance Services 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 the State Plan, individuals may use this service for assistance with activities of daily living (ADLs) by legally responsible individuals.
Personal Emergency Response System (PERS)	PERS is an electronic device, which enables certain individuals to secure help in the event of an emergency. The client may also wear portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. Trained professionals staff the response center.
Physical Therapy	Physical therapists may provide treatment training programs designed to: 1) preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and ADLs; and 2) prevent, to the extent possible, irreducible or progressive disabilities through means such as orthotic prosthetic appliance, assistive and adaptive devices, positioning, behavior adaptations, and sensory stimulation.
Post Acute Rehabilitation Services	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. Consumers are taught strategies to overcome barriers created by their disability, learn compensatory techniques for memory loss and behavior problems and relearn day-to-

Service	Definition
	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 consumer.
Prevocational Services	Prevocational training services are habilitative activities that foster employability for a HCBS consumer. These services are aimed at preparing an individual for paid or unpaid employment, and include teaching concepts such as compliance, attending, task completion, problem solving, endurance, work speed, work, accuracy, attention span, motor skills and safety.
Private Duty Nursing	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 individual at home or in an adult residential care facility. Private duty nursing services are medically necessary services provided to consumers who require continuous in-home nursing care that is not available from a home health agency.
Residential Habilitation	Residential Habilitation is provided in an Adult Foster Home (AFH), Group Home, Assisted Living Facility (ALF) or Residential Hospice. Residential habilitation is a bundled service that may include personal assistance supports or habilitation to meet the specific needs of each resident; homemaker services; medication oversight; social activities; personal care; recreational activities, transportation; medical escort; and 24-hour on-site awake staff to meet the needs of the residents and provide supervision for safety and security.
Respiratory Therapy	Services include direct treatment, ongoing assessment, equipment monitoring and upkeep, pulmonary education and rehabilitation for those 21 and older.
Respite Care	Respite care is temporary, short-term care provided to consumers in need of supportive care to relieve those persons who normally provide the care. Respite care is only utilized to relieve a non-paid caregiver.
Senior Companion	Senior Companion Services are directed at providing companionship and assistance. The service includes respite, socialization, supervision, and homemaking.
Specialized Child Care for Medically Fragile Children	This service provides day care for medically fragile children who, because of their disability, cannot be served in traditional childcare settings.
Specialized Medical Equipment and Supplies	Specialized medical equipment and supplies include devices, controls, or appliances, specified in the service and support plan, which enable consumers to increase their abilities 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. It also includes

Service	Definition
	items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under Medicaid State plan.
Speech Therapy and Audiology	Speech therapy may include: 1) Screening and evaluation of individuals with respect to speech and hearing functions. 2) Comprehensive speech and language evaluations when indicated by screening results. 3) Participation in the continuing interdisciplinary evaluation of individuals for purposes of beginning monitoring and following up on individualized habilitation programs. 4) Treatment services as an extension of the evaluation process including consultation with appropriate people involved with the individual for speech improvement and speech education activities to design specialized programs for developing each individual's communication skills in comprehension, including speech, reading, auditory training, and skills in expression.
Supported Employment	Supported employment includes activities needed to sustain paid work by consumers, including supervision and training for persons for whom unsupported or competitive employment at or above the minimum wage is unlikely. Supported employment is conducted in a variety of settings. Supported employment may include group community employment such as crews, enclaves or individual community employment.
Supported Living	Supported living is a comprehensive habilitation service designed to support individuals with brain injuries, or other severe disabilities, in the community. 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.
Vehicle Modification	Vehicle modifications are modifications made to a personal vehicle that will allow a consumer to be more independent. These modifications would be specified in the service plan as necessary to enable the consumer to more fully integrate into the community and to ensure their health, safety and welfare.
WRAP	Wellness Recovery Action Plan (WRAP) is a manualized group intervention for adults with mental illness. WRAP guides participants through the process of identifying and understanding their personal

Service	Definition
	wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness. WRAP has the following goals: 1) Teach participants how to implement the key concepts of recovery (hope, personal responsibility, education, self-advocacy, and support) in their day-to-day lives. 2) Help participants organize a list of their wellness tools—activities they can use to help themselves feel better when they are experiencing mental health difficulties and to prevent these difficulties from arising. 3) Assist each participant in creating an advance directive that guides the involvement of family members or supporters when he or she can no longer take appropriate actions on his or her own behalf. 4) Help each participant develop an individualized post-crisis plan for use as the mental health difficulty subsides, to promote a return to wellness.

Developmentally Disabled 1915c Waivers

DDP operates three waivers – 1) **Comprehensive waiver** for individuals with developmental disabilities; 2) **Community supports waiver** with more limited DD services and supports; and 3) **Autism waiver** providing benefits and services for children with autism up to eight years old. Neither the community supports waiver nor autism waiver are relevant to the MFP demonstration project. The benefits and services included in the comprehensive waiver are listed and defined the following table. A fee schedule for these services is included as a separate attachment with the budget narrative.

Table 11: Developmental Disabilities Comprehensive Waiver Benefits and Services

Service	Definition
Day Habilitation	Services designed to assist individuals in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successful in home and community based settings. These services are provided in day programs/settings.

Service	Definition
Homemaker	Homemaker services consist of general household activities provided by a homemaker when the person regularly responsible for these activities is unable to manage the home and care for himself/herself or others in the home, or is engaged in providing habilitation and support services to the individual with disabilities. Services include meal preparation, cleaning, simple household repairs, laundry, shopping for food and supplies, and routine household care.
Live-in Caregiver	Payment for additional costs of rent and food that can reasonably be attributed to an unrelated live-in caregiver who resides in the same household as the waiver participant. Staff qualified to delivery residential habilitation provides live-in caregiver service.
Residential Habilitation	Services designed to assist individuals in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings. Habilitation is provided to an individual wherever she/he may live.
Respite	Respite care includes any services (e.g. traditional respite hours, recreation or leisure activities for the recipient and caregiver, summer camp) designed to meet the safety and daily care needs of the recipient and the needs of the recipient's caregiver in relation to reducing stress generated by the provision of constant care to the individual receiving waiver services.
Supported Employment	Supported employment is for persons with developmental disabilities who, because of their disabilities, need intensive ongoing support to perform in a work setting. It provides the opportunity to work: work for pay in regular employment; integrate with non-disabled persons who are not paid caregivers; and receive long term support services in order to retain the employment. Activities may include pre-placement activities, job market analysis/job development, job match/screening, job placement/training, ongoing assessment and support and service coordination, and transportation.
WCCM – Waiver-funded Children's Case Management	Services furnished to assist individuals in gaining access to needed medical, social, educational, and other services. Case management includes comprehensive assessment and periodic reassessment, development and periodic revision of a specific plan of care, referral and related activities, monitoring and follow up activities.
Occupational Therapy Services	Occupational therapists may provide evaluation, consultation, training, and treatment.
Physical Therapy Services	Physical therapists may provide treatment training programs designed to: 1) preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and ADLs; and 2)

Service	Definition
	prevent, to the extent possible, irreducible or progressive disabilities through means such as orthotic prosthetic appliance, assistive and adaptive devices, positioning, behavior adaptations, and sensory stimulation.
Psychological and Counseling Services	Psychological and counseling services may include individual and group therapy; consultation with providers and caregivers directly involved with the individual; development and monitoring of behavior programs; participation in the individual planning process; and counseling for primary caregivers when their needs are related to problems dealing with the child with the disability.
Speech Therapy Services	Speech therapy may include: 1) Screening and evaluation of individuals with respect to speech and hearing functions. 2) Comprehensive speech and language evaluations when indicated by screening results. 3) Participation in the continuing interdisciplinary evaluation of individuals for purposes of beginning monitoring and following up on individualized habilitation programs. 4) Treatment services as an extension of the evaluation process including consultation with appropriate people involved with the individual for speech improvement and speech education activities to design specialized programs for developing each individual's communication skills in comprehension, including speech, reading, auditory training, and skills in expression.
Personal Supports	Personal supports are only available to participants who self-direct some or all of their services with employer authority. The personal supports worker is hired by and the employee of the participant or the participant's representative. The personal supports worker assists the participant in carrying out daily living tasks and other activities essential for living in the community, including assistance with homemaking, personal care, general supervision, and community integration.
Supports Brokerage	Service/function that assists the participant (or family or representative) in arranging for, directing, and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long term needs, developing options to meet those needs, and accessing identified supports and services.
Adult Companion	Non-medical care, supervision and socialization, provided to a functionally impaired individual. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The

Service	Definition
	provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the individual.
Adult Foster Support	This service pays for extraordinary supervision and support by a principal care giver licensed as an adult foster care provider who lives in the home. The total number of service recipients (including participants served in the waiver) living in the adult foster home, who are unrelated to the principal care provider, cannot exceed four persons
Assisted Living	Payments for services rendered in an assisted living facility, including personal care, homemaker services, medication oversight, social and recreation activities, 24 hour on site response staff to meet the unpredictable needs of recipients and supervision for safety and security. Separate payment will not be made for those services integral to and inherent in the provision of the personal care facility service.
Board Certified Behavior Analyst	The Board Certified Behavior Analyst (BCBA) functions include the following: 1) Designing behavioral assessments and functional analyses of behavior and interpreting assessment and evaluation results for staff and unpaid caregivers providing services to enrolled waiver recipients. 2) Designing, monitoring and modifying written behavior intervention procedures and skill acquisition procedures. Written plans of intervention developed by the BCBA generally require the collection of data by staff or unpaid caregivers providing direct support. Decisions made by the BCBA in designing, monitoring and modifying behavior intervention and skill acquisition procedures are generally based on the review and analysis of collected data. 3) Training staff and unpaid caregivers in the implementation of formal and informal procedures designed to reduce problem behaviors and/or to increase appropriate behaviors. 4) Attending planning meetings for purpose of providing guidance and information to planning team members in the setting of appropriate goals and objectives for persons who need BCBA services.
Caregiver Training and Support	Caregiver training and support are services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the waiver. This service may not be provided in order to train paid caregivers. Training includes instruction about

Service	Definition
	treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the participant at home. Support must be aimed at assisting the unpaid caregiver in meeting the needs of the participant.
Community Transition Services	Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institution to a DDP waiver funded HCBS residential service. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: 1) Security deposits required to obtain a lease on an apartment or home. 2) Essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items and bath/bed linens. 3) Set-up fees or deposits for utility or services access, including telephone, electricity, heating and water. 4) Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy. 5) Moving expenses. 6) Necessary home accessibility adaptations. 7) Activities to assess need, arrange for and procure needed resources.
Dietician	These services provided by a registered dietitian or licensed nutritionist include meal planning, consultation with and training for caregivers, and education for the individual served. The service does not include the cost of meals.
Environmental Modification/ Adaptive Equipment	Environmental modifications are physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual 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 individual. Environmental modifications may be made to a recipient's home or vehicle (wheelchair lift, wheelchair lock down devices, adapted driving controls, etc.) for the purpose of increasing independent functioning and safety or to enable family members or other caregivers to provide the care required by the recipient.

Service	Definition
	Adaptive equipment necessary to obtain and retain employment or to increase independent functioning in completing activities of daily living when such equipment is not available through other sources may be provided.
Individual Goods and Services	Individual Goods and Services are services, supports or goods that enhance opportunities to achieve outcomes related to living arrangements, relationships, inclusion in the community and work as clearly identified and documented in the service plan. Items or services under individual goods and services fall into the following categories: 1) Membership/fees 2) Devices/supplies
Meals	This service provides hot or other appropriate meals once or twice a day, up to seven days a week.
Personal Care	Personal Care Services Include: 1) Assistance with personal hygiene, dressing, eating and ambulatory needs of the individual. 2) Performance of household tasks incidental to the person's health care needs or otherwise necessary to contribute to maintaining the individual at home. 3) Supervision for health and safety reasons.
PERS	Personal Emergency Response System (PERS) is an electronic device that enables waiver participants to secure help m an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center.
Private Duty Nursing	Private Duty Nursing service is to provide medically necessary nursing services to individuals when these services exceed the established Medicaid limits or are different from the service provided under the State Plan. They will be provided where they are needed, whether in the home or in the individual's day activity setting. Services may include medical management, direct treatment, consultation, and training for the individual and/or his caregivers.
Respiratory Therapy	These services are provided by a licensed respiratory therapist and may include direct treatment to the individual, ongoing assessment of the person's medical conditions, equipment monitoring and upkeep, and pulmonary education and rehabilitation. Without these services, individuals with severe pulmonary conditions would have to be institutionalized.
Transportation	Service offered in order to enable individuals served on the waiver to

Service	Definition
	gain access to waiver and other community services, activities and resources, specified by the plan of care.

Program for Youth with Serious Emotional Disturbances 1915 (i) HCBS State Plan

Montana's PRTF waiver began operating in 2007, and expired on September 30, 2012. CMHB submitted a successful application to CMS for a 1915c HCBS bridge waiver to continue services to families and youth currently on the PRTF demonstration waiver/grant. CMHB has also submitted a successful 1915i HCBS State Plan program request to make HCBS services available statewide. CMS approved the 1915(i) State Plan program to be effective on January 1, 2013. Proposed Administrative Rules of Montana have been filed to support these changes.

The benefits and services included in the 1915i HCBS State Plan program are listed and defined in the table below. A fee schedule for these services is included as a separate attachment with the budget narrative.

Table 12: Youth with SED State Plan Program Benefits and Services

Service	Definition
Peer-to-Peer Services	Peer-to-Peer services are designed to offer and promote support to the parent/guardian of the youth with SED and/or to the youth with SED. Peer-to-peer services are geared toward promoting self-empowerment of the parent or youth, enhancing community living skills and developing natural supports. These services are intended to assist the parent/guardian or youth in being able to access appropriate formal and informal services for the youth in the community. The individualized plan of care must identify a need for this service.
Consultative Clinical and Therapeutic Services	Consultative Clinical and Therapeutic Services provide treating physicians and mid-level practitioners with access to the psychiatric expertise and consultation in the areas of diagnosis, treatment, behavior, and medication management.
Supplemental Supportive	Customized Goods and Services allow for the purchase of services or goods not reimbursed by Medicaid. These Customized Goods and

Service	Definition
Service	Services typically are used by the youth to facilitate access to supports designed to improve and maintain the youth in the community.
Education and Support Services	Education and Support Services are provided to family members, unpaid caregivers, and persons providing treatment or otherwise involved in the youth's life. Education and Support Services include instruction about the diagnostic characteristics and treatment regimens for the youth, including medication for the youth, and behavioral management.
Family Support Specialist	Family Support Specialist services provide support and interventions to parents and youth, under the guidance of the In-Home Therapist. These services may include, but are not limited to: 1) Assisting the In-Home Therapist in family therapy by providing feedback to the in-home therapist about observable family dynamics. 2) Providing education to parents regarding their child's mental illness. 3) Coaching, supporting, and encouraging parenting techniques learned through parenting classes and/or family therapy. 4) Providing, as necessary, parenting skills specific to the child. 5) Participating in family activities in order to assist parents in applying specific parenting methods in order to change family dynamics. 6) Working with youth to access any types of wellness recovery tools such as a wellness recovery action plan tool kit. 7) Serving as a member of the crisis intervention team.
Geographic Factor for Travel	A geographical factor of $.50 per mile may be available to a Family Support Specialist, Wraparound Facilitator, Peer-to-Peer Specialist, In-Home Therapist or Co-Occurring Service Provider when the following circumstances are met: 1) The provider is traveling out of the location where the provider has its regular office, excluding satellite offices; 2) The provider is traveling a distance greater than 25 miles one way from the office to the youth's home; 3) The geographical factor will include the initial 25 miles and return trip; 4) The geographical factor is prior authorized by the plan manager; and 5) The geographical factor and those providers authorized to receive it are included in the youth's plan of care.
In-Home Therapy	In-Home Therapists provide face-to-face, individual, and family therapy for youth and parent(s) or legal guardians in the youth's residence at times convenient for the youth and family.

Service	Definition
Non-Medical Transportation	Non-Medical Transportation is the provision of transportation through common carrier or private vehicle for the youth's access to and from social or other nonmedical activities that are included in the waiver plan of care.
Respite Care	Respite Care is the provision of supportive care to a youth so as to relieve those unpaid persons normally providing day-to-day care for the youth from that responsibility. Respite care services may be provided only on a short-term basis, such as part of a day, weekends, or vacation periods.
Wraparound Facilitation	Wraparound services are comprehensive services comprised of a variety of specific tasks and activities designed to carry out the wraparound process, including: assembling the wraparound team; facilitating plan of care meetings; working with the department in identifying providers of services and other community resources to meet family and youth needs; making necessary referrals for youth; documenting and maintaining all information regarding the plan of care and the cost plan, including revisions; presenting plan of care and cost plans to the plan manager for approval; providing copies of the plan of care to the youth and family/guardian; monitoring the implementation of the plan of care; maintaining communication between all wraparound team members; consulting with family and other team members to ensure the services the youth and family are receiving continue to meet the youth's needs; educating new team members about the wraparound process; and maintaining team cohesiveness.
Specialized Evaluation Services	Specialized Evaluation Services provide access to necessary evaluation services with brief consultation that are otherwise unavailable or not covered by state plan Medicaid or other funding sources. The youth's need for this service must be indicated in the plan of care. Services may include but are not limited to: Applied Behavior Analysis, psychosexual evaluation, and pharmacogenetic evaluation.
Crisis Intervention Service	Crisis Intervention Service includes a short-term (not greater than 14 days) placement in a therapeutic group home or youth shelter home when intervention and short-term placement are necessary to avoid escalation and acute care admission. If there is indication a higher level of service is necessary, appropriate referrals will be made for the youth. Crisis Intervention Service allows families who are worn down and unable to continue coping an opportunity for their youth to receive this service while continuing to be involved with their youth.
Co-Occurring Services	Co-Occurring Services are designed to provide assessment/evaluation, education and treatment for co-occurring mental health and chemical dependency issues for youth through an integrated approach. Co-

Service	Definition
	Occurring Services are intended to improve or maintain current levels of functioning and to reduce further exacerbation of the youth's mental health and chemical dependency issues.

In addition to these services, Montana may offer the following MFP demonstration services when required by an individual's plan of care.

1. MFP Transition Services

DPHHS will support MFP participants in their transitions by paying one-time costs assessed as needed to support transitions. These costs may include security deposits (including first month's rent), moving expenses, payment toward past bills affecting ability to meet rental qualifications, set up fees or deposits for utilities or service access, furniture, other household goods, services needed for health and safety, and home accessibility adaptations. Transition coordinators can authorize payment for up to $4,000 of goods and services without prior approval. Transition services costs can exceed this amount with approval.

Unit of Service:	Unit – consumers can receive more than one unit of transition service, as defined in their plans of care
Rate:	$2,000

2. Regional Transition Coordinators

Regional transition coordinators will provide supports for consumers' needs as they transition from institutions to the community.

- Transition coordinators will work with a team, including the consumer, family members, institutional providers, discharge planners, peer mentor/advocate,

and community providers (including CILs) to **develop a transition plan and oversee its implementation**.

- Transition coordinators will **coordinate services** around the transition, including the transition services (listed above under demonstration and supplemental services), such as home modifications, vehicle modifications, and utility deposits, connecting participants to peer mentors, working with local housing coordinators, and selecting other MFP demonstration and supplemental services needed by the consumer to successfully transition.

Unit of Service:	1 Transition
Rate:	$5,000

3. Companion Services

MFP adult and youth participants and/or family members may be paired, when appropriate and available, with peers for support before, during, and following their transitions.

- Peers are **persons or family members whose life experience provides expertise** that professional training can't replicate. Peers will begin interacting with MFP participants or family members before the transition occurs, will stay in touch regularly, and work to integrate participants into the community and provide support to families.
- Montana will **partner with Centers for Independent Living, People First, Area Agencies on Aging, NAMI** and other networks statewide to support this service.

Companion services, as with all services, have a limit within an individual's plan of care. The amount of this service approved and provided will vary based on the needs of the individual. Companion services cannot be provided by the consumer's legally responsible relatives or those family members who normally provide the care.

Unit of Service:	15 minutes
Rate:	$5.22

4. Peer Mentor/Advocate

Peer mentors or advocates have a different role than peer companions. More than socialization, mentors/advocates work with consumers and family members to **introduce them into the culture of disability**. A peer mentor/advocate serves as a consumer advocate and provides consumer information and support from a peer perspective. Montana will **partner with Centers for Independent Living, People First, and Consumer Direct, Area Agencies on Aging, NAMI, Local Advisory Councils, Montana Peer Network, Montana Mental Health Association** and other networks statewide to support this service.

Unit of Service:	15 minutes
Rate:	$7.00

5. Connecting Information Technology

Montana is a rural/frontier state, with many Montanans living far from services, neighbors, and family. Montana will be using MFP as an opportunity to increase its use of technology to connect participants to health services, families, peers, and social opportunities. If required by the plan of care:

- Montana may **support communication needs** including hardware and associated costs to maintain connectivity or provide enhanced supervision, monitoring, and diagnostic needs.
- Montana may purchase information technology equipment or software needed to support **medication management.**
- Montana will seek out **group purchasing** for these products and services for participants.

Connecting Information Technology Purchase	
Unit of Service:	1
Rate:	$800
Connecting Information Technology Set Up	
Unit of Service:	1
Rate:	$100
Connecting Information Technology Monthly	
Unit of Service:	12
Rate:	$58
Monitoring, Diagnostic Information Technology	
Unit of Service:	1
Rate:	$700
Monitoring, Diagnostic Information Technology Monthly	
Unit of Service:	12
Rate:	$150
Medication Management Technology	
Unit of Service:	1
Rate:	$900

6. Geographic Factor for Provider Travel

Many miles often separate towns in Montana. It is not unusual to drive for 50 miles to reach the closest town. In order to improve access to services in rural Montana,

the State will use a geographic factor to reimburse providers traveling more than 25 miles to provide services.

Unit of Service:	1 mile (once traveled 25 miles)
Rate:	$0.5

7. Addictive Treatment Services

Montana has limited resources focused on substance abuse, gambling, and other addictive disorders for adults or children on Medicaid. Individuals with developmental disabilities, traumatic brain injuries, and cognitive disorders in Montana have a particular need for these services. Under MFP, the State will support services to fill this gap.

Unit of Service:	Individual: 15 minutes / group: visit
Rate:	Individual: $11.25 / group: $9.00

8. Modifying existing vehicles for accessibility

Transportation is often an obstacle for individuals who are disabled with accessibility needs to fully engage in employment, recreation, and social activities. Making modifications to an existing vehicle would be specified in the service plan as necessary to enable a consumer with accessibility needs to more fully integrate into the community and to ensure their health, safety and welfare.

Unit of Service:	1
Rate:	$4,000

9. Transportation supports

Montana will provide required financial support to individuals needing another method of accessing transportation beyond a purchased vehicle. If required by the plan of care:

- MFP may pay costs associated with **licensing, insuring, or maintaining a vehicle** to promote independent vehicle usage.
- The State may provide **transportation vouchers** to help participants access public transportation options.
- The State may provide **mileage reimbursement** to support transportation needs.

Licensing, Insuring, Maintaining	
Unit of Service:	1
Rate:	$1,650
Transportation Vouchers	
Unit of Service:	1 trip
Rate:	$12.16
Mileage Reimbursement	
Unit of Service:	1 mile
Rate:	$0.5

10. Overnight or Enhanced Staffing and Supervision

MFP participants living alone and needing supervision can have overnight or enhanced staffing to help support the transition for a limited time. Overnight or enhanced staffing supervision will be provided based on individual needs defined in the plan of care. Generally this service will be available for 30 to 45 days, unless extenuating circumstances warrant a longer timeframe.

Unit of Service:	1 night
Rate:	$40

Montana may offer an additional demonstration service in future years of the Community Choice Partnership MFP demonstration project. Montana plans to develop a **Community First Choice** service package, including personal assistance and additional services are currently part of Montana's State plan. The State intends to include this as a demonstration service once the analysis is complete and the service is better defined. This will allow Montana to see how best to bundle these services in a future Community First Choice State Plan amendment.

Below are tables outlining services for each participant group. MFP participants will be enrolled in a waiver or State Plan program upon entry into the MFP demonstration. These qualified services are listed as 'QS'; demonstration services are marked as 'DS'.

Big Sky Waiver for Individuals who are Elderly or Physically Disabled

Services	QS	DS	Unit	Rate
Adult Day Health	X		15 minutes	$2.04
Case Management	X		15 minutes	$14.45
			1 month (based on $8.87/day)	$274.97
Case Management plus Supported Living Coordination	X		1 month (based on $17.15/day)	$531.65
Community Supports Services – Bonanza Option*	X		15 minutes	$5.22
Community Supports Services – Transportation Miles Bonanza Option (Bonanza is the self-direction within the Big Sky Waiver)*	X		1 mile	$0.51
Community Transition Services	X		Service	$2,000
Consultative Clinical and Therapeutic Services	X		Service	$350
Consumer Goods and Services –	X		Service or item	$500

Services	QS	DS	Unit	Rate
Bonanza Option*				
Day Habilitation	X		1 day	$74.20
Environmental Accessibility Adaptations – Home Modification	X		Service	$4,000
Family Training and Support	X		15 minutes	$7.86
Financial Management Services – Bonanza Option*	X		1 month	$160
Health and Wellness	X		Session	$175
Adaptive Recreational Therapy	X		Session	$55
Exercise Classes	X		Class	$65
Health Club Membership	X		1 Month	$65
Hippotherapy	X		Session	$45
Wellness Classes	X		Session	$175
Homemaker	X		15 minutes	$3.20 – $4.08
Homemaker Chore	X		Service	$250
Independence Advisor – Bonanza Option*	X		1 month	$160
Non-Medical Transportation	X		1 mile	$0.33
			1 trip	$12.16
Nutrition (Meals)	X		1 meal	$5.26
Nutrition Classes, Nutritionalist	X		Session	$45.75
Nutrition Counseling, Dietician	X		Visit	$45.75
Occupational Therapy – Evaluation	X		Visit	$54.47
Occupational Therapy – Group	X		15 minutes	$12.99
Occupational Therapy – Individual	X		15 minutes	$22.05
Pain and Symptom Management	X		Session	$650
Acupuncture	X		Session	$70
Chiropractic	X		Session	$75
CrainioSacral	X		Session	$70
Hyperbaric Oxygen Therapy	X		Session	Negotiated
Massage Therapy	X		Session	$70
Mind-Body Therapies (i.e. Hypnosis and Biofeedback)	X		Session	$125
Specialized Nursing Services	X		Session	$70
Pain Mitigation Counseling/Coaching	X		Treatment	$650
Reflexology	X		Session	$70
Personal Assistance Attendant – Agency-Based	X		15 minutes	$4.45 – $4.96
Personal Assistance Nurse Supervision – Agency-Based	X		15 minutes	$4.45 – $4.96

Services	QS	DS	Unit	Rate
Personal Assistance Attendant – Self-Directed	X		15 minutes	$3.68 – $4.16
Personal Assistance Oversight – Self-Directed	X		15 minutes	$3.68 – $4.16
Personal Assistance Attendant	X		1 day	$9.74
PERS Rental	X		1 month	$69
PERS Installation and Testing	X		Item	$100
PERS Purchase	X		Item	$800
Physical Therapy – Evaluation	X		Visit	$49.36
Physical Therapy – Group	X		15 minutes	$12.99
Physical Therapy – Individual	X		15 minutes	$22.05
Post Acute Rehabilitation – Community Residential Habilitation	X		1 day	$717.09
Post Acute Rehabilitation – Comprehensive Day Treatment	X		1 hour	$95.61
Prevocational Services	X		1 hour	$7.24
Private Duty Nursing – LPN	X		15 minutes	$6.87
Private Duty Nursing – RN	X		15 minutes	$8.14
Registered Nurse Supervision	X		15 minutes	$11.25
Residential Habilitation – Assisted Living Facilities and Adult Foster Home	X		1 day	$70.65
Res Hab – Residential Hospice	X		1 day	$80
Res Hab – Child Foster Care	X		15 minutes	$100.80
Res Hab – Group Home	X		1 day	$145.91
Res Hab – TBI-AR	X		1 day	$100.80
Respiratory Therapy Procedures	X		15 minutes	$8.14
Respiratory Therapy	X		Visit	$25
Respite Care	X		15 minutes	$3.20 – $4.08
Respite Care – Assisted Living and Adult Foster Care	X		Day	$161.75
Respite Care – Hospital	X		Day	$360
Respite Care – Nursing Facility	X		Day	Medicaid rate
Senior Companion	X		15 minutes	$1.25
Specialized Child Care for Children	X		15 minutes	$5.22
Specialized Medical Equipment and Supplies	X		Item	$2,000
Specially Trained Attendant	X		15 minutes	$5.22
Specially Trained Attendant – LPN	X		15 minutes	$6.87
Specially Trained Attendant – RN	X		15 minutes	$8.14
Speech Therapy – Evaluation	X		Visit	$114.20

Services	QS	DS	Unit	Rate
Speech Therapy – Group	X		15 minutes	$18.34
Speech Therapy – Individual	X		15 minutes	$56.05
Supported Employment	X		15 minutes	$12.12
Supported Living	X		1 day	$213.20
Vehicle Modification	X		Service	$4,000
Addictive Treatment Services – Group		X	Visit	$9
Addictive Treatment Services – Individual		X	15 minutes	$11.25
Companion Services		X	15 minutes	$5.22
Connecting Information Technology – Purchase		X	Item	$800
Connecting IT – Set Up		X	Service	$100
Connecting IT Monthly		X	1 month	$58
Connecting IT – Medication Management Technology Purchase		X	Item	$900
Connecting IT – Monitoring, Diagnostic Information Technology Purchase		X	Item	$700
Connecting IT – Monitoring, Diagnostic Information Technology Monthly		X	1 month	$150
Geographic Factor for Travel		X	1 mile	$0.50
MFP Transition Services		X	Unit	$2,000
Overnight and Enhanced Staffing		X	1 night	$40
Peer Mentor/Advocate		X	15 minutes	$7
Regional Transition Coordinators		X	1 transition	$5,000
Transportation Supports – Licensing, Insuring, Maintaining		X	Service	$1,650
Transportation Supports – Transportation Vouchers		X	1 trip	$12.16
Transportation Supports – Mileage Reimbursement		X	1 mile	$0.50

Waiver for Individuals with Severe Disabling Mental Illness

Services	QS	DS	Unit	Rate
Adult Day Health	X		15 minutes	$2.04
Case Management	X		1 day	$10.17
Community Transition Services	X		Service	$2,000
Day Habilitation	X		1 day	$74.20
Habilitation Aide	X		1 hour	$18.08

Services	QS	DS	Unit	Rate
Health and Wellness	X		Session	$175
Adaptive Recreational Therapy	X		Session	$55
Exercise Classes	X		Class	$65
Health Club Membership	X		1 Month	$65
Hippotherapy	X		Session	$45
Wellness Classes	X		Session	$175
Homemaker	X		15 minutes	$4.08
Homemaker Chore	X		Diem	$250
Illness Management Recovery	X		45-50 minutes	$52.63
Nutrition (Meals)	X		1 meal	$5.26
Nutrition Classes, Nutritionalist	X		Session	$45.75
Nutrition Counseling, Dietician	X		Visit	$45.75
Occupational Therapy – Evaluation	X		Visit	$54.47
Occupational Therapy – Group	X		15 minutes	$12.99
Occupational Therapy – Individual	X		15 minutes	$22.05
Pain and Symptom Management	X		Session	$650
Acupuncture	X		Session	$70
Chiropractic	X		Session	$75
CrainioSacral	X		Session	$70
Hyperbaric Oxygen Therapy	X		Session	Negotiated
Massage Therapy	X		Session	$70
Mind-Body Therapies (i.e. Hypnosis and Biofeedback)	X		Session	$125
Specialized Nursing Services	X		Session	$70
Pain Mitigation Counseling/Coaching	X		Treatment	$650
Reflexology	X		Session	$70
Personal Assistance Attendant	X		15 minutes	$4.96
			1 day	$9.74
Personal Assistance Nurse Supervision	X		15 minutes	$4.96
PERS Rental	X		1 month	$69
PERS Installation and Testing	X		Item	$100
PERS Purchase	X		Item	$800
Prevocational Services	X		1 hour	$7.24
Private Duty Nursing – LPN	X		15 minutes	$6.87
Private Duty Nursing – RN	X		15 minutes	$8.14
Psychosocial Consultation (extended state plan services)	X		15 minutes	$12.92
Registered Nurse Supervision	X		15 minutes	$11.25
Residential Habilitation – Assisted Living Facilities and Adult Foster Home	X		1 day	$71.67

Services	QS	DS	Unit	Rate
Residential Habilitation – Group Home	X		1 day	$145.91
Respiratory Therapy Procedures	X		15 minutes	$8.14
Respite Care	X		15 minutes	$4.08
Respite Care – Assisted Living	X		Day	$158.78
Respite Care – Nursing Facility	X		Day	Medicaid rate
Specialized Medical Equipment and Supplies	X		Item	$2,000
Specially Trained Attendant	X		15 minutes	$5.22
Supported Employment	X		15 minutes	$12.12
Supported Living	X		1 day	$213.20
Transportation – Miles	X		1 mile	$0.33
Transportation – Trip	X		1 trip	$12.16
Wellness Recovery Action Plan	X		Registration	$142.34
Companion Services		X	15 minutes	$5.22
Connecting Information Technology – Purchase		X	Item	$800
Connecting IT – Set Up		X	Service	$100
Connecting IT Monthly		X	1 month	$58
Connecting IT – Medication Management Technology Purchase		X	Item	$900
Connecting IT – Monitoring, Diagnostic Information Technology Purchase		X	Item	$700
Connecting IT – Monitoring, Diagnostic Information Technology Monthly		X	1 month	$150
Geographic Factor for Travel		X	1 mile	$0.50
MFP Transition Services		X	Unit	$2,000
Overnight and Enhanced Staffing		X	1 night	$40
Peer Mentor/Advocate		X	15 minutes	$7
Regional Transition Coordinators		X	1 transition	$5,000
Substance Use Related Disorders – Group		X	Visit	$9
Substance Use Related Disorders Counseling – Individual		X	15 minutes	$11.25
Transportation Supports – Licensing, Insuring, Maintaining		X	Service	$1,650
Transportation Supports – Transportation Vouchers		X	1 trip	$12.16
Transportation Supports – Mileage Reimbursement		X	1 mile	$0.50

Services	QS	DS	Unit	Rate
Vehicle Modification		X	Service	$4,000

Waiver for Individuals with Developmental Disabilities

Services	QS	DS	Unit	Rate
Adaptive Equipment	X		Item	Actual cost + admin
Adult Companion	X		1 hour	$17.90
Adult Foster Support	X		1 month	$639.50–$3,973.76
Assisted Living	X		1 month	Medicaid rate
Board Certified Behavior Analyst	X		1 hour	$52.17
Caregiving Training and Support	X		1 hour	$46.70
Community Transition Services	X		Cost	$2,000
Day Habilitation	X		1 day	Staff hrs x $13.07–$13.66 + $6.37–$7.93 consumer pd
Dietician	X		1 hour	$56.48
Environmental Modification/Adaptive Equipment	X		Item	Actual cost + admin
Individual Goods and Services	X		Cost	Actual cost + admin
Homemaker	X		1 hour	$17.90
Live-in Caregiver	X		Cost	Varies
Meals	X		1 meal	$5
Occupational Therapy	X		1 hour	$80.76
Personal Care	X		1 hour	$17.90
Personal Supports	X		1 hour	$17.90
PERS	X		Cost	Actual cost + admin
Physical Therapy Services	X		1 hour	$80.76
Private Duty Nursing – LPN	X		1 hour	$27.48
Private Duty Nursing – RN	X		1 hour	$32.56
Psychosocial and Counseling Services	X		1 hour	$56.42
Residential Habilitation – Residential Community Home	X		1 day	Staff hrs x $17.74–$25.16
Residential Habilitation – Children's Group Home	X		1 day	Staff hrs x $20.55–$21.46
Residential Habilitation – Supported Living	X		1 hour	$19.94–$27.54
			1 month	$598.10 –

Services	QS	DS	Unit	Rate
				$897.15
Residential Habilitation – Residential Training Supports	X		1 hour	$19.81–$27.39
Respiratory Therapy Procedures	X		1 hour	$34.29
Respite Care	X		1 hour	$13.48
			1 month	Monthly fee + 15%
Respite Care – Assisted Living	X		Day	$158.78
Respite Care – Nursing Facility	X		Day	Medicaid rate
Speech Therapy Services	X		1 hour	$56.06
Supported Employment	X		1 month	$353.01–$1,042.22
			1 hour, exception rate	$33.62
Supports Brokerage	X		1 hour	$25.85
Transportation – Miles	X		1 mile	State Plan rate
Transportation – Week	X		1 week	$0.803/indiv $0.4015/group
Transportation – Month	X		1 month	State Plan rate
WCCM – Waiver-funded Children's Case Management	X		15 minutes	$15.45
Addictive Treatment Services – Group		X	Visit	$9
Addictive Treatment Services – Individual		X	15 minutes	$11.25
Companion Services		X	15 minutes	$5.22
Connecting Information Technology – Purchase		X	Item	$800
Connecting IT – Set Up		X	Service	$100
Connecting IT Monthly		X	1 month	$58
Connecting IT – Medication Management Technology Purchase		X	Item	$900
Connecting IT – Monitoring, Diagnostic Information Technology Purchase		X	Item	$700
Connecting IT – Monitoring, Diagnostic Information Technology Monthly		X	1 month	$150
Geographic Factor for Travel		X	1 mile	$0.50
MFP Transition Services		X	Unit	$2,000
Overnight and Enhanced Staffing		X	1 night	$40
Peer Mentor/Advocate		X	15 minutes	$7

Services	QS	DS	Unit	Rate
Regional Transition Coordinators		X	1 transition	$5,000
Transportation Supports – Licensing, Insuring, Maintaining		X	Service	$1,650
Transportation Supports – Transportation Vouchers		X	1 trip	$12.16
Transportation Supports – Mileage Reimbursement		X	1 mile	$0.50
Vehicle Modification		X	Service	$4,000

State Plan Program for Youth with Severe Emotional Disturbance

Services	QS	DS	Unit	Rate
Co-Occurring Services	X		Visit	$123.50
Consultative Clinical and Therapeutic Services	X		Consultation	$80 – $120
Crisis Intervention Service	X		1 day (cannot exceed 14 days)	$200
Education and Support Services	X		Session	$75
Family Support Specialist			15 minutes	$14
Geographic Factor for Travel	X		1 mile	$0.50
In-Home Therapy	X		Visit	$110
Non-Medical Transportation	X		1 mile	$0.33
Peer-to-Peer Services – to parent	X		15 minutes	$11
Peer-to-Peer Services – to youth	X		15 minutes	$10
Respite Care	X		15 minutes	$5.32
			1 day	$200
Specialized Evaluation Services	X		Evaluation with consultation	Actual cost ($1,500 cap/enrollment year)
Supplemental Supportive Service	X		Service	Actual cost ($1,000 cap/enrollment year)
Wraparound Facilitation	X		15 minutes	$15
Addictive Treatment Services – Group		X	Visit	$9
Addictive Treatment Services – Individual		X	15 minutes	$11.25
Companion Services		X	15 minutes	$5.22
Connecting Information Technology – Purchase		X	Item	$800

Services	QS	DS	Unit	Rate
Connecting IT – Set Up		X	Service	$100
Connecting IT Monthly		X	1 month	$58
Connecting IT – Medication Management Technology Purchase		X	Item	$900
Connecting IT – Monitoring, Diagnostic Information Technology Purchase		X	Item	$700
Connecting IT – Monitoring, Diagnostic Information Technology Monthly		X	1 month	$150
Overnight and Enhanced Staffing		X	1 night	$40
MFP Transition Services		X	Unit	$2,000
Peer Mentor/Advocate		X	15 minutes	$7.00
Regional Transition Coordinators		X	1 transition	$5,000

B.6 Consumer Supports

Montana's MFP demonstration project model is consumer-driven. Participants and their family members will be involved in all key MFP processes including assessment, care planning, transitioning, supervising and determining the effectiveness of existing services and supports, and revising of plans of care. The transition team will ensure that participants have access to the assistance and support that is available under the demonstration including back-up systems and supports, and supplemental support services in addition to the usual HCBS package of services.

Description of Educational Materials

The informational packet, described in Section B.3, will contain educational materials about the procedures for participants to access needed assistance and supports. All potential participants will receive a copy of this packet, and portions will also be used for training.

Description of 24-Hour Back Up Systems

Participants will develop 24-hour back up systems with their case management team. Transition team members will participate in the development of back-up plans, which must be developed before a consumer transitions to the community. Plans will vary based on the target population.

- **Clients with developmental disabilities** transitioning from MDC have 24-hour on call staff immediately upon transition. As DD consumers begin participating in MFP, many will transition to supported living environments,

which also have 24-hour staffing. Consumers with developmental disabilities will also develop 24-hour back up plans to ensure participants have uninterrupted access to critical services and supports.

- **Youth with SED** transitioning from PRTFs have a crisis plan developed upon discharge home in conjunction with their wraparound team. Crisis plans are individualized and specific to the youth and family. The plans are informed by a functional behavior assessment inclusive of youth and families. If the plan doesn't work in crisis, it is modified.
- **Participants with SDMI** develop a Wellness Recovery Action Plan (WRAP) with their case management team, which lays out specifically what a consumer needs in a crisis. People listed in the plan are notified and have a copy of the plan. A copy of the plan is included in Appendix F-2.
- **Participants who are elderly or physically disabled** transitioning from a nursing facility will develop a back-up plan with their case management team. In addition, all consumers will have a PERS to provide 24-hour back-up support if needed.

The 24-hour back-up plans for all populations will address issues of transportation, direct service workers, repair, replacement, and loan equipment for durable medical equipment or adaptive technology, and access to medical care.

Participants with Developmental Disabilities

Consumers with developmental disabilities will develop a 24/7 back up plan with their transition team, including their targeted case manager. These plans will include three levels of back up:

i) Contracted agency back up

ii) Personal support structure

iii) Emergency back up

Clients with developmental disabilities or their families will primarily rely on contracted agency staff for 24/7 back up. Agencies contracted with the Developmental Disabilities Program are required to have 24-hour staffing. Participants self-directing services are able to access these back up services, and specific agencies will be identified in back up plans.

Consumers with developmental disabilities will also identify one or more individuals within their personal support structure who may provide back-up services and supports to them in their back up plans. These individuals should live close to the participant and be knowledgeable about her/his needs. The case management team will discuss the plan with the designated back-up supports.

If other options fail, MFP participants will be able to seek help through emergency response systems. Consumers will also be able to access assistance for abuse, neglect, and exploitation through the State's Adult Protective Services (APS) and Child Protective Services (CPS) phone lines. There is a statewide CPS toll free telephone number available 24-hours a day that receives and triages reports. Cases opened by

APS or CPS will be investigated until a safe resolution for the consumer is made. These toll free numbers are widely published across the State.

All consumers are advised to call 911 in the event of a crisis where health or safety is in immediate jeopardy.

Participants who are Elderly, have Physical Disabilities, or have Severe Disabling Mental Illness

MFP participants who are elderly, physically disabled, or have SDMI will develop a 24/7 back up plan with their transition team, including their case management teams. These plans are personalized based on consumer needs and supports available to each consumer, and will generally include four levels of back up:

i) Primary back up support structure

ii) Secondary supports and services available through informal support network

iii) Personal emergency response system

iv) Emergency back up

Consumers will identify primary back-ups for all critical supports and services in their plans of care. Primary back-ups will include provider agencies and individuals who have been engaged to provide critical, emergency, and back-up services and supports. Montana requires agency-based providers to ensure continuity of care by providing coverage for no-shows and other unexpected changes in planned service delivery for critical needs. This provides 24-hour back up for direct service workers.

In back-up plans, consumers will identify one or more individuals within their personal support structure who may provide back-up services and supports to them in

the event that other back-ups fail. These individuals should live close to the participant and be knowledgeable about her/his needs. The case management team will discuss the plan with the designated back-up supports.

All MFP participants who are elderly, physically disabled, or have SDMI will be provided a Personal Emergency Response System (PERS). When a participant uses the emergency button on a PERS, an immediate responder connects to the consumer via a speaker installed in the individual's home. Based on the consumer's response to questions, the responder contacts the appropriate supports. The consumer provides names and contact information of people to be contacted in the event of PERS activation when the unit is installed. When necessary, the responder can also contact 911 on behalf of the individual.

If other options fail, MFP participants will be able to seek help through emergency response systems. Consumers will also be able to access assistance for abuse, neglect, and exploitation through the State's APS and CPS phone lines. Cases opened by APS or CPS will be investigated until a safe resolution for the consumer is made. These toll free numbers are widely published across the State.

All consumers are advised to call 911 in the event of a crisis where health or safety is in immediate jeopardy.

Participants with Serious Emotional Disturbance (PRTF)

MFP participants with SED will develop a 24/7 back up plan with their transition team, including their wraparound facilitators. The 24/7 back up plan is included in their crisis plan, which includes the following three elements:

i) Primary back up support structure

ii) Secondary supports and services available through informal support network

iii) Emergency back up

Consumers, family members, and the wraparound team will identify primary back-ups for all critical supports and services in their plans of care. Primary back-ups will include provider agencies and individuals who have been engaged to provide critical, emergency, and back-up services and supports. Montana requires agency-based providers to ensure continuity of care by providing coverage for no-shows and other unexpected changes in planned service delivery for critical needs. This provides 24-hour back up for direct service workers.

In back-up plans, consumers and families will identify one or more individuals within their personal support structure who may provide back-up services and supports to them in the event that other back-ups fail. These individuals should live close to the participant and be knowledgeable about her/his needs. The wraparound facilitator will discuss the plan with the designated back-up supports.

If other options fail, MFP participants will be able to seek help through emergency response systems. Consumers will also be able to access assistance for abuse, neglect, and exploitation through the State's CPS phone lines. There is a statewide CPS toll free telephone number available 24-hours a day that receives and triages reports. Cases opened by CPS will be investigated until a safe resolution for the consumer is made. These toll free numbers are widely published across the State.

All consumers are advised to call 911 in the event of a crisis where health or safety is in immediate jeopardy.

Based on information from the 2012 MFP conference, the State will explore the possibility of implementing a 1-800 number to triage 24/7 backup calls. This number would serve all MFP participants.

Integrated into the back-up planning process is the risk assessment and mitigation planning. The transition team will assess risks for each participant in a consensus process led by the consumer and family with involvement from providers, staff, and discharge planners. Each program will use its own risk assessment forms and mitigation processes, which are currently in place. The identified risks and mitigation approaches will be reflected in the 24-hour back-up plan.

Montana will evaluate the effectiveness of emergency back-up plans through its quality management system. The State will require consistent reporting from the case management teams working with the targeted MFP populations, as well as the agency and emergency response back-ups. This will support consistent data to assess the effectiveness and reliability across the spectrum of approaches and teams. The data will inform ongoing quality improvement to back-up plans. These reporting requirements will be in place before MFP transitions begin.

Transition coordinators and case managers will also monitor individual participant's usage of back-up systems. Frequent usage may indicate the consumer's service providers and supports are not functioning well, and the plan of care may need to be modified.

Grievance and Resolution Process for Back-Up System Failures

MFP participants can file grievances about the failure of back up systems in multiple ways. They can: 1) file grievances with their provider or case management agency; 2) call the Citizens' Advocate 800 number or the Department; or 3) submit complaints through the Medicaid consumer hotline. All grievances about back-up system failures will be integrated into the quality management system. The State will monitor provider performance and identify program improvement strategies, when necessary, based on this data. This quality assurance analysis will occur at the individual consumer/provider level, as well as using aggregate data to analyze macro trends across the State.

Members of the individual's transition team will assist with the resolution process. Participants will be instructed to contact their transition coordinator, peer advocate/mentor, case manager, or other member of their transition team when back-up systems fail. These individuals will determine the reason for the problem and develop, along with the participant, improvement strategies to resolve the problem.

Montana will include instructions for reporting 24-hour back up system failures with the participant information used to supplement the MFP informational packet once a consumer decides to participate in the demonstration. This information will also be available on the MFP webpage.

Additional Consumer Quality Assurances

In addition to a consumer's plan of care and 24-hour back-up system plan, the State will also have a risk assessment and mitigation plan and critical incident response system (CIRS) to ensure quality, health, and safety for MFP participants.

The transition team develops the **risk assessment and mitigation plan** during the transition assessment process. The assessment covers: health and medical conditions, caregiver and support needs, financial situation, legal issues, housing availability, linkages with medical and health care providers, identification with the transitioning community, and other factors that may adversely affect the welfare and safety of the participant. The plan of care will contain a section devoted to measures that address risk factors and a mitigation plan for each participant. Consumer's back-up plans will also reflect identified risks by focusing on service areas or supports deemed particularly critical or risk prone.

Critical incidents may include abuse, neglect, exploitation, unexpected hospitalizations, injuries, medication errors, or other incidents negatively impacting a participant's health and safety. Transition coordinators, peer advocates/mentors, and case managers will educate participants about how to recognize a critical incident and how to respond. Each participant will have a reference guide with names and phone numbers to use in critical incidences. Each DPHHS HCBS waiver and State Plan program has a CMS-approved CIRS system that will be used by MFP participants.

B.7 Self-Direction

Montana offers self-direction opportunities for three of the targeted populations – 1) consumers who are elderly, 2) consumers with physical disabilities, and 3) consumers with developmental disabilities not living in a congregate setting. The current self-direct opportunities will remain the same within the Community Choice Partnership MFP demonstration project. During the initial assessment, the transition team will explore the potential participant's capacity and desire to self-direct her/his own services. Consumers who are elderly, physically disabled, or have developmental disabilities wanting to pursue self-direction will have the current self-direct resources join their transition teams. This may be an independence adviser (for consumers who are elderly or physically disabled), or a support broker (for consumers with developmental disabilities). These individuals will work with the consumer and others are on the transition team to develop the plan of care. However, the State anticipates that none of the transitioning consumers with developmental disabilities will be eligible for self-direction.

Montana's Bonanza option under the Montana Big Sky Waiver for consumers who are elderly or physically disabled is a consumer-directed model where participants plan and direct their own care, and are also responsible for budgeting and spending. The provider agency is the legal employer, and the consumer serves as the managing employer. One unique feature of the program is that consumers can pay legally responsible individuals for care up to 40 hours per week. Montana offers training for consumers selecting self-directed care to support them in managing their care

successfully. Participants receive initial training where they are assisted in selecting a certified independence advisor. Consumers will work with independence advisors to:

1. Learn how to successfully self-direct services.
2. Develop a person-centered Service Plan.
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 to track expenditures.
10. Monitor the provision of the services to ensure the consumer's health and welfare.
11. Coordinate with the financial manager to ensure that consumers or personal representatives budget appropriately to meet their needs as defined in the service plan.

Consumers and independence advisors interact routinely with a certified financial manager, also selected by the consumer. The financial manager will: 1) complete all necessary payroll and employment forms; 2) report and pay payroll tasks;

3) monitor and manage the spending plan; 4) certify and enroll the independence advisor; and 5) monitor spending in the services and supports plan.

The waivers and State Plan program services that do not explicitly include self-directed services emphasize consumer choice and control through their inclusive approach to case management. MFP will continue and grow consumer control by having consumers and families as integral components to transition teams. Consumers and families will have control and choice in the demonstration and supplemental services comprising their plans of care.

Current self-direction forms from the approved Big Sky waiver are included in the appendices.

Voluntary Self-Direction Termination

Consumers choosing to self-direct may opt out of this option at any time, and receive agency-based services under the traditional model of service delivery. Consumers would notify their independence advisor, who works with others as appropriate to coordinate services and supports to ensure no break in vital services and a timely revision of the service plan. The consumer will participate in a planning meeting to determine precisely what the individual wants with their resource allocation in a traditional model of service delivery.

The case manager or independence advisor will record the reason for the return in the quality management database. The MFP project team will analyze the data and look for opportunities to improve Montana's self-direction programs through additional training and supports.

Under no circumstances will ongoing services be reduced or terminated if an individual seeks a new provider or a traditional service delivery model.

State Termination of Self-Direction

The State will intervene when the quality management system or other source identifies an instance where the participant-directed option is not in the best interest of the consumer because of a health or safety issue posing an undue risk to the consumer or others. The team will develop and implement a corrective action plan to address the presenting issues, including additional training or change of a personal/authorized representative. If the prescribed interventions do not ameliorate the situation, the consumer 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. The independence advisor will ensure that no break in vital services and a timely revision of the service plan occurs. The consumer may appeal this decision by requesting a fair hearing through the DPHHS Fair Hearing process.

State Self-Direction Goal

Less than 2% of Montana's Big Sky Waiver and approximately 8% of waiver consumers with developmental disabilities opt for self-directed care. The State believes that none of the MFP participants with developmental disabilities will use self-direction because of their care needs and the fact that most, if not all, will reside in congregate settings. If the two percent rate remains the same under the Community Choice

Partnership MFP demonstration project, that means five people of the total MFP population of 235 will use self-direction.

Montana would like to see this figure increase to address the growing care gap in the State. An obstacle to further self-direction expansion under the Big Sky Waiver has been training capacity. The State will address this issue under the Community Choice Partnership MFP demonstration project by implementing a new training approach. The MFP project director will conduct an analysis of available training approaches within the first year of the project. One possibility is the consumer-directed training series from the Vocational Rehabilitation Institute in Pennsylvania. Expanding Montana's training approach beyond in-person training will support more individuals in successfully self-directing their care. Montana's goal is to have 8% of the participants who are elderly or physically disabled self-directing their care by 2016. The State plans to place further increase the number of participants self-directing using the following approaches:

- Implementing a State Plan option under Community First Choice, which will focus on increasing self-direction.
- DDP is implementing a standalone self-direction waiver for individuals with developmental disabilities, which should take effect in July 2013. DDP is planning to further promote self-direction under this waiver.
- The Senior Long Term Care (SLTC) Division is reevaluating how to promote self-direction within the Big Sky Waiver for consumers who are elderly or physically disabled.

- The Addictive and Mental Disorders Division (AMDD) plans to put self-direction in place by 2016.

Although the SDMI waiver and the 1915(i) State Plan program do not explicitly have self-direction at this point, both include significant consumer involvement through the WRAP and wraparound approaches employed.

Additionally, some SDMI, DD, and Big Sky Waiver consumers not self-directing under the waiver do in fact self-direct under the State Plan Personal Assistance Services program.

B.8 Quality

DPHHS is responsible for the oversight and evaluation of the Community Choice Partnership MFP demonstration project. The quality management system will be used in conjunction with the HCBS 1915c waivers and 1915i State Plan program quality assurances. Montana will also conduct oversight to ensure the Community Choice Partnership MFP demonstration complies with federal assurances and other federal requirements.

Under current processes, the Department staff performs announced quality assurance reviews. The purpose of the review is to ensure that optimal services are being provided to consumers and that program rules and policies are being followed. Quality assurance results are used to improve the programs and services and confirm that case management teams are meeting the requirements of their contract with the Department. The quality assurance review is divided into four components:

1. **CMS Quality Assurance Performance Measures**: A quarterly report completed by the case management team, which documents compliance with federal assurances and remediation efforts when necessary.
2. **Provider Prepared Standards**: A documentation process where the case management team provides information to demonstrate compliance with specific Department standards. This report is completed prior to the onsite review at the request of the Department staff.
3. **On-going Oversight Review Standards**: Department standards, which are reviewed and addressed on an on-going basis.

4. **Performance Review Standards**: Department Performance Standards, which are addressed via a review of records.

1915c Waiver and 1915i State Plan Program Integration

All MFP participants will be enrolled in an HCBS waiver or State Plan program during their demonstration participation, and fall within the purview of quality assurance and improvement activities as defined in Montana's 1915c waiver and 1915i State Plan program applications.

The MFP project will ensure quality of care offered under the Community Choice Partnership MFP demonstration collaboratively with SLTC, AMDD, DSD, and Disability Transitions, along with BFSD and TSD. Montana's MFP demonstration project will use a memorandum of understanding (MOU) to outline how quality work will be coordinated across divisions. There will be a designated person in each of the programs who will work with the MFP director and assistant director to coordinate around and resolve quality issues. Each program will be responsible for the analysis based on consistent factors/metrics, and then meet at least quarterly to discuss findings, or more often if necessary. The State anticipates meetings to be more frequent at the beginning of MFP implementation.

All programs include either a case management team or a case management-like team. These teams in each of the program areas will manage quality processes.

- DDP uses targeted case management
- SLTC uses case management teams
- AMDD uses case management teams

- CMHB uses wraparound facilitators, who function similarly to case managers

Montana will flag MFP participants in the MMIS to ensure they are included in the quality sampling process. Additionally, the State will ensure the MFP transition coordinators are trained in quality processes to retain the current level of quality oversight.

1915b, State Plan Amendment, or 1115 Waiver

Montana will not be using existing 1915b, State Plan Amendment, or an 1115 waiver to serve individuals during or after the MFP transition year.

1915c Waiver and 1915i State Plan Assurances

The Quality Improvement System under the Community Choice Partnership MFP demonstration is identical to the ones implemented through existing 1915c waivers and the 1915i State Plan program. These meet CMS assurances regarding:

- Level of care determinations
- Service plan description
- Identification of qualified HCBS providers for participants being transitioned
- Health and welfare
- Administrative authority

Supplemental Demonstration Services Quality Assurances

Montana is not proposing any supplemental demonstration services within its MFP demonstration project.

Additional MFP Quality Assurance Requirements

Descriptions of the three additional MFP quality assurance requirements – 1) 24/7 back up system for critical services, including monitoring of its usefulness and effectiveness; 2) risk assessment and mitigation process for all program participants, including monitoring; and 3) incident management system used to monitor health and welfare of the MFP participants back up plans – are included under the Consumer Supports section (B.6) of this operational protocol.

B.9 Housing

Housing is one of the largest obstacles to individuals transitioning to community settings in Montana. Because of this, the Community Choice Partnership MFP demonstration project is expending a significant effort to increase the availability of affordable, accessible housing. The role of the State housing coordinator will be critical in growing a collaborative relationship with the Department of Commerce to support the breadth of work outlined in this area.

Process for Documenting Type of Residences to which Participants Transition

The State housing coordinator will train and work with regional transition coordinators to connect MFP participants with housing in a qualified residence. Montana developed a checklist for regional transition coordinators to use to verify that each MFP participant is moving into an MFP qualified residence. Regional transition coordinators will use a centralized housing registry to assist with placements and track where each participant moves upon transition.

The State housing coordinator is responsible for collaborating with local Public Housing Agencies, developers, contractors, landlords, congregate living providers, and DPHHS licensing to populate the centralized registry. This registry will serve as a tool to identify residential opportunities statewide. Regional transition coordinators may assist with this local housing work.

Once a transition coordinator successfully places an MFP participant, she/he will record the type of qualified residence and the funding mechanism for that placement in the housing registry. The State housing coordinator and the Department will be able to

query the registry to see how many MFP participants live in each type of qualified residence.

Montana's Community Choice Partnership MFP demonstration project focuses on a wide spectrum of targeted groups coming from varied institutional settings. Because of this, Montana has a large number of qualified residences into which MFP participants may transition, including:

1. **Homes** owned, leased, or rented by individuals or families.
2. **Apartments** owned, leased, or rented by individuals or families. Apartments may include shared service delivery options, public housing, and Housing Choice Voucher Section 8.
3. **Assisted living facilities** meeting the MFP qualified residence criteria of:[5]
    a. Having a lease or lease-like agreement
    b. Must be an apartment containing living, sleeping, bathing, and cooking areas
    c. Having lockable access and egress
    d. Not requiring services be provided as a condition of tenancy or from a specific company for services available in addition to those included in the rate
    e. Not requiring notification of absences from the facility
    f. Having a common practice of aging in place

[5] These criteria are subject to change based on CMS regulations.

g. Not reserving the right to assign apartments or change apartment assignments

These requirements can be modified to support a participant's plan of care.

4. **Developmental Disabilities group homes** with four or fewer unrelated individuals residing together.
5. **Adult foster homes** with four or fewer unrelated individuals residing together.
6. **Youth foster homes** with four or fewer unrelated individuals residing together.
7. **Children's mental health group homes** with four or fewer unrelated individuals residing together.
8. **Adult mental health group homes** with four or fewer unrelated individuals residing together.
9. **Adult Intensive Community Based Rehabilitation Homes (ICBR)** with four or fewer unrelated individuals residing together.

Methods to Ensure Sufficient Supply of Qualified Residences

Existing or planned inventories and/or needs assessments of accessible and affordable housing

Affordable, accessible housing is one of the largest barriers for institutionalized consumers to return to community settings in Montana. A large percentage of the residential settings that have historically been used for transitions in the State do not meet MFP qualified residence requirements. Individuals transitioning from nursing

facilities have primarily (68%) transitioned into assisted living facilities, with the remaining 33% moving to homes or apartments independently or with family members, or to adult foster homes. The State modifies approximately 15 homes and apartments annually to increase accessibility for consumers transitioning from facilities. Individuals with developmental disabilities generally transition to Developmental Disabilities group homes or home to families. In Montana, many existing DD group homes have more than four unrelated people exempting caregivers living together. Very few individuals with SDMI have transitioned from nursing facilities or IMDs. Consumers that have transitioned generally moved to adult mental health group homes or ICBRs.

While Montana does not have a precise inventory of accessible homes and apartments, it knows that the supply is limited. Less than 20% of homes in the State have, as a minimum standard, an accessible entrance (Seekins, Traci, Ravesloot, & Oreskovich, 2010). The Montana Home Choice Coalition and the State of Montana Independent Living Council Housing Task Force in collaboration with the Rural Institute of the University of Montana have made increasing the supply of accessible housing and promoting a minimum standard of accessibility in all housing-visitability an important goal. The Accessibility Ambassadors project has focused on both publicly funded housing as well as privately developed housing. Due to their advocacy, the state of Montana Low Income Housing Tax Credit (LIHTC), Community Development Block Grant (CDBG), and HOME Programs recently adopted visitability as their minimum accessibility standard in all funded housing.

The availability of affordable housing is a challenge statewide. Long waiting lists is the norm for subsidized housing of all types. The Montana Department of Commerce Housing Choice Voucher program currently has over 10,000 households on the waiting list for 6,500 plus vouchers throughout the State – requiring a wait of 24 months or more. Other local public housing authority's Housing Choice Vouchers programs around the state have similar waiting lists. The wait for a public housing unit depending on unit size and community is normally a shorter wait of nine months to a year. Access to affordable and accessible housing varies widely among Montana's seven tribal reservations. Affordable housing is particularly challenging to find in eastern Montana, which has been experiencing a housing shortage because of the recent influx of workers to the Bakken oil field.

Many developers and landlords do not include accessibility information in their property listings. A few registries and search engines exist to support individuals searching for affordable, accessible housing, but landlords only partially participate. This results in these units remaining vacant, which reinforces the misperception that there is little unmet need for affordable, accessible units.

Montana's State housing coordinator will build a centralized housing registry to document the inventory of affordable, accessible units. The housing coordinator will work with the Montana Department of Commerce and local Public Housing Authorities to create and populate this registry. The State will build on the infrastructure of: http://mthousingsearch.com/ and use the concepts regarding accessibility definition and search-ability from http://www.socialserve.com/ for the registry. The housing

coordinator will conduct regional surveys to determine the current inventory and occupancy of qualified residences statewide as a first step in developing the registry.

Methods to address identified shortages including plans to coordinate with Housing Finance Agencies, Public Housing authorities and other housing programs

Montana is planning to reinvigorate the work of the Montana Home Choice Coalition under this grant. This coalition has operated for 12 years, bringing together the affordable housing and disability communities to collaboratively address housing affordability and accessibility issues. The coalition brings persons with disabilities and advocates together with Federal, State, and local housing and services programs, affordable housing and disability nonprofit providers, State legislators, and representatives of Montana's Congressional delegation to create better housing choices for all Montanans with disabilities.

The Home Choice Coalition has established working relationships within the affordable housing and disability communities statewide. The coalition has worked to create community integrated housing opportunities for persons with disabilities across the age and ability spectrum addressing housing needs related to homelessness, Olmstead housing, integrated community rental housing, and expanding homeownership opportunities.

The coalition and the Montana Independent Living Council Housing Task Force have worked closely together to address issues of both affordability and accessibility. In the past year, the coalition and Housing Task Force workgroup have fostered a regular meeting between the Governor's office, DPHHS, and the Department of Commerce, Housing Division to work more closely across traditional agency boundaries to better

address the housing needs of persons with disabilities and better link services to individuals living in housing.

This working partnership has included working to develop a proposed Housing Bridge program to use State general funds to pay rental assistance for individuals while on the waiting list for the Housing Choice Voucher (Section 8). It has also supported the Department of Commerce and DPHHS in submitting an 811 Reform Demonstration Rental Assistance grant application. The application was submitted on August 3, 2012. Montana was notified that the application was successful in February 2013.

The State housing coordinator will lead the work to continue and grow these collaborations under the Montana Community Choice Partnership MFP demonstration project. Montana has the advantage of having one statewide public housing authority in the Department of Commerce. The statewide public housing authority has 13 agents distributed around the state – mainly Human Resource Development Councils (HRDCs) and Public Housing Authorities. The centralized housing authority will support easier collaboration with DPHHS and a State housing coordinator. In addition, Montana has 11 other public housing authorities in communities across the State, as well as seven tribal housing authorities serving Montana's seven tribal nations' reservations.

Specific opportunities for the housing/DPHHS collaboration to address are included in the following section.

Methods to address identified shortages including strategies to promote available, affordable, accessible housing

Recent Accomplishments

A recent success in Montana was passing a requirement for State programs to adopt visitability for all LIHTC, CDBG, and HOME-funded housing. Montana Disabilities and Health Program representatives have educated approximately 8,300 consumers, builders, architects, policy makers, and other housing stakeholders about visitability as an alternative for home design. This work will help increase the inventory of housing that can be lived in or visited by individuals with disabilities.

Additionally, the Montana Home Choice Coalition has assisted over 120 persons with disabilities to become homeowners utilizing new resources such as the Housing Choice Voucher Section 8 Homeownership option, as well HOME-funded down payment assistance (as much as $40,000 per household for a family with a disability), and advantageous mortgage financing with the Montana Board of Housing (including low-interest Disabled Affordable Accessible Homeownership Program), and USDA Rural Development. The coalition has also demonstrated the importance of housing in supporting individuals with severe disabilities transitioning from facilities to community living. The coalition's Olmstead Initiative has created over 42 community living opportunities for persons previously living long-term in State-funded facilities.

Current Work

The State is working on two initiatives currently that will help increase availability of affordable, accessible housing:

1. The **811 Reform Demonstration Rental Assistance Grant** application, if successful, will bring $2 million in rental assistance to Montanans. The DPHHS/ Commerce workgroup is working with interested project-based housing

providers to provide housing vouchers with services for extremely low-income individuals eligible for the HCBS Big Sky waiver and the mental health waiver for persons with SDMI. This funding would increase the number of integrated, affordable and accessible rental units available to MFP participants. The grant application was submitted on August 3rd, and Montana was notified in February 2013 that the application was successful.

2. Montana has a housing task force working to create a **State-funded Housing Bridge Program**. The Housing Bridge Program would use State general funds to pay rental assistance for individuals while on the waiting list for the Section 8 Housing Choice Voucher. As Montana continues to work on this initiative in advance of the 2013 legislative session, the task force can structure the program to fund transitioning individuals as a priority population. If the bridge program is funded, the MFP State housing coordinator will work with local Housing Authorities to also have it coordinate with local housing voucher programs.

Future Strategies

In addition to the two current initiatives, Montana plans to pursue multiple additional strategies under the leadership of the MFP State housing coordinator to increase the availability of affordable, accessible housing. The MFP planning stakeholder advisory council defined the approaches listed below to help obtain this goal. The State housing coordinator will create an action plan to implement these strategies upon CMS' award of the MFP grant. The action plan will prioritize strategies

to ensure the number of affordable, accessible units available meets the demand created by MFP transitions.

1. **Provide housing search assistance** – the regional transition coordinators will work individually with MFP participants throughout the process of locating and moving into accessible/affordable housing. The regional transition coordinators, in conjunction with the State housing coordinator as necessary, will help participants resolve issues as they arise. The transition coordinators will also work with the outreach specialists to ensure potential MFP participants know about the housing assistance they will receive through the Community Choice Partnership MFP demonstration project.
2. **Create and populate centralized housing registry –** the State housing coordinator and regional transition coordinators will work closely with developers and landlords to develop and populate the housing registry, incorporating well-defined accessibility information. The State will provide education and technical assistance to help other housing resources use the registry.
3. **Educate local, State, and Federal officials about housing's crucial role** in supporting the success of MFP participants as they transition. The State housing coordinator may invite some members of the Montana legislature to join the Montana Home Choice Coalition. The State coordinator will hold a legislative briefing on the issue during the 2013 legislative session.

4. **Work with Tribal housing entities** on each reservation to analyze the housing resources, and identify strategies to increase capacity to support tribal members remaining close to home.
5. **Request preference in public housing plans** for people with disabilities and, within that subgroup, for individuals transitioning from facilities. This can be done by:
    a. Creating a mandate/legislation that MFP participants move quickly to the head of the line for the Housing Choice Voucher.
    b. Commenting in the Section 8 program to request preference for MFP participants.
    c. Advocate for local public housing authorities to prioritize individuals with disabilities or transitioning from institutions.
6. **Increase 504 requirements** – The State housing coordinator will work with stakeholders to increase the percentage of State-required fully accessible housing.
7. **Obtain homebuyer assistance** to help people with accessibility needs. The State housing coordinator will work to ensure home ownership is part of the menu for individuals making transitions.
8. **Support modifications to existing structures** through a funding mechanism. The housing coordinators can identify creative ways to support housing modification with local contractors. For example, she/he may find volume savings in bulk ramp system purchases and work with contractors to install these systems at a

low cost. The Board of Housing could be funded to **create a low interest housing modification program** to pay for modifications based on income eligibility.

9. **Reduce housing discrimination through legislation** – some landlords do not want to participate in Section 8 programs. The State of Utah addressed this discrimination barrier by passing legislation not allowing landlords to discriminate based on funding source. The State housing coordinator will look at pursuing a similar strategy in Montana.
10. **Conduct outreach regarding universal design concepts** – Montana may reach out to developers and contractors to promote universal design concepts/Smart Houses. The State housing coordinator will present at annual contracting conferences. The barrier to increased implementation of these concepts is cost. Smart Houses add approximately 30% to the cost of a home. The State housing coordinator will analyze means to offsetting that cost or incentivizing this building approach.
11. **Educate developers about accessibility** – Montana needs to define what accessibility means and then educate developers, contractors, and landlords about the issue. Centers for Independent Living and the Housing Task Force can assist with this education.
12. **Enforce accessibility requirements** – the accessibility requirements need to be enforced to ensure developers are meeting standards.

13. **Offer accessibility tax credits** – Montana can encourage increased accessible private housing by offering tax credits to developers and property owners, similar to the State of Montana's energy efficiency tax credit. The State housing coordinator will explore ways to implement this strategy.
14. **Implement Tenant-Based Rental Assistance (TBRA) program** to provide financial assistance allowing MFP participants subsisting on Supplemental Security Income (SSI) to pay market rental rates, and remain in the community. Under the HOME program, tenants would pay 30% of the rent, and TBRA would cover the remainder. This will be available to MFP participants after they transition out of the program into waiver services.
15. **Expand State Supplement Program** to support additional affordable/accessible housing. Montana supplements SSI payments with State general funds to create more affordable housing through this program. The Community Choice Partnership MFP demonstration's housing efforts can build on this precedent, perhaps through the TBRA program, or through another means.
16. **Address subsidized housing eligibility obstacles** including bad credit, bad rental history, history of damage in previous rental(s), and criminal records. The regional transition coordinators will need to be able to work through these issues individually. The State housing coordinator may also come up with universal approaches to create trust with landlords in these situations.
17. **Preserve housing for individuals in institutions** – Medicaid does not take property from individuals in a nursing facility or other institution who express a

desire to return home. However, additional mechanisms may be implemented to further preserve housing for individuals who are institutionalized including training of case managers system-wide, early identification, and housing waiting list placement.

18. **Implement State housing trust fund** in combination with LIHTC and other funding mechanisms (i.e. taxes on real estate transfers and purchases, State general fund) to increase supply of affordable housing. The State housing coordinator will work with housing stakeholders to create this fund, and create a structure prioritizing housing serving transitioning individuals.
19. **Include housing information on the Department's Bridge to Benefits** one stop shop online system, and work with Department of Commerce to include disability service and eligibility information on Commerce housing websites.
20. **Promote smaller group settings** with appropriate services and supports for consumers who generally need to live in larger congregate settings to have their needs met.

B.10 Continuity of Care Post-Demonstration

All MFP participants will continue to receive the services they need after the end of the demonstration period. Montana Community Choice Partnership MFP participants will receive HCBS waiver or State Plan program services while participating in the demonstration, and these services will continue as participants exit the demonstration.

Consumers will be reassessed as they exit MFP to determine whether they continue to meet eligibility criteria and to determine whether changes are needed to their plans of care. Because participants are already on a waiver or State Plan program, there will be no lapse in services for MFP demonstration participants and a transition plan is not required. If a participant's level of care needs decreased over the course of the MFP demonstration and she/he is no longer eligible for HCBS 1915c waivers and 1915i State Plan programs, a transition coordinator or case manager will assist the individual in enrolling in other State Plan services to support continued care. Disability Transition Services will offer additional supports to individuals seeking employment after they exit the MFP demonstration project.

Use of new demonstration services will be assessed during the demonstration to determine the potential for their inclusion in HCBS waivers and State Plan programs in the future.

Managed Care Participants

This is not applicable to Montana. The State does not use a managed care model.

HCBS waiver participants

MFP participants will transition onto HCBS 1915c waivers at the beginning of their MFP demonstration period, and this eligibility will continue to provide services to consumers on waivers as they exit the demonstration. The State does not need to amend its waivers to create slot capacity. Montana has slot capacity within its existing waiver authorities to serve the estimated number of MFP participants.

SLTC, DSD, and AMDD will amend waivers to incorporate any new demonstration services successful in meeting consumer needs.

Section 1115 Participants

This is not applicable to Montana.

HCBS State Plan Program Participants

CMHB will be transitioning youth with SED onto its 1915i HCBS State Plan program as they enter the MFP demonstration. Youth age out of the 1915(i) State Plan program at age 18, unless enrolled in secondary school. Youth who age out during the 365-day MFP period will be assessed for eligibility and referred to the other MFP-related waivers (SDMI, DD, Big Sky Waiver) early in the MFP process. Those not eligible for waivers would be able to receive a reduced package of services under Personal Assistance Services or Community First Choice programs if Medicaid eligible.

Montana will also be developing a Community First Choice (CFC) State Plan option under the MFP program. Individuals transitioning to HCBS Waiver or State Plan program services will be guaranteed no disruption in services at the end of their MFP participation.

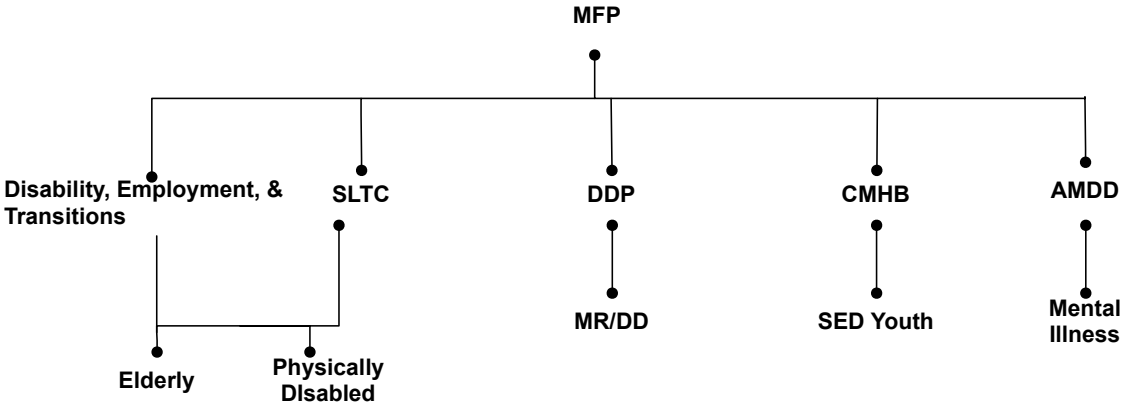
C. Project Administration

DPHHS SLTC is the division responsible for managing the Montana Community Choice Partnership MFP demonstration project grant. The MFP project team is also responsible for maintaining relationships with and overseeing the MFP-related work of the other divisions, bureaus, and other organizations in Montana's LTSS system involved in the project.

C.1 Organizational Chart

Because MFP services and supports are modeled on those the target populations will receive in the HCBS waiver or State Plan program upon exiting MFP, the division or bureau responsible for the core services for each target population is jointly responsible for overseeing the demonstration for that population. The chart below depicts the high-level organizational responsibilities for the target population groups.

Figure 4: High-level Responsibility for Target Populations



The target population-focused division or bureau (SLTC, DDP, CMHB, AMDD, or Disability, Employment, and Transitions) will be responsible for managing the respective local service delivery system. The MFP project director will oversee this work by

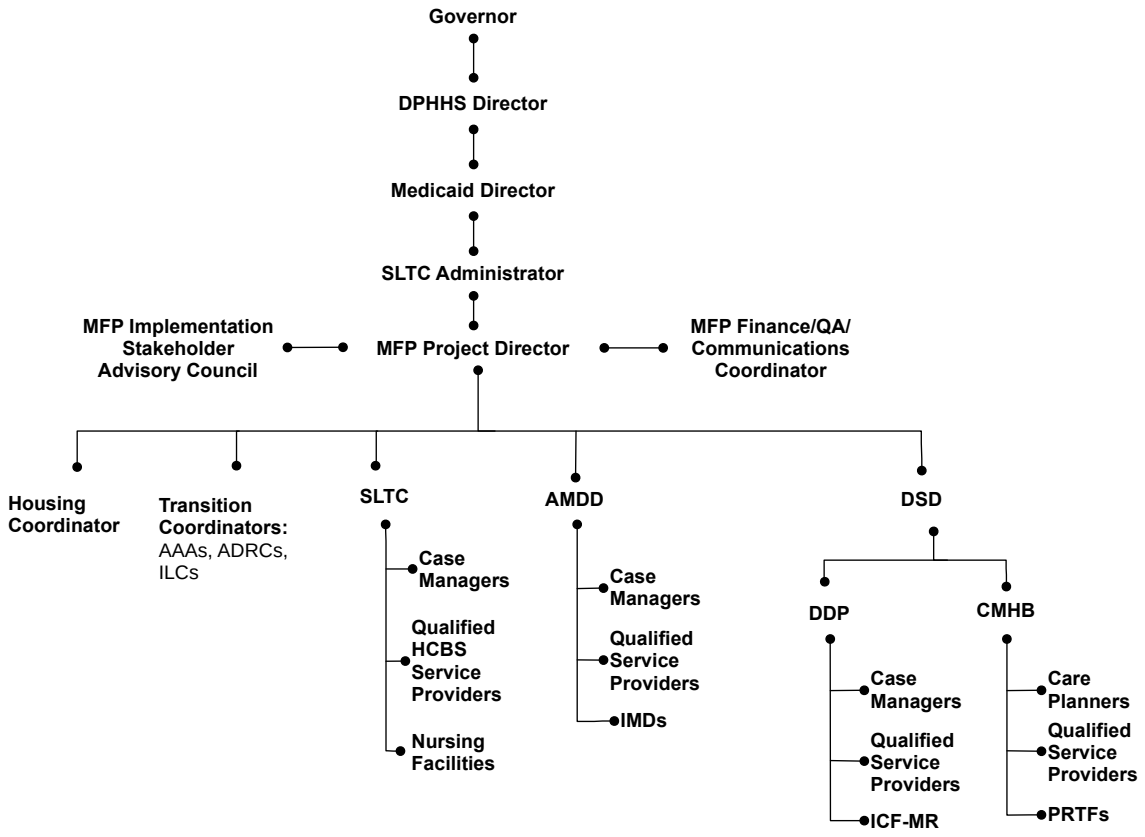
analyzing aggregate data to assess overall demonstration project implementation, operations, and outcomes. The table below outlines the service delivery system per target population.

Table 13: Local Service Delivery System per Target Population

Population	Service Delivery System
Elderly	• Case management by Mountain Pacific Quality Health • Transition coordination by Centers for Independent Living, AAAs, ADRCs, and case managers • Demonstration and supplemental services by enrolled providers
Disabled	• Case management by Mountain Pacific Quality Health • Transition coordination by Centers for Independent Living, AAAs, ADRCs, and case managers • Demonstration and supplemental services by enrolled providers
MR/DD	• Case management by MDC social workers • Transition coordination by MDC social workers, possibly supplemented by Centers for Independent Living and ADRCs • Demonstration and supplemental services by enrolled providers
Mental Illness	• Case management by Mountain Pacific Quality Health • Transition coordination by Centers for Independent Living, AAAs, ADRCs, mental health centers, federally qualified health centers, community health clinics, and case management teams • Demonstration and supplemental services by enrolled providers
SED Youth	• Care planning by wraparound facilitators • Transition coordination by State transition coordinator and transition team including CMHB regional staff and PRTF discharge planners • Demonstration and supplemental services by providers enrolled as HCBS providers for youth with SED

The detailed organizational chart below shows the relationship of the MFP project and the collaborating divisions and bureaus with the participant-facing services. The chart also demonstrates the relationship of the demonstration project with the Medicaid Director and Montana's Medicaid Agency, the Medicaid and Health Services Branch.

Figure 5: Detailed MFP Demonstration Project Organizational Chart



C.2 Staffing Plan

The Community Choice Partnership MFP Project Director Is A Full Time Position

The job description for the Community Choice Partnership MFP project director is included in Appendix F-5. This position is 100% dedicated to the MFP demonstration project.

Number and Title of Dedicated Positions

Montana will fill four positions using administrative funds from the Community Choice Partnership MFP demonstration project:

1. MFP Project Director

2. MFP Assistant Director

3. State Transition Coordinator

4. State Housing Coordinator

Percentage of Time for Each Position is Dedicated

Each of the four positions funded through MFP administrative funds will be dedicated full time to the Montana Community Choice Partnership MFP demonstration project.

Roles and Responsibilities

The responsibilities of the four MFP full time positions are included in the table below.

Table 14: MFP Key Staff Roles and Responsibilities

Role	Responsibilities
MFP Project Director	• Oversee MFP work and provide strategic guidance • Lead project communication and reporting with CMS • Lead project communication with SLTC Administrator and Medicaid Director • Serve as liaison with other DPHHS divisions/bureaus and oversee MFP work done via these agencies • Manage relationships with facility providers • Manage relationships with individual advocacy/stakeholder groups beyond Community Choice Partnership MFP stakeholder advisory council • Coordinate training work
MFP Assistant Director	• Coordinate Community Choice Partnership MFP stakeholder advisory council work with contracted facilitator • Create MFP financial reports, working with BFSD and MMIS fiscal agent contractor • Create and implement project communication plan • Oversee communication/outreach/marketing/education material creation • Conduct quality assurance over Community Choice Partnership MFP

	demonstration activities • Aggregate data across participant populations and analyze to determine what is working well and where there is opportunity for improvement • Define and implement mitigation strategies for risks and issues jointly with MFP project director • Manage contractors supporting MFP implementation and operations work • Support other work as requested by MFP project director
State Transition Coordinator	• Train local transition coordinators across target population areas • Coordinate referrals statewide ensuring all referrals are centrally tracked and assigned a regional transition coordinator • Work with State housing coordinator to support local transition coordinators in connecting participants with housing • Establish relationships and serve as liaison with local service providers, community-based organizations, and other community stakeholders across target population spectrum • Oversee outreach efforts in facility settings • Coordinate peer mentoring/advocacy with contractors • Work to increase access to needed services, e.g. transportation or employment, through regional transition coordinators. • Conduct quality assurance over regional transition work and intercede to improve quality and outcomes as needed (training, increased capacity)
State Housing Coordinator	• Train local transition coordinators to support housing efforts • Create and maintain housing registry • Lead statewide and regional strategic/system change efforts outlined in Section 9, Housing, of the operational protocol • Develop and maintain relationships with Department of Commerce and other housing stakeholders • Lead housing outreach activities • Advocate at local, state, and national levels to increase affordable, accessible housing options for individuals transitioning • Collaborate with housing organizations and stakeholders to develop best practices for transitioning individuals • Work with local housing authorities and other stakeholders to increase housing supply • Focus on developing provider-managed assisted living that meets MFP qualified housing requirements • Report on housing metrics for MFP demonstration project

Positions Providing In-Kind Support

Additional DPHHS staff funded through other sources will support the MFP project in Montana. These staff members include the SLTC Administrator, a BFSD budget analyst, a TSD information technology analyst, the Department Public Information Officer, and the DPHHS Web Designer.

Table 15: In Kind Staff Roles, Responsibilities, and Time Dedicated

In-Kind Staff	Responsibilities	Time Dedicated
SLTC Administrator	Represent MFP demonstration project to legislature	15%
BFSD Budget Analyst	Support financial reporting	15%
TSD IT Analyst	Provide IT oversight and support IT contract management	CY2013: 50% CY2014 – 2016: 5%
DPHHS Web Designer	Develop MFP webpage and maintain webpage ongoing	CY2013: 25% CY2014 – 2016: 8%
DPHHS Public Information Officer	Support communication efforts	CY2013: 8% CY2014 – 2016: 3%

Additional detail about these positions, including bios and position descriptions, is available upon request.

Contracted Individuals Supporting the Grant

Montana is planning to use contractors to supplement MFP project and DPHHS staff. The Community Choice Partnership MFP demonstration will contract with ADRCs, AAAs, Centers for Independent Living, and Mental Health Centers to supplement existing case managers as local MFP transition coordinators. Local transition coordinators will be responsible for:

- Assembling the local transition team

- Conducting individual outreach
- Completing required paperwork with MFP participants
- Assessing service needs and risks
- Conducting options counseling
- Leading transition plan development with transition team
- Developing 24-hour back-up plan with transition team
- Participating in plan of care development
- Coordinating transition services including housing, transportation, and employment
- Educating and training consumers and families – this may include general MFP training, employment, blind/visually impaired, deaf/hearing impaired
- Advocating for the consumer
- Following up with participants post-transition for 3-12 months
- Possibly assisting with transition from MFP to waiver/State Plan program

Montana will contract with an organization to conduct Quality of Life surveys with participants. The contractor will conduct an initial assessment prior to each participant's transition, another 11 months post-transition, and a final assessment 24-months after transition. The contractor will use the Mathematica tool and conduct surveys in person with the participant or a knowledgeable representative.

The State will contract with trainers to create training materials and conduct training with State staff, contractors, providers, caregivers, consumers, and families. This will likely be multiple trainers focusing on varied topics.

Montana will continue to contract with a facilitator for the Community Choice Partnership MFP stakeholder advisory council meetings and community forums. This contractor will be responsible for coordinating meetings, creating outreach material, facilitating sessions, and writing up the results for inclusion on the MFP webpage.

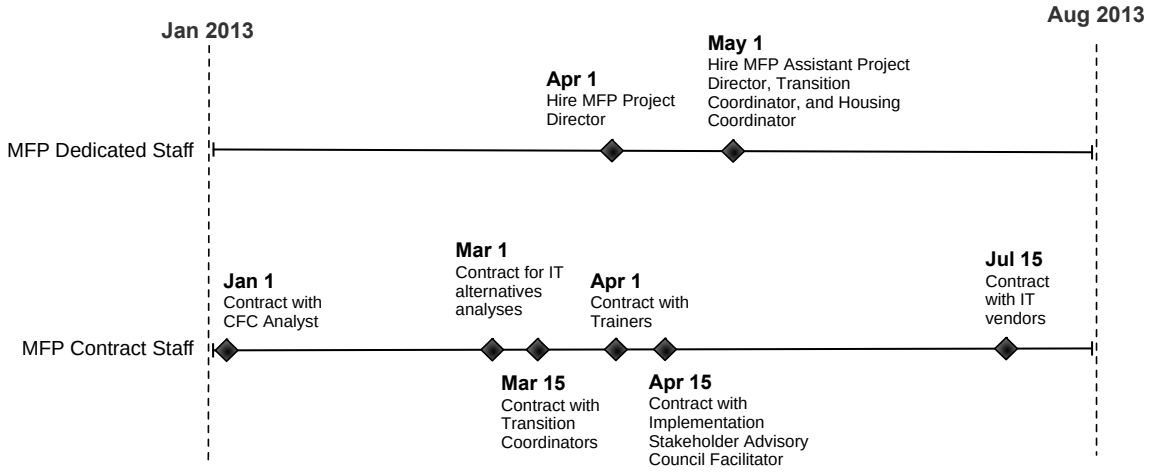
The Community Choice Partnership MFP demonstration project will contract with a Community First Choice (CFC) analyst. This individual will conduct a detailed analysis to determine how to best implement CFC in the State, and develop a demonstration service based on the proposed approach to be piloted during the MFP project.

Montana will also contract for information technology support. The State will preliminarily contract for a vendor to conduct two alternatives analyses – one focused on how to implement a centralized quality management system and the other to determine the best approach to automate the CMHB critical incident response system. Montana will use contractors to implement and operate these systems or software services in addition to implementing enhancements to the SLTC critical incident response system.

Detailed Staffing Timeline

The following timeline depicts when Montana will hire MFP staff and bring on contractors to support the Community Choice Partnership MFP demonstration project.

Figure 6: Staff Timeline



Montana plans to hire its MFP project director upon CMS preliminary approval of the operational protocol. The project director will oversee refinement of the operational protocol and lead all subsequent hiring and contracting decisions.

Entity Responsible for Staff Performance Assessment

SLTC is responsible for assessing staff performance.

C.3 Billing and Reimbursement Procedures

Montana uses the MMIS claims processing system or the Agency Wide Accounting Client System (AWACS), DSD/DDP's claims system, to verify that participants are Medicaid eligible on the date of service delivery. Montana will only allow claims to be paid for services provided within an individual's eligibility period. All MFP participants will be flagged in the MMIS and AWACS to support proper billing and oversight processes.

The State provides financial oversight to assure that claim coding and payment are in line with the waiver or State Plan program reimbursement methodology. Paid

claims reports will be run quarterly or more often is needed. These reports will depict the services utilized, the number of consumers using each service and the total dollar amount paid for each service. In addition, case management teams and financial managers will submit quarterly utilization reports to the state documenting expenditures by service. Case managers and financial managers are required to prior authorize waiver services. They inform the MMIS or AWACS of the allowed services and the number of units or dollar amount for which providers are permitted to bill for each recipient. The Audit and Compliance Bureau will conduct financial audits upon request of the managing division or bureau.

Claims that do not have the appropriate procedure codes and/or rates are denied by the 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 the fiscal agent or the Department. State staff will always assist providers who encounter ongoing problems with the billing system.

In instances in which claims are paid that should not have been, providers would be asked to reimburse the Department. If the provider fails to do so, the amount owed would be taken out of future claims submitted.

Billing processes directly from providers to the State's claims payment systems. For all self-directed services, the provider billing flows from the provider through the Fiscal Management Services Entity (FMSE) and then to the MMIS or AWACS for payment.

MMIS and AWACS verify recipient eligibility for Medicaid and the waiver or State Plan program. Case management teams or financial managers prior authorize all services in the consumer's plan of care. These prior authorizations are submitted to the state's fiscal intermediary. Case managers receive monthly utilization reports from providers documenting units of service provided. These are compared to individual service plans, compiled and forwarded to the managing program. There the data is tabulated and further compared to paid claims data from MMIS or AWACS.

Financial managers operate as limited fiscal agents and make payments for consumers in the participant directed option. Fiscal managers submit claims to Medicaid for payment and monitor expenditures. Quarterly utilization reports are reviewed by the Medicaid agency.

D. Evaluation

Montana will not be conducting its own evaluation of the Community Choice Partnership MFP demonstration project, and instead will rely on CMS for these services.

E. Budget

Budget information is included in the budget narrative, contained in a separate document. Montana included its MFP budget worksheet as a separate attachment with the budget narrative.

Attachment 1: Risk Assessments

The following tools are currently used by the HCBS waivers and State Plan program, in which the MFP participants will be enrolled. These assessment tools will be used in the MFP demonstration program.

1.1 Risk Prevention Assessment From for Individuals Who Are Elderly or Physically Disabled

Consumer's Name:

Medicaid Number:

Case Manager:

Consider normal and unusual risks in each area and discuss preventative measures, as well as strengths and assets you have to address the issue. The Senior and Long Term Care (SLTC) Division values the balancing of rights and risks. The SLTC Division requires the HCBS waiver consumer and his/her planning team to make good choices in implementing reasonable safety and prevention measures. The risk assessment should be summarized in the Risk Agreement and attached to service plan.

List specific risks	How do you evaluate the risk? (high, medium, low) Have you weighed the risk to possible outcomes?	What can be done to prevent these risks? What strengths and assets do you have to help with prevention?	Who can help you with preventive measures?	What support services can help you reduce the risk?	How can your service plan help reduce this risk?
Home					

List specific risks	How do you evaluate the risk? (high, medium, low) Have you weighed the risk to possible outcomes?	What can be done to prevent these risks? What strengths and assets do you have to help with prevention?	Who can help you with preventive measures?	What support services can help you reduce the risk?	How can your service plan help reduce this risk?
Leisure					
Community					
Health					
Work/School					
Other					

1.2 Risk Negotiation Process for Individuals Who Are Elderly or Physically Disabled

PURPOSE

HCBS providers shall support consumers in consumer-direction to the maximum extent possible and assist them in decision-making through informed consent. Waiver service providers shall support a consumer's informed choice unless the consumer's actions or decisions endanger themselves or others. Under HCBS, states are required to ensure consumers are protected from abuse, neglect and exploitation and get appropriate assistance and intervention if their choices jeopardize their health and welfare.

Consumers capable of making informed choices have the right to decide the types and amount of services they receive. Consumers have the right to receive services under conditions of acceptable risk in which they assume the risks associated with decisions made under conditions of informed consent.

To help identify risks and possible preventive measures, the consumer and case management team may choose to complete the Risk Prevention Assessment Form in HCBS 899-29a.

If there are risks that a consumer wishes to take knowingly and in an informed way, and those risks are acceptable to the case management team in terms of health and welfare assurance, the CMT should complete a Risk Negotiation assessment and tool. The Risk Negotiation tool is used by the CMT to assess risk and takes into consideration the consumer's preferences and choices. CMTs should make every effort

to resolve issues that create risk for consumers and may lead to denial or termination of services.

If the CMT cannot assure health and welfare based on the results of the risk negotiation process and tool (e.g. the CMT determines that the risk is unacceptable) the CMT must contact the Regional Program Officer to discuss whether discharge from HCBS is appropriate.

PROCESS

If the CMT identifies a situation which puts the consumer's health and safety at risk, the CMT should meet with the consumer, their legal representative (if applicable) and other appropriate family, friends and support staff to complete the Risk Negotiation tool. (See HCBS 899-29) In all circumstances, the CMT should work with the consumer to discuss service options to resolve or reduce the risk and ensure the consumer understands the potential consequences of his/her choices.

Whenever a Risk Negotiation tool is completed, CMTs must document that the consumer meets capacity and is able to make an informed choice. If the CMT questions whether a consumer meets capacity a referral to APS, a Mental Health professional or the consumer's Health Care professional should be made to help determine capacity.

If the risk identified by the CMT puts the consumer or support staff in immediate or imminent danger, the CMT should contact the appropriate agency as appropriate e.g. law enforcement, county health official, public health, mental health crisis response

team. If the risk identified relates to suspected abuse, neglect or exploitation, an APS referral must be made

CMTs should take into account the following when completing the Risk Negotiation tool:

- Have the potential risks/benefits been weighed?
- What can be done differently to prevent these risks?
- What strengths/resources does the consumer have toward prevention?
- Who can help the consumer with prevention?
- What supports or services (formal or informal) would minimize the risks?
- Who can provide the supports?

In all cases the CMT should keep the following documentation in the consumer's chart:

- Documentation of consumer capacity and understanding of the consequences/risks of their informed choices.
- Documentation of all the services and supports offered and the specific interventions tried by the CMT (formal & informal).
- Documentation of the specific needs not being met.
- Recommendations and reasons why the needs cannot be met.

If the consumer does not agree with the CMT's assessment and/or does not agree to the recommended services in the Service Plan, and the CMT believes the

consumer's choice continues to jeopardize health and safety, the CMT should contact the Regional Program Officer for a discussion about needed corrective action and/or possible termination from HCBS.

1.3 Risk Negotiation Agreement Form for Individuals Who Are Elderly or Physically Disabled

Date: _____
Consumer: _____
Medicaid ID #: _____

Section 1: Description of the consumer's needs, including needs that cannot be met:

_____
_____
_____
_____
_____

Section 2: Description of the services that can be provided:

_____
_____
_____
_____
_____

Section 3: Description of the potential risk to the consumer:

_____
_____
_____
_____
_____

Section 4:

- ❑ Support service options (including nursing home services) have been explained to the consumer
- ❑ The consumer understands and accepts the risks associated with his/her current Plan of Care

- ❑ The consumer's health and welfare cannot be assured and discharge from HCBS waiver will be implemented.

- ❑ The consumer does not have a guardian and has not been declared incompetent.

Consumer:
Signature_____ Date _____

HCBS Case Manager:
Signature_____ Date _____

Regional Program Officer:
Signature_____ Date _____

HCBS Program Manager:
Signature_____ Date _____

1.4 Risk Prevention, Assessment, and Management Plan for Individuals with Severe Disabling Mental Illness

You have the right to decide about risks in your life. One of your responsibilities in the HCBS Waiver is to identify potential risks to your health and safety, discuss them with your Case Management Team (CMT), and plan support services in your Plan of Care (POC) to guard against those risks. As you develop your POC, consider some risk factors in your life and think about ways you can use your POC to lessen those risks. Following are examples of risks to consider:

- A worker who doesn't show up regularly. You can choose to develop a plan for when the worker does not show up or choose to forgo that worker's service that day.

- A significant person in your life is capable of abuse, neglect, or exploitation. Unsafe living conditions, inadequate medical equipment, fire, and safety hazards, etc.
- Personal habits, i.e., smoking (when smoking creates a risk), substance abuse, gambling/financial mismanagement, refusing critical services.
- Increased health risks due to your disability.

If you ignore certain risks that may affect your health and safety while participating in the SDMI HCBS program, your CMT will ask you to complete and sign a Risk Negotiation Agreement Form. See SDMI 915b.

List specific risks	How do you evaluate the risk? (high, medium, low) Have you weighed the risk to possible outcomes?	What can be done to prevent these risks? What strengths and assets do you have to help with prevention?	Who can help you with preventive measures?	What support services can help you reduce the risk?	How can your service plan help reduce this risk?
Home					
Leisure					

List specific risks	How do you evaluate the risk? (high, medium, low) Have you weighed the risk to possible outcomes?	What can be done to prevent these risks? What strengths and assets do you have to help with prevention?	Who can help you with preventive measures?	What support services can help you reduce the risk?	How can your service plan help reduce this risk?
Community					
Health					
Work/School					
Other					

1.5 Risk Negotiation Process and Agreement for Individuals with Severe Disabling Mental Illness

SDMI HCBS providers and staff shall support consumers in consumer-direction to the maximum extent possible and assist them in decision-making through informed consent. Case Managers and Community Program Officers and other service providers shall support a consumer's informed choice regarding life, liberty, and the pursuit of health and happiness, unless the consumer's actions or decisions endanger others.

Consumers capable of making informed choices have the right to decide the types and amount of services they receive. You have the right to receive services under conditions of acceptable risk in which you assume the risks associated with decisions you make under conditions of informed consent.

However, If you ignore certain risks that may affect your health and safety while participating in the SDMI HCBS waiver program, Case Management Team (CMT) or Department will ask you to complete and sign a Risk Negotiation Agreement Form, which will be sent to the Community Program Officer (CPO) for review. The consumer receives copies of the form.

The Risk Negotiation Agreement Form will be completed when:

- The CMT or Department has identified a risk and
- The consumer understands the consequences of his/her decisions but is still at significant risk of harm.

The CPO will review the risk and present other services or actions that may reduce the risk. If you refuse other services or actions, or significant risk of harm remains, the CMT will offer to initiate a Risk Negotiation Agreement with you. The written Risk Negotiation Agreement includes:

- A description of your needs, including those that cannot be met;
- A description of the services that can be provided;
- A description of the potential risks to you;

- A statement that other service options (including nursing home services) have been explained to you and that you understand and accept the risks;
- Signatures of the consumer, CMT and CPO.

Date: _____
Consumer: _____
Medicaid ID #: _____

Section 1: Description of the consumer's needs, including needs that cannot be met:
_____
_____
_____
_____
_____

Section 2: Description of the services that can be provided:
_____
_____
_____
_____
_____

Section 3: Description of the potential risk to the consumer:
_____
_____
_____
_____
_____

Section 4:

- ❑ The consumer and CMT have developed a Risk Prevention, Assessment and Management Plan
  Date of Plan: _____
  Date of Reassessment: _____
  Outcome of Plan to Date: _____
  _____

- ❑ Support service options (including nursing home services) have been explained to the consumer

- ❑ The consumer understands and accepts the risks associated with his/her current Plan of Care

Consumer:
Signature_____ Date _____

HCBS Case Manager:
Signature_____ Date _____

Regional Program Officer:
Signature_____ Date _____

HCBS Program Manager:
Signature_____ Date _____

1.6 Community Placement Profile Including Risk Assessment for Individuals with Developmental Disabilities

Case Manager:	Phone:		Date Completed:
INDIVIDUAL'S INFORMATION SOCIAL SECURITY NUMBER: ADDRESS: PHONE:			
DOB:		Updated:	
SEX:		Primary Disability with Diagnostic Codes:	
HEIGHT: WEIGHT:			
MARTIAL STATUS:		Secondary Disabilities with Diagnostic Codes:	
SPOUSE NAME: N/A		PRIMARY DOCTOR:	
LEGAL GUARDIAN/ADDRESS:		Dentist:	
RELATIONSHIP TO PERSON:		OTHER MEDICAL	Name: Phone:

TELEPHONE:		Hospital Preference:	
MEDICAID NUMBER:		INSURANCE NAME/ADDRESS: GROUP #: POLICY #:	
MEDICARE NUMBER:			
BURIAL FUND: YES____ NO____			
TRUST FUND: YES_____NO____			
LIFE INSURANCE: YES_____NO____			

Referral Source

Family and Significant Others to Client in Priority of Emergency Contact:

NAME	RELATIONSHIP	ADDRESS	PHONE

Family Interest: ( ) Strong Interest ( ) No Contact ( ) Some Interest ( ) No

Financial: (check those that apply)

TYPE	RECEIVES & AMOUNT	HAS APPLIED FOR	DENIED
Medicaid			
Social Security	$ monthly		
SSI	$ monthly		
Medically Needy			

Name of Payee:

Current Services and Supports and/or Educational/Vocational Status:

Services Desired:

____ Check here if serious maladaptive behaviors:

____ Check here if significant medical concerns:

Special Aids or Equipment Used: if any of the following are used/needed, indicate by X

	Walker		Hearing Aid				Artificial Limbs
	Cane		Special Bed		Ileostomy Equipment		Head Protective Device
	Crutches		Special Chair		Colostomy Equipment		Positioning Equipment
	Brace Splint		Feeding Tube		Gastrostomy Equipment		Communication Aid
	Glasses		Catheter (Bladder)		Belly Board		Special Eating Utensils
	Dentures		Electric Wheelchair		Orthopedic Shoes		Other (specify): Orthocart/Bathing Sling

Social Information:

1. Describe where the individual was born and spent formative years, and when family and doctor first noted the primary/secondary disability. Describe any significant events that have occurred in his/her life.

2. List education, special education, and related services provided to the individual, including all residential placements outside the family home with dates of placements.

3. List other agencies in which the person is or has been involved (current and past) with the phone number and name of a contact person for each agency.

4. What would be the best living arrangement for this person? Include number of housemates, preferred characteristics of housemates and staff, and type and frequency of supervision.

5. What geographical area do the person and/or family members prefer? Are there opportunities to fulfill the person's vocational interests?

6. Provide information about who is important in this person's life. Will there be opportunities for contact in the new living arrangement?

Medical Information

Significant Medical History

Medications: List the medications the individual receives and reason: As of

Medication	Reason

7. Describe the current medical status and history for the individual including: allergies, medical/dental limitations, recent hospitalizations and surgeries, the need for invasive procedures, high blood pressure, etc.

8. Describe the person's ability to see and hear. Do they need glasses or other adaptive equipment? Are hearing aids used? Does person use sign language to communicate? Do caregivers need specialized training in order to enhance the person's living arrangement?

9. Describe the current status of the person's dental and oral health? When was the last dental visit?

10. Describe how often the individual needs medical/mental health services.

11. Does this person have any serious health concerns that need fairly constant medical monitoring?

Communication Methods and Environmental Concerns:

12. Illustrate the person's communication methods. If non-verbal how does the person interact with others?

13. How does the person move in his/her environment? What adaptive equipment is needed? List any environmental adaptation and/or assistance required, including toilet use needs, adaptive commode, etc. Will staff need training to better assist the person in their new environment?

14. Describe individual characteristics of the person including such things as preferred learning style, unique sense of humor, long/short-term retention, and reading/writing skills.

15. Does the person have a need for an adaptive bathtub instead of a shower due to

hygienic, medical need, or personal preference?

Mealtime Considerations:

16. Mealtime patterns and nutritional status including: special diets, positioning during mealtime and adaptive equipment needed.

17. Does the person need extra time to finish eating (up to one hour)? Are there any other issues important to help the staff and the person to make mealtime more relaxed?

Behavioral Supports Needed:

18. Issues specific to the person that will need to be addressed in planning for the move to the new community?

19. What type and frequency of supervision will be necessary to keep the person safe in the community?

20. Illustrate the security features or adaptations that are necessary in the living environment for safety of the person and the community.

21. What type of supports will be needed? Include behavioral, psychiatric, counseling, the need for monitoring, and any anticipated adjustment issues.

22. Describe the areas of vulnerability and risk to the individual (sexual, financial, safety, etc.).

23. Is there a potential that the individual will abuse others or engage in illegal acts? Explain:

24. Describe in detail serious and minor problem behaviors that the individual currently exhibits or has exhibited in past.

Training and Skills Development:

25. Describe vocational interests and employment history of the individual (time on task without supervision, response to supervision, etc.).

26. Does the person have self-care skills (eating, dressing, personal hygiene, etc.)?

27. Is the person able to monitor his or her own diet or exercise program?

28. Can the person monitor his or her own health management, including self-medication and sex education?

29. List future goals, plans, and/or dreams that this individual has.

30. List hobbies, other leisure time activities, as well as social and recreation activities in which the person likes to participate given the opportunity to plan his/her free time.

31. List any environmental, cultural, spiritual, or other factors important to assisting the individual in a placement.

Support Programs:

32. Would the person benefit from speech/language therapy?

33. Occupational therapy?

34. Physical therapy?

35. Psychological counseling?

36. Is there adaptive equipment the person could be utilizing?

37. Describe the person's transportation needs. Are there any behavioral concerns when transporting?

38. Would the person benefit from supported employment or a day treatment program? What are his or her limitations in regard to these services (rest breaks, less than 8 hours, etc.)?

39. Will the person need durable medical equipment and/or communication devices?

40. Provide the case manager's assessment concerning the individual's needs, (frequency of contacts, intensity, etc.) for case management services

41. Is there any other information that you would like to add about this client?

1.7 Risk Assessment for Youth with Serious Emotional Disturbance

Domain/ discussion guide	Assessment
Family and Culture: Who is the family by their definition? How do they communicate, respond and make rules? What are the family roles? Is there a cultural theme the family relates to? Are there serious unmet needs for any family member that impairs functioning? Are there any special pet 'family members'?	Strengths: Needs: Comments:
Social, Friends, Fun: What are things the family enjoys doing? Who do they socialize with? What, if anything, do they do for fun? Are their special friendships that support the family? What holidays or events are important to the family? What are their beliefs about how the fit into their community?	Strengths: Needs: Comments:
Residence/Neighborhood: Do the current living arrangements meet the family's needs? Does the neighborhood feel safe to the family and allow the possibility to be outside the home? Are there any difficulties with the current living situation? Who in the neighborhood helps the family out? Do all family members have adequate personal space?	Strengths: Needs: Comments:
Financial: Is the family able to meet their basic needs? Are they eligible for support under other systems? Who in the family is employed? Can the family meet their monthly financial obligations? Are there large, outstanding bills?	Strengths: Needs: Comments:
Vocational: Do older children have access to employment opportunities? What skills give them a sense of accomplishment? Who is working in the home? Does the family have skills they want to develop to increase vocational opportunities? Are the children involved in daily living skill-building at school, church, or in any setting? Are there special vocational needs for the youth ?	Strengths: Needs: Comments:

Education: What will it take to ensure a viable education for the identified client? For what sort of future are they being prepared? Are their rights intact? What was the best school year for the client and what was good about it? How could educational support be improved? What skills does the youth need to learn best?	Strengths: Needs: Comments:
Legal: Are any family members involved in the judicial system, on probation or on parole? Are there issues around custody?	Strengths: Needs: Comments:
Medical: Are health care needs met? Does the family have access to specialized medical services they might need? Does the identified client or any family member need medication management for and general health or mental health issues? Does transportation to medical care exist? What is the health status of all family members at this time?	Strengths: Needs: Comments:
Spiritual: Does the family or any member of the family belong to a faith community of any kind? What does that look like? Do any family members attend faith community group meetings? Do they attend special gatherings on any holidays?	Strengths: Needs: Comments:
Behavioral/Emotional/Psychological: What are the unmet needs of the referred youth in these areas? What are the unmet needs of any family members in these areas? Are there unresolved issues that impede normal interactions within the family or community? What does the family identify as a 'crisis' and how do they deal with it? Who supports the family with struggles (professional and socially)? How do they do so? What is the youth's strongest point in their eyes and in	Strengths: Needs: Comments:

their family's? What supports does the family currently have?	
Safety/Crisis: Is everyone in the family currently safe? Is there any potential danger to the family or community? Describe the family's 'crisis plan'. Are firearms and medications stored safely. What strengths does the family use to resolve safety concerns?	Strengths: Needs: Comments:

Attachment 2: Other Assessment Tools

The State will tailor the Nursing Home Transition Needs Survey included in the manual, "ABCs of Nursing Home Transition: an Orientation Manual for New Transition Facilitators," to meet Montana's needs. Transition coordinators will use this tool in addition to the level of care assessment tool currently used in the State. Montana will also have a subject matter expert modify the Brief MAST assessment tool to screen for alcohol/substance abuse and other addictive disorders. Based on screening outcomes, regional transition coordinators will refer transition candidates for additional assessment. Copies of the Nursing Home Transition Needs Survey, the level of care assessment form, and the Brief MAST assessment are attached.

2.1 Nursing Home Transition Needs Survey

Developed for Independence First by Julie Alexander, Independent Living Coordinator and Advocate

Transition Services

1. Do you feel that you are able to direct and manage your own care?
   - Have you previously managed your own care?
   - When and how long?

2. Which agencies, if any, have you chosen to assist you in this transition into the community?

3. Have you selected a company for home care supplies if needed? Please provide name and phone number:

Housing Services

1. Have you obtained a housing list from an Independent Living Coordinator?

2. Have you placed your name on a waiting list for a housing complex in which you would like to reside?

3. Do you need accessible housing?

4. Do you have funds to pay for housing?

5. Are you being evicted from your current living situation? If so, when?

6. What is your target date for moving?

7. What is the date of your lease?

8. Have you reviewed your lease?

9. What is the date housing was secured?

10. What date was the security deposit paid and rent paid?

11. What date is the move scheduled for?

12. What is the date you pick up your keys?

13. If needed, are duplicate key(s) and/or key cards made and obtained?

Utility Services

1. Have you scheduled an appointment for your telephone service to be installed?

2. Have you scheduled an appointment for your electricity to be turned on?

3. Have you scheduled an appointment for your gas service to be installed?

4. If you want cable television, have you made an appointment for installation?

5. Have you requested that the Post Office change your address?

Funding Resources

1. Do you think that you will need Community Options Program (COP) funding or Title 19 assistance as you deal with independent living issues?
   - If so, have you applied for these funds?
   - Are you on a waiting list for COP or Title 19?
   - When will you receive COP or Title 19?

2. If you have Title 19 funding, have you checked into whether or not this nursing home Title 19 can be transferred to independent living Title 19?
   - Have you initiated such a transfer?
   - What is the name and phone number of the Social Worker assisting you with this transfer

3. Will you be eligible for Veteran's Services?

4. Have you checked into the process of the transfer of SSI/SSDI income from the nursing home to the community?
   - Have you started the process of this transfer?

Personal Health Needs

1. Do you have your physician's approval for nursing home transition? Check any of the following activities you need assistance with:
   - Bathing in tub
   - Bathing in bed
   - Sponge bath

2. Do you need assistance with dressing? Check all that apply:
   - Lower extremities
   - Upper extremities
   - No assistance needed

3. Do you need assistance with toileting? Check all that apply:
   - With pads
   - Getting on and off the commode
   - No assistance needed

4. Do you need assistance with bowel care? Check all that apply:
   - Suppositories
   - Laxatives
   - Other
   - No assistance needed

5. Do you need assistance with bladder care? Check all that apply:
   - Catheter
   - Urinal
   - Other
   - No assistance needed

6. Do you need assistance eating? Check all that apply:
   - Feeding
   - Set up
   - Cutting Food
   - Clean up
   - Meal preparation

7. Do you need assistance with housekeeping? Check all that apply:
   - Dusting
   - Mopping
   - Vacuuming
   - General cleaning
   - Other
   - No assistance needed

8. Do you need assistance transferring from one place to another? Check all that apply:
   - Hoyer lift
   - Pivot lift
   - Need for worker to assist with equipment
   - Other
   - No assistance needed

9. Provide the names and phone numbers of supportive family members, friends or community advocates.

Personal Care Assistance Services

1. Do you need personal care assistance? If so, have you contacted: PAS at IndependenceFirst
   - MA Program
   - Attendant Referral Program

2. Have you scheduled a needs assessment by these programs?
   - PAS at IndependenceFirst assessment
   - MA assessment
   - Attendant Referral Program assessment
   - COP worker assessment

3. What is the date assessments will be completed?

4. What is the target date for funding to be secured?

5. Have you recruited attendants and back up attendants?

6. Have you hired attendants?

7. Have you been orientated to the employer or employee manager role?

8. Have you made sure your attendant worker has received training and certification?

9. What is the date of certification?

Assistive Technology/Devices Services

1. Do you need assistive technology or devices to assist you with your independent living needs?

2. Do you know what types of technology or devices you might like to use?

3. Would you like an assistive technology assessment?

4. If assistive technology/devices are required, have you ordered these pieces of equipment?

5. Have you worked out a plan of payment for this equipment?
   - Do you need funding assistance to purchase this equipment?

6. Have you worked out delivery plan for the equipment?

7. Do you need assistance in learning how to use the technology/devices or equipment?

Medical Services

1. Will your doctor follow you into the community?
   - If not, have you identified another doctor who is willing to accept you?
   - Have you scheduled an appointment within two weeks of transition?

2. What is the name and phone number of the pharmacy you have selected?
   - Does the pharmacy deliver?

3. Will your doctor write a prescription for a 30-day supply to meet your medication needs during transition?

Furnishings for Your New Home

1. Have you completed the attached transition checklist detailing what possessions you have and what possessions you will need to purchase before transition takes place?
   - Do you have money to make such purchases?
   - Are you aware of places which may donate furnishings?

2. Have you coordinated your move?
   - Do you need assistance moving?
   - Do you need assistance setting up?

Budgeting/Money Management Services

1. Have you established a monthly budget?
   - Do you need assistance with this task?

- Have you written a "trial budget?"
- Do you need training in the areas of budgeting and money management?

2. Do you need to make arrangements for direct deposit of your income at a bank?

3. Have you established a bank account?
- Checking
- Savings

4. Do you need a payee?

5. Do you need to apply for additional forms of identification?

Transportation Services
1. Are you able to take care of your transportation needs?

2. Do you need specialized transportation?

3. Are you approved for Title 19 or User Side subsidy transportation?

4. Do you know how to schedule appointments to use specialized transportation?

Meal Planning Services
1. Do you need independent living skills training in this area?

2. Have you coordinated a plan so that you can purchase, cook and eat meals?

3. Who will do the initial shopping for groceries and supplies?

Social and Leisure Activities
1. Are you able to geographically orient yourself to your new neighborhood?

2. Do you need assistance in meeting your new landlord and neighbors?

3. Do you need assistance in planning daily or weekly social activities?

4. Do you want independent living training to assist you with any of these activities?

2.2 Level of Care Assessment Form

State of Montana
Department of Public Health and Human Services

LEVEL OF CARE DETERMINATION

Identifying Information

Applicant DOE, JOHN
Id#
SSN
D.O.B. 01/01/2001
Gender
Marital Status
Race
LOC Type Initial
Service Choice
Referral Reason

Referral Date 06/14/2012
Anticipated LOS
Screen Request By
Agency/Relation
Phone

Nursing Facility Admit Date
Medicare Skilled? Date

Addresses and Contacts

County
Home Address
Living Arrangement

Mountain-Pacific Contacts

Hearing and Vision

Hearing	
Comm. Devices	
Modes of Expression	Speech
Making Self Understood	
Vision	
Vision Appliances	

Diagnoses and Medications

Physician : City

Primary Diagnosis	None
Other Diagnoses	None
Pain	
Sleeping Adequately	
Respiratory Status	No problem
Medications	None
Med. Administration	
Med. Compliance	

Cognitive Status

Comatose	
Oriented:	
Short Term Memory	
Long Term Memory	
Confusion	
Daily Decision Making	
Delirium/Disordered Thinking	
Behavioral Problems	None
Isolation	
Anxiety	
Depression	
Indicators	None

Height and Weight

ADL/IADL's

Self Performance 0-Independent 1-SBA 2-Limited Assistance 3-Extensive Assistance 4-Total Dependence 5-Age Appropriate 6-Unknown

Support Provider	0-None 1-Setup Help Only 2-One Person Assist 3-Two Person Assist 4-Total Care 5-Mechanical Assistance 6-Unknown
Needs Met	0-Totally met 1-Met now, but will need help 2-Need partially met 3-Need not met 4-Need not relevant
Who	0-Self 1-Spouse 2-Sibling 3-Child/Child's spouse 4-Parent 5-Other relative 6-PAS 7-Other agency 8-Unpaid Other 9-No One

ADL/IADL	Self Perform	Support Provider	Needs Met	Who	Comments
Bathing					
Dressing					
Personal hygiene					
Toilet use					
Transfer					
Bed Mobility					
Ambulation, inside					
Ambulation, outside					
Exercise					
Medication management					
Eating					
Meal preparation					
Housework					
Laundry					
Shopping/errands					
Transportation - Drive self					
Transportation - Public					
Socialization activities					
Supervision					
Phone use					
Summon help					
HCBS time management					
Money management					
Home maintenance					

Bowel and Bladder

Bowel Continence	Not indicated
Bowel Program	Not indicated
Bladder Continence	Not indicated
Bladder Program	Not indicated
Ulcers, Skin Problems or Lesions	Not indicated
Skin Treatments	N/A
Foot Problems	N/A

Services

Formal Services Services	Uses	Needs	HCBS Services Waiver Service

Home Environment / Assistive Devices

Assistive Devices

Social Support / Economic Status

Is the current system of caregivers sufficient?

Consumer does without each month due to lack of funds?

Financial Management :

Coverages : None

LOC Determination

Determination Not Assigned **Effective:**
Sub-choice

Criteria
Category A **Category B**

Referral/Placements
Provider

Completed:

2.3 Brief MAST

Brief MAST

Client _____

Date _____

Instructions: Place a X on the line indicating your response.

	Yes	No
1. Do you feel you are a normal drinker?	____	____
2. Do friends or relatives think you are a normal drinker?	____	____
3. Have you ever attended a meeting of Alcoholics Anonymous AA?	____	____
4. Have you ever lost friends or girlfriends/boyfriends because of your drinking?	____	____
5. Have you ever gotten into trouble at work because of drinking?	____	____
6. Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking?	____	____
7. Have you ever had delirium tremens DTs, severe shaking, after heavy drinking?	____	____
8. Have you ever gone to anyone for help about your drinking?	____	____
9. Have you ever been in a hospital because of your drinking?	____	____
10. Have you ever been arrested for drunk driving or driving after drinking?	____	____

2.4 Housing Checklist

Purpose

Transition teams will use this housing checklist to verify that each MFP participant is moving into an MFP qualified residence. Residences only need to qualify under one of the three following categories to be considered an MFP qualified residence:

1. Home
2. Apartment
3. Community-based residential setting

Home

1. The home is owned or leased by the individual or the individual's family member.	NA	Yes	No
2. If leased, the leasee is the MFP participant or a family representative.	NA	Yes	No
This home is a qualified MFP residence.	NA	Yes	No

Apartment

Apartments may include assisted living facilities.

1. The apartment has an individual lease.	NA	Yes	No
2. The apartment has lockable access and egress.	NA	Yes	No
3. The apartment has a living area over which the individual or the individual's family has domain and control.	NA	Yes	No
4. The apartment has a sleeping area over which the individual or the individual's family has domain and control.	NA	Yes	No
5. The apartment has a bathing area over which the individual or the individual's family has domain and control.	NA	Yes	No
6. The apartment has a cooking area over which the individual or the individual's family has domain and control.	NA	Yes	No
7. The apartment comports with federal fair housing guidelines.	NA	Yes	No
8. The apartment lease includes rules and/or regulations from a service agency as conditions of tenancy or includes a requirement to receive services from a specific company.	NA	Yes	No
9. The apartment lease requires notification of periods of absence.	NA	Yes	No
10. The apartment lease includes provisions for being admitted, discharged, or transferred out of or into a facility.	NA	Yes	No
11. The apartment lease reserves the right to assign apartments and change apartment assignments.	NA	Yes	No

This apartment is a qualified MFP residence (Criteria 1-7 are met and have a 'yes' marked next to them, and 8-11 have a 'no' marked next to them).	NA	Yes	No

Community-based residential setting			
1. The residence in a community-based residential setting has no more than four unrelated individuals living together, not including caregivers.	NA	Yes	No
2. The residence is part of a larger congregate care setting (campus) separated from typical community dwellings.	NA	Yes	No
This community-based residential setting is a qualified MFP residence.	NA	Yes	No

Attachment 3: Outreach Materials

3.1 HCBS Booklet for MFP

This booklet will be modified for MFP use.

May 2010

HOME AND COMMUNITY BASED SERVICES aka the "Medicaid Waiver" Program

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Senior and Long Term Care Division

For consumers who are elderly or who have physical disabilities and are at risk of institutionalization

MONTANA
Department of Public Health & Human Services
Senior and Long Term Care Division
P.O. Box 4210
Helena, Montana 59620

HOME AND COMMUNITY BASED SERVICES (HCBS) PHILOSOPHY

The HCBS program recognizes that people with disabilities and the elderly have the right to participate fully in society and as a part of their communities. They have the identical civil rights as people without disabilities. For many, these goals cannot be achieved without necessary community supports and services.

The HCBS program makes services available so people can live fully integrated lives within their own communities by means of self-determination, choice, and control. Services are many and varied, allowing consumers to choose those that are most appropriate to meet their needs.

Choice is paramount as people with disabilities and the elderly know best how their needs can be met. In the HCBS program, the consumer is in charge and directs the plan of care. Case managers work with consumers and assist as requested. They facilitate the provision of services and work with providers on the consumer's behalf. Case managers ensure a holistic approach to care planning, balancing the medical and psychosocial needs of consumers.

Montana's program has evolved since its inception in 1983. It has been revamped many times as we continue to improve opportunities and respond to the needs of our consumers.

TABLE OF CONTENTS

Home and Community Based Services (HCBS) Philosophy	2
What is the Home and Community Based Services Waiver?	5
Montana's Program	6
Eligibility for Services	7
Freedom of Choice	7
How to Apply	8
Who we Serve	9
Waiting Lists	9
Frequently Asked Questions	10
Right to a Fair Hearing	18
SERVICES	19
Bonanza Option	19
Adult Day Health	19
Case Management	20
Community Supports—Bonanza Option	20
Community Transition	21
Consultative Clinical and Therapeutic Services	22
Consumer Goods and Services	22
Day Habilitation	23
Dietetic Services	24
Environmental Accessibility Adaptations	24
Family Training and Support	25
Financial Management—Bonanza Option	26
Health and Wellness	27
Homemaker and Homemaker Chore	27
Independence Advisor—Bonanza Option	28
Non-Medical Transportation	28

TABLE OF CONTENTS

Nutrition	29
Pain and Symptom Management	30
Personal Assistance	30
Personal Emergency Response Systems	31
Post Acute Rehabilitation	31
Prevocational Services	32
Private Duty Nursing	33
Residential Habilitation	34
Respite	34
Senior Companion	34
Specialized Child Care for Fragile Children	35
Specialized Medical Equipment and Supplies	36
Supported Employment	36
Supported Living	37
Therapies	
Vehicle Modifications	
HCBS Case Management Teams	38
Regional Program Officers	41

RPO Office	Phone	Counties
Billings Office 2121 Rosebud Dr. Suite D Billings, MT 59102	Phone: 655-7644 Phone: 655-7635 FAX: 655-7646	Big Horn, Carbon, Golden Valley, Musselshell, Stillwater, Treasure, Wheatland, Yellowstone
Bozeman Office 220 W. Lamme, Suite 1E Martel Building Bozeman, MT 59715	Phone: 586-4089 FAX: 782-8728	Gallatin, Madison, Park, Sweetgrass
Butte Office 700 Casey Butte, MT 59701	Phone: 496-4989 FAX: 782-8728	Beaverhead, Deer Lodge, Granite, Silver Bow, Montana State Prison
Glendive Office 218 W. Bell, Suite 205 Glendive, MT 59330	Phone: 377-6252 FAX: 377-1240	Carter, Custer, Daniels, Dawson, Fallon, Garfield, McCone, Powder River, Prairie, Richland, Roosevelt, Rosebud, Sheridan, Valley, Wibaux
Great Falls Office 201 1st Street South Great Falls, MT 59405	Phone: 453-8902 Phone: 453-8975 FAX: 454-6084	Blaine, Cascade, Choteau, Fergus, Glacier, Hill, Judith Basin, Liberty, Petroleum, Phillips, Pondera, Teton, Toole
Helena Office 2030 11th Ave. Helena, MT 59604	Phone: 444-1707 FAX: 444-7743	Broadwater, Jefferson, Lewis & Clark, Meagher, Powell, Montana State Hospital Long Term Care Unit
Kalispell Office 121 Financial Dr Ste B Kalispell, MT 59903	Phone: 755-5420 FAX: 751-5944	Flathead, Lake, Lincoln
Missoula Office 2681 Palmer Missoula, MT 59808	Phone: 329-1312 Phone: 329-1310 FAX: 329-1313	Mineral, Missoula, Ravalli, Sanders

Case Management Teams Counties

Area VIII Agency on Aging Case Management 1801 Benefis Court Great Falls, MT 59405 Phone: 454-6990 Fax: 454-6926	Cascade
Area X Agency on Aging c/o Area VIII 1801 Benefis Court Great Falls, MT 59405 Phone: 454-6990 Fax: 454-6926	Hill
Area XI Agency on Aging Case Management 337 Stephens Ave Missoula, MT 59802 Phone: 728-7682 Fax: 728-7684	Missoula, Ravalli
Area IV Agency on Aging Case Management 201 S Main P.O. Box 1717 Helena, MT 59624 Phone: 447-1680 Fax: 457-7365	Broadwater, Gallatin, Jefferson, Lewis & Clark, Meagher, Park, Sweet Grass
Area III Agency on Aging c/o Area VIII 1801 Benefis Court Great Falls, MT 59405 Phone: 454-6990 Fax: 454-6926	Blaine, Choteau, Glacier, Liberty, Pondera, Teton, Toole
Area V Agency on Aging Case Management c/o Spectrum Medical, Inc 3475 Monroe Ave, Ste 102 Butte, MT 59701 Phone: 723-7987 Fax: 723-4120	Beaverhead, Deer Lodge, Granite, Madison, Powell, Silver Bow
Area IX Agency on Aging c/o NW MT Human Resources 214 Main Street P.O. Box 8300 Kalispell, MT 59904 Phone: 758-5422 Fax: 752-6582	Flathead

WHAT IS THE HOME AND COMMUNITY BASED SERVICES WAIVER?

Medicaid Home and Community Based Services (HCBS) waivers recognize that many individuals at risk of institutionalization can be served in their homes and communities at a cost no higher than that of institutional care, while promoting independence and family support.

These programs were created in response to a mother's plight watching her daughter Katie Beckett spend most of her first three years of life residing in a hospital. Katie's mother wanted to care for her daughter at home. In 1981, the Beckett's story drew the attention of then President Ronald Reagan who signed the "Katie Beckett waiver" into law.

Before this legislation, Medicaid long-term care benefits were limited to home health, personal care services, and institutions. With this legislation, states were allowed flexibility to develop and implement creative alternatives to provide services to Medicaid-eligible individuals in their own homes and communities instead of institutions.

The waiver program described in this booklet is geared to the elderly and persons with physical disabilities. Other waiver programs serve different populations and offer different services.

MONTANA'S MEDICAID WAIVER PROGRAM

Montana was one of the first states to develop its own Medicaid Waiver program. In 1983, two years after the passage of the "Katie Beckett Waiver," Montana implemented the HCBS program for the elderly and people with physical disabilities.

Home and Community Based Services are individually approved and customized to meet the consumer's needs. The consumer, in conjunction with a case management team, develops an individual cost-effective plan of care. The teams are the cornerstones of the program. The recipient and team maintain contact with each other to ensure services are provided as prescribed in the plan.

Currently, Montana serves over 2000 people through the elderly and physically disabled waiver program. The number of recipients served is limited by the availability of funds. Case management teams have a fixed number of consumers they can serve a year. New recipients are admitted to the program as others are discharged or as new funding becomes available. The program often has a waiting list.

Case Management Teams Counties

Sidney Health Center Case Management 216 14th Ave SW Sidney, MT 59270 Phone: 488-2193 Fax: 433-3918	Daniels, Dawson, McCone, Richland, Roosevelt, Sheridan, Valley
NW MT Human Resources 214 Main Street P.O. Box 8300 Kalispell, MT 59904 Phone: 758-5422 Fax: 755-4168	Flathead, Lake, Lincoln, Sanders
Spectrum Medical, Inc Case Management 3475 Monroe Ave, Ste 102 Butte, MT 59701 Phone: 723-7987 Fax: 723-4120	Beaverhead, Deer Lodge, Granite, Powell, Silver Bow
Central Montana Medical Center Case Management 408 Wendell Lewistown, MT 59457 Phone: 535- 6297 Fax: 538-6267	Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Phillips, Wheatland
Area II Agency on Aging Case Management 1504 Fourth St W Roundup, MT 59072 Phone: 323-1320 Fax: 323-3859	Big Horn, Carbon, Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Stillwater, Sweet Grass, Wheatland, Yellowstone, Northern Cheyenne and Crow Reservations
Western Montana AAA Case Management 110 Main St Ste 5 Polson, MT 59860 Phone: 883-7284 Fax: 883-7363	Lake, Lincoln, Mineral, Ravalli, Sanders

Case Management Teams Counties

Community Medical Center 2685 Palmer Ste D Missoula, MT 59808 Phone: 327-4585 Fax: 327-4484	Mineral, Missoula, Ravalli
Partners in Home Care Case Management 2687 Palmer, Ste B Missoula, MT 59808 Phone: 728-8848 Fax: 327-3727	Mineral, Missoula, Ravalli
RiverStone Health 123 S 27th St Billings, MT 59101 Phone: 247-3226 Fax: 247-3203	Big Horn, Carbon, Rosebud, Stillwater, Sweet Grass, Treasure, Yellowstone
Easter Seals Case Management 815 2nd St S, Ste 107 Great Falls, MT 59405 Phone: 771-2807 Fax: 761-1390	Blaine, Cascade, Choteau, Glacier, Hill, Liberty, Pondera, Teton, Toole
Spectrum Medical, Inc. Case Management 205 Haggerty Lane Ste 240 Bozeman, MT 59715 Phone: 586-3134 Fax: 585-4885	Gallatin, Madison, Meagher, Park, Sweet Grass
L&C City-Co Health Dept Case Management 1930 9th Ave, Ste 207 Helena, MT 59601 Phone: 443-2584 Fax: 457-8990	Broadwater, Jefferson, Lewis and Clark
Holy Rosary Home Care Case Management 2600 Wilson St #30 Miles City, MT 59301 Phone: 233-3810 Fax: 233-7134	Carter, Custer, Dawson, Fallon, Garfield, Powder River, Prairie, Rosebud, Wibaux

ELIGIBILITY FOR SERVICES

Who is eligible for services?

To qualify for the HCBS program, a recipient must meet these criteria:

- be financially eligible for Medicaid;
- be 65 years or older or be determined physically disabled by the Social Security Administration;
- have an unmet need that can only be met through a home and community based service;
- meet the minimum level of care requirements for nursing facility placement; and
- be at risk of going to an institution.

Freedom of Choice

If an individual meets the level of care requirements for a long-term care facility, the individual has a choice of HCBS or nursing facility services. Choosing HCBS, however, does not guarantee immediate access to the program as there is often a waiting list for this option.

HOW TO APPLY

It is a two-step process. A consumer must qualify for both financial eligibility and medical eligibility.

1. for financial eligibility determination contact the local County Office of Public Assistance for a Long-Term Care application. After completing this document, an eligibility specialist will review the application and determine Medicaid financial eligibility.

2. Contact Mountain Pacific Quality Health at 1-800-219-7035 or 1-406-443-0320 in Helena for a level of care assessment screening. A nurse or a social worker will assess the consumer's needs to determine whether the consumer meets nursing home level of care criteria. This is usually done over the telephone by talking to the consumer and/or family members, friends, or health care professionals.

Note: Having a Medicaid card neither guarantees financial eligibility for long-term care services nor medical eligibility. Having a Medicaid card does not mean that the person will meet level of care or financial eligibility for the HCBS waiver. You may contact a Regional Program Officer or a Case Management Team if you need help with the process. Contact information is at the back of this booklet.

TRAUMATIC BRAIN INJURY (TBI) SERVICES

Supported Employment

Supported employment includes activities needed to sustain paid work by consumers, including supervision and training for persons for whom unsupported or competitive employment at or above the minimum wage is unlikely.

Supported employment occurs in a variety of settings. It may include group community employment such as crews, enclaves, or individual community employment.

Transportation may be provided between the consumer's home and the job site or between job sites in cases where the consumer works in more than one place.

TRAUMATIC BRAIN INJURY (TBI) SERVICES

Community Residential Rehabilitation

Community residential rehabilitation is comprehensive day treatment program with a residential component. It operates 7 days a week, 24 hours a day.

Prevocational Training

Prevocational training services are habilitative activities that foster a consumer's employability. Services aim to prepare an individual for paid or unpaid employment.

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

Services are provided to persons who may or may not join the general workforce or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

WHO WE SERVE

Consumers served under this program require nursing facility level of care. A small percentage of individuals served at home are ventilator dependent and, without the HCBS program, would be in a hospital. In addition, the program also serves a number of individuals with a traumatic brain injury who would have been served in out-of-state rehabilitation facilities, inpatient rehabilitation, or remained inappropriately placed in nursing homes, group homes, or other institutions were it not for the specialized services available under the HCBS program.

Waiting Lists

People on the waiting list are not served on a first come first served basis. They are evaluated by the case management team when a slot opens and the consumer with the greatest need is selected.

FREQUENTLY ASKED QUESTIONS

Do I have to be Destitute to Receive Services?

No, but Medicaid is designed to assist people with medical needs and limited financial resources. However, when a married individual needs long-term care services such as the Home and Community Base Services waiver or a nursing facility, federal policy allows the non-Medicaid spouse who resides at home to retain a maximum of half of the couple's resources, up to a specified amount, which changes yearly.

Some assets are exempt such as the home in which they live, household goods, and one automobile. There also are regulations concerning the amount of monthly income the spouse may retain. A resource assessment from the local County Office of Public Assistance can provide more details.

TRAUMATIC BRAIN INJURY (TBI) SERVICES

Comprehensive Day Treatment

Comprehensive day treatment is a nonresidential program for persons with a traumatic brain injury or another severe cognitive disability. There are two hospital-based facilities in Montana: Headways in Billings and Bridges in Missoula. These programs try to maximize the consumer's functional independence through intensive therapies three to five days a week.

Consumers learn strategies to overcome barriers created by their disability and compensatory techniques for memory loss or behavioral problems and relearn day-to-day living skills. The goal of this program is to facilitate integration into the community and reduce the consumer's level of disability.

This service is provided under the direction of an interdisciplinary team consisting of a board certified physiatrist, a licensed neuropsychologist, a licensed psychologist, therapists, and other appropriate support staff.

Slots are limited and prior authorization from the Department is necessary.

TRAUMATIC BRAIN INJURY (TBI) SERVICES

Cognitive Rehabilitation

This is a short-term program designed to teach individuals with a brain injury to function with their injury by reinforcing, strengthening, or reestablishing previously learned behaviors or by establishing new behavioral patterns or compensatory mechanisms at home, work, or in the community.

Behavioral Programming

This short-term service provides continuous in-depth assessment of behaviors and interactions of an individual with a traumatic brain injury with others to develop an appropriate behavioral program. The assessment may be in the consumer's home, workplace, community, or an outpatient setting.

FREQUENTLY ASKED QUESTIONS

What About Transferring Assets?

There are certain circumstances when a Medicaid applicant or recipient can transfer resources without penalties. For example, they can transfer their home at any time to: a spouse, a child who is under 21, blind, or determined disabled by Social Security, and sometimes to a sibling or caretaker son or daughter.

If an applicant transferred assets before applying for Medicaid, the transfer may affect the applicant's eligibility for home and community based services or nursing facility benefits. For specific questions regarding transfer of assets and Medicaid eligibility, contact an eligibility specialist at the County Office of Public Assistance.

FREQUENTLY ASKED QUESTIONS

How Does the Lien and Estate Recovery Law Affect a Waiver Recipient?

To help pay for the increasing number of individuals needing Medicaid-reimbursed medical care, federal law requires states to recover the costs of medical and long-term care services from the estates of deceased Medicaid recipients who received services at age 55 or older, or who resided in a nursing home, or who received HCBS services.

Recovery involves filing liens on the recipient's home and filing claims against the estate. However, recovery is not made when there is a surviving spouse or certain dependents.

For more information on the state lien and recovery program, contact the Estate Division of the Recovery Unit at 1-888-378-2836.

Another good resource is the State Information and Assistance Program at 1-800-332-2272.

SUPPORTED LIVING SERVICES

This is a comprehensive habilitation service designed to assist individuals with severe disabilities such as a traumatic brain injury, late stage multiple sclerosis, severe cerebral palsy, or those who are partially ventilator dependent who require 24-hour supervision.

Supported Living is specifically intended to transition individuals from an institutional setting to a more independent living situation. Services help consumers to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to reside successfully in their own homes or in a shared living situation.

Specific services include: independent living evaluation, service coordination, homemaking, habilitation aides, behavioral programming, nonmedical transportation, day habilitation, residential habilitation, prevocational training, supported employment, and 24-hour availability of staff for supervision and safety, and specially trained attendants.

Slots for this services are limited and require Department prior authorization.

SERVICES

Family Training and Support

This service is provided to families of children with disabilities ages 0 to 21 who are ineligible for Developmental Disabilities waiver. An agency employee under contract with the Disability Services Division:

- Teaches families and others who work or play with the child about the child's disability and how best to meet the child's needs;
- Teaches activities that families can do with their child to help promote the child's development;
- Collaborates with case managers and families regarding environmental modifications or adaptations benefiting the child;
- Assesses the child for unmet needs, determines progress, and identifies areas of strength;
- Provides emotional support to families and suggests resources for additional support;
- Advocates for the family for other supports and services; and
- Assists the family and case management team with the child's transition and referral to special education.

FREQUENTLY ASKED QUESTIONS

What is the Medically Needy Program?

Some individuals with significant medical expenses may meet Medicaid financial eligibility through the Medically Needy program. This is a Medicaid program for aged, blind, or disabled individuals or families whose income exceeds Medicaid limits but who have significant medical needs. The individual or family pays the difference between their countable income and the Medically Needy Income Limit (MNIL) toward medical expenses each month and Medicaid pays the balance. The difference between countable income and the MNIL is called a "spend-down" or "incurment." For more information call your County Office of Public Assistance.

What is Waiver of Deeming?

This is an eligibility option available only through HCBS Waivers. Under waiver of deeming, parental assets and income are waived when determining Medicaid eligibility of a child served in the waiver program. Only the child's personal assets and income are used to determine Medicaid eligibility. The primary purpose of waiver of deeming is to keep children at home with their families instead of placing them in institutions or relinquishing custody of them to the state to obtain Medicaid funding.

FREQUENTLY ASKED QUESTIONS

Can a Family Member be Paid to Care for me?

In certain circumstances, Medicaid may allow legally responsible relatives to be paid for some caregiving tasks for consumers.

For a legally responsible relative, including biological or adoptive parents of recipients under 18, spouses of adult recipients, and court-appointed guardians to be paid for providing HCBS services, all of the following must be met.

The service must:

- be defined as a service or support in the federally approved waiver;
- be necessary to avoid institutionalization;
- be specified in the consumer's plan of care;
- be provided by a parent or spouse who meets the provider qualifications and training standards specified in the waiver for that service;
- be paid at a rate not to exceed what is allowed by the Department for payment of similar services; and
- not be an activity the family would ordinarily perform or is responsible to perform.

SERVICES

Therapies: Occupational, Physical, Speech and Audiology

Therapy provided under the HCBS program differs from those available under the Medicaid State Plan because they are restorative or palliative and are not limited in number.

Transportation

This covers transportation for social or other nonmedical reasons by common carrier or private vehicle.

SERVICES

Specialized Medical Equipment and Supplies

These items are designed to maintain or improve an individual's ability to remain at home and function in the community and includes the provision of adapted vans and service animals.

Items must be functionally necessary and relate specifically to the consumer's disability; provide for the consumer's accessibility, increased independence, health, or safety; and be the most cost-effective item that can meet the consumer's needs.

Specially Trained Attendant

Specially trained attendants are employees of a personal assistance agency who have received an additional 20 hours of training to meet the specific needs of a consumer.

The family member who is a service provider will comply with the following:

- A parent or parents, in combination, or a spouse may not provide more than 40 hours of services in a seven-day period. For parents, 40 hours is the total amount regardless of the number of children who receive waiver services;
- For self-directed personal assistance, the family member must maintain and submit time sheets and other required documentation for hours paid; and
- Married individuals must be offered a choice of providers. If they choose their spouse as a care provider, it must be documented in the plan of care.

FREQUENTLY ASKED QUESTIONS

How Many Services can I Select from the Menu?

There is not a limit on the number of services a consumer can choose. Rather, the consumer decides which services can best meet his or her needs while remaining within the budget for each slot.

How are my Services Selected?

The consumer determines what services to select from the HCBS menu based on individual needs and desires. Selected services must be medically necessary and unavailable from other sources. The case managers can help consumers decide. Oftentimes, case managers can refer consumers to free services available from other government or community programs.

Sometimes desired services are not immediately available such as adult residential services, which often have a waiting list. The case managers can help the consumer select appropriate services while waiting for an adult residential slot.

SERVICES

Special Child Care for Children with Severe Medical Conditions

This service provides day care for medically fragile children who, because of their disability, cannot be served in traditional child care settings. At a minimum, the service consists of supervision and socialization. At a maximum, it consists of hands-on, intensive, specialized personal care.

SERVICES

Respiratory Therapy

Services include direct treatment, ongoing assessment of medical condition, equipment monitoring and upkeep, pulmonary education, and rehabilitation.

Respite Care

Respite care is temporary, short-term care provided to consumers in need of supportive care to relieve unpaid persons who normally provide care. Payment for room and board may be included.

Respite can be provided in the consumer's home, another residence, foster home, hospital, nursing facility, group home, licensed personal care facility, residential hospice, or therapeutic camp for children or adults with disabilities.

FREQUENTLY ASKED QUESTIONS

How is a Consumer's HCBS Budget Determined?

A consumer's HCBS budget is determined from the individual's needs up to an established monetary cap. The federal government requires state Medicaid agencies to ensure that the cost of providing home and community based services will not exceed the cost of care for the identical population in an institution.

Case Management Teams are allocated a fixed number of slots to admit consumers into the HCBS program. The Department issues slots to control and estimate program expenditures and establishes a cost per slot. Each team is allotted an annual budget. Case management teams are required to provide services within these budgets.

For most consumers, costs cannot exceed those of a nursing facility. For a small number of individuals who are ventilator dependent, costs should not exceed those of hospital placement, and for some individuals with traumatic brain injuries, the costs should not exceed those of an out-of-state rehabilitation facility. In addition to established individual caps, funding is also dependent upon state legislative allocation.

RIGHT TO A FAIR HEARING

If a Medicaid applicant or recipient is denied services, is there an appeals process?

Yes. Most adverse actions are appealable. Adverse actions are those decisions made by the Department that negatively affect consumers such as a denial or reduction of services.

The appeals process is called a fair hearing. This process allows an individual to tell the Department why he or she disagrees with the Department's decision. During this process, you can present additional information that may reverse the initial decision. It also allows the Department to explain why a decision was made.

A consumer, provider, or personal representative must request a hearing in writing and mail the request to the Department of Public Health and Human Services, Hearings Officer, P.O. Box 202953 Helena, MT 59620.

This request must be postmarked or delivered no later than 90 calendar days following the date of Notice of Determination.

SERVICES

Private Duty Nursing

These are medically necessary services for consumers who require continuous in-home nursing care not available from a home health agency or from the State Plan Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children.

Psychosocial Consultation

Psychosocial consultation is limited to consultation with providers and caregivers directly involved with the consumer and development and monitoring of behavioral programs.

SERVICES

Personal Emergency Response System

A Personal Emergency Response System is an electronic, telephonic, or mechanical system that enables individuals at high risk of institutionalization to summon help in an emergency. The system alerts medical professionals, support staff, or other designated parties to respond to a consumer's emergency request.

The consumer may also wear a portable "help" button to allow for mobility. The system is connected to the person's telephone and is programmed to signal a response center once a "help" button is activated.

This service is limited to individuals who live alone or who are alone for significant parts of the day, and who would otherwise require extensive routine supervision.

The device must be connected to a local emergency response system with the capacity to activate emergency medical personnel.

SERVICES

Adult Day Health

Adult Day Health provides a broad range of health, nutritional, recreational, social, and habilitative services in a licensed facility. Residential overnight services are excluded. Services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week.

Adult Residential

Adult Residential services are provided in a licensed Assisted Living Facility, Adult Foster Home, or Residential Hospice. Consumers must pay for room and board. Slots for this service are limited and specific criteria must be met.

SERVICES

Case Management

Case management is a fundamental and mandatory HCBS service. Case managers assist consumers in accessing HCBS and State Plan services as well as other medical, social, and educational services, regardless of the funding source. Each case management team consists of a registered nurse and a social worker. They assess each consumer's needs, develop an individualized care plan with each consumer, and manage and monitor services.

Chemical Dependency Counseling

This service provides individual and/or group counseling to consumers with substance abuse problems. Treatment is in outpatient settings only.

SERVICES

Personal Assistance Services

Personal assistance under the HCBS program may include supervision for health and safety reasons, socialization, escort and transportation for non-medical reasons, specially trained attendants for consumers with extensive needs, or an extension of State Plan personal assistance services.

Some consumers, because of their disability, require help caring for their children. A consumer's personal assistance time may be used to provide hands-on care for their children. However, this personal assistance must be done in the presence of and at the direction of the consumer parent.

SERVICES

Homemaker

Homemaker services consist of general household management necessary to maintain and operate a home for consumers unable to manage their own home or when the individual normally responsible for home-making is absent. Activities may also include: general and heavy-duty housecleaning, meal preparation, minor home repairs, and chores such as yard care, wood chopping and stacking, walkway maintenance, and helping a consumer find and relocate to other housing.

Nutrition

Nutrition services include congregate meals or home-delivered meals such as "Meals on Wheels." However, a full nutritional regimen of three meals a day may not be provided through this service.

SERVICES

Consumer/Family Intensive Support

This service provides a unique set of supports to a consumer and family that includes pain and symptom management, guidance and support, and volunteer coordination.

Pain and symptom management focuses on maintaining a consumer's comfort.

Guidance and support is provided by an individual the consumer chooses to offer psychosocial support to the consumer, family, or significant others for issues relating to loss, grief, and adjustment to chronic disease, disability, or aging.

Volunteer coordination is done by an individual selected by the case management team to coordinate volunteer services prescribed by a health care professional.

SERVICES

Dietitian

Dietitian services are related to the management of a consumer's nutritional needs. A registered dietitian or a licensed nutritionist evaluates and monitors the consumer's nutritional status, provides nutritional education and counseling and discusses meal planning for consumers with medically restricted diets or for consumers who do not have healthy eating habits.

Environmental Accessibility Adaptations

Environmental accessibility adaptations are modifications to a consumer's home that are designed to maintain or improve the consumer's ability to remain at home and prevent institutionalization. Adaptations may include the installation of a ramp, grab-bars, widening of doorways, bathroom modifications, or installation of specialized electric and plumbing systems necessary to accommodate specialized medical equipment and supplies for the consumer's welfare.

SERVICES

Environmental adaptations may also include modifications to a personal vehicle if it allows more consumer independence. All services must meet applicable state or local building codes.

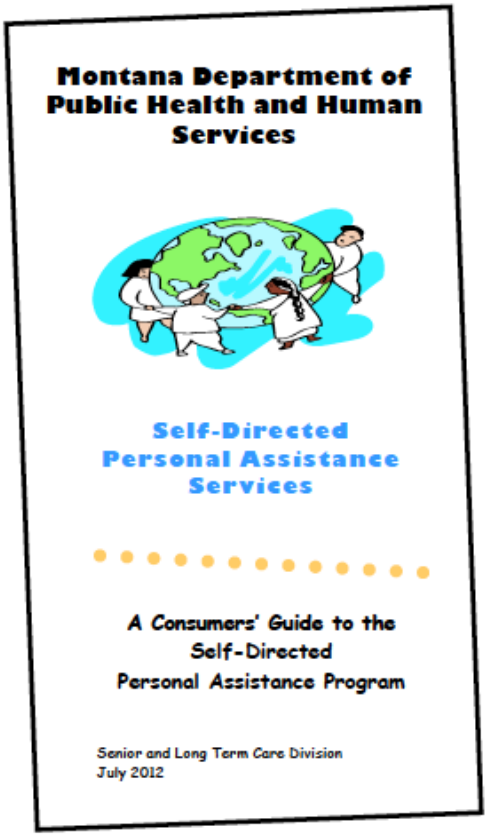
Exclusions: adaptations or improvements to the home that are not of direct medical or remedial benefit to the consumer such as carpeting, roof repair, central air conditioning, etc.

Habilitation

These are services designed to help persons acquire, retain, or improve self-help, social, and adaptive skills necessary to reside successfully in a home and community based setting. Services include: day habilitation, habilitation aide, prevocational services, residential habilitation, supported employment, and transportation to and from a day treatment program. Also included are: independent living evaluations and training services to enhance the consumer's ability to achieve maximum independence in homemaking, personal hygiene, money management, transportation, and use of community resources.

3.2 Self-Direct Brochure

Montana will modify this handout for the MFP demonstration project.

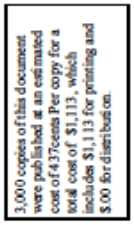


Montana Department of Public Health and Human Services

Self-Directed Personal Assistance Services

A Consumers' Guide to the Self-Directed Personal Assistance Program

Senior and Long Term Care Division
July 2012



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Senior and Long Term Care Division
PO Box 4210
Helena, Montana 59604-4210

Self-Directed Program Philosophy

The personal assistance program is designed to provide long term supportive care in the home setting. In the self-directed option, the consumer is in charge of:

- Managing and directing their own personal assistance services
- Recruiting, hiring, training, and discharging their attendants
- Completing paperwork properly and according to program rules
- Following the program rules to remain eligible for the program

Montana Department of Public Health and Human Services

NEED MORE INFORMATION??

The following is a list of the Regional Program Officers (RPO) Offices in Montana. Please feel free to call the RPO office in your area.

RPO Office	Phone	Counties
Billings Office 2121 Rosebud Dr. Suite D Billings, MT 59102	Phone: 655-7644 Phone: 655-7635 FAX: 655-7646	Big Horn, Carbon, Golden Valley, Musselshell, Stillwater, Treasure, Wheatland, Yellowstone
Bozeman Office 220 W. Lamme, Suite 1E Martel Building Bozeman, MT 59715	Phone: 586-4089 FAX: 587-7863	Gallatin, Madison, Park, Sweetgrass
Butte Office 700 Casey Butte, MT 59701	Phone: 496-4989 FAX: 782-8728	Beaverhead, Deer Lodge, Granite, Silver Bow, Montana State Prison
Glendive Office 218 W. Bell, Suite 205 Glendive, MT 59330	Phone: 377-6252 FAX: 377-1240	Carter, Custer, Daniels, Dawson, Fallon, Garfield, McCone, Powder River, Prairie, Richland, Roosevelt, Rosebud, Sheridan, Valley, Wibaux
Great Falls Office 201 1st Street South Great Falls, MT 59405	Phone: 453-8902 Phone: 453-8975 FAX: 454-6082	Blaine, Cascade, Chotean, Fergus, Glacier, Hill, Judith Basin, Liberty, Petroleum, Phillips, Pondera, Teton, Toole
Helena Office Mailing Address:: PO Box 4210 Helena, MT 59604 Street Address: 2030 11th Ave	Phone: 444-1707 FAX: 444-7743	Broadwater, Jefferson, Lewis & Clark, Meagher, Powell, Montana State Hospital Long Term Care Unit
Kalispell Office 121 Financial Dr #B Kalispell, MT 59901	Phone: 755-5420 FAX: 751-5944	Flathead, Lake, Lincoln
Missoula Office 2681 Palmer, Suite K Missoula, MT 59808	Phone: 329-1312 Phone: 329-1310 FAX: 329-1313	Mineral, Missoula, Ravalli, Sanders

Page 13

How do I Request a Fair Hearing?

You may request a fair hearing with the Department of Public Health and Human Services under the following circumstances:

- Reduction in your service level, if you disagree.
- Denial of services, based on eligibility criteria.

You must request a fair hearing in writing. Mail the request to:

Department of Public Health and Human Services
Hearings Officer
PO Box 202953
Helena, Mt 59620-2953

A request for a fair hearing must be postmarked or delivered no later than 90 calendar days following the date of notice of determination. Your provider agency or local Regional Program Officer can help you with any questions (see list on the next page).

What do I do if I have a complaint?

As a recipient of Medicaid, the Department of Public Health and Human Services does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, age, sex, handicap, political beliefs, religion, or disability.

In case you have questions or in the event that you wish to file a complaint alleging violations, please contact:

Client Discrimination Complaint Coordinator	OR	*Office for Civil Rights*
406-444-4211 or		US DHHS
TDD: 866-735-2968		1961 Stout St, Room 1426
		Denver, CO 80294-3528
		303-844-2024
		TDD: 303-844-3439

Table of Contents

What Exactly is the Self-Directed Program?	2
What is a Personal Assistant?	2
Who is Eligible for the Program?	3
What is a Personal Representative?	3
How Do I Get Services?	4
What Am I Responsible For?	5
What Will the Provider Agency be Responsible for?	6
Can My Family Help Me and Get Paid?	7
How Old Do I Have To Be?	7
When Should I Contact My Provider Agency?	8
What are Health Maintenance Activities?	8
What services can I receive?	9
What services can't I receive?	10
How do I find and hire a worker?	11
How do I request a Fair Hearing?	12
What do I do if I have a discrimination complaint?	12
Where do I go if I need more information?	13

▶ Self-Directed 101

What exactly is the Self-Directed Personal Assistance Program?

The Self-Directed Personal Assistance Program is designed for individuals who wish to assume the responsibility and flexibility of managing their care. This includes managing a personal assistant's work schedule, length of employment, and training.

A provider agency provides oversight of your self-directed personal assistance services. A provider agency is an organization that enrolls with the Department of Public Health and Human Services to oversee personal assistance services. You can choose which agency you use.

What is a Personal Assistant?

Personal Assistants (assistants) are people who are dedicated to helping you stay in your home. Personal assistants vary in age and can be a man or a woman.

Personal assistants help you with your activities of daily living. Activities of daily living include bathing, dressing, grooming, toileting, transferring, positioning, mobility, meal preparation, eating, exercise, and medication assistance. You will train your personal assistant regarding your specific needs.

A personal assistant is an employee of the provider agency you choose and the assistant must meet the provider's hiring conditions. However, you manage the assistant's work schedule, environment, length of employment, and training.

Page 2

Montana Department of Public Health and Human Services

How do I find and Hire a Worker?

The Department of Public Health and Human Services publishes a booklet with information on how to find and hire workers. You can request a copy of the booklet "Hiring In Home Help" from your provider agency or your local Regional Program Officer (see pg 13).

It is your responsibility to set the job expectations for your workers. You are responsible for providing on-the-job training for your personal assistant. You are also responsible for making sure they complete the tasks you are authorized in the time you are allotted each week.

Your provider agency will not train your personal assistant. In some cases, an experienced assistant may train a new assistant.

Once you've found the right person to be your personal assistant, let your provider agency know who you've chosen. Once you let them know your provider agency will be responsible for the following activities related to your care:

1. Assisting you and your personal assistant in completing the required paperwork; and
2. Paying your personal assistant. This will include reviewing all timesheets to make sure you are complying with the program.

Page 11

What Services can't I receive?

The list below shows some of the household duties that your personal assistant is *not* allowed to do:

- Cleaning floor and furniture in areas that you do not use. For example, cleaning the entire living room if you use only your bedroom.
- Doing laundry or bedding that you do not use. For example, doing the laundry for the entire family.
- Shopping for groceries or household items that you do not need for health or nutrition.
- Supervision, babysitting, or friendly visiting.
- Taking care of your pets-unless the pet is also a service animal trained to help you stay in your home.
- Taking care of your lawn, window washing, and cutting wood.
- Paying your bills
- Running errands for you
  This program is not a housekeeping program.

DON'T FORGET! YOU AREN'T ELIGIBLE TO RECEIVE SELF-DIRECTED SERVICES IN A NURSING HOME OR HOSPITAL

Who is eligible for the Self-Directed Personal Assistance Program?

In order to participate in the Self-Directed Program you must:

1. Be eligible for Full Medicaid;
2. Have a medical condition that requires you to need in-home assistance;
3. Be able to make choices about your activities of daily living and understand the impact of these choices;
4. Be able to assume responsibility for the choices you make; and
5. Be capable of managing all tasks related to your care.

What is a Personal Representative?

Under certain circumstances, a Personal Representative may assume these responsibilities on your behalf. A Personal Representative is someone who represents your interests and is not a paid caregiver.

A Personal Representative must:

- Be an individual who understands your care needs;
- Be capable of directing your care;
- Have a personal relationship with you;
- Be immediately available to provide or obtain back up services in the case of an emergency or when a personal assistant does not show up; and
- Assume all medical and related liability associated with directing your care.

You can ask your provider agency or your local Regional Program Officer any questions you have about being eligible for the Self-Directed Program. A list of Program Officers is on page 13.

Self-Directed 101

How do I get services and who decides what services I will receive?

You can call a local personal assistance agency yourself or have your personal representative do this on your behalf. You can also call Mountain Pacific Quality Health. Mountain Pacific Quality Health is an organization that contracts with the State of Montana to perform authorization functions of the Personal Assistance Services Program.

The type of care authorized is dependent upon your needs, living situation, and approval of your health care professional. A health care professional can be a certified physician assistant, nurse practitioner, registered nurse, occupational therapist, or a medical social worker who is working as part of a case management team.

After a call is made, a referral is sent on to a nurse at Mountain Pacific Quality Health. A nurse will contact you within 10 working days and visit you at your home within 30 working days of receiving the referral.

During the visit, the nurse will do the following:

- Find out what you need help with;
- Determine if you are capable of directing your own care;
- Explain the process; and
- Give you materials explaining the program and a list of providers in your area.

You can call Mountain Pacific Quality Health at any time with a referral. They can be reached at 1-800-268-1146 ext 6830.

Page 4

Montana Department of Public Health and Human Services

What Services can I receive?

Make sure you understand and can clearly communicate what services you need help with. The potential services which Medicaid will pay for are listed below:

Service	Examples	Restrictions
Activities of Daily Living	• Bathing • Dressing • Grooming • Toileting • Transferring • Positioning • Meal preparation • Eating (including tube feeding) • Exercise • Medication assist	These services may only be provided to the person receiving personal assistance services. These services can only be provided in the home of the person receiving the services.
Housekeeping Tasks (to ensure a safe environment)	• Changing bed sheets • Light housekeeping • Cleaning medical equipment • Laundry • Washing dishes	• Maximum of 3 hours/week can be spent on these tasks • Household tasks may only be provided if the person has one of the activities of daily living needs outlined above. • This does not include household tasks for the entire family. When you live with a family, the family must do most tasks.
Escort to medical appointments	Going with and assisting a person to medical appointments paid for by Medicaid .	Escort is only approved when you need hands on assistance to or at a medical appointment and when a family member or significant other is unavailable to transport.

Page 9

When should I contact my Provider Agency?

Once you are enrolled in the Self-Directed Personal Assistance Program, there are specific times when you should contact your provider agency. These include:

- If your needs change and you need more or less assistance;
- If you are being harmed, abused, or neglected;
- When you are hospitalized or go into a nursing home; and
- When you need to hire or fire a personal assistant.

Calling in concerns to your provider agency protects you and allows your provider agency to better assist you in managing your services. In turn, if the assistant has difficulty in providing services to you, they may also notify the provider

What are Health Maintenance Activities?

Health maintenance activities are skilled nursing tasks that can be done by your personal assistant if your health care professional agrees.

Health maintenance activities that you may direct include:

- Administering medications.
- Urinary systems management.
- Wound care.
- Bowel Care.

You can choose to direct all or some of these activities. These services can only be provided as outlined in your service plan.

What am I responsible for?

There are a number of things you are responsible for to be eligible to participate in the self-directed program.

- You must obtain approval from your health care professional to participate in the program.
- You must be able to make your own decisions and choices or have someone you trust make decisions and choices for you.
- You must have an emergency back up plan in place in case your personal assistant doesn't show up.
- You must participate in a review twice a year with your provider agency. This ensures that everything is going well and that you are getting the care you need to stay in your home.
- You are authorized a certain number of hours per week and it is your responsibility to get your needs met within that time.
- If your needs change, you must contact your provider agency.
- You must review and approve your personal assistants' time sheets. Time sheets are a legal document and must show the tasks that you are directing in your home. Putting the wrong information on your personal assistants' timesheet is illegal and constitutes fraud.
- You must participate in a yearly review with Mountain Pacific Quality Health. They will review your care needs to make sure you are getting the services you need.

Under the Self-Directed Personal Assistance Program, you assume all medical and related liability regarding your care. If you have a Personal Representative, they assume this liability for you.

If you are not interested in doing all of this you can select agency-based services where the provider agency is responsible for training and scheduling your attendants. Contact your provider agency for more information.

What will the provider agency I choose be responsible for?

Before you begin self-directed services in your home, your provider agency must do the following things:

1. Give you information regarding policies and program philosophy;
2. Tell you what they are responsible for and what you can do if you have a complaint about your care;
3. Make sure that you understand what services you're authorized for and that you are using your services correctly;
4. Make sure that your plan of care is signed by a health care professional; and
5. Review your plans for back-up, personal assistant recruitment and training.

All of the information you share with your provider agency is confidential. Your provider agency will comply with all federal standards for the protection of your personal health information.

The provider agency will become the employer of record and will review all timesheets that are approved by you.

A representative from your provider agency will visit you at your home at least two times per year to monitor and review your care needs.

Can my family help me and get paid for it?

Immediate family members *cannot* be paid by Medicaid to provide personal assistance to you.

Immediate family includes the following:

- Husband or wife;
- Natural parent of a minor child (less than 18 years old);
- Adoptive parent of a minor child;
- Step-parent of a minor child;
- Foster parent of a minor child; and
- Legal guardian.

Other family members, such as nieces, grandchildren or an uncle may be eligible for payment if they are hired by your provider agency.

Provider agencies do not have to hire your relatives and all personal assistants must meet the provider's hiring conditions. If a provider agency does hire your family member, they must also meet the provider's hiring conditions.

How old do I have to be to receive Personal Assistance Services?

You may receive personal assistance services regardless of your age. However, if you are under the age of 18, you will receive services based on medical need, age appropriateness, and family support. You must also have a personal representative helping you manage your care.

3.3 MFP Flyer

This language will be formatted into a flyer for MFP outreach.

Money Follows the Person

The Montana Community Choice Partnership Money Follows the Person demonstration project will help Montana rebalance its long-term care systems to transition people with Medicaid from institutions to the community. You or your loved one may be eligible if:

- You receive Medicaid
- You have lived in an institution for 90 days
    - Nursing home
    - Montana Developmental Center
    - Montana State Hospital
    - Montana Mental Health Nursing Care Center
    - Psychiatric residential treatment facility
- You are interested in transitioning back to the community

The State believes that long term supports need to be person centered, consumer directed, and community based to best meet the needs of most Montanans.

With Money Follows the Person:

- You will work with a transition coordinator and team who will help you move back to your own home or into a new home or apartment.
- You decide where you will live and what services you need.
- Your transition team will connect you with medical, recreational, employment, volunteer opportunities, or other services you may need.
- You will be able to purchase items to smooth your transition home, such as furniture or a wheelchair ramp.
- Your transition plan is developed to reflect your choices and to meet your needs.

Contact Montana's Money Follows the Person project director if you are interested in Money Follows the Person or want to learn more:

- Phone number
- Website
- Email