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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Major Changes

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

1. Update program name from the Severe and Disabling Mental Illness Home and Community Based Services (SDMI) waiver to the Hope Waiver;
2. Update language to remove outdated information, correct entity name changes, program staff position titles, update contracted case management entity from two to one, correct grammar and to provide clarifying details regarding the overall waiver administration, oversight and operations;
3. Update performance measures/quality assurance standards; and
4. Address updates outlined in CMS' new waiver application document and 1915(c) technical guide.

Appendix A:
Update prior authorization situations managed by the Quality Improvement Organization (QIO);
Remove requirement for BHDD program staff to review and approval all PCRPs; and
Update quality assurance review processes.

Appendix B:
Update reserve capacity purposes and determination and add two new reserve capacity groups;
Remove the requirement for Person-Centered Recovery Plans to be submitted to the program for approval and oversight; and
Update case management team's responsibilities for record maintenance.

Appendix C:
Update service definitions to define individual service delivery model;
Update Residential Habilitation, Case Management, Consultative Clinical and Therapeutic Services, Health and Wellness, and Pain and Symptom Management service definitions and scope;
Update provider definitions for Health and Wellness and Specialized Medical Equipment and Supplies;
Update the provisions of care by Legally Responsible Individuals/Relatives/Legal Guardians; and
Respond to HCBS settings process and assurances required by new waiver application document.

Appendix D:
Remove the requirement for the department to approve initial, annual and/or updated PCRPs;
Remove the requirement for the department to review specific components in the PCRPs prior to authorization;
Update program staff quality assurance review responsibilities;
More clearly define risk assessment and mitigation processes;
Update the list of services provided by the contracted case management entity and the providers availability for each service;
Remove the requirement for direct approval from the State for the approval of the Intensive Mental Health Group Home service;
Respond to Conflict of Interest assurances list required by new waiver application document;
Clarify the telephone contact (monthly call) requirements with members must be completed verbally;
Add requirement to use SMART goal process within the PCRP goal definitions.

Appendix E:
Remove reference to MP completing capacity assessment;

Appendix F: no significant changes
Appendix G: no significant changes

Appendix H:
Update program survey process.

Appendix I:
Update claim review process from program staff to QIO;
Update financial oversight details;
Remove requirement for case management teams to conduct quarterly internal audits; and
Update rate methodology, rates, billing and claims information.

Appendix J:
Update estimates and rate methodologies.

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

1. Request Information (1 of 3)

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

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

Hope Waiver

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MT.0455
Draft ID: MT.013.04.00

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

Regular Waiver

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

07/01/25

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

The Behavioral Health and Developmental Disabilities Division of the Montana Department of Public Health and Human Services operates a 1915(b)(4) selective contracting program for the provision of case management service which became effective October 1, 2018.

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

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☒ **section 1915(b)(4) (selective contracting/limit number of providers)**

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

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

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

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

☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Hope Waiver is available to qualifying individuals experiencing a severe and disabling mental illness need who require long-term supports at a level typically provided in a nursing facility. A person experiencing a severe and disabling mental illness is defined as someone who is 18 years of age or older who presently or any time in the past 12 months had a qualifying mental illness interfering with the member's functioning and has significant difficulty in community living without supportive treatment or services of a long-term or indefinite duration as a result of the member's diagnosis. The member has chronic and persistent symptoms resulting in impaired functioning. In addition, a member who has involuntarily committed for at least 30 consecutive days because of a mental disorder at Montana State Hospital or the Montana Mental Health Nursing Care Center, within the past 12 months is also eligible.

The Department of Public Health and Human Services, Behavioral Health and Developmental Disabilities Division (BHDD) is the lead agency for the operation of the Hope Waiver. The State Medicaid Director is the Branch Manager for the Department of Public Health and Human Services. BHDD has defined a range of community-based services designed to support individuals with severe and disabling mental illness to remain in the community. These services are: Adult Day Health, Case Management, Residential Habilitation, Respite, Supported Employment, Behavioral Intervention Assistant, Community Transition, Consultative Clinical and Therapeutic Services, Environmental Accessibility Adaptations, Health and Wellness, Homemaker Chore, Life Coach, Meals, Non-Medical Transportation, Pain and Symptom Management, Personal Assistance Service, Personal Emergency Response System, Private Duty Nursing, and Specialized Medical Equipment and Supplies.

BHDD contracts with one (1) local, non-state case management agencies to enable individuals with long term care needs to access appropriate supportive services. That agency forms a statewide network providing case management and care coordination for Hope Waiver members. Through a person-centered recovery planning process, waiver members assist the case managers to identify services and community supports needed to prevent placement in a Nursing Facility. In addition, BHDD contracts with a Quality Improvement Organization to provide initial and ongoing level of care screens and utilization management of Hope Waiver services.

The goal of the Hope Waiver includes providing quality care while maintaining financial accountability. Hope Waiver providers are enrolled Montana Medicaid providers and all payments will occur through the Fiscal Intermediary. The providers of waiver services receive payments directly and providers retain 100% of these payments. Public and non-public providers receive the same amount of Medicaid reimbursement. There are no intergovernmental transfer policies or certified public expenditures of non-state public agencies included within the Hope Waiver. The exception to these processes occur when an Organized Health Care Delivery System is utilized.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals.

3. Components of the Waiver Request

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

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

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

care.

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

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

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

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

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect

to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver

participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem.

During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

TO BE UPDATED AFTER PUBLIC COMMENT IS COMPLETE

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the state of the state's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Perrotta

First Name: Jean

Title: Hope Waiver Section Supervisor

Agency: Montana Department of Public Health and Human Services Behavioral Health and

Address: PO Box 202905

Address 2: 301 South Park Ave, Suite 320

City: Helena

State: **Montana**

Zip: 59620

Phone: (406) 497-6609 **Ext:** ☐ **TTY**

Fax: (406) 444-4435

E-mail: jperrotta@mt.gov

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

Last Name: Rime

First Name: Carla

Title: Medicaid State Plan and Waiver Coordinator

Agency: Department of Public Health and Human Services

Address: PO Box 4210

Address 2: 111 N. Sanders

City: Helena

State: **Montana**

Zip: 59604

Phone: (406) 444-6047 **Ext:** ☐ **TTY**

Fax: (406) 444-1970

E-mail: CRime2@mt.gov

8. Authorizing Signature

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Montana**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

From Appendix I-2-a:
AMENDMENT EFFECTIVE 11/12/23
The rate increases made with the Appendix K, in May 2023, are being implemented permanently with this amendment effective 11/12/2023. The rate increases applied/applies to the following services:
• Case Management
• Respite
• Consultative Clinical and Therapeutic services
• Adult Day Health
• Behavioral Intervention Assistant
• Homemaker chore
• Nutrition (Meals)
• Private duty nursing
• Personal assistant attendant-agency based and self-directed
• Residential habilitation
• Mental health group home
• Intensive mental health group home
• Assisted living/adult foster care
• Non-Medical Transportation-miles
• Life coach

Public comment

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

Montana Department of Public Health and Human Services, Behavioral Health and Developmental Disabilities Division

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

(1) Behavioral Health and Developmental Disabilities Division (BHDD) is responsible for the design, implementation, and monitoring of all activities associated with this waiver.
(2) There is no single document serving to outline the roles and responsibilities of all staff related to waiver operation. Multiple documents serve to outline the responsibilities of assigned staff regarding specific aspects of the waiver, including BHDD rules and policies relating directly to the operation of the waiver. BHDD maintains organizational charts, individual position descriptions, and web-based information serving to assist persons who need assistance in accessing information about the waiver and the staff within BHDD who are responsible for decision making based on waiver issues. The waiver application is the authoritative document serving to outline the person/positions responsible for ensuring all the requirements of the waiver are met (more detail regarding implementation detail is available in various BHDD and provider forms, policies, administrative directives, and rules).
(3) The Medicaid Director and his/her designee are ultimately responsible for ensuring problems in the administration of the waiver are resolved. The Medicaid Director and his/her designee are not directly involved in the day to day operational decisions of the BHDD staff. The waiver Program Managers, Supervisor, Treatment Bureau Chief, and the BHDD Administrator share information and a copy of the waiver with the State Medicaid Director and/or his/her designee prior to the submittal of waiver renewals, amendments, or new waiver application to CMS.

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

Appendix A: Waiver Administration and Operation

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

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

The Montana Department of Public Health and Human Services, Behavioral Health and Developmental Disabilities Division (BHDD), contracts with a Quality Improvement Organization to complete level of care assessments for members referred to the waiver and will prior authorize the following situations: Environmental Accessibility Adaptions and Specialized Medical Equipment and Supplies (over $500).

BHDD contracts with one case management agency serving the State of Montana. Case management services are managed through a Section 1915(b) waiver which provides conflict free case management for the Hope Waiver. These services include waiver operational and administrative services, general case management, functional and level of care reevaluations, service planning, referral care coordination, utilization review, service monitoring, reporting, and follow up. The case management agency was selected through a competitive bid process. The case management entity does provide direct waiver services.

The Montana Department of Public Health and Human Services contracts with a Fiscal Agent to maintain the Medicaid Management Information System (MMIS), process claims, assist in the provider enrollment/application process, including verification of provider information, maintain a call center, respond to provider questions and complaints, and produce reports.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Department of Public Health and Human Services, Behavioral Health and Developmental Disabilities Division (BHDD), Treatment Bureau.

Appendix A: Waiver Administration and Operation

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

The Behavioral Health and Developmental Disabilities Division (BHDD) provides ongoing oversight to contracted and/or local/regional non-state entities. The Quality Assurance Program Manager also completes monthly data reviews on a random set of members comparing services prior authorized to services billed in the Medicaid Management Information System (MMIS).

Mountain Pacific Quality Health (QIO) will submit a management report to BHDD on a quarterly basis. The report will capture data on the date of level of care assessments and days elapsed between the request for the level of care and the date the LOC recommendation was submitted to the SMA. BHDD will monitor the report to ensure reassessments and information regarding level of care determination are provided in a timely manner. These reviews will occur annually. Assessment of the contract agency's performance is part of the quality management strategy outlined in Appendix H.

Case Management Teams (CMTs) will submit annual reports to the state as well as monthly utilization reports. These reports will ensure quality assurance measures are met in accordance with performance measures in Appendix H. CMTs will receive desk-level reviews at least every three years or more frequently if necessary. CMTs are also monitored on an on-going basis by Hope Program Officers and Program Managers via quality assurance communications.

Conduent provides a monthly report summarizing internal monitoring of the system and processes (i.e., recipient subsystem, provider enrollment, claims processing and documents, verify changes requested for codes were made appropriately). The MMIS coordinator and senior Medicaid policy analyst meet with Conduent weekly to discuss progress and/or problems with system updates. Monthly status meetings are held between department staff and Conduent staff. In addition, Conduent completes internal audits to review their system processes and effectiveness as a contractor.

The Montana Department of Public Health and Human Services, via the Director's Office, oversees the contract with the Fiscal Agent.

Appendix A: Waiver Administration and Operation

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

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and Percent of Hope Waiver provider applicants approved by Hope Waiver program staff within 45 business days. Numerator: Number of Hope Waiver provider applicants approved by Hope Waiver program staff within 45 business days. Denominator: Total number of Hope Waiver providers applicants.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of level of care evaluations completed within 3 business days.
Numerator: Number of level of care evaluations completed within 3 business days.
Denominator: Total number of level of care evaluations completed.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of members with PCRP completed within 30 business days of active enrollment into Hope Waiver program. Numerator: Number of members with PCRP completed within 30 business day of active enrollment into Hope Waiver program. Denominator: Total number of qualifying members enrolled.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

		Interval =
☒ **Other** Specify: Contracted Case Management entity	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Delegated responsibilities of contracted agencies/vendors are monitored, corrected, and remediated by the Behavioral Health and Developmental Disabilities Division (BHDD). During routine annual evaluation or by notice of an occurrence, BHDD works with sister agencies and/or contracted agencies to provide technical assistance, or some other appropriate resolution based on the identified situation. A Quality Assurance Point (QAP) is issued for deficiencies found during these reviews.

A QAP is a written understanding of an identified area of noncompliance. The QAP includes an agreement of steps needing to be taken to correct deficiencies. The correction of the findings or deficiency must be completed within 30-days, and the Program Manager must sign off on the QAP, before it can be considered accepted or “closed”. The results of the QAPs are compiled and maintained in central office. QAPs are tracked in a data base and are monitored by the Program Manager, who verifies the deficiency has been resolved by either confirmation from the Program Officers or by verification from the case management teams. If a QAP is not closed within the 30 days, the Program Manager discusses this with the Case Management Teams and sets a new deadline if necessary. If a situation arises and cannot be resolved at the regional level, the Mental Health Supervisor is contacted to provide additional support in assuring a positive outcome. The Program Manager continues to monitor the status of the resolution. These results are compiled and maintained in the central office and reviewed for trends in deficiencies needing additional attention.

If problems are identified during the annual audit, BHDD communicates findings directly to the case management teams, and documents findings in the case management team’s annual report of audit findings, and if needed, requires corrective action. BHDD conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. If a compliance issue extends to multiple case management teams, BHDD provides clarification through formal Policy Memos, formal training, or both. Technical assistance is provided to case management teams via phone and e-mail. If issues arise at any other time, BHDD works with the responsible parties (case manager, case management supervisor, case management Administrator) to ensure appropriate remediation occurs.

If a situation arises and cannot be resolved at this level, the Mental Health Supervisor is involved to provide additional support in assuring a positive outcome. The Program Manager continues to monitor the status of the resolution. These results are compiled and maintained in the central office and reviewed for trends in deficiencies that needs additional attention.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☒ **Mental Illness**					
	☒	**Mental Illness**	18		☒
	☐	**Serious Emotional Disturbance**			

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

(1) To be found to have a “Severe Disabling Mental Illness (SDMI)” a member must:
(a) be 18 years or older;
(b) presently or any time in the past 12 months has had a diagnosable mental illness, as described below, that has interfered with the member’s functioning;
(c) has significant difficulty in community living without supportive treatment or services of a long-term or indefinite duration as a result of the member’s diagnosis; and
(d) has three areas of at least high level of impairment as indicated by a score of three or above on the Hope Waiver Evaluation and Level of Impairment form.

(2) Has been involuntarily committed for at least 30 consecutive days, because of a mental disorder, at Montana State Hospital or the Montana Mental Health Nursing Care Center within the past 12 months or has one of the following diagnosis (excludes mild and Not Otherwise Specified (NOS)):
(a) Schizophrenia Spectrum;
(b) Bipolar I and Bipolar II Disorders;
(c) Depressive Disorders as follows:
Major depressive disorder, moderate
Major depressive disorder, severe w/out psychotic features
Major depressive disorder, severe with psychotic features
Major depressive disorder, recurrent, moderate
Major depressive disorder, recurrent, severe w/out psychotic features
Major depressive disorder, recurrent, severe, with psychotic features
(d) Trauma- and Stressor-Related Disorders as follows:
Post-traumatic stress disorder, acute
Post-traumatic stress disorder, chronic
(e) Anxiety Disorders as follows:
Generalized Anxiety Disorder
(f) Borderline Personality Disorder.

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	600
Year 2	650
Year 3	750
Year 4	750
Year 5	750

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of

participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes
Transitioning individuals with Money Follows the Person grant funding
Transitioning individuals from youth-based Medicaid programs to adult coverage through the Hope Waiver
Transitioning individuals from Montana State Hospital or the Montana Mental Health Nursing Care Center

Appendix B: Participant Access and Eligibility

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

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

Transitioning individuals with Money Follows the Person grant funding

Purpose *(describe):*

As of July 1, 2020, three (3) waiver members have transitioned using the Money Follows the Person (MFP) grant. Individuals transitioning to the Hope Waiver using Money Follows the Person grant funding may be offered enrollment into the program without being required to have the highest score of individuals on the wait list when the individual meets the

criteria for the Intensive Mental Health Group Home service.

Describe how the amount of reserved capacity was determined:

The Behavioral Health and Developmental Disabilities Division is currently participating in a work group whose purpose is to further develop Money Follows the Person (MFP) grant. The work group consists of the MFP program manager and representatives from Montana's 1915(c) Home and Community Based Waivers. The work group focuses on early identification of potential MFP participants as well as training targeted groups.

The reserve capacity was determined using the average allocated to the waiver's other reserve capacity groups to create parity in access.

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

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

Appendix B: Participant Access and Eligibility

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

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

Transitioning individuals from youth-based Medicaid programs to adult coverage through the Hope Waiver

Purpose *(describe):*

The Behavioral Health and Developmental Disabilities Division (BHDD) is reserving capacity to provide for the community transition of youth aging out of state plan youth-based programs who otherwise meet the Hope Waiver program/service criteria. Individuals transitioning to the Hope Waiver from youth-based Medicaid programs may be offered enrollment into the program without being required to have the highest score of individuals on the wait list when the individual meets the criteria for the Intensive Mental Health Group Home service.

Describe how the amount of reserved capacity was determined:

The Behavioral Health and Developmental Disabilities Division is currently participating in a work group whose purpose is to further develop opportunities for the successful transition of youth transitioning out of state plan youth-based programs. The work group consists of state program managers/officers, complex care coordinators, Department of Family Services and representatives from Montana's 1915(c) Home and Community Based Waivers. The work group focuses on early identification of potential youth as well as training targeted groups.

The reserve capacity was determined using the average allocated to the waiver's other reserve capacity groups to create parity in access.

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

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

Waiver Year	Capacity Reserved
Year 5	4

Appendix B: Participant Access and Eligibility

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

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

Transitioning individuals from Montana State Hospital or the Montana Mental Health Nursing Care Center

Purpose *(describe):*

The Behavioral Health and Developmental Disabilities Division (BHDD) is reserving capacity to provide for the community transition of individuals discharging from Montana State Hospital (MSH) or the Montana Mental Health Nursing Care Center (MMHNCC). Individuals transitioning to the Hope Waiver from Montana State Hospital or the Montana Mental Health Nursing Care Center may be offered enrollment into the program without being required to have the highest score of individuals on the wait list when the individual meets the criteria for the Intensive Mental Health Group Home service..

Describe how the amount of reserved capacity was determined:

The Behavioral Health and Developmental Disabilities Division is currently participating in a work group whose purpose is to further support transitions from the Montana State Hospital and the Montana Mental Health Nursing Care Center. The work group consists of the Hope Waiver program staff and representatives from Montana State Hospital. The work group is focusing on early identification of potential MSH discharges as well as training targeted groups.

The reserve capacity was determined using the average allocated to the waiver's other reserve capacity groups to create parity in access.

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

Waiver Year	Capacity Reserved
Year 1	3
Year 2	8
Year 3	30
Year 4	40
Year 5	50

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

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

Applicants receive two separate evaluations prior to enrollment or placement on the waitlist for the Hope Waiver. Those evaluations are the level of care evaluation and the Hope Waiver level of impairment evaluation. The case management teams utilize these evaluations to determine the applicant's placement on the waitlist which assures an objective approach as the evaluations establish the applicant's level of care and functional needs.

Opportunities to move from the wait list to enrollment into the program are provided to the applicant with the highest score.
Applicants are enrolled based upon the date of the case management team's verification of Medicaid eligibility and verification the member meets the functional impairment, level of care, provider availability and additional program criteria of this application.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

◉ **Section 1634 State**

○ **SSI Criteria State**

○ **209(b) State**

2. Miller Trust State.

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

◉ **No**

○ **Yes**

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

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

☐ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**

☐ **Pregnant Women (42 CFR § 435.116)**

☐ **Infants and Children under Age 19 (42 CFR § 435.118)**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**

☒ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR § 435.330)**

☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**

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

Specify:

42 CFR § 435.135 - Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977

42 U.S. Code § 1383c - Eligibility for medical assistance of aged, blind, or disabled individuals under State's medical assistance plan

42 CFR § 435.119 - Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL.

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.**

Select one and complete Appendix B-5.

◉ **All individuals in the special home and community-based waiver group under 42 CFR § 435.217**

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

Check each that applies:

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

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage:

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

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

○ **Use spousal post-eligibility rules under section 1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

◉ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules at 42 CFR § 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
◉ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

○ **Not Applicable (see instructions)**
○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

◉ **The amount is determined using the following formula:**

Specify:

Allowance for the spouse only:
Calculation 1
Maximum spousal standard – Spouse's gross income = Maximum spousal allowance

Calculation 2
Shelter expenses – Basic shelter allowance = Excess shelter expense + Basic needs standard = Community spouse's maintenance needs – Spouse's gross income = Spousal allowance.

The community spouse is entitled to the lesser of calculation 1 or 2.

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**
○ **AFDC need standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount changes, this item will be revised.

◉ **The amount is determined using the following formula:**

Specify:

Basic needs standard – gross income of dependent family member. The difference of that calculation is then divided by 3 and the remaining amount is the family allowance.

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this

section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules at 42 CFR § 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in section 1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
◉ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount changes, this item will be revised.

◉ **The amount is determined using the following formula:**

Specify:

Basic needs standard – gross income of dependent family member. The difference of that calculation is then divided by 3 and the remaining amount is the family allowance.

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State ? January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

  Allowance for the spouse only:
  Calculation 1
  Maximum spousal standard – Spouse's gross income = Maximum spousal allowance

  Calculation 2
  Shelter expenses – Basic shelter allowance = Excess shelter expense + Basic needs standard = Community spouse's maintenance needs – Spouse's gross income = Spousal allowance.

  The community spouse is entitled to the lesser of calculation 1 or 2.

- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- ◉ **Other**

Specify:

The Quality Improvement Organization under contract with the department.

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

(1) Licensed Registered Nurse;
(2) Licensed Practical Nurse; or
(3) Individuals with a bachelor's degree in a human behavioral science or related field of study.

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

The following criteria is used for the initial evaluation and reevaluation to determine a member needs services through the Hope Waiver:

A Quality Improvement Organization completes the initial level of care evaluations and reevaluations using the 'Institutional Level of Care Criteria Nursing Facility, Home and Community Based Services, and Community First Choice' criteria and the MARS Level of Care Determination form. The name of the level of care instrument used to complete the level of care determination is "MARS Level of Care Determination." This evaluation includes the following areas of focus:
(1) Identification of specific functional/medical barriers or problems, which includes mental status and ADL/IADLs;
(2) Assessment of the state of the issues, how they interface with the member's current living environment and resources, identification of services, equipment, and resources which would accommodate those needs; and
(3) Specification of the types of services, equipment, or resources needed to improve interface.

Placement decisions for individuals applying for nursing home/home and community-based services involve a systemic analysis of the individual's medical, functional, cognitive, and environmental resources and limitations. Primarily these decisions are anchored by objective boundaries from which clinical judgment, or subjective expertise, is used to interpret the boundaries. Members must meet a minimum level of deficiency in one of two established criteria. The specific areas of focus for data collection are as follows:
a) Identification of specific functional/medical barriers or problems;
b) Assessment of the status of these issues (particularly as they interface with the individual's current living environment and resources) and identification of services, equipment, and/or resources, if any, which currently accommodate those needs, and;
c) Specification of the types of services, equipment, or resources needed to improve that interface.

Once institutional level of care has been determined, the member is referred to a mental health professional who administers the 'Hope Waiver, Evaluation and Level of Impairment' assessment. This assessment is completed face to face and confirms the member's eligibility as related to a SDMI diagnosis. This assessment includes a functional assessment focused on the member's SDMI in areas of:
(1) Self-Care/Basic Needs;
(2) Employment/Education/Housing/Financial;
(3) Family/Interpersonal Relationships;
(4) Mood/Thought Functioning, Self-harm/Other-harm; and
(5) Substance Use.

In addition, the LOI measures the outcomes of treatment for mental health symptoms and resulting behaviors and guides service needs in the member's PCRP. The LOC and LOI performs different functions; however, the use of both forms is complimentary and enhances the person-centered recovery plan (PCRP) process.

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

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

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

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

Members are referred to the Quality Improvement Organization (QIO) to complete the initial level of care evaluations via the telephone. An applicant may be referred to the QIO from any source (self, family member, treatment provider, etc.) Once the member is in contact with the QIO, the QIO outreaches the member to initiate the telephonic LOC evaluation.The QIO completes a telephonic interview. If a determination cannot be made based upon this interview, the QIO completes an outreach to other individuals who can assist with the evaluation. This can include the applicant's physician, family members, etc.

Once the Quality Improvement Organization determines the member meets the level of care, the member is referred to a mental health professional of their choice who administers the 'Hope Waiver Evaluation and Level of Impairment' assessment face to face and forwards the assessment results to the Quality Improvement Organization. If the mental health professional determined the member meets the level of impairment criteria, the Quality Improvement Organization refers qualifying members to the appropriate case management team.

The case management teams review the member's assessments and either admits them to the waiver first come first served (if there is no wait list) or adds the member to the wait list using an average of the member's combined level of care/level of impairment scores for wait list placement.

The case management teams are required to review the status of members quarterly and within 12 months of the initial or previous assessment. A review may be completed sooner if there is a significant change in the member's condition or if required by program criteria. Case management teams refers the member to a mental health professional who administers the 'Hope Waiver Evaluation and Level of Impairment' assessment. The case management team obtains the diagnoses and level of impairment from this assessment, if the member meets the level of impairment for the Severe and Disabling Mental Illness, Home and Community Based waiver, the case management team completes the following tasks:
(1) Reviews the Person-Center Recovery Plan, service agreements, and provider contracts or agreements;
(2) Evaluates service effectiveness, quality of care, and appropriateness of services;
(3) Verifies continuing Medicaid eligibility and other financial and program eligibility;
(4) Completes a new care plan and service agreements;
(5) Maintains appropriate documentation, including type and frequency of long-term care services the member is receiving for certification of continued program eligibility, if required by the program for a continued stay review; and
(6) Submits appropriate documentation for authorization of services, in accordance with program requirements.

If the member no longer meets the level of impairment for the Hope Waiver Evaluation and Level of Impairment' assessment, to the Quality Improvement Organization to complete a reevaluation of the member's level of care needs using the same criteria as the initial evaluation.

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

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

  Specify the other schedule:

The case management teams are required to review the status of members within 12 months of the initial or previous assessment. A review may be completed sooner if there is a significant change in the member's condition or if required by program criteria. If the member no longer meets the level of impairment for the Hope Waiver at the annual review, the case management team refers the member, along with the most current 'Hope Waiver, Evaluation and Level of Impairment' assessment, to the Quality Improvement Organization to complete a reevaluation of the member's level of care needs using the same criteria as the initial evaluation.

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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

Case Management Teams utilize a reminder system to ensure re-evaluations are completed in a timely manner.

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

The Quality Improvement Organization must maintain evaluations and reevaluation for a minimum of three years as required by 45 CFR 92.42.

The case management teams must review the members' status within 12 months of the initial or previous assessment. A review may be completed sooner if there is a significant change in the member's condition or if required by program criteria. The Screening Determination is the form used by the QIO and the case management to make a level of care determination for the waiver program. The re-evaluation is kept in the care management system, and a copy of the related service plan documentation is submitted to the Office of Public Assistance.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of applicants who received a LOC determination prior to receipt of services. Numerator: Total number of applicants who received a LOC determination prior to receipt of services. Denominator: Total number of applicants.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to

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

Performance Measure:
Number and percent of LOC/LOI evaluations where processes/instruments described in the approved waiver were used in the representative sample. Numerator: Number of LOC/LOI evaluations where processes/instruments described in the approved waiver were used in the representative sample. Denominator: Total number of LOC/LOI evaluations completed in the representative sample.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of applicants who received an initial LOC denial and were provided Fair Hearing rights. Numerator: Total number of applicants who received an initial LOC denial and were provided Fair Hearing rights. Denominator: Total number of applicants who received an initial LOC denial.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

		Confidence Interval =
☒ **Other** Specify: Quality Improvement Organization	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

The Quality Improvement Organization submits reports monthly/quarterly to the Behavioral Health and Developmental Disabilities Division (BHDD). Reported information includes:
(1) The number/percent of services requiring prior authorization were processed within 14 work days;
(2) The number and percent of submitted prior authorizations approved;
(3) The number of applicants who received a level of care determination indicating need for institutional level of care prior to receipt of services;
(4) The number/percent of initial level of care determinations made by qualified contractors as specified in the approved waiver; and
(5) The number of enrolled members who receive a level of care denial and were provided information and access to the fair hearing process.
This allows BHDD to identify and address potential issues as they arise.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Delegated responsibilities of contracted agencies/vendors are monitored, corrected, and remediated by the Behavioral Health and Developmental Disabilities Division (BHDD). During routine annual evaluation or by notice of an occurrence, BHDD works with sister agencies and/or contracted agencies to provide technical assistance, or some other appropriate resolution based on the identified situation. If remediation does not occur timely or appropriately, BHDD issues a Quality Assurance Point (QAP) or other notice to cure the deficiency to the contracted agency. This requires the agency to take specific action within a designated time frame to achieve compliance. BHDD conducts follow-up monitoring to assure corrective action implementation and ongoing compliance.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

During the level of care determination, the Quality Improvement Organization will inform eligible members of the feasible alternatives available under the waiver and allow members to choose either institutional or waiver services. The Screening Determination Form documenting choice will be maintained on file at the Quality Improvement Organization.

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

The QIO maintains the screening determination form informing applicants if they met the eligibility requirements of the waiver and provides them with the choice of waiver services, nursing facility, or Communities First Choice. The form is kept for a minimum of three years.

Appendix B: Participant Access and Eligibility

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

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

Behavioral Health and Developmental Disabilities (BHDD) will make reasonable accommodation upon request. Accommodations for foreign translators will be arranged through available computer programs or the local college and university system. Accommodations for members who are deaf or hearing impaired will be made through Montana Communications Access Program for the Deaf and Hard of Hearing Services. BHDD will utilize other resources as indicated and available. Members are notified of the opportunity for reasonable accommodations in the Medicaid application process and in the Medicaid Screening determination letter.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Health**		
Statutory Service	**Case Management**		

Service Type	Service		
Statutory Service	Residential Habilitation		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Other Service	Behavioral Intervention Assistant		
Other Service	Community Transition		
Other Service	Consultative Clinical and Therapeutic Services		
Other Service	Environmental Accessibility Adaptations		
Other Service	Health and Wellness		
Other Service	Homemaker Chore		
Other Service	Life Coach		
Other Service	Meals		
Other Service	Non-Medical Transportation		
Other Service	Pain and Symptom Management		
Other Service	Personal Assistance Service		
Other Service	Personal Emergency Response System		
Other Service	Private Duty Nursing		
Other Service	Specialized Medical Equipment and Supplies		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Adult Day Health is a social model which provides nutritional, recreational, social services, and supervision in licensed group settings for members who cannot structure their own daily activities, desire social interaction, or cannot be safely left alone at home. Adult day health services are furnished in an outpatient setting enriching members lives through an engaging social community and activities that build upon each member's interests, skills, knowledge, and unique abilities. The scope of Adult Day Health service does not duplicate State Plan services or habilitation aid services. This service is offered outside the member's place of residence and are normally furnished four or more hours per day on a regularly scheduled basis. Adult day health does not include residential overnight services. Transportation between the member's place of residence and the adult day health center will be provided as a component part of adult day health services and the cost of this transportation is included in the rate paid to providers of adult day health services.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs that reflect individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

This service is not duplicative of the transportation services or meals under the distinct meals service and does not constitute a "full nutritional regimen" (three meals per day). Services offered in this waiver are limited based on the member's assessed need for services and are not prior authorized by the state medicaid agency.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health Provider

Provider Qualifications

License *(specify):*

Adult Day Care must be licensed according to Administrative Rules Title 37, Chapter 106, subchapter 26 and subchapter 3.

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.430.
Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.
Department of Public Health and Human Services/Quality Assurance Division.
Applicable standards are verified by the service provider agency.

Frequency of Verification:

Upon enrollment and annually thereafter.
As needed by the provider.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

Service Definition *(Scope):*

Case management assists members in gaining access to Home and Community Based Services, State Plan Services, as well as needed medical, behavioral health, social, educational, financial, and employment services regardless of the funding source. This includes, but is not limited to, the following:
(1) Completing an assessment of each member's needs;
(2) Ongoing monitoring of member service provision, health, and welfare;
(3) Assistance in accessing supports to transition from an institutional setting (this does not include direct transition services);
(4) Developing, implementing, and monitoring each member's Person-Centered Recovery Plan (PCRP), as stated in Appendix D;
(5) Providing service coordination to ensure member's health and safety and addressing service and provider issues;
(6) Providing policy education and support to members who chose to direct their own services;
(7) Providing oversight and management of program enrollment requests by
a. Managing the program wait list as outlined policy,
b. Monitoring the status of the evaluation requests submitted to the Office of Public Assistance (OPA),
c. Acting in a timely fashion in response to OPA evaluation determinations, and
d. Providing clear guidance to members, providers and other stakeholders on program enrollment policies and procedures;
(8) Referring members for a level of care re-evaluation, when indicated, as stated in Appendix B;
(9) Supporting the Department's administrative review and fair hearing process by being informed of the process, providing documentation needed to support case management team actions and attending administrative review and/or fair hearings as needed to support the department's participation and application of policy and procedures; and
(10) timely and accurate processing of providers' service authorization for service delivery.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Case Management services are limited to providers authorized to provide services under the 1915(b) waiver.

Case management service can be provided to a member transitioning from an institution for 90 days prior to transitioning to the waiver. A Person-Centered Recovery Plan must be developed within the first 30 days.

Case management services cannot be bill for this time until the member is enrolled in the waiver.

Services offered in this waiver are limited based on the member's assessed need for services and are not prior authorized by the state medicaid agency.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management Providers

Provider Qualifications

License *(specify):*

Registered Nurse or Licensed Practical Nurse
Licensed Clinical Social Worker or a Licensed Clinical Professional Counselor.

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.425.

A case management team must consist of:
(1) a case manager with a bachelor's level education in the field of Human Services; and
(2) a licensed mental health therapist to provide clinical supervision for every two case managers.

The case management agency chosen through the competitive procurement process to provide case management services is responsible to adhere to the guidelines in the Request for Proposals, contract, and program policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Residential Habilitation provides 24 hours of available services and supports designed to ensure health, safety and welfare of a member and assist the member in the acquisition and improvement of behaviors necessary to live and participate in the community.

Residential Habilitation is provided in a licensed:
1. Adult Foster Home,
2. Assisted Living Facility,
3. Adult Group Home,
4. Mental Health Group Home, or
5. Intensive Mental Health Group Home

Residential Habilitation is a bundled service.

ADULT FOSTER CARE, ADULT GROUP HOME AND ASSISTED LIVING services must include these service components:
(a) personal assistance supports or habilitation to meet the specific needs of each resident;
(b) homemaker services;
(c) medication management and oversight;
(d) social activities;
(e) personal care;
(f) recreational activities;
(g) non-medical transportation; and
(h) 24-hour on-site awake staff to meet the needs of the residents and provide supervision for safety and security.

The MENTAL HEALTH GROUP HOME service must include these service components:
(a) personal assistance supports or habilitation to meet the specific needs of the member;
(b) homemaker services;
(c) medication management and oversight;
(d) social activities;
(e) personal care;
(f) recreational activities;
(g) non-medical transportation; and

(h) 24-hour on-site awake staff to meet the needs of the member and provide supervision for safety and security.

The INTENSIVE MENTAL HEALTH GROUP HOME service must include these service components:
(a) assistance with activities of daily living and instrumental activities of daily living, as needed;
(b) medication management, administration, and oversite;
(c) medical escort;
(d) crisis stabilization services as needed by the member;
(e) close supervision and support of daily living activities;
(f) access to community involvement;
(g) care coordination;
(h) discharge planning; and
(i) transportation and supervision, if appropriate, to suitable community resources.

GROUP HOME STAFFING RATIOS AND/OR CLINICAL SUPERVISION REQUIREMENTS:

(1) Adult Group Home: 1:8 staffing ratio, 24 hour onsite awake staff.
(2) Mental Health Adult Group Homes consist of the following staff:
(a) a program supervisor, .5 FTE, who provides clinical supervision as determined in the member's Person-Centered Recovery Plan;
(b) a residential manager, 1.0 FTE; and
(c) 24-hour onsite awake staff with a minimum 1:4 staffing ratio for at least 16 hours per day during awake hours and at least one staff for eight hours during sleeping hours.

(3) Intensive Mental Health Group Home must consist of the following staff:
(a) a program supervisor, .5 FTE, who provides clinical supervision as described in the member's Person-Centered Recovery Plan;
(b) a residential manager, 1.0 FTE; and
(c) 24 hour onsite awake staff with at least a 1:3 staffing ratio for at least 16 hours per day during awake hours and at least one staff for eight hours during sleeping hours, as determined by the provider.

MENTAL HEALTH GROUP HOME:
In addition to the requirements outlined in this service, MHGH members must meet all of the following three criteria:
(1) The Severe and Disabling Illness criteria as described in this application,
(2) One of the following conditions:
(a) Recurrent inpatient admissions (2 or more Montana State Hospital or the Montana Mental Health Nursing Care Center within the last 12 months);
(b) Re-occurring homelessness, due to mental health symptoms, within the last 12 months;
(c) Incarceration and/or involvement in the criminal justice system, due to mental health symptoms, within the last 12 months; and/or
(d) Involuntarily committed because of a mental disorder to the Montana State Hospital or the Montana Mental Health Nursing Care Center for at least 45 consecutive days at least once in the past 12 months; and
(3) On the Hope Waiver Level of Impairment, the members must meet a severe level of impairment (regardless of diagnosis) in Area 1 (Self Care) or Area 2 (Basic Needs).

INTENSIVE MENTAL HEALTH GROUP HOME:
In addition to the requirements outlined in this service, IMHGH members must meet all of the following three criteria:
(1) The Severe and Disabling Illness criteria as described in this application,
(2) One of the following conditions:
(a) Recurrent inpatient admissions (2 or more Montana State Hospital or the Montana Mental Health Nursing Care Center within the last 12 months);
(b) Re-occurring homelessness, due to mental health symptoms, within the last 12 months;
(c) Incarceration and/or involvement in the criminal justice system, due to mental health symptoms, within the last 12 months;
(d) Member has utilized emergency services more than 2 times within the last 90 days, such as emergency department, police department, crisis receiving/stabilization, mobile crisis response services, or 988; and/or
(e) Involuntarily committed because of a mental disorder to the Montana State Hospital or the Montana Mental Health Nursing Care Center for at least 45 consecutive days at least once in the past 12 months; and
(3) On the Hope Waiver Level of Impairment, the members must meet a severe level of impairment (regardless of diagnosis) in Area 1 (Self Care) and Area 2 (Basic Needs).

Provider owned or leased facilities where residential habilitation services are furnished must be compliant with the Americans with Disabilities Act.

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

Medicaid does not reimburse for room and board in a residential habilitation setting.

This service will not duplicate any other services the waiver member receives.

The provider may not bill Medicaid for services on days the resident is absent from the facility, unless retainer days have been approved by the case management team. The provider may bill on date of admission and discharge from a hospital or nursing facility.

If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer. Services offered in this waiver are limited based on the member's assessed need for services and are not prior authorized by the state Medicaid agency.

Members in residential habilitation may not receive the following services under the Hope Waiver:
(1) Personal Assistance Service;
(2) Homemaker Chore;
(3) Environmental Accessibility Adaptations;
(4) Respite (except foster care); or
(5) Meals.

RESPITE
Respite may be provided in a residential habilitation setting for the provider of other service types as specified under Respite but may not be provided on the behalf of a residential habilitation setting.

RETAINER DAYS
Providers of this service may be eligible for a retainer payment if authorized by the case management team. Retainer days are days on which the member is either in hospital, nursing facility or on vacation and the team has authorized the provider to be reimbursed for services in order to keep their placement in the residential setting. Retainer days are limited to 30 days a Person Centered Recovery Plan year and may not be used for any other service if used for residential habilitation.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Foster Care
Agency	Assisted Living Facility
Agency	Group Home

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Adult Foster Care

Provider Qualifications

License *(specify):*

Enrolled as an Adult Foster Care provider according to Administrative Rules Title 37, Chapter 100, subchapter 1.
Governed by Title 50, Health and Safety, Chapter 5, Montana Code Annotated .

Certificate *(specify):*

Other Standard *(specify):*

Foster Care provider requirements as listed in ARM 37.90.455.

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.
Department of Public Health and Human Services/Quality Assurance Division.
Applicable standards are verified by the service provider agency.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Enrolled as an Assisted Living provider according to Administrative Rules Title 37, Chapter 106, subchapter 28.

Certificate *(specify):*

Other Standard *(specify):*

Assisted Living provider requirements as listed in ARM NEW RULE iv [proposed ARM 37-918].

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.
Department of Public Health and Human Services/Quality Assurance Division.
Applicable standards are verified by the service provider agency.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

Group Homes must be licensed according to Administrative Rules Title 37, Chapter 100, subchapter 4.
Group Homes must be licensed according to Administrative Rules Title 37, Chapter 106.

Certificate *(specify):*

Other Standard *(specify):*

Intensive Mental Health Group Home provider requirements as listed in ARM NEW RULE V[proposed MAR 37-918]
Mental Health Group Home provider requirements as listed in ARM NEW RULE VI[proposed MAR 37-918]
Adult Group Home provider requirements as listed in ARM NEW RULE VII[proposed MAR 37-918]

Clinical supervision provides clinical oversight within the group home, conducts and supervises the treatment plan, and provides clinical treatment to the member as medically necessary. Counselors must be licensed through the Montana Board of Behavioral Health. Title 37, Chapter 22 and 23, Montana Code Annotated

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.
Department of Public Health and Human Services/Quality Assurance Division.
Applicable standards are verified by the service provider agency.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Services provided to members unable to care for themselves are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the member. Respite care can be provided in the member's residence or by placing the member in another private residence, adult residential setting, or licensed nursing facility. Respite care may be made available to members who receive residential habilitation, foster care for the relief of a foster care provider, provided there is no duplication of payment.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period respite is furnished. Respite care may not be furnished for the purpose of compensating relief or substitute staff for a waiver residential service. FFP is not claimed for the provision of room and board. Services offered in this waiver are limited based on the member's assessed need for services and are not prior authorized by the state Medicaid agency. Respite in an institutional setting cannot exceed 30 days at a time due to the settings regulation.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Agency/Home Health Agency
Agency	Nursing Facility
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Care Agency/Home Health Agency

Provider Qualifications

License *(specify):*

Licensed as a Home Health Agency, Title 37, Chapter 106, Subchapter 3; Title 50, Chapter 5 Montana Code Annotated

Certificate *(specify):*

Medicare Certified.

Other Standard *(specify):*

Personal care provider requirements as listed in ARM 37.90.431.
Provider requirements as listed in ARM 37.90.438.

Direct Care Staff:
(1) Be at least 18 years of age;
(2) Within 30 days of hire receive training in:
* abuse reporting,
* incident reporting,
* client confidentiality, and
* any specialty training relating to the need of the member served, as outlined in the plan of care.
(3) Possess the ability to complete documentation requirements of the program;
(4) Agree to a state criminal background check;
(5) Possess a valid driver’s license and proof of automobile liability insurance if transporting the member;
(6) Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
(7) Complete 8 hours of Mental Health Training annually.

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.
Department of Public Health and Human Services/Quality Assurance Division.
Applicable standards are verified by the service provider agency.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License *(specify):*

Enrolled as a Nursing Facility provider according to Administrative Rules Title 37, Chapter 106, subchapter 6.

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.438.

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.
Department of Public Health and Human Services/Quality Assurance Division.
Applicable standards are verified by the service provider agency.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Enrolled as an Assisted Living provider according to Administrative Rules Title 37, Chapter 106, subchapter 28.

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.438.

Licensed as a Home Health Agency, Title 37, Chapter 106, Subchapter 3; Title 50, Chapter 5 Montana Code Annotated

Provider requirements as listed in ARM 37.90.431.

Direct Care Staff:

(1) Be at least 18 years of age;
(2) Within 30 days of hire receive training in:
* abuse reporting,
* incident reporting,
* client confidentiality, and
* any specialty training relating to the need of the member served, as outlined in the plan of care.
(3) Possess the ability to complete documentation requirements of the program;
(4) Agree to a state criminal background check;
(5) Possess a valid driver's license and proof of automobile liability insurance if transporting the member;
(6) Advocate for the member to assure that the member's rights are protected, and the member's needs and preferences are honored; and
(7) Complete 8 hours of Mental Health Training annually.

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.
Department of Public Health and Human Services/Quality Assurance Division.
Applicable standards are verified by the service provider agency.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Supported employment services are the ongoing supports to members who, because of their mental illness, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job meeting personal and career goals.

Supported employment includes both job development and ongoing supported employment. Supported employment may include: rapid job search; individualized job development and placement according to the member's preferences, strengths, and work experiences; on-the-job training in work and work-related skills; ongoing support, including follow-along supports; monitoring of the member's performance on the job; cultivating natural supports on the job; training in related skills needed to obtain and retain employment such as behavioral interventions and self-efficacy; and negotiation with prospective employers. Supported employment is provided in a variety of community settings.
Supported employment service is provided 1:1 and may include supports in a group community employment setting such as crews or individual community employment settings, however, the specific supported employment services are not provided to a group.

All supported employment service options shall be reviewed and considered as a component of a member's person-centered recovery plan no less than annually, more frequently as necessary or as requested by the member. These services and supports should be designed to support successful employment outcomes consistent with the member's goals.

Members with two or more types of non-residential habilitation services may not have the non-residential habilitation services billed during the same period of time.

Personal care is a component of this service unless member has extensive needs. Waiver may supplement personal care assistance during prevocational services when a member's needs exceed the limits of the state plan program.
Documentation is maintained in the file of each individual receiving this service stating the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
Transportation may be provided between the member's place of residence and the job site or between job sites (in cases where the member is working in more than one place) as a component of supported employment services. Use of community transportation, including specialized transportation, is encouraged.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

This service is not duplicative of the transportation service. Supported employment does not duplicate or replace services required to be provided by the school under IDEA.
Waiver funding is not available for the provision of vocational services (e.g., sheltered work performed in a facility) where members are supervised in producing goods or performing services under contract to third parties.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported

employment; or
2. Payments that are passed through to users of supported employment services.

For Supported Employment services assisting the member to achieve self-employment through the operation of a business; Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.
Services offered in this waiver are limited based on the member's assessed need for services and are not prior authorized by the state medicaid agency.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Entity
Individual	Supported Employment Entity

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Entity

Provider Qualifications

License *(specify):*

Be licensed within the scope of their business.

Certificate *(specify):*

Other Standard *(specify):*

Supported employment services are provided by public or private employment agencies, Independent Living Centers, organizations providing support for individuals with disabilities, and Mental Health Centers.

Provider requirements as listed in New Rule [proposed] XIV, MAR 37-918

Direct Care Staff must have:
(1) an associate degree in vocational rehabilitation, career development, or disability services;
(2) an Individual Placement Services (IPS) certification; or
(3) two years of experience in vocational rehabilitation, career development, or disability services and receive an IPS certification within six months of hire.
and
(1) Be at least 18 years of age;

(2) Within 30 days of hire receive training in:
* abuse reporting,
* incident reporting,
* client confidentiality, and
* any specialty training relating to the need of the member served, as outlined in the plan of care.
(3) Possess the ability to complete documentation requirements of the program;
(4) Agree to a state criminal background check;
(5) Possess a valid driver's license and proof of automobile liability insurance if transporting the member;
(6) Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
(7) Complete 8 hours of Mental Health Training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.
Department of Public Health and Human Services/Quality Assurance Division.
Applicable standards are verified by the service provider agency.

Frequency of Verification:

Upon enrollment and annually thereafter.
Exclusion list is reviewed monthly.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

Supported Employment Entity

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.439.
Must be insured.

Direct Care Staff must have:
(1) an associate degree in vocational rehabilitation, career development, or disability services;
(2) an Individual Placement Services (IPS) certification; or
(3) two years of experience in vocational rehabilitation, career development, or disability services and receive an IPS certification within six months of hire.
and
(1) Be at least 18 years of age;
(2) Sign an affidavit regarding confidentiality and HIPAA;
(3) Possess the ability to communicate effectively with the member/personal representative;
(4) Possess the ability to complete documentation requirements of the program;
(5) Demonstrate to the member specific competencies necessary to perform paid tasks;
(6) Complete a self-declaration regarding infections and contagious diseases;
(7) Agree to a state criminal background check;
(8) Possess a valid driver's license and proof of automobile liability insurance if transporting the member;

(9) Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation;
(10) Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
(11) Complete 8 hours of Mental Health Training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Applicable standards are verified by the service provider agency.

Frequency of Verification:

Upon enrollment and annually thereafter.
Exclusion list is reviewed monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Intervention Assistant

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Behavioral Intervention Assistant (BIA) services are habilitative services provided when Medicaid State Plan Community First Choice/Personal Assistant Service (CFC/PAS) provided in state plan and Personal Assistant Services (PAS) provided in the waiver are insufficient in meeting the behavioral health needs of the member and assistance is required in activities of daily living, instrumental activities of daily living, and/or social, behavioral, and adaptive skills. BIA's must possess specialized skills to address the challenging behaviors of members with a Severe and Disabling Mental Illness which differs in scope and nature from CFC/PAS and PAS. This includes redirecting inappropriate and unsafe behaviors, providing supervision to address a member's safety, and extensive cuing to prompt. BIA services may be provided long term for members needing supervision, or intermittently, as needed by the member. A member's need for this service is represented by the need for assistance with mood/thought functioning and/or exhibiting tendencies of harm to self or others in addition to assistance with self-care. This service may be needed episodically or continuously.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

BIA does not require prior authorization when provided in the community but does require authorization when provided in a residential setting such as an assisted living facility on a short term basis to assist to assist the member transition into an new facility or as authorized by the Behavioral Health and Developmental Disabilities Division.
BIA may not be provided with personal assistance services or with supported employment services.

If a member chooses to self-direct their services as a co-employer, it is through an agency providing personal assistance, behavioral intervention assistance, and life coach type services, ensuring members are successful with the self-direction experience.

The agencies will:
(1) Advise, train and support the member, as needed and necessary;
(2) Assist with recruiting, interviewing, hiring, training and managing, and/or dismissing workers;
(3) Manage the employee which includes mandatory agency training and payroll; and
(4) Assist with monitoring health and welfare.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Entity/Home Health Agency
Individual	Personal Care Entity (Individual)

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Intervention Assistant

Provider Category:

Agency

Provider Type:

Personal Care Entity/Home Health Agency

Provider Qualifications

License *(specify):*

Licensed as a Home Health Agency, Title 37, Chapter 106, Subchapter 3; Title 50, Chapter 5 Montana Code Annotated

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements:
(1) Be at least 18 years of age;
(2) Within 30 days of hire receive training in:
* abuse reporting,
* incident reporting,
* client confidentiality, and
* any specialty training relating to the need of the member served, as outlined in the plan of care.
(3) Possess the ability to complete documentation requirements of the program;
(4) Agree to a state criminal background check;
(5) Possess a valid driver's license and proof of automobile liability insurance if transporting the member;
(6) Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
(7) Complete 8 hours of Mental Health Training within six months of hire then annually thereafter in order to possess specialized skills to address the challenging behaviors of members. •Additional training designated by the Behavioral Health and Developmental Disabilities Division for specialty behavioral interventions.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.
Department of Public Health and Human Services/Quality Assurance Division.
Applicable standards are verified by the service provider agency.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Intervention Assistant

Provider Category:

Individual

Provider Type:

Personal Care Entity (Individual)

Provider Qualifications

License *(specify):*

An individual person with a business license

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements:
(1) Be at least 18 years of age;
(2) Within 30 days of hire receive training in:
* abuse reporting,
* incident reporting,
* client confidentiality, and
* any specialty training relating to the need of the member served, as outlined in the plan of care.
(3) Possess the ability to complete documentation requirements of the program;
(4) Agree to a state criminal background check;
(5) Possess a valid driver's license and proof of automobile liability insurance if transporting the member;
(6) Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
(7) Complete 8 hours of Mental Health Training within six months of hire then annually thereafter in order to possess specialized skills to address the challenging behaviors of members. •Additional training designated by the Behavioral Health and Developmental Disabilities Division for specialty behavioral interventions.

Self-direction:
(1) If a member chooses to self-direct their services as a co-employer, it is through an agency providing personal assistance, behavioral intervention assistance, and life coach type services, ensuring members are successful with the self-direction experience.
(2) The BIA must:
(a) be at least 18 years of age;
(b) receive training, within 30 days of hire in:
(i) abuse reporting; (ii) incident reporting;
(iii) client confidentiality; and
(iv) any specialty training required or needed to sufficiently address the entire needs of the member to provide whole person care;
(c) possess the ability to complete documentation requirements of the program; and
(d) possess a valid driver's license and proof of auto liability insurance if transporting the member.
(3) A BIA must complete 8 hours of mental health training within six months of hire then annually thereafter in order to possess specialized skills to address the challenging behaviors of members.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.
Department of Public Health and Human Services/Quality Assurance Division.
Applicable standards are verified by the service provider agency.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Community Transition Services are non-recurring set up expenses for members who are transitioning from an institutional or other provider-operated living arrangement to a living arrangement in a private residence where the member is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a member to establish a basic household. Allowable Community Transition Services expenses include:
(1) Security deposits are required to obtain a lease on an apartment or home;
(2) Setup fees or deposits to access basic utilities or services (telephone, electricity, heat, and water);
(3) Services necessary for the member's health and safety such as one-time cleaning prior to occupancy;
(4) Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens;
(5) Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence;
(6) Fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state issued ID, Social Security Card, or criminal background check.

To access Community Transition Services, a member must be transitioning from an institutional to a community living arrangement and participate in a needs assessment through which they demonstrate a need for the service based on the following: The member demonstrates a need for the coordination and purchase of one-time, non-recurring expenses necessary for a member to establish a basic household in the community demonstrating health, safety, or institutional risk and other services/resources to meet the need are not available.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Community Transition Services do not include rental or mortgage expenses, ongoing food costs, regular utility charges, or items intended for purely diversional, recreational, or entertainment purposes. Community Transition Services expenses do not include the furnishing of living arrangements owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing. Community Transition Services expenses do not include payment for room and board. Services offered in this waiver are limited based on the member's assessed need for services and are not prior authorized by the state medicaid agency.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Individual

Provider Type:

Dependent Upon Specific Service/Support Required

Provider Qualifications

License *(specify):*

Be licensed within the scope of their business

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.415.

Provider must be properly insured.

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Case Management Provider

Provider Qualifications

License *(specify):*

Registered Nurse or Licensed Practical Nurse Licensed Clinical Social Worker or a Licensed Clinical Professional Counselor.

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.425.

A case management team must consist of:
(1) case manager with a bachelor's level education in the field of human Services; and
(2) a licensed mental health therapist to provide clinical supervision for every two case managers.

The case management agency chosen through the competitive procurement process to provide case management services is responsible to adhere to the guidelines in the Request for Proposals, contract, and program policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consultative Clinical and Therapeutic Services

HCBS Taxonomy:

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

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

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

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

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

Service Definition *(Scope):*

Comprehensive services providing expertise, training, and technical assistance to improve the ability of paid and unpaid caregivers to carry out therapeutic interventions and reduce challenges interfering with a member's daily functioning and quality of life whose complex mental health or behavioral issues would benefit from a more clinical approach and specialized interventions.

Depending on the area of need, consultation activities are provided by professionals in psychiatry, psychology, neuro-psychology, or behavior management specializing in specific intervention modalities.

This service may be delivered in the member's home or in the community as described in the service plan.

Consultative clinical and therapeutic services include:
(a) Training and technical assistance for the member's unpaid caregivers to carry out therapeutic interventions necessary to reduce a specific challenge interfering with a specific member's daily functioning and quality of life; or
(b) Training and technical assistance for the member's paid waiver service caregivers to carry out specialized therapeutic interventions necessary to reduce a specific challenge interfering with a specific member's ability to receive and maintain waiver services.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

This service will not duplicate or replace services available under the state plan or other waiver services. This service is intended to support paid and unpaid caregivers to address a specific member whose complex mental health or behavioral issues exceed the scope of the waiver's Life Coach, Behavioral Intervention Assistant and/or clinical services required per policy for residential habilitation setting.

In addition, this service will not be provided to members 18-21 years of age eligible under EPSDT as the state is required to provide this service to these members through Early and Periodic Screening, Diagnostic and Treatment. Consultative clinical and therapeutic services must meet a documented behavioral need that cannot be addressed through other waiver or state plan services and may only be provided when necessary to support a paid or unpaid caregiver.

This service is limited to a maximum of $2000 per member per annual PCRP time period.

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

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

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Psychiatrist, Psychologist, Neuro-Psychiatrist, Licensed Clinical Professional Counselor, Licensed Clinical Social Worker
Agency	Psychiatrist, Psychologist, Neuro-Psychiatrist, Licensed Clinical Professional Counselor, Licensed Clinical Social Worker

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Psychiatrist, Psychologist, Neuro-Psychiatrist, Licensed Clinical Professional Counselor, Licensed Clinical Social Worker

Provider Qualifications

License *(specify):*

As required by state law by the Board of Medical Examiners, Title 2, Chapter 15, Montana Code Annotated
Psychologist must be licensed with the Montana Board of Psychologist. Title 37, Chapter 17, Montana Code Annotated
Counselors must be licensed through the Montana Board of Behavioral Health. Title 37, Chapter 22 and 23, Montana Code Annotated

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.441.

Direct Care Staff must:
(1) Be at least 18 years of age;
(2) Sign an affidavit regarding confidentiality and HIPAA;
(3) Possess the ability to communicate effectively with the member/personal representative;
(4) Possess the ability to complete documentation requirements of the program;
(5) Demonstrate to the member specific competencies necessary to perform paid tasks;
(6) Complete a self-declaration regarding infections and contagious diseases;
(7) Agree to a state criminal background check;
(8) Possess a valid driver’s license and proof of automobile liability insurance if transporting the member;
(9) Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation;
(10) Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
(11) Complete 8 hours of Mental Health Training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Psychiatrist, Psychologist, Neuro-Psychiatrist, Licensed Clinical Professional Counselor, Licensed Clinical Social Worker

Provider Qualifications

License *(specify):*

As required by state law by the Board of Medical Examiners, Title 2, Chapter 15, Montana Code Annotated
Psychologist must be licensed with the Montana Board of Psychologist. Title 37, Chapter 17, Montana Code Annotated
Counselors must be licensed through the Montana Board of Behavioral Health. Title 37, Chapter 22 and 23, Montana Code Annotated

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.441.

Direct Care Staff must:
(1) Be at least 18 years of age;
(2) Sign an affidavit regarding confidentiality and HIPAA;
(3) Possess the ability to communicate effectively with the member/personal representative;
(4) Possess the ability to complete documentation requirements of the program;
(5) Demonstrate to the member specific competencies necessary to perform paid tasks;
(6) Complete a self-declaration regarding infections and contagious diseases;
(7) Agree to a state criminal background check;
(8) Possess a valid driver’s license and proof of automobile liability insurance if transporting the member;
(9) Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation;
(10) Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
(11) Complete 8 hours of Mental Health Training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Those physical adaptations to the home required for the member's Person-Centered Recovery Plan, which are necessary to enable the member to function with greater independence in the home and without which the member would require institutionalization. This service is available only when a member's needs exceed the limits of the state plan program. Such adaptations may include the installation of ramps and grab-bars, widening doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies and are necessary for the welfare of the member. This excludes those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member, such as carpeting, roof repair, central air conditioning, etc. All services shall be provided in accordance with applicable state and local building codes.

The Hope Waiver supports individual member’s access and integration into their community. Services are delivered to individual members based on their specific needs that reflect individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once . All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Services offered in this waiver are limited based on the member’s assessed need for services and are prior authorized by the state Medicaid agency or it's designee. This is not a stand alone service and are limited to a one-time purchase. The services under the Severe and Disabling Mental Illness, Home and Community-Based Services Waiver are limited to additional services not otherwise covered under the state plan, including Early and Periodic Screening, Diagnostic and Treatment for members who are 18 to 21 years of age, but consistent with waiver objectives of avoiding institutionalization.

Adaptations added to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a

wheelchair.

Environmental accessibility adaptations may not be furnished to adapt living arrangements owned or leased by providers of waiver services.

Environmental Accessibility Adaptations can be authorized up to 180 consecutive days of admission in advance to enrollment to the waiver. Environmental accessibility adaptations begun while the member was institutionalized is not considered complete, and may not be billed until, the date the member is enrolled into the waiver.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Construction Company, Building Contractor
Individual	Construction Company, Building Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Construction Company, Building Contractor

Provider Qualifications

License *(specify):*

An appropriate license through the Montana Department of Labor and Industry.

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.461.
Provider must be properly insured.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Construction Company, Building Contractor

Provider Qualifications

License *(specify):*

An appropriate license through the Montana Department of Labor and Industry.

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.461.
Provider must be properly insured.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Health and Wellness

HCBS Taxonomy:

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

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

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

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

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

Service Definition *(Scope):*

Health and Wellness is available to members focused on maintaining and/or improving social, cognitive, emotional, physical and spiritual functioning. This service provides opportunities for members to integrate into their community with non-disabled peers. Each service must be received in an integrated setting where individuals with and without disabilities engage in health and wellness activities. Health and Wellness activities include opportunities that provide for community integration and the development of meaningful connections as well as social supports. The service intent is to establish an opportunity for members to engage in health and wellness community-integrated activities at a frequency and service delivery type typically experienced by individuals without disabilities.

This services focuses on healthy habits thereby preventing or delaying higher cost institutional care.

The service includes:
(1) Classes on weight loss, smoking cessation, and healthy lifestyles. Classes must not exceed one per day and are limited to no more than 12 classes within a member's PCRP annual period;
(2) Health club/fitness center memberships. Memberships are limited to no more than one monthly membership per member;
(3) Art, music, dance and exercise classes. Classes must not exceed one per day and are limited to no more than 12 classes within a member's PCRP annual period;
(4) Costs associated with participating in adaptive sports/recreational activities such as rental costs of adaptive equipment needed to participate in adaptive sports. This cost does not include the fee for the recreational activity, such as ski-lift tickets, horse rentals, swimming pool entrance fees or lessons and professional guide fees. This service is limited to no more than 12 rental costs for one adaptive sport within a member's PCRP annual period;
(5) Classes on managing disabilities such as Living Well with a Disability. Classes must not exceed one per day and are limited to no more than 12 classes within a member's PCRP annual period; and
(6) Hippotherapy a physical therapy treatment strategy that uses equine movement as part of an integrated intervention program to achieve functional outcomes. Classes must not exceed one per day and are limited to no more than 12 sessions within a member's PCRP annual period.

The service must be documented in the person-centered recovery plan (PCRP), be related directly to the member's disability, and the member must be referred by an appropriately licensed professional. The service must be delivered in the community and outlined in the PCRP. The goals, activities, and outcomes of the Health and Wellness service must be documented in the PCRP and monitored, reviewed, and updated quarterly.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to be delivered solely to one or more waiver members and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Services offered in this waiver are limited based on the member's assessed need for services and not prior authorized by the state Medicaid agency.

Services must be cost-effective. This is determined by comparing the options available to the member and choosing the one

that provides the most benefit for the least cost.

Services provided must be tied to goals in the person-centered recovery plan and necessary to prevent institutionalization.

Services provided under Health and Wellness cannot duplicate other services provided within the waiver.

This service must be used to pay for the member to participate in the Health and Wellness categories outlined in this section and must not be used to provide supplemental support services for members such as:

A. Assisting the member in identifying, developing or providing leisure activity education and/or planning services; or
B. Assisting the member to schedule leisure activity education and/or planning; or
C. Accompanying the member to the Health and Wellness activity; or
D. Assisting the member to build independence, coping, social and/or relationship skills.

This service must not be used to engage members in activities created with a focus on and/or limit the member's engagement to individuals with disabilities.

Each referring provider is required to carry an active license or certificate of designation in their specialty and scope of practice as required by state law, administrative rules, and appropriate requirements pertaining to the provider's licensure. The referral may be through a OT, PT, MD, LCSW, LCPC, PSYCH, RN, APRN, PA, or a NP. A licensed professional is reimbursed for this service by billing the appropriate CPT code. The claim is submitted through the MMIS system and is funded through state plan.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Living Centers
Individual	Providers Approved by the Department Dependent Upon Specific Service/Support Required

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:

Agency

Provider Type:

Independent Living Centers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.417.

Direct Care Staff must have:
(1) Be at least 18 years of age;
(2) Within 30 days of hire receive training in:
* abuse reporting,
* incident reporting,
* client confidentiality, and
* any specialty training relating to the need of the member served, as outlined in the plan of care.
(3) Possess the ability to complete documentation requirements of the program;
(4) Agree to a state criminal background check;
(5) Possess a valid driver's license and proof of automobile liability insurance if transporting the member;
(6) Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
(7) Complete 8 hours of Mental Health Training annually.

Montana Centers for Independent Living are non-residential, consumer-controlled, community-based, private, non-profit organizations providing individual and systems advocacy services by and for persons with all types of disabilities. The independent living program provides persons with disabilities the services needed to achieve their desired way of life. These services include the four core IL services: information and referrals to appropriate organizations, independent living (IL) skills training, individual and systems change advocacy, and peer mentoring. Other services provided include benefits counseling and planning, housing information, help with accessibility issues and personal care assistance. Full inclusion and integration of individuals with disabilities into the mainstream of American society is primary. This philosophy is implemented through the Montana Independent Living Council and the network of Montana Centers for Independent Living.

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:

Individual

Provider Type:

Providers Approved by the Department Dependent Upon Specific Service/Support Required

Provider Qualifications

License *(specify):*

Be licensed within the scope of their business.

Psychologist must be licensed with the Montana Board of Psychologist. Title 37, Chapter 17, Montana Code Annotated
Counselors must be licensed through the Montana Board of Behavioral Health. Title 37, Chapter 22 and 23, Montana Code Annotated
Occupational Therapist must be licensed with the Montana Board of Occupational Therapist. Title 37, Chapter 24, Montana Code Annotated

Physical Therapist must be licensed through the Montana Board of Physical Therapy. Title 37, Chapter 11, Montana Code Annotated
Or Credentialed through The American Hippotherapy Certification Board (AHCB)

Certificate *(specify):*

Dependent upon specific provider
o Health lifestyle providers include private providers, local medical facilities.
o Hippotherapy – horse therapy business or individual providers.
o Art therapy – eligible art instructors, or therapists.
o Health Club Memberships – locally owned clubs, YMCAs or medical centers with associated health facilities.

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.417.
Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402.

Verification of Provider Qualifications

Entity Responsible for Verification:

Program Officers with the Department of Public Health and Human Services

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Homemaker Chore

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Homemaker Chore services are provided to members unable to manage their own homes.

Homemaker Chore activities include extensive cleaning beyond the scope of general household cleaning under any other state plan service. Services are needed to maintain the home in a sanitary and safe environment. This service includes heavy household chores such as deep cleaning floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

These services are provided only when neither the member nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service. Homemaker Chore services are not allowed for a resident in an adult residential setting with the exception of moving expenses.Services offered in this waiver are limited based on the member's assessed need for services and are prior authorized by the state medicaid agency or their designee.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homemaker/Janitorial entity
Individual	Providers Approved by the Department Dependent Upon Specific Service/Support Required

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Homemaker Chore

Provider Category:

Agency

Provider Type:

Homemaker/Janitorial entity

Provider Qualifications

License *(specify):*

Workers are employees of a business entity licensed and insured to deliver professional services.

Certificate *(specify):*

Other Standard *(specify):*

Agency requirements as listed in ARM 37.90.437.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Homemaker Chore

Provider Category:

Individual

Provider Type:

Providers Approved by the Department Dependent Upon Specific Service/Support Required

Provider Qualifications

License *(specify):*

A business entity, licensed and insured to deliver personal care services.

Certificate *(specify):*

Other Standard *(specify):*

Agency requirements as listed in ARM 37.90.437.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Life Coach

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Life Coach is a holistic approach to addressing the social determinants of health impacting a member's overall health and well-being and addresses the obstacles impeding a member's progress towards self-sufficiency, improved health, and well-being. Life Coaches aim to motivate, offer emotional support, create confidence in their clients, and to be an accountability partner and a guide offering feedback, new ideas, and emotional support as the member works towards recovery.

This is accomplished through evaluating, educating, guiding, inspiring, and supporting the member in developing independent living skills. Social determinants of health addressed with a Life Coach include:
Economic Stability:
(1) Access to financial literacy to assist the member in building money management and budgeting skills;
(2) Access to long term employment, adult education, and job training (this may include connecting the member to the supported employment service if it identified in the Person-Centered Recovery Plan); and
(3) Navigation of public services.

Housing and Neighbors:
Access to safe affordable housing and improved environmental conditions.

Education:
Access to extracurricular activities and mentoring, enrollment in job training.

Social Relationships:
Social cohesion, civic participation, perception of discrimination and equity.

Food and Nutrition:

Regular and consistent access to healthy foods, education on nutrition and overall health impacts.

Life Coaches may be provided by: (a) independent living centers; (b) personal care entities; or (c) other entities approved by the department. (2) All Life Coaches must be approved by the department. (3) Life Coaches must have at least 8 hours of specialized behavioral health training annually, approved by the department.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Services offered in this waiver are limited based on the member's assessed need for services and are not prior authorized by the state Medicaid agency.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Living Centers/Personal Care Entities
Individual	Other Entities Approved by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Coach

Provider Category:

Agency

Provider Type:

Independent Living Centers/Personal Care Entities

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements:

Providers of fiscal services must be employees of a business entity, licensed, insured to deliver professional services. Direct Care Staff must:

(1) Be at least 18 years of age;
(2) Sign an affidavit regarding confidentiality and HIPAA;
(3) Possess the ability to communicate effectively with the member/personal representative;
(4) Possess the ability to complete documentation requirements of the program;
(5) Demonstrate to the member specific competencies necessary to perform paid tasks;
(6) Complete a self-declaration regarding infections and contagious diseases;
(7) Agree to a state criminal background check;
(8) Possess a valid driver's license and proof of automobile liability insurance if transporting the member;
(9) Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation;
(10) Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
(11) Complete 8 hours of Mental Health Training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Coach

Provider Category:

Individual

Provider Type:

Other Entities Approved by the Department

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements:

Providers of fiscal services must be a business entity, licensed, and insured to deliver professional services.

Direct Care Staff must:
(1) Be at least 18 years of age;
(2) Sign an affidavit regarding confidentiality and HIPAA;
(3) Possess the ability to communicate effectively with the member/personal representative;
(4) Possess the ability to complete documentation requirements of the program;
(5) Demonstrate to the member specific competencies necessary to perform paid tasks;
(6) Complete a self-declaration regarding infections and contagious diseases;
(7) Agree to a state criminal background check;
(8) Possess a valid driver's license and proof of automobile liability insurance if transporting the member;
(9) Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation;
(10) Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and

(11) Complete 8 hours of Mental Health Training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

This service provides hot or other appropriate meals once or twice a day, up to seven days a week. A full nutritional regimen (three meals per day) will not be provided, in keeping with the exclusion of room and board as covered services. Members must need special assistance to ensure adequate nutrition due to:
(a) special nutritional needs; or

(b) the member's inability to gain access to proper nutrition due to a disability.

Some individuals need special assistance with their diets and the special meals service can help ensure these individuals would receive adequate nourishment. This service will only be provided to individuals who are not eligible for meal services under any other source or need different or more extensive services than are otherwise available. This service must be cost effective and necessary to prevent institutionalization.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Services offered in this waiver are limited based on the member's assessed need for services and are not prior authorized by the state Medicaid agency.

Meal services will not be furnished to members receiving Residential Habilitation or during the time period they are in an Adult Day Health setting.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Meal Preparation
Agency	Non-profit Entity, Public Entity, Meal Preparation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Meals

Provider Category:

Individual

Provider Type:

Meal Preparation

Provider Qualifications

License *(specify):*

Depending on type of service, must be licensed/certified as required by Montana state law.

Certificate *(specify):*

Other Standard *(specify):*

Agency requirements as listed in ARM 37.40.1476.
Provider requirements as listed in ARM 37.90.446.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Meals

Provider Category:

Agency

Provider Type:

Non-profit Entity, Public Entity, Meal Preparation

Provider Qualifications

License *(specify):*

Retirement Homes must comply with the licensing requirements located in Administrative Rules of Montana, Title 37, Chapter 106, subchapter 25.

Certificate *(specify):*

Other Standard *(specify):*

Agency requirements as listed in ARM 37.40.1476.
Provider requirements as listed in ARM 37.90.446.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Non-medical transportation means travel furnished by common carrier or private vehicle for non-medical reasons as defined in the member's Person-Centered Recovery Plan. Medical transportation is available under the State Plan Medicaid Program. Transportation Services must meet the following criteria:
(1) Be provided only after volunteer, State Plan Medicaid, or other publicly funded transportation programs have been exhausted or determined to be inappropriate; and
(2) Be provided in the most cost effective mode.

Transportation provider must provide proof of:
(1) A valid Montana drivers license;
(2) Adequate automobile insurance; and
(3) Assurance the vehicle is in compliance with all applicable federal, state, and local laws and regulations.

The Hope Waiver supports individual member’s access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once . All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Services offered in this waiver are limited based on the member’s assessed need for services and are not prior authorized by the state Medicaid agency. This service may only be reimbursed with services not including transportation as an integral part of their rate.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

- ☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Cabs/ Other Entities Approved by the Department
Agency	Accessible Transportation Providers/ Personal Care Entities

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Cabs/ Other Entities Approved by the Department

Provider Qualifications

License *(specify):*

Must meet all pertinent state laws and regulations.

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.450.

Non-medical transportation providers must provide proof of:
(1) Valid Montana driver's license;
(2) Adequate automobile insurance; and
(3) Assurance the vehicle is in compliance with all applicable federal, state, and local laws and regulations.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Accessible Transportation Providers/ Personal Care Entities

Provider Qualifications

License *(specify):*

Must meet all pertinent state laws and regulations.

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.450.

Non-medical transportation providers must provide proof of:
• A valid Montana driver's license;
• Adequate automobile insurance; and
• Assurance the vehicle is in compliance with all applicable federal, state, and local laws and regulations.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Pain and Symptom Management

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

This service allows for the provision of traditional and non-traditional methods of pain management. All treatments require written documentation by a health care professional indicating that the treatment will not harm the member prior to initial authorization and must meet evidence-based criteria as determined by the National Institute of Health (NIH).

This service is limited to:

(1) Acupuncture. Acupuncture is a technique in which practitioners insert fine needles into the skin to treat health problems. The needles may be manipulated manually or stimulated with small electrical currents (electroacupuncture);

(2) Reflexology. Reflexology is a practice in which different amounts of pressure are applied to specific points on the feet or hands. These points are believed to match up with certain other parts of the body;

(3) Massage therapy. Massage therapists use their fingers, hands, forearms and elbows to manipulate the muscles and other soft tissues of the body. Variations in focus and technique lead to different types of massage, including Swedish, deep tissue and sports massage. Massage therapy can also include Reiki: Reiki is a complementary health approach in which practitioners place their hands lightly on or just above a person, with the goal of directing energy to help facilitate the person’s own healing response;

(4) Craniosacral therapy. Craniosacral therapy (CST) is defined as an intervention based on a gentle touch that allegedly releases restrictions in any tissues influencing the craniosacral system;

(5) Mind-body therapies to include hypnosis and biofeedback. Hypnosis is the induction of a deeply relaxed state, with increased suggestibility and suspension of critical faculties; Biofeedback is a technique used to improve the ability to modify involuntary processes consciously;

(6) Pain mitigation counseling/coaching (PMCC). Pain mitigation counseling/coaching is used to address a member's needs for long-term pain relief. PMCC results in finalizing a plan with the member to:
a. Identify the member's obstacles to receiving long-term pain relief;
b. Educate and support the member in establishing a strategy to address those obstacles; and
c. Provide the member with a list of community resources available to assist the member to work through the process independently.
PMCC must not duplicate the services available through State Plan services.

(7) Chiropractic therapy. Chiropractic is a licensed health care profession that emphasizes the body’s ability to heal itself. Treatment typically involves manual therapy, often including spinal manipulation. Other forms of treatment, such as exercise and nutritional counseling, may be used as well.

The Hope Waiver supports individual member’s access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Services offered in this waiver are limited based on the member’s assessed need for services and are not prior authorized by the state Medicaid agency. The services are limited to additional services not otherwise covered under the Medicaid state plan. The service must be documented stating it's directly related to a member's disability, necessary to avoid institutionalization and address functional impairments or other member needs, if left unaddressed, would prevent the member from engaging in everyday community activities. Services must be prescribed by a licensed health care professional. The Person-Centered Recovery Plan must include the need for the service, the anticipated number of sessions, and expected outcomes.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Hospitals

Provider Qualifications

License *(specify):*

Hospitals must be licensed according to Administrative Rules of Montana, Title 37, Chapter 106, subchapter 4.

Certificate *(specify):*

Other Standard *(specify):*

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402.

Each provider of service in the area of Pain and Symptom Management is required to carry an active license or certificate of designation in their specialty and scope of practice as required by state law, administrative rules, and appropriate requirements pertaining to the provider's licensure. Acquiring licensure and certification includes completion of minimum hours of training initially dependent on specialty, and continuing education annually to ensure providers effectively perform their role for each chosen specialty, this includes education in ethics and professional boundaries. Licensing board verification includes the Montana Board of Behavioral Health, Montana Board of Chiropractors, Montana Board of Medical Examiners, Montana Board of Nursing, and Montana Board of Psychologist.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Psychologist, Counselor, Hypnotist, Massage Therapists, Chiropractors, Acupuncturists, Specialized RN

Provider Qualifications

License *(specify):*

Psychologist must be licensed with the Montana Board of Psychologist. Title 37, Chapter 17, Montana Code Annotated

Counselors must be licensed through the Montana Board of Behavioral Health. Title 37, Chapter 22 and 23, Montana Code Annotated

Hypnotist must be license through the Montana Board of Behavioral Health.

Massage Therapists must be licensed through the Montana Board of Massage Therapy. Title 37, Chapter 33, Montana Code Annotated

Chiropractors must be licensed by the Montana Board of Chiropractors. Title 37, Chapter 12, Montana Code Annotated

Acupuncture must be licensed with the Board of Medical Examiners. Title 37, Chapter 13, Montana Code Annotated

Specialized Advance Practice Registered Nurse (APRN) must hold an active MT RN license or RN license with a multistate designation from a compact state and must provide a transcript of a graduate level degree. Title 37, Chapter 8, Montana Code Annotated

Certificate *(specify):*

Other Standard *(specify):*

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402.

Each provider of service in the area of Pain and Symptom Management is required to carry an active license or certificate of designation in their specialty and scope of practice as required by state law, administrative rules, and appropriate requirements pertaining to the provider’s licensure. Acquiring licensure and certification includes completion of minimum hours of training initially dependent on specialty, and continuing education annually to ensure providers effectively perform their role for each chosen specialty, this includes education in ethics and professional boundaries. Licensing board verification includes the Montana Board of Behavioral Health, Montana Board of Chiropractors, Montana Board of Medical Examiners, Montana Board of Nursing, and Montana Board of Psychologist.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Pain and Symptom Management

Provider Category:

Agency

Provider Type:

Psychologist, Counselor, Hypnotist Massage Therapists, Chiropractors, Acupuncturists, Specialized RN

Provider Qualifications

License *(specify):*

Psychologist must be licensed with the Montana Board of Psychologist. Title 37, Chapter 17, Montana Code Annotated

Counselors must be licensed through the Montana Board of Behavioral Health. Title 37, Chapter 22 and 23, Montana Code Annotated

Hypnotist must be license through the Montana Board of Behavioral Health.

Massage Therapists must be licensed through the Montana Board of Massage Therapy. Title 37, Chapter 33, Montana Code Annotated

Chiropractors must be licensed by the Montana Board of Chiropractors. Title 37, Chapter 12, Montana Code Annotated

Acupuncture must be licensed with the Board of Medical Examiners. Title 37, Chapter 13, Montana Code Annotated

Specialized Advance Practice Registered Nurse (APRN) must hold an active MT RN license or RN license with a multistate designation from a compact state and must provide a transcript of a graduate level degree. Title 37, Chapter 8, Montana Code Annotated

Certificate *(specify):*

Other Standard *(specify):*

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402.

Each provider of service in the area of Pain and Symptom Management is required to carry an active license or certificate of designation in their specialty and scope of practice as required by state law, administrative rules, and appropriate requirements pertaining to the provider’s licensure. Acquiring licensure and certification includes completion of minimum hours of training initially dependent on specialty, and continuing education annually to ensure providers effectively perform their role for each chosen specialty, this includes education in ethics and professional boundaries. Licensing board verification includes the Montana Board of Behavioral Health, Montana Board of Chiropractors, Montana Board of Medical Examiners, Montana Board of Nursing, and Montana Board of Psychologist.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Assistance Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Services are provided if/when the scope, amount, or duration of the available Medicaid State Plan, Community First Choice/Personal Assistance Services (CFC/PAS), is insufficient in meeting the needs of the member. Service must document the need:
(1) Of more than 42 hours of ADL/IADL assistance provided in the Medicaid State Plan Personal Care (CFC/PAS); and/or
(2) For assistance outside of the member's home.

Personal assistance services may include supervision for health and safety reasons, socialization not requiring behavioral supports, and escort and transportation for non-medical reasons. Socialization is available to those members who require personal assistance to physically access the community, rather than just assistance with access to social restorative/behavioral needs. Tasks involve direct hands-on supervision and assistance, from cueing and prompting, to total assistance, as well as functional assistance with the navigation of public services and support to enhance independence with community activities. All personal assistance service attendants are supervised by registered nurses.

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Services offered in this waiver are limited based on the member's assessed need for services and are not prior authorized by the state Medicaid agency. Personal Assistance services are not allowed for a resident residing in an adult residential setting. Services under this definition may not duplicate non-medical transportation services.

Retainer days may not be used for any other Home and Community Based Services when they are utilized for personal care

services. If a provider rate includes vacancy savings, retainer days are a duplication of services and may not be paid in addition. Retainer days are limited to 30 days per year. Retainer payments are provided for personal assistance services when the person is hospitalized or visiting with family. Without these retainer days an individual loses their scheduled time slot.

The state does not authorize “bed-hold” days in nursing facilities. However, if an individual is hospitalized the “bed hold” days are authorized for personal assistance services. The total number of days allowed are 30 days for retainer payments in a personal care plan year.

Members may use any combination of agency-based and self-directed. Members choosing self-direction must be capable/willing to manage all tasks related to service delivery. This includes the ability to manage recruitment, hiring, scheduling, training, directing, and dismissal of worker(s).
It is the responsibility of the provider agency to ensure assistants are appropriately trained under agency-based services.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Provider/Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Assistance Service

Provider Category:

Agency

Provider Type:

Personal Care Provider/Home Health Agency

Provider Qualifications

License *(specify):*

Licensed as a Home Health Agency, Title 37, Chapter 106, Subchapter 3; Title 50, Chapter 5 Montana Code Annotated

Certificate *(specify):*

Medicare Certified.

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.431.

Direct Care Staff:
(1) Be at least 18 years of age;
(2) Within 30 days of hire receive training in:
* abuse reporting,
* incident reporting,

* client confidentiality, and
* any specialty training relating to the need of the member served, as outlined in the plan of care.
(3) Possess the ability to complete documentation requirements of the program;
(4) Agree to a state criminal background check;
(5) Possess a valid driver's license and proof of automobile liability insurance if transporting the member;
(6) Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
(7) Complete 8 hours of Mental Health Training annually.

Providers must be enrolled as a Medicaid provider and have a provider agreement according to 37.85.402

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.
Department of Public Health and Human Services/Quality Assurance Division.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

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

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

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

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

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

Service Definition *(Scope):*

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

The Hope Waiver supports individual member's access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Services offered in this waiver are limited based on the member's assessed need for services and are not prior authorized by the state medicaid agency. The provision of a personal emergency response system as a service does not include the purchase, installation, or routine monthly charges of a telephone (ARM 37.90.448)

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Alert Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Personal Alert Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.448.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/ Fiscal Intermediary Contractor.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Duty Nursing

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

The RN or LPN must be from a home health agency or an independent agency.
A Registered Nurse is required to have supervision of the provider agency or a physician.

Legal guardians are employed by an agency or provided under self-direction with oversite of an agency. The agency, case management team, and member are responsible to ensure member’s best interests are served. Determinations are made on a case by case basis and case management teams are required to document the basis for the decision regarding the best interest of the member.

A relative or legal guardian may not provide more than 40 hours of paid time in a seven-day period.

The Hope Waiver supports individual member’s access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once and/or in a non-integrated setting. Services provided in a non-integrated setting can be seen as isolating individuals with disabilities from the broader community and does not promote integration into typical community settings. All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Services offered in this waiver are limited based on the member’s assessed need for services and are not prior authorized by the state medicaid agency. This service will not duplicate or replace services available under the Medicaid state plan. A member's legally responsible person, relative, or legal guardian may provide private duty nursing if they are licensed in accordance with state regulation and are enrolled as a Montana Medicaid Provider. A relative or legal guardian may not provide more than 40 hours of paid time in a seven-day period

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Home Health Entity
Agency	Home Health Entity

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Individual

Provider Type:

Home Health Entity

Provider Qualifications

License *(specify):*

Licensed Registered Nurse or Licensed Practical Nurse according to Administrative Rules of Montana, Title 8, Chapter 32, subchapter 4.

Certificate *(specify):*

Other Standard *(specify):*

Meets the state's definition as an independent contractor.

Provider requirements as listed in ARM 37.90.447.

Direct Care Staff must:
•Be at least 18 years of age;
•Sign an affidavit regarding confidentiality and HIPAA;
•Possess the ability to communicate effectively with the member/personal representative;
•Possess the ability to complete documentation requirements of the program;
•Demonstrate to the member specific competencies necessary to perform paid tasks;
•Complete a self-declaration regarding infections and contagious diseases;
•Agree to a state criminal background check;
•Possess a valid driver’s license and proof of automobile liability insurance if transporting the member;
•Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and
•Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
•Complete 8 hours of Mental Health Training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Home Health Entity

Provider Qualifications

License *(specify):*

Licensed Registered Nurse or Licensed Practical Nurse according to Administrative Rules of Montana, Title 8, Chapter 32,

subchapter 4.

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.447.

Direct Care Staff must:
•Be at least 18 years of age;
•Sign an affidavit regarding confidentiality and HIPAA;
•Possess the ability to communicate effectively with the member/personal representative;
•Possess the ability to complete documentation requirements of the program;
•Demonstrate to the member specific competencies necessary to perform paid tasks;
•Complete a self-declaration regarding infections and contagious diseases;
•Agree to a state criminal background check;
•Possess a valid driver's license and proof of automobile liability insurance if transporting the member;
•Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and
•Advocate for the member to assure the member's rights are protected, and the member's needs and preferences are honored; and
•Complete 8 hours of Mental Health Training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

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

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

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

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

Service Definition *(Scope):*

Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place, as defined at § 440.70(c)(1). Specialized Medical Equipment and Supplies include devices, controls, or appliances, specified in the Person-Centered Recovery Plan, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.
Specialized Medical Equipment and Supplies include:
(1) The provision of service animals;
(2) Items necessary for life support;
(3) Ancillary supplies and equipment necessary to the proper functioning of such items; and
(4) Durable and non-durable medical equipment not available under Medicaid State plan.

Items excluded are those items not of direct medical or remedial benefit to the member. All items shall meet applicable standards of manufacture, design, and installation. All specialized medical equipment and supplied must have a denial from Medicare (if applicable) and Medicaid prior to waiver service being provided.
Specialized Medical Equipment and Supplies include selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing the equipment. This service also includes training or technical assistance for the member or, where appropriate, the family members, guardians, advocates, or authorized representatives of the member.

Medical equipment requiring retrofitting and is essential to a member transitioning from an institutional to a community living arrangement may be purchased and installed prior to admission to the waiver.
The need for medical equipment and supplies must be documented in the member's Person-Centered Recovery Plan and be directly related to the member’s disability and impairment.

Medical equipment and supplies service is necessary to avoid institutionalization and address functional impairments or other participant needs, if left unaddressed, would prevent the person from engaging in everyday community activities. Based upon the member’s physician recommendation, corresponding diagnosis, and prescribed treatment, some over the counter medications and complementary alternative medications may be provided.

The Hope Waiver supports individual member’s access and integration into their community. Services are delivered to individual members based on their specific needs reflecting their individual preferences and goals. Therefore, services must not be delivered in a coordinated manner to multiple individuals at once . All Hope Waiver services are tailored and delivered based on individual versus group needs.

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

Services offered in this waiver are limited based on the member’s assessed need for services and are prior authorized by the state Medicaid agency or their designee. Specialized Medical Equipment and Supplies will be limited to a one-time purchase with the exception of supplies not covered by Medicaid State plan services. The Behavioral Health and Developmental Disabilities Division, at its discretion, may authorize an exception to this.
Specialized Medical Equipment and Supplies will not pay for vehicles, vehicle licenses, or insurance.
This service will not duplicate or replace services available under the state plan. In addition, this service will not be provided to members 18-21 years of age eligible under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as the state is required to provide this service to these members through EPSDT.
Members are required to have a face-to-face visit with a physician or authorized non-physician practitioner for the initial prescription of home health services and certain DME.
FFP cannot be claimed until the member is on the waiver.

OTC's not covered under state plan including those coverable under state plan but available in an insufficient quantity to meet the needs of the member are a covered service. A prescription is required from a physician, nurse practitioner or the appropriated licensed provider for all OTC.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Providers/Retailers

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Providers/Retailers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider requirements as listed in ARM 37.90.449.

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

Retail providers such as a pharmacy will be providing OTC medications, OTCs would not be provided by a SME provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary.

Frequency of Verification:

Upon enrollment and annually thereafter.

Appendix C: Participant Services

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

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

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

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Contracted Case Management Agency through the 1915(b)(4) waiver.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

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

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

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

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

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

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

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

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

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

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

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

For the purpose of this section, a legally responsible individual shall be defined as a spouse, or a court appointed guardian of an adult waiver member.

Extraordinary care is defined as care exceeding the range of activities a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the member and avoid institutionalization.

The following personal care services may be provided by a legally responsible individual:
(a) private duty nursing
(b) personal assistance
(c) respite
(d) behavioral intervention assistant

To ensure the provision of services by a legally responsible individual is in the best interest of the participant the following must be met:
(1) The member must be offered a choice of providers. If the member or his/her authorized representative chooses a legally responsible individual as a care provider, it must be documented in the Person-Centered Recovery Plan;
(2) The CMT must document the basis for the decision regarding the best interest of the member;
(3) Legally responsible individuals who exercise decision making authority are employed by an agency or provided under self-direction with oversite of an agency. The agency, case management team, and member are responsible to ensure member's best interests are served. Determinations are made on a case-by-case basis;
(4) At the required quarterly face to face reviews, the CMT's discuss the provision of services with the member to ensure it is being provided and the member is satisfied with the quality. This also allows the case management team the opportunity to review in person for delivery of services; and
(5) The case management team checks in with the legally Responsible Individual to see if there are concerns regarding the risk factors. A back-up plan is part of the Person-Centered Recovery Plan providing relief to the caregiver in the event they are at risk.

For authorization of the provision of the personal care service(s) provided by a legally responsible individual it must meet all service criteria identified in C-3 include the following circumstances:
(1) The case management team (CMT) must assess the member’s need for extraordinary care using the following criteria:
(a) it must meet the definition of extraordinary; the activity is one exceeding the range of activities a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the member and avoid institutionalization
AND the member meets either (b) or (c) as listed below:
(b) the member scores as severely or gravely impaired on the Behavioral Health and Developmental Disabilities (BHDD) Hope Waiver Evaluation and Level of Impairment (LOI) Form in Areas One, Two, or Seven;
(c) the member scores a 4 (total dependence) in the Activities of Daily Living/Instrumental Activities of Daily Living section on the Level of Care form; and
(2) The legally responsible individual must meet all provider qualifications and training standards specified in the waiver for that service; and
(3) The CMT must provide objective, written documentation presented at the time of the service authorization there are no other viable service/provider alternatives.

In addition to case management, monitoring and reporting activities required for all waiver services, the following additional requirements are employed when a legally responsible individual is paid to provide personal care service(s) to a member. For services allowing a legally responsible individual to be paid for the provision of services, all of the following must be met to ensure payments are paid only for services rendered:
(1) The legally responsible individual must be enrolled with a provider agency to receive payment;
(2) The provider agency for both agency based and self-directed services are required to collect timesheets from the legally responsible individual and submit the timesheets to the CMT's to review for services authorized/services provided;
(3) Quarterly reviews of expenditures, and health, safety and welfare status of the member are discussed with the member at the quarterly face to face review;
(4) Monthly reviews by the provider agency of hours billed for legally responsible individual provided care;

(5) A legally responsible individual who is also a member's authorized representative may not be paid to provide services;
(6) A member's spouse employed by a personal care agency, must meet all the criteria in this section to be reimbursed to provide personal care to his/her spouse;
(7) A member's legally responsible individual may not provide more than 40 hours of paid time for waiver authorized services in a seven-day period;
(8) Must be a service/support specified in the member's Person-Centered Recovery Plan;
(9) Must be paid at a rate not exceeding what is allowed by the department for the specific waiver service;
(10) The legally responsible individual must utilize Electronic Visit Verification (EVV) as required for verification of payment for all personal care service providers.

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

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

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

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

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

For the purpose of this section a relative shall be defined as all persons related to the member by virtue of blood, marriage, adoption or Montana common law to include:
(a) Parent
(b) Child
(c) Sibling
(d) Niece or nephew.
(e) Grandparent.
(f) Aunt or uncle.

Payments to relatives can be made for the following services:
(a) private duty nursing
(b) personal assistance services
(c) non-medical transportation
(d) behavioral intervention assistant
(e) life coach
(f) respite

Payments to legal guardians can be made for the following non-personal care services:
(a) non-medical transportation
(b) life coach

The relative or legal guardian who is a service provider for the services listed above, must comply with the following to ensure payments are made only for services rendered:
(1) Relatives or legal guardian to whom payment is made must be employed by an agency and be held to the same standards of an agency-based service;
(2) The relative or legal guardian must have the skills, abilities, and meet the provider qualifications to provide the service;
(3) Only services approved in the Person-Centered Recovery Plan are reimbursable;
(4) The provider agency for both agency based and self-directed services are required to collect timesheets from the legal guardian and submit the timesheets to the CMT's to review for services authorized/services provided. In addition, at the quarterly face to face meetings, the CMT's discuss the provision of services with the member to ensure it is being provided and the member is satisfied with the quality. This also allows the case management team the opportunity to review in person for delivery of services;
(5) Service delivery must be cost effective;
(6) A relative or legal guardian of the member may provide up to 40 hours of waiver authorized services in a seven-day period as outlined in the member's Person-Centered Recovery Plan; and
(7) The relative or legal guardian must utilize Electronic Visit Verification (EVV) as required for verification of payment for all agency-based and self-direct personal care service providers to include the following: private duty nursing, personal assistance service, behavioral intervention assistant, and respite.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

All potential Hope Waiver providers may become Medicaid providers as long as they meet the provider qualifications. Providers meeting all the provider requirements are encouraged to enroll as Medicaid providers. All requests for enrollment in the Medicaid Program must be made through the state's Fiscal Intermediary Contractor. The Contractor will provide interested providers with enrollment information. There is a continuous, open enrollment of waiver service providers. Additionally, the state has established an on-line process for potential providers to access information electronically. The on-line process allows potential providers to access the provider application as well as applicable provider manuals for specific services at any time. The web sites for this electronic process are:
https://medicaidprovider.mt.gov/providerenrollment
https://mtaccesstohealth.portal.conduent.com/mt/general/providerEnrollmentHome.do

The enrollment application must be completed in its entirety before the Contractor is able to process the enrollment application. This is the same process for enrollment of any Montana Medicaid provider. As specified in the contract between the Department and the Contractor, Contractor will forward all completed enrollment applications to the BHDD, Department of Public Health and Human Services, for approval, procedure codes and rates. BHDD will act upon the completed enrollment application within five working days of receipt and return it to the Fiscal Intermediary for action.

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

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

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- (●) **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ( ) **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - [ ] **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - [ ] **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - [ ] **The HCBS must be identified in the individual's person-centered service plan; and**
  - [ ] **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: **(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and Percent of licensed/certified enrolled providers continuing to meet licensure/certification standards. Numerator: Number of licensed and/or certified providers continuing to meet licensure/certification standards. Denominator: Total number of providers required to meet licensure/certification standards.

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

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

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of newly enrolled providers that meet licensure/certification standards prior to providing services. Numerator: Number of newly enrolled providers that met licensure/certification standards prior to providing services. Denominator: Total number of newly enrolled providers required meet licensure/certification standards prior to providing services.

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

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted provider	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of non-licensed/non-certified providers that meet waiver provider requirements. Numerator: Number of non-licensed/non-certified providers that meet waiver provider requirements. Denominator: Total number of non-licensed/non-certified waiver providers

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

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

Specify: State's Fiscal Intermediary Contractor		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to

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

Performance Measure:
Number and percent of held trainings from Hope Waiver program staff and/or case management teams about program goals, policies, and the approved waiver.
Numerator: Number of held trainings from Hope Waiver program staff and/or case management teams about program goals, policies, and the approved waiver.
Denominator: Total number trainings by Hope Waiver program staff and/or case management teams

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers that received trainings by Hope Waiver program.
Numerator: Number of providers that received trainings by Hope Waiver program.
Denominator: Total number of waiver providers required to received training.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
The denominator is the total number of existing waiver providers (by type) who continue to meet training requirements during the certification peroid.

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Program Officers ensure agencies are informed of relevant changes in state and federal policy and procedures and to assist in the training of new agency oversight staff around program policy and procedures (at agency request). Program Officers provide a provider training report to the Program Manager capturing training dates, attendees, and the materials provided. The Program Manager use the Program Officer training report to assure appropriate training is provided to participating providers.

In addition, the case management team is contractually responsible for educating participating providers about the goals of the program as well as all program policies and rules governing the program. The case management team serves as a liaison between the providers and members if necessary.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Providers not having the required qualifications, license, or certifications for the specific Hope Wavier service cannot be enrolled as a waiver provider for that service. If a provider's license/certification has been revoked, the agency/individual will no longer be allowed to provide the service. Repayment procedures will be initiated for payment for services provided after the license/certification expiration date. Members will be given a new choice of providers if available and assisted in the transition process.

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

The Department does not do criminal background checks; however, Fiscal Intermediary checks with licensing entities within the Department of Labor and Industries, the Excluded Individual and Entities List, and Medicare exclusion lists prior to enrolling the provider. The hard copy of the Licensee Lookup System indicates any adverse action or information regarding the enrolled provider and may prevent that individual or agency from being enrolled as an Hope Waiver provider. When a provider license is renewed the Fiscal Intermediary will once again check the Excluded Individual and Entities List, Medicare Exclusion list and the Licensee Lookup System prior to re-enrollment of provider. All contracts issued by the Department go through a review process to ensure the potential contractor is not on the Federal Debarment List.

When deficiencies are noted, a letter is sent to the provider requesting a plan of correction. The plan of correction is due 30 days from receipt of letter. The Program Manager review and either approve or determine the plan of correction is not acceptable. If the plan of correction is unacceptable the provider must respond within 2 weeks with additional requested compliance. If the response is still unacceptable the Behavioral Health and Developmental Disabilities Division (BHDD) will suspend the provider from receiving new referrals or cease all program operations. The provider will no longer provide services until the matter has been resolved. The BHDD can remove a provider when the provider continuously does not meet the standards.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- (●) **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

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

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are

assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

Hope Waiver services are delivered in the following residential and non-residential settings:
a. Adult Foster Care Homes (residential, provider-controlled and operated);
b. Assisted Living Facilities (residential, provider-controlled and operated);
c. Adult Group Homes, Mental Health Group Homes and Intensive Mental Health Group Homes (residential, provider-controlled and operated);
d. Supported Employment (non-residential, provider-controlled and operated); and
e. Adult Day Care (non-residential, provider-controlled and operated.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Hope Waiver providers must meet the following general requirements:
1. Is integrated in and supports access to the greater community
2. Provides opportunities to seek employment and work in competitive, integrated settings, engage in community life, and control personal resources
3. Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting with the options documented in the person-centered plan of care based on the individual's needs and preferences
4. Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS
5. Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
6. Optimizes individual initiative autonomy, and independence in making life choices
7. Facilitates individual choice regarding services and supports, and who provides them

Additional Requirements for Provider-Owned or Controlled Settings are listed below:
1. Has a lease or other legally enforceable agreement providing similar protections
2. Has privacy in their unit, including lockable entrance, bedroom and bathroom doors, choice of roommates, and freedom to furnish or decorate the unit
3. Control their own schedule, including access to food at any time
4. May have visitors at any time
5. The setting is physically accessible

Any modification of the settings rule requirements must be supported by a specific assessed need and justified in the Hope Waiver person-centered plan of care with the following items documented in the plan:
1. Identifies a specific and individualized assessed need
2. Documents the positive interventions and supports used prior to any modifications to the person-centered plan of care
3. Documents less intrusive methods of meeting the needs have been tried but did not work
4. Includes a clear description of the condition directly proportionate to the specific assessed need
5. Includes regular collection and review of data to measure the ongoing effectiveness of the modification
6. Includes established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
7. Includes the informed consent of the individual
8. Includes an assurance interventions and supports will cause no harm to the individual

The Hope Waiver continues to utilize the DPHHS-approved provider self-assessment as the primary feature of the ongoing oversight process. The PSA is used to assess and estimate the level of individual HCBS settings compliance. Providers are required to complete self-assessments for each discrete setting operated by the provider. Waiver program staff then perform an evaluation of the PSAs via desk reviews, provider follow-up member survey information and/or on-site reviews. All new providers must complete a PSA prior to enrollment and all existing providers must complete a new PSA at least once every five years for each distinct setting. Each new PSA cycle will initiate a PSA desk review with provider follow-up as needed.

In 2024, DPHHS deployed an electronic assessment and case tracking solution. This efficiency step allows providers and the Department to work effectively using provider completed assessments, discrete site level documentation, document storage and routing and document follow-up and results tracking. Monitoring of ongoing compliance is a continuous process by several state and program staff. Hope Waiver program staff, and BSW/DDP program staff for shared settings, provide oversight of member health and safety and community integration.
DPHHS created a validation tool used by program officers, quality assurance specialists, and licensing specialists. Validation visits are completed by licensing staff or program officers and entered into the case tracking solution. This approach will retain the existing validation tool and process while making the results readily available to program officers and quality assurance personnel. visits will be performed by a program officer/quality assurance personnel at the discrete setting. The electronic case tracking solution will allow staff visibility into the last full validation and the risk assessment of the site.

DPHHS has and will continue to take a series of steps to guide providers in ensuring full compliance with HCBS settings, such as informational letters, training sessions and, and other targeted communications. If a concern with compliance is discovered, the provider will be required to submit a corrective action plan to DPHHS describing the steps to be taken

and expected timelines to achieve compliance.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☒ **Facilitates individual choice regarding services and supports, and who provides them.**

☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

○ **No, the waiver does not include provider-owned or controlled settings.**

◉ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

- ☒ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**
- ☒ **Each individual has privacy in their sleeping or living unit:**
  - ☒ **Units have entrance doors lockable by the individual.**
  - ☒ **Only appropriate staff have keys to unit entrance doors.**
  - ☒ **Individuals sharing units have a choice of roommates in that setting.**
  - ☒ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**
- ☒ **Individuals have the freedom and support to control their own schedules and activities.**
- ☒ **Individuals have access to food at any time.**
- ☒ **Individuals are able to have visitors of their choosing at any time.**
- ☒ **The setting is physically accessible to the individual.**
- ☒ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Recovery Plan (PCRP)

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker**
  Specify qualifications:
- ☐ **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

The department has in place safeguards to mitigate and address potential problems that may arise which include:
• All members are provided with the Hope Waiver Bill of Rights and Responsibilities at initial intake into the waiver program and at annual review of their Person-Centered Recovery Plan (PCRP). The Bill of Rights is a document informing members they have the right to choose from the full range of services available in the waiver, if appropriate, and that services will be delivered by a qualified provider of their choice.
• The department will provide annual Free Choice of Provider training to contracted case management staff and Hope Waiver providers.

In addition to the above-mentioned safeguards, AWARE, Inc. is administratively separate in the plan development function from the direct service provider functions and is organized in a manner to remove any conflict of interest when providing case management services to Hope Waiver members. AWARE's case management services are housed in their Community Care and Treatment division with a Service Director who is independent from the AWARE Adult Mental Health Residential Division. AWARE has developed policies for case management services to allow for arrangements to remove conflict of interest. In addition, AWARE's structure and workflow outlines clear expectations between case management activities and responsibilities to the plan of care, drawing a clear division of labor between the service provider and case management provider. AWARE's Quality Improvement (QI) division is charged with conducting annual and periodic audits to ensure quality of services and compliance with State and Federal regulations and agency standards. QI manages the creation and maintenance of policy and procedure, ensuring compliance and adherence to best practices. The QI team is independent of program service directors and provides objective audits reported to the AWARE executive team.

AWARE has an established Grievance Policy and process reviewed at intake and annually with each member at the time of their annual Plan of Care. Members are given a business card outlining the grievance procedure and the member and members' team sign the grievance process form in acknowledgment of the established process. This process starts with the member and case manager and incorporates the case manager supervisor. If the grievance is not resolved after meeting with the case manager and supervisor, the member proceeds through AWARE supervisory structure to the CEO if needed. If a member is not satisfied with their case manager or team even after attempts have been made to remedy the concern, AWARE will transfer the case to another case manager of the member's choice. Members can also request a Fair Hearing or contact advocacy groups to dispute the outcome which is included in the member's intake packet and offered as additional support. AWARE sends a report quarterly to the State for review on the total number of member grievances filed for the given time frame, and total number of grievances following policy which includes a clear and accessible dispute resolution process. The waiver participant can request a Fair Hearing or contact advocacy groups to dispute this assertion. This information is included in the member's intake packet and offered as additional support.

AWARE was selected as the sole contractor for case management through the state procurement process. Based on the scoring matrix used, AWARE was selected for case management services for this waiver. The term of the Contract with AWARE is from July 1, 2021 through June 30, 2024 unless terminated in accordance with the Contract. Renewals of this Contract, by written agreement of the parties, may be made at one-year intervals, or any interval agreed upon by both parties. The Contract may not be renewed for more than a total of 7 years.

AWARE provides for four additional services Hope Waiver members may qualify for and utilize. These services include:
1. Residential Habilitation: Intensive Mental Health Group Homes (IMHGH);
2. Health and Wellness
3. Transportation - Miles
4. Consultative Clinical and Therapeutic Services

Provider availability for the services identified above include:
a. IMHGH is only offered by two providers in Montana. Due to the rural nature of the state, in several areas of the state, AWARE may be the only option for a IMHGH provider. All participants using AWARE for their IMHGH services are informed about the two options for IMHGH providers and given the option to select either provider.
b. Health and Wellness, Transportation - Miles is offered by multiple providers throughout Montana
c. Consultative Clinical and Therapeutic Services is currently only offered by one provider, Aware.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a*

process in place to ensure:

☒ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☒ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☒ **Direct oversight of the process or periodic evaluation by a state agency;**

☒ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☒ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Waiver members develop their Person-Centered Recovery Plans (PCRP) with their case management team. The case management team maximizes the extent to which the member participates by explaining the PCRP process; assisting the member to explore and identify his/her preferences, desired outcomes, goals, and the services and supports will assist him/her in achieving desired outcomes; identifying and reviewing with the member issues to be discussed during the planning process; and giving each member an opportunity to determine the location and time of planning meetings, participants attending the meetings, and frequency and length of the meetings.

Members, guardians and/or legal representative may choose among qualified providers and services. The case management team advise the member and/or guardians or the legal representative of the range of services and supports for which the member is eligible throughout the person-centered support planning process. The choice of services and providers for the waiver benefit package is ensured by facilitating a person-centered support planning process and providing a list of all providers from which to choose. Waiver clients and/or guardians and legal representatives are informed they have the authority to select and invite individuals of their choice to actively participate in the person-centered support planning process.

When scheduling to meet with the member and or member’s legal guardian or representative the case management team makes reasonable attempts to schedule the meeting at a time and location convenient for all participants. In addition, the member has the authority to select and invite individuals of his/her choice to actively participate in the person-centered support planning process. The member must be seen at the time of the initial assessment and at the re-determination to ensure the member is in the home.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the

participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Person-Centered Recovery Plan (PCRP) is a written plan developed by the member and the case management team to assess the member's status and needs. The PCRP outlines the services available to meet the member's identified needs as well as the cost of the identified services.

An initial plan must be developed at the time of the member's enrollment, which is the date the member begins receiving services under the Hope Waiver. Upon enrollment, the case management team must initiate the Strength Assessment to determine the members strengths, needs, preferences, goals, and desired outcomes, along with his/her health status and risk factors. The Strength Assessment must be completed within three months of the member's enrollment. The initial plan is considered an interim plan created based on the Level of Care, Level of Impairment, and from information obtained by the case management team. Upon completion of the strength assessment, the PCRP is finalized.

The member and/or legal guardian have the authority to select and invite individuals of their choice to actively participate in the assessment process. The member and the members chosen group provide the case management team with information about the member's needs, preferences, and goals. In addition, the case management team obtains the Hope Waiver Evaluation and Level of Impairment form and health status information from the member's medical and behavioral health provider(s) or the Quality Improvement Organization. The case management team also identifies if any natural supports provided by a caregiver living in the home are above and beyond the workload of a normal family/household routine and works with the member and/or the group of representatives to identify and address risk factors with appropriate parties.

Members are given a written "Client Bill of Rights" informing them and/or the legal guardian of their rights prior to the PCRP being developed as well as during annual reviews done each year. This information consists of:
(1) Choice of services and providers;
(2) Choice of waiver or nursing facility;
(3) Options for services and providers; and
(4) Information regarding state plan and Early and Periodic Screening, Diagnostic and Treatment services must be accessed prior to accessing waiver services.

The case management team must ensure the PCRP includes at least the following components:
(1) Diagnosis, symptoms, complaints, and complications indicating the need for services;
(2) The Hope Waiver Evaluation and Level of Impairment form;
(3) Specific short-term objectives and long-term goals (each goal for the member is documented using the SMART goal process which identifies the Specific, Measurable, Achievable, Realistic, and Timely criteria);
(4) A discharge plan which describes elements necessary for independence;
(5) A description of risk factors and the recommendations identified to support the health and safety of the member;
(6) Identification of at least two services the member requires, including the frequency of the services and the type of providers;
Note: the service of meals cannot be counted as one of the two services.
(7) Any orders for the following:
(a) medication;
(b) treatments, including mental health regime;
(c) restorative and rehabilitative services;
(d) activities;
(e) therapies;
(f) social services;
(g) diet; and
(h) other procedures recommended for the health and safety of the member to meet the objectives of the PCRP.
(8) The Strength Assessment;
(9) Identification of formal and informal supports;
(10) Crisis plan;
(11) A cost sheet which projects the annualized costs of the PCRP;
(12) Service Plan settings requirements assurances; and
(13) Signatures of all individuals who participated in development of the PCRP including the member and/or representatives and the case management team. Signatures by the member on the PCRP acknowledges freedom of choice providers.

Case management teams are responsible to implement and monitor the PCRP. The Case management teams must have, at a minimum, monthly verbal telephone contact with the member and a face to face review every three months. During these contacts, or when the members condition warrants it, the member and/or legal guardian and the case management team must update the PCRP to reflect the members current condition. Subsequent annual reviews of the PCRP are completed as described above.

Although all PCRPs are subject to review by the Program Officers at any time, the case management teams are responsible for reviewing all portions of the plan annually utilizing the criteria outlined below:
(1) Does the PCRP include all necessary components listed above;
(2) Do the services identified in the PCRP correlate with the Hope Waiver Evaluation and Level of Impairment assessment, health status information from the member's medical and behavioral health provider(s), and the Strength Assessment;
(3) Do the services align with the members identified needs, preferences, and goals;
(4) Is there a defined crisis plan adequately addressing the member's needs and is consistent with State policy;
(5) Does the PCRP have the correct signatures; and
(6) Is each service authorized in the PCRP cost-effective and not duplicative of other waiver services and/or services available through standard Medicaid?

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☒ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☒ **A specific and individualized assessed need for the modification.**
- ☒ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☒ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☒ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☒ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☒ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☒ **Informed consent of the individual.**
- ☒ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Risks are assessed as part of the person-centered support planning process during a face-to face interview in the member's home and are documented in the member's electronic record. Information is provided to every member and to family members or other supports as approved by the member, to prepare them for playing a greater role in the support, service planning, and delivery process. The information covers health and safety factors, emergency back-up planning created with the member, and risk identification, assessment, and management. Members conduct a self-assessment as part of the planning and implementation process and may choose to have family members and other supports participate with the self-assessment. The case management team is responsible to establish a risk management assessment plan when the CMT has identified a risk for/to the member. The plan will include a risk management assessment assessing the potential and perceived risks, provides person-centered support around the member's needs and preferences, identifies and documents potential risks and consequences and maps out mitigation strategies for each identified risk. The risk assessment plan documents the member's capacity to make an informed decision and situations in which a legal guardian/representative exists. If the member refuses to engage and/or sign the risk assessment plan, the case management team will contact a Program Officer to identify options available to the member.

Member created back-up plans and risk identification and management are included in the Person-Centered Recovery Plan and may be included and paid for by the waiver program when appropriate. The back-up plan may include an assessment of critical services and a back-up strategy for each identified critical service. The back-up may also include the following solutions:
(1) Informal (for example, family, friends, and neighbors);
(2) Enrolled Medicaid provider network (for example, personal assistant agencies); and
(3) System level (local emergency response).

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Case management teams are required to provide members with a choice of qualified providers during development of the Person-Centered Recovery Plan. Case management teams are located throughout the state, although some services or options available in one geographic location may not be available in other geographic locations. The member can choose qualified providers from the list. If the member in unsatisfied with the available qualified providers, the case management teams or the member must solicit other providers for the service who would be required to enroll as a Medicaid waiver provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The case management teams are responsible for the development and monitoring of the Person-Centered Recovery Plans (PCRPs) for all waiver members. Review of participant service plans are also conducted when prior authorizations, risk negotiations, and/or serious occurrence reports are submitted to ensure services are not only ensuring health and safety but assisting the member to accomplish service plan goals. These processes ensure plans have been developed in accordance with applicable policies and procedures and each service plan ensures the health and welfare of waiver participants. The case management team conducts an annual member survey to ensure members:
1. Feel they are in charge of their PCRP development;
2. Agee to all the services outlined in their PCRP;
3. Have freedom of choice of service providers; and
4. Receive a signed copy of their PCRP.
Satisfaction surveys are sent to 100% of waiver members.

For Hope Waiver participant service plans, an internal chart audit must be completed at least quarterly. Each quarter, a Program Officer is responsible to draw a 10% random sample of active members during that quarter. Remediation efforts of noncompliance are documented in an internal chart audit form.

When there has been a systemic issue of noncompliance found during chart audits, the Program Officer or Program Manager creates a Quality Improvement Project (QIP) to identify how the CMT will prevent future issues of noncompliance.

The audit requires multiple standard reviews including Plan of Care Completeness (e.g. Recipient Identifying Information, Medical Information, Functional Overview, Orders for Medication, Specific Services, Goals and Objectives, Psychosocial Summary, Discharge Plan, Cost Sheet, and signatures).

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- (●) **Every three months or more frequently when necessary**
- ( ) **Every six months or more frequently when necessary**
- ( ) **Every twelve months or more frequently when necessary**
- ( ) **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

- [x] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case management team has direct contact with the member via monthly monitoring verbal phone calls and reviews the Person-Centered Recovery Plan (PCRP) with the member every three months. Any issues with the PCRP and the delivery and implementation of services is discussed at this time. The review is conducted at the member's place of residence, place of service, or other appropriate setting as determined by the member's needs. This is an opportunity for case management teams to monitor the service delivery, health, and welfare of the member. This review includes the evaluation and assessing strategies for meeting the needs, preferences, and goals of the member. It also includes evaluating and obtaining information concerning the member's satisfaction with the services, effectiveness of services being provided, an informal assessment of changes in member's function, service appropriateness, and service cost effectiveness.

Case management teams are required to complete several aspects of quality assurance and improvement oversight in addition to the quality assurance and quality improvement activities conducted by the Behavioral Health and Developmental Disabilities Division (BHDD). Case management teams submit monthly utilization reports to ensure quality assurance measures are met in accordance with performance measures. Program Officers complete a desk review annually and provide on-going monitoring through bi-weekly calls.

BHDD holds a monthly Oversight Committee meeting to review and discuss the management of the waiver. Members of the Oversight Committee include the Program Supervisor, Program Manager, Quality Assurance Program Manager, and the Program Officers. During the Oversight Committee meeting the following is reviewed:
(1) Incident management;
(2) Trends and patterns;
(3) Identification of individuals and systemic issues and strategies to mitigate; and
(4) Potential training opportunities.

The Critical Incident Review Committee (CIRC) completes an internal investigation of all critical incidents entered into the Quality Assurance Management System (QAMS) bi-weekly. The Critical Incident Review Committee investigates if policies were followed and whether notifications were made within appropriate time frames. Internal investigation of critical incidents include determining if the incident is a result of a failure to follow federal regulation, Montana statute, the Administrative Rules of Montana, and/or the provider agencies' policy, if there was adequate staff present to ensure health and safety and was the staff adequately trained in the components of the person's person-centered recover plan to ensure health and safety. Results of the internal investigation may be shared with the case management team, providers, or proper authorities.

Monitoring efforts used to ensure PCRP appropriateness and completeness are done on an annual basis by the Program Officers and include:
a. Required forms - confirms services meet the member's unique needs by reviewing progress notes, Level of Care and Level of Impairment (LOC/LOI) screening results, intake data, Medicaid eligibility, member's recovery marker, SDMI determination, and required HIPPA information.
b. Completeness of PCRP – document the services provided in the PCRP were developed using the member's the LOI, member's strength assessment, and member's selected goals. To verify cost effectiveness, the PCRP includes service cost sheets, cost amendments, explanation of services provided, member's selected goals, back up and emergency plans and discharge plan.
c. Plan effectiveness – is documented through case management teams' records of in person and phone meetings to discuss the effectiveness of services, back-up plans, and member's progress toward recovery markers and personal goals.
d. Effective charting - progress notes and documentation of all member/case management team contact is used to ensure services are furnished in accordance with the PCRP.
e. Waiting List – applicants on the waiting list receive a new LOC and LOI assessment every three months to verify the applicants' Medicaid eligibility for admission to the waiver.
f. Verification the members' signature page is current and includes the following statements:

- My plan addresses my needs and personal goals, including health and safety
- I have made a free choice of services and qualified providers for each service included in my Service Plan.
- I have received information on Abuse/Neglect and Exploitation and know how to report it.
- I have received a choice between institutional care or HCBS.
- I have participated in the development of this service plan and agree with it.

Issues or problems identified during annual program evaluations will be directed to the administrator or director of the case management teams and reported in the member's annual report of findings. Case management teams are required to

submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the case management team's remediation action plan, BHDD reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies. In addition to annual data collection and analysis, BHDD's Program Officers and Program Manager remediates problems as they arise based on the severity of the problem or by nature of the compliance issue. For issues or problems arising at any other time throughout the year, technical assistance may be provided to case managers, supervisors, or administrators, and a confidential report will be documented in the waiver recipient care file when appropriate. BHDD reviews and tracks the on-going referrals and complaints to ensure a resolution is reached, and the member's health and safety has been maintained.

BHDD provides remediation training to the case management teams annually to assist with improving compliance with performance measures. The remediation process includes a standardized template for individual Corrective Action Plans (CAP) to ensure all of the essential elements, including a root-cause analysis, are addressed in the CAP. Time limited CAP's are required for each performance measure below the 86% CMS compliance standard. The CAP must also include a detailed account of actions to be taken, staff responsible for implementing the actions, time frames, and a date for completion. BHDD reviews the CAP, and either accepts or requires additional remedial action. Then BHDD follows up with each individual case management team quarterly to monitor the progress of the action items outlined in their CAP.

BHDD utilizes information from the reviews to develop statewide training and determine the need for individual agency technical assistance for case management and service provider agencies. In addition, BHDD utilizes this information to identify problematic practices with individual case management teams and/or providers and to take additional action such as investigating, referring the agency to licensure for complaint investigation or directing the agency to take corrective action. If BHDD identifies problematic trends in the reports, they will require a written CAP by the case management teams and/or provider agencies to mitigate future occurrences.

AWARE has an established Grievance Policy and process reviewed at intake and annually with each member at the time of their yearly Plan of Care. Members are given a business card outlining the grievance procedure. The member and the members' team sign the grievance process form in acknowledgment of the established process. This process starts with the member and case manager and incorporates the case manager's supervisor. If the grievance is not resolved after meeting with the case manager and supervisor, the member proceeds through AWARE's supervisory structure to the CEO, if needed.

If a member is not satisfied with their case manager or team even after attempts have been made to remedy the concern, AWARE will transfer the case to another case manager of the member's choice. Members can also request a Fair Hearing or contact advocacy groups to dispute the outcome which is included in the member's intake packet and offered as additional support.

b. Monitoring Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

All members are provided with the Hope Waiver Bill of Rights and Responsibilities at initial intake into the waiver program and at annual reviews of their Person-Centered Recovery Plan (PCRP). The Bill of Rights is a document informing members they have the right to choose from the full range of services available in the waiver, if appropriate, and services will be delivered by a qualified provider of their choice. The department will provide annual Free Choice of Provider training to contracted case management staff and Hope Waiver providers.

In addition to the above-mentioned safeguards, AWARE's contracted case management team is administratively separate in the plan development function from the direct service provider functions and is organized in a manner to remove any conflict of interest when providing case management services to Hope Waiver members.

AWARE's contracted case management team has an established Grievance Policy and process reviewed at intake and annually with each member at the time of their yearly Plan of Care. Members are given a business card outlining the grievance procedure. The member and members' team sign the grievance process form in acknowledgment of the established process. This process starts with the member and case manager and incorporates the case manager's supervisor. If the grievance is not resolved after meeting with the case manager and supervisor, the member proceeds through AWARE supervisory structure to the CEO, if needed. If a member is not satisfied with their case manager or team even after attempts have been made to remedy the concern, AWARE will transfer the case to another case manager of the member's choice.

Based upon the scoring matrix, AWARE was selected for case management services for this waiver. A member can also request a copy of the RFP process from the Department. Montana offers the opportunity to protest an award if there is a violation of the Montana Procurement Act per Administrative Rules of Montana. The protest must be in writing 14 days after contract execution and detail all of the protestor's objections and allegations of violations of the Montana Procurement Act.

If the member still disagrees, they can request a Fair Hearing with the Office of Administrative Fair Hearings per Administrative Rules of Montana, or contact advocacy groups (i.e., Ombudsman, Disability Rights) to dispute the outcome as well a file a dispute with the US Department of Health and Human Services Civil Rights. This information is included in the member's intake packet and offered as additional support.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☒ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☒ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☒ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☒ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☒ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans

for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participantsï?½ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
 # and % PCRP's that include services and supports (including health and safety risk factors) aligning with the member's assessed needs/personal goals in the representative sample. Numerator: # of PCRP's that include services and supports (including health and safety risk factors) aligning with the member's assessed needs/personal goals. Denominator: Total # of PCRPs in the representative sample.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☒ **Other** Specify: Case management teams	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

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

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

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and Percent of member PCRP's in the representative sample updated/revised annually. Numerator: Number of member PCRP's in the representative sample updated/revised annually. Denominator: Total number of PCRP's in the representative sample requiring updates/revisions annually.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☒ **Other** Specify: Case management teams	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of member PCRP's in the representative sample updated/revised as warranted by changes in the member's needs. Numerator: Number of member PCRP's in the representative sample updated/revised as warranted by changes in the member's needs. Denominator: Total number of member PCRP's in the representative sample requiring updates/revisions warranted by changes in the member's needs.

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☒ **Other** Specify: Case management teams	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of PCRP's in the representative sample where amount of services was delivered in accordance with the PCRP. Numerator: Number of PCRP's in the representative sample where amount of services was delivered in accordance with the PCRP. Denominator: Total number of PRCP's in the representative sample.

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

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

		95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percent of PCRP's in the representative sample where the scope of services was delivered in accordance with the PCRP. Numerator: Number of PCRP's in the representative sample where the scope of services was delivered in accordance with the PCRP. Denominator: Total number of PCRP's in the representative sample.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of PCRP's in the representative sample where the duration of services was delivered in accordance with the PCRP. Numerator: Number of PCRP's in the representative sample where the duration of services was delivered in accordance with the PCRP. Denominator: Total number of PCRP's in the representative sample.

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

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

		95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percent of PCRP's in the representative sample where the frequency of services was delivered in accordance with the PCRP. Numerator: Number of PCRP's in the representative sample where the frequency of services was delivered in accordance with the PCRP. Denominator: Total number of PCRP's in the representative sample.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of PCRP's in the representative sample where the type of service was delivered in accordance with the PCRP. Numerator: Number of PCRP's in the representative sample where the type of service was delivered in accordance with the PCRP. Denominator: Total number of PCRP's in the representative sample.

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

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

		95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and Percent of members who were afforded a choice of services. Numerator: Number of members who were afforded a choice of services. Denominator: Total number of members.

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of members who were afforded a choice of providers.
Numerator: Number of members who were afforded a choice of providers.
Denominator: Total number of members.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

		Sample Confidence Interval =
☒ **Other** Specify: Case management teams	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Designated Behavioral Health and Developmental Disabilities (BHDD) staff will conduct reviews of Case Management Teams (CMTs) at least every three years. However, if a significant issue or deficiency is discovered at any time, a targeted review would be completed and include on-site activities. Assessing the Service Plan is part of that process. The BHDD staff will address any errors or missing information with the CMT for correction. When a plan is not developed in accordance with program policy and procedure, the BHDD staff will work with the CMT to take appropriate corrective action.

The BHDD staff will respond to any immediate concerns related to the health and safety of the member. Data collected in the reviews will be outlined in a report and the CMT will need to submit corrections to BHDD for approval. Issues identified will be shared with CMTs through a Quality Assurance Communication (QAC).

CMTs are required to respond to the QACs with resolution efforts according to the specified time frames. All QACs corresponding to a review must be resolved and returned to BHDD prior to closure of the review. If a CMT identifies areas of non-compliance during their internal audits, they will act to immediately rectify the problem and update the Service Plan if necessary. If BHDD staff identify a significant discrepancy between scope of services in plan and number of services actually provided, the case will be referred to the Program Officer for follow up with the CMT.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

When plans indicate performance measures were not met by the Case Management Team (CMT), the program staff will immediately set up a meeting with the CMT. The CMT will work with the member to review the appropriate documentation, update the Person-Centered Recovery Plan (PCRP) as needed and/or sign the PCRP. If there appears to be a pattern of failure to do this within a CMT, a written remediation plan will be required, within 30 days, describing initiated safeguards to ensure plans will meet the performance standards.

If during reviews and meetings with members, the designated BHDD staff determine Person-Centered Recovery Plans do not sufficiently address members' needs and/or do not need policy requirements, they will initiate a Quality Assurance Communication (QAC). The CMT will have 30 days to respond with a remediation plan to correct the deficiency. If necessary, the program staff will follow up with training or further instructions for the agency.

When paid claims indicate services were not provided in type, scope, amount, duration, and frequency as indicated in the Person-Centered Recovery Plan, the designated BHDD program staff will immediately issue a QAC to the agency requesting an explanation of any discrepancy and remediation plan within 30 days.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Members in the waiver will be offered an opportunity to self-direct services as a co-employer. Once a participant's comprehensive assessment and PCRP process has been completed, and assessed waiver services are identified, the participant may select the specific services they wish to self-direct from the list of services that can be self-directed. The participant may also receive some of the services in their PCRP through traditional supports and services from a provider agency, ensuring no services are duplicative. Services self-directed as a co-employer include: Personal Assistance Services, Behavioral Intervention Assistance and Life Coach.

The health care professional must certify the member/personal representative is capable of managing the tasks and understands the risks involved. The member/personal representative must:
(1) Be capable of making choices about activities of daily living, understand the impact of their choices, and assume responsibility for those choices;
(2) Be capable of managing all tasks related to service delivery including recruiting, hiring, scheduling, training, directing, and dismissal of attendants; and
(3) Understand the shared responsibility between the member and the provider agency.

Members will be able to choose from several agencies providing personal assistance type services, ensuring members are successful with the self-direction experience. The provider agencies will:
(1) Advise, train and support the member, as needed and necessary;
(2) Assist with recruiting, interviewing, hiring, training and managing, and/or dismissing workers;
(3) Manage the employee including mandatory agency training and payroll; and
(4) Assist with monitoring health and welfare.

The entities involved in supporting participant direction include case managers, the Quality Improvement Organization, and the provider agencies.

The case management teams will assist the member to develop an emergency backup plan, identifying and mitigating risks or potential risks, and monitors the health and safety of the member.
Agency-based PAS managed by provider agencies under agreement with Medicaid are not available to members who are participating in the self-directed program. The use of PAS managed by provider agencies is permissible if the member's backup plan fails.

Members in the waiver will be offered an opportunity to self-direct services as a co-employer. Once a participant's comprehensive assessment and PCRP process has been completed, and assessed waiver services are identified, the participant may select the specific services they wish to self-direct from the list of self-directed services. The participant may also receive some of the services in their PCRP through traditional supports and services from a provider agency, ensuring no services are duplicative. Services self-directed as a co-employer include: PAS, BIA and Life Coach.

The case manager is responsible for educating members regarding participant directed opportunities. Case managers meet with members to detail the participant directed service options during the intake process, annual visit, as well as throughout their service plan year as indicated through assessed need. Case managers provide assistance for informed decision-making by individuals and their families/representatives about the election of participant direction with information and training on the roles, risks, and responsibilities assumed by those who choose participant direction. Case Managers will also inform members they are able to assist with the development of formal/informal supports, plan development, as well as available resources for self-direction. Case manager's are also responsible for overseeing the service delivery in the self-direct option. If a member indicates an interest in the self-directed option, the case management team is responsible to refer the member to the Quality Improvement Organization who then completes a capacity interview over the telephone by a registered nurse.
The health care professional must certify the member/personal representative is capable of managing the tasks and understands the risks involved. The member/personal representative must:

(1) Be capable of making choices about activities of daily living, understand the impact of their choices, and assume responsibility for those choices;
(2) Be capable of managing all tasks related to service delivery including recruiting, hiring, scheduling, training, directing, and dismissal of attendants; and
(3) Understand the shared responsibility between the member and the provider agency.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- (●) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

To be eligible for the program the member must meet all the following criteria:
(1) Be Medicaid eligible and meet nursing facility level of care criteria;
(2) Demonstrate a medical and functional need for assistance with activities of daily living (ADL), which is substantiated by symptoms and a medical diagnosis;
(3) Have the ability to direct services authorized by a Health Care Professional;
(4) Obtain a Health Care Professional approval to self-direct SDMI services;
(5) Meet capacity to direct self-direct services or have a personal representative meet capacity to direct services; and
(6) Be capable of assuming the management responsibilities of self-direct services.
(7) Be capable of managing all tasks related to service delivery. This includes the ability to manage recruitment, hiring, scheduling, training, directing and dismissal of worker(s).

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The most important component of the outreach strategy is developing and disseminating material to inform members about the benefits and potential liabilities of self-direction of services. Behavioral Health and Developmental Disabilities Division (BHDD) is developing a brochure describing the responsibilities of the agency, member, provider, and the case management team; description of the advantages and disadvantages to self-directed services; frequently asked questions; and resources. The brochure will be provided to the Quality Improvement Organization, case management teams, Program Officers, and Personal Assistance Services (PAS) provider agencies. This information will be included as part of the intake process provided by the case management teams and stored in the members files. This will be done prior to the commencement of services. At any point during the outreach stages a member is free to opt out of the participant directed services and select to receive the PAS type services via the traditional agency-based model.

Currently, upon intake into the waiver and again at annual review, case management teams inform every member and/or their representatives about self-direct services options.

At the beginning of the initial PCRP, the case management team informs the member of their option to self-direct services. The case management team describes the program, the options available in the program, and the member’s responsibilities. If the member is interested in self-directed services, they are referred to Mountain Pacific (MP), where a nurse does a capacity interview over the phone. Using the Personal Assistance Services/Community First Choice form the nurse interviews the member to determine their functional capability. Results of the interview are forwarded to the case management team. If the member is deemed appropriate for self-directed services, the case management team links the member to an agency who works with the member to start the search and hiring process which is incorporated into the PCRP. Completed forms are kept at MP and documented in the member’s PCRP. BHDD provides the polices which directs the case management teams in the requirements they must follow in regard to informing the member of the option to self-direct. In addition, the BHDD updated self-direct brochure will be ready to publish on the BHDD website on or about July 1, 2024, which will expand the case management team’s ability to effectively communicate to the member.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The state does not provide for the direction of waiver services by a representative.**
- ◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☐ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A personal representative will be required for any member who has impaired judgment as identified on the assessment used by Quality Improvement Agency and/or is unable to:
(1) Understand his/her own personal care needs;
(2) Make decisions about his/her care;
(3) Organize his/her lifestyle and environment by making these choices;
(4) Understand how to recruit, hire, train, and supervise providers of care;
(5) Understand the impact of his/her decisions and assume responsibility for the results; or
(6) When circumstances indicate a change of competency or ability to self-direct services demonstrated by noncompliance with program objectives.

The member, Quality Improvement Organization, case management team (CMT), Adult Protective Services, or Behavioral Health and Developmental Disabilities Division may request a personal representative be appointed. A personal representative may be a legal guardian, or other legally appointed personal representative, or a family member or friend. The personal representative must demonstrate:
(1) A strong personal commitment to the member;
(2) Ability to be immediately available to provide or obtain backup services in case of an emergency or when an attendant does not show;
(3) Knowledge of the member's preferences;

In addition the personal representative must:
(1) Agree to predetermined frequency of contact with member;
(2) Be willing and capable of complying with all criteria and responsibilities of consumers;
(3) Be at least 18 years of age; and
(4) Obtain the approval from the member and/or a consensus from other family members to serve in this capacity if applicable.
A personal representative may not be paid for this service nor be a paid worker or paid to provide any other waiver services to the member. Each personal representative will be required to complete and sign an Authorized Personal Representative Designation Form and participate in Person Centered Recovery Plan development and reviews.

The non-legal representative will be under the scrutiny of the CMT. CMTs have monthly phone contact with members and meet face-to-face quarterly. Face-to-face contact allow for the CMT to assess the members condition and condition of the home. If the non-legal representative does not fulfill the agreement and does not demonstrate an ongoing commitment to the member, is consistently unavailable for meetings, maintains minimal contact with the member or does not honor the member's preferences the representative will be removed as the personal representative.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Behavioral Intervention Assistant	☒	☐
Life Coach	☒	☐
Personal Assistance Service	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

○ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☐ **Private entities**

◉ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Homemaker **Chore**	☐
Behavioral **Intervention Assistant**	☒
Health and **Wellness**	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Adult Day Health	☐
Private Duty Nursing	☐
Supported Employment	☐
Environmental Accessibility Adaptations	☐
Consultative Clinical and Therapeutic Services	☐
Specialized Medical Equipment and Supplies	☐
Life Coach	☒
Personal Assistance Service	☒
Respite	☐
Personal Emergency Response System	☐
Meals	☐
Community Transition	☐
Non-Medical Transportation	☐
Pain and Symptom Management	☐
Case Management	☐
Residential Habilitation	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A member may, at any time, return to the traditional provider agency-based model. The member will notify the agency of their intention. The case management team will coordinate services to ensure no break in vital services and timely revision of the Personal Centered Recovery Plan occurs. The reason for the voluntary termination will be documented in the members file.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

When the case management team or Behavioral Health and Developmental Disabilities Division identifies an instance where the self-directed option is not in the best interest of the member and corrective action (additional training, appointment or change of personal representative, etc.) does not ameliorate the situation, the member will be informed in writing of the plan to transfer to agency-based service delivery. The case management team works in collaboration with the provider agency to ensure no break in vital services and a timely revision of the Person-Centered Recovery Plan occurs. The member may appeal this decision by requesting a fair hearing through the Fair Hearing process.

The fair hearing rights are included in the guide provided to every member participating in the program. When the member is terminated from self-direction, a letter will be sent to the member and personal representative, if appropriate, informing them of their right to appeal the decision and request a fair hearing.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	10	
Year 2	15	
Year 3	20	
Year 4	20	
Year 5	20	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The member (or member's personal representative) functions as the co-employer (managing employer) of the Personal Assistance Service provider. An agency is the common law employer of the member selected/recruited staff and performs payroll and human resource functions. Supports are available to assist the member in conducting employer related functions.

The mechanism in place to ensure members maintain authority and control are the mandatory monthly case management team's contact with the member and with the providers.

The member signs a member agreement form which outlines the member's role and responsibilities as a self-directed co-employer. The member participates in the creation of the person-centered recovery plan and signs the person-centered recovery plan once complete. Once the person-centered recovery plan is signed by the member and the case management team provides a copy of the person-centered recovery plan to the provider agency. The member must sign off on time sheet daily and provide the time sheets to the provider agency. The provider agency is required to compare all time sheet to the person-centered recovery plan to ensure services are delivered according to the person-centered recovery plan. If there are any issues with service delivery the agency would discuss the issues with the case management team and the member during the monthly meeting. If issues continue to arise, the Program Officer can also provide suggestions and support to the member.

The agency with choice is provided a copy of the person-centered recovery plan reflecting the member's goals and desires. By reviewing the time sheets and following the services outlined in the person-centered recovery plan, this reflects the agency with choice service delivery model and the key elements of the self-direct model.

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☐ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☐ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**

○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The member is notified of the Fair Hearing process by eligibility staff when they complete the Medicaid application process, by the Quality Improvement Organization when they receive their level of care assessment, and by the case management teams during the development of the Person-Centered Recovery Plan.

The member is also notified of the Fair Hearing process by the case management team when there is an adverse action such as a denial, reduction, suspension, or termination of services. The case management team informs the member they will continue to receive waiver services while an appeal is under consideration. The case management team provides information regarding the Fair Hearing process on an on-going basis through routine contact with the member.

Resources are available to members during the Fair hearing process through the Mental Health Ombudsman, Montana Disability Rights Program, and personal attorneys of the member and/or family. Documentation the member received notification of the Fair Hearing process is retained in agency files.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving

their right to a Fair Hearing. *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Behavioral Health and Developmental Disabilities Division (BHDD) has established a system of identifying, reporting, and monitoring serious occurrences involving members served by BHDD's Hope Waiver in order to manage and mitigate overall risk to the member. A "serious occurrence" means a significant incident, including abuse, neglect, and exploitation as defined by Montana Code Annotated, 52-5-803, involving a member which affects the health, welfare, or safety of the member under the circumstances listed below. Incidents are classified as critical and non-critical incidents:
(1) Critical incidents are serious in nature and pose a risk to the health, safety, or welfare of the waiver member or others; and
(2) Non-critical incidents are minor in nature and do not pose a risk to the health, safety, or welfare of the waiver member or others.

Types of serious occurrences required to be reported:
(1) Suspected or known physical, emotional, sexual, financial or verbal abuse;
(2) Neglect of the member, self-neglect, or neglect by a paid caregiver;
(3) Sexual harassment by an agency employee or individual;
(4) Any injury resulting in hospital emergency room or equivalent level of treatment. The injury may be either observed or discovered;
(5) An unsafe or unsanitary working or living environment which puts the worker and/or member at risk;
(6) Any event reported to Adult Protective Services, law enforcement, the Ombudsman Program, Quality Assurance Division/Licensure, or the Drug Utilization Review Board;
(7) Referrals to the Medicaid Fraud Unit;
(8) Psychiatric Emergency: Admission of a member to a hospital or mental health facility for a psychiatric emergency;
(9) Medication Emergency: When there is a discrepancy between what a physician prescribes and what a member takes and these results in hospital emergency room or equivalent level of treatment or hospital admission;
(10) Suicide ideation, attempt, threat, or death;
(11) Unauthorized use of restrictive interventions, seclusion, or restraints; or
(12) Fiscal exploitation.

The population accessing the waiver are vulnerable and all individuals employed by a provider agency participating in the waiver program are mandatory reporters of suspected abuse, neglect, or exploitation and are required to immediately refer all suspected abuse, neglect, or exploitation to Adult Protective Services.

The BHDD Critical Incident Review Committee completes an internal Investigation of all Serious Occurrences entered into the Quality Assurance Management System monthly. The Critical Incident Review Committee investigates if policies were followed and whether notifications were made within appropriate timeframes. Internal investigation of Serious Occurrences includes determining if the incident is a result of a failure to follow federal regulation, Montana statute, the Administrative Rules of Montana, and/or the provider agencies' policy, if there was adequate staff present to ensure health and safety and was the staff adequately trained in the components of the person's plan of care to ensure health and safety. Results of the internal investigation may be shared with the case management team, providers, or proper authorities.

Adult Protective Services is the investigation unit for all reports of abuse, neglect or exploitation. All reports referred to Adult Protective Services are received through a centralized office where trained staff assess the situation and route a report to staff located in field offices across the state. Local staff evaluate, assess, prioritize reports, and initiate emergency intervention activities which may include:
(1) Investigating complaints;
(2) Coordinating family and community support resources;
(3) Strengthening current living situations;
(4) Developing and protecting personal financial resources; and
(5) Facilitating legal intervention.

If a critical incident occurs, an investigation is immediately initiated whereas an investigation for a non-critical incident is initiated within five to ten days. Adult Protective Services collaborates with the Department of Justice, law enforcement, Federal Bureau of Investigation, and the Medicaid Fraud Control Unit. If a conflict arises, Adult Protective Services works with outside investigative agencies to mitigate the conflict. Adult Protective Services keeps data on all reports of Abuse, Neglect and Exploitation.

All incidents are reported to the case management team and to Program Officers. Case managers and providers use QAMS to report incidents. Other providers, members, family members, and other concerned individuals who do not have access may report incidents to the case management teams who enter it into the system. QAMS reporting is reviewed against adult protective services and our monthly review of emergency room reports to ensure critical incidences are reported into QAMS.

In addition to filing a report with Adult Protective Services, case management teams and provider agencies must initiate a serious occurrence report in the Quality Assurance Management System within 24 hours of receiving the information or witnessing a serious occurrence. Case management teams complete the corrective action plan and send to the Program Officers for review within 5 days. This time frame allows for incidents to be investigated while giving the case manager and provider time to gather all pertinent information, including speaking to all individuals involved and to develop a corrective action plan meaningful in preventing a future incident. The individuals entering the serious occurrence report into the Quality Assurance Management System are required to document the cause and effect of the incident, develop an action plan to address the problem, and document steps to be taken to prevent incidents from occurring in the future.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Case management teams provide members an informational brochure, as indicated by the signature of the member, on identifying, addressing, and protecting someone from abuse, neglect, and exploitation and how to notify the appropriate authorities:
(1) Upon enrollment;
(2) During the development of the person-centered recovery plan;
(3) At the annual review of the person-centered recovery plan; and
(4) At quarterly face to face meetings with the case management teams.
Members can also access information on the Adult Protective Services website as needed.

Case management teams are required to train members on an annual basis regarding their Bill of Rights to ensure members understand their right to be free of abuse, neglect, and exploitation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

There are two entities receiving and managing serious occurrences for the Behavioral Health and Developmental Disabilities Division (BHDD): Adult Protective Services and case management teams.

ADULT PROTECTIVE SERVICES
Adult Protective Services is the investigation unit for all reports of abuse, neglect or exploitation. All reports referred to the investigative unit at Adult Protective Services funnel through a centralized office where trained staff assess the situation and route the report to staff located in field offices across the state. If a critical incident occurs, an investigation is immediately initiated whereas an investigation for a non-critical incident is initiated within five to ten days.

Local staff evaluate, assess, prioritize reports, and initiate emergency intervention activities which may include:
(1) Investigating complaints;
(2) Coordinating family and community support resources;
(3) Strengthening current living situations;
(4) Developing and protecting personal financial resources; and
(5) Facilitating legal intervention.

Adult Protective Services does not rely on any one individual or entity. Investigations are conducted in many different residential settings such as - private homes, assisted living, group homes, nursing homes, independent living programs, hospital, etc. Adult Protective Services follows strict protocols on investigations and must establish a preponderance of the evidence when establishing a report's truth or accuracy. When appropriate, Adult Protective Services collaborates with Department of Justice, law enforcement, the Federal Bureau of Investigations, Medicaid Fraud Control Units, etc. Adult Protective Services obtains any investigative material a service provider may have gathered but does not rely solely on this material. Adult Protective Services will make a referral to local law enforcement for illegal activities, theft, embezzlement, and incidents involving significant abuse. Adult Protective Services keeps data on all reports of abuse, neglect, and exploitation. BHDD is notified of all intent to investigate a report and the outcome of the investigation.

CASE MANAGEMENT TEAMS
Case management teams both make and receive serious occurrence reports. Reports to the case management teams are made by providers, members, family members, and other concerned individuals. These reports either go directly to Adult Protective Services and/or are entered as a serious occurrence report in the Quality Assurance Management System. Case management teams have ongoing communication with members, families, and provider agencies, throughout the process. Case management teams:
(1) Follow up with the authority responsible for the investigation to ensure the health and safety of the member;
(2) Monitors the services provided to the member and makes necessary changes to the member's person-centered recovery plan;
(3) Communicates with the member, this information is documented in the members case file; and
(4) Works with the member to develop an action plan to correct or prevent the incident from reoccurring in the future.

Upon closure of the serious occurrence report, the results of the investigation are communicated to the member or member's family/legal representative. During an active investigation, the responsible authority may be not able to share details with the case management team due to confidentiality rules. In addition, BHDD receives a notification from Adult Protective Services stating a report has been filed and a notification when the investigation is complete which includes the outcomes of the investigation and recommended follow up actions.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Behavioral Health and Developmental Developmental Division (BHDD) is responsible for overseeing the reporting of and response to serious occurrences effecting waiver members. Case management teams or provider agencies must complete a serious occurrence report in the Quality Assurance Management System within 24hours of receiving the information or witnessing a serious occurrence. The individual entering the serious occurrence report into the Quality Assurance Management System is required to document the cause and effect of the incident, develop an action plan to address the problem, and document steps taken to prevent incidents from occurring in the future.

BHDD's Program Officers review each serious occurrence report within five business days to confirm agreement with the action plan or to ask clarifying questions, if necessary. Once confirmed, the serious occurrence report is returned to the provider or case management team and monitored by the Program Officers. The Program Officers are responsible for ensuring the action plan is activated, identified issues are resolved, and compliance has occurred. Documentation of contact, ongoing monitoring activities, and outcomes are entered and stored in the Quality Assurance Management System.

BHDD's Program Manager and Quality Assurance (QA) Program Manager generate monthly reports to monitor serious occurrence report entered into the Quality Assurance Management System. The QA Program Manager analyzes the serious occurrence report by incident type, member characteristics, incident response time, remediation outcomes, and timeliness. In addition, the QA Program Manager generates and reviews monthly utilization reports of all occurrences of emergency room and urgent care visits for waiver members by claim diagnosis and procedures billed. The purpose of this report is to detect unreported serious occurrences.

BHDD holds a monthly Oversight Committee meeting to review and discuss the management of serious occurrences. Members of the Oversight Committee include the Program Manager, Quality Assurance Program Manager, and the Program Officers. During the Oversight Committee meeting the following is reviewed:
(1) Outstanding serious occurrence report;
(2) Trends and patterns;
(3) Strategies and necessary training for prevention of future serious occurrences; and
(4) Potential unreported incidents.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Behavioral Health and Developmental Disabilities Division (BHDD) is responsible for detecting unauthorized use of restraints. To detect any unauthorized use of restraints, the case management teams provide members with a Bill of Clients Rights which contains a signature section allowing members to indicate they were provided information regarding members rights (including the prohibition on restraints), complaint procedures, and who to contact to report critical incidents. The member's signature is confirmation the member has been provided this information and understands their rights regarding restraints.

In addition, BHDD's Quality Assurance Program Manager generates and reviews monthly utilization reports of all occurrences of emergency room and urgent care visits for waiver members by claim diagnosis and procedures billed. The purpose of this report is to detect unreported serious occurrences.

The use of restraints requires a serious occurrence report. Restraints are not currently captured as a separate category/sub category of incidents, but Program Officers can determine this from the incident narrative.

BHDD holds a monthly Oversight Committee meeting to review and discuss the management of serious occurrences. Members of the Oversight Committee include the Program Manager, Quality Assurance Program Manager, and the Program Officers. During the Oversight Committee meeting the following is reviewed:
(1) Outstanding serious occurrence report;
(2) Trends and patterns;
(3) Strategies and necessary training for prevention of future serious occurrences; and
(4) Potential unreported incidents.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Behavioral Health and Developmental Disabilities Division (BHDD) is responsible for detecting unauthorized use of restrictive interventions. To detect any unauthorized use of restrictive intervention, the case management team provides members with a Bill of Clients Rights which contains a signature section allowing members to indicate they were provided information regarding members rights (including the prohibition on restrictive interventions), complaint procedures, and who to contact to report critical incidents. The member's signature is confirmation the member has been provided this information and understands their rights regarding restrictive interventions.

In addition, BHDD's Quality Assurance Program Manager generates and reviews monthly utilization reports of all occurrences of emergency room and urgent care visits for waiver members by claim diagnosis and procedures billed. The purpose of this report is to detect unreported serious occurrences.

Program Officers review all Serious Occurrence Reports, progress notes at annual review, and emergency room reporting to detect if there has been a possible use of restrictive interventions and if further investigation is warranted. Investigation includes communication with members, the case management teams, providers, and other individuals pertinent to uncover additional information as needed. The Program Officer follows up if a Serious Occurrence Report was warranted but was not entered, and Adult Protective Services is contacted if appropriate

The use of restrictive interventions requires a serious occurrence report. Restrictive interventions are not currently captured as a separate category/sub category of incidents, but Program Officers can determine this from the incident narrative.

BHDD holds a monthly Oversight Committee meeting to review and discuss the management of serious occurrences. Members of the Oversight Committee include the Program Manager, Quality Assurance Program Manager, and the Program Officers. During the Oversight Committee meeting the following is reviewed:
(1) Outstanding serious occurrence report;
(2) Trends and patterns;
(3) Strategies and necessary training for prevention of future serious occurrences; and
(4) Potential unreported incidents.

BHDD currently has a process in place to inform service providers about the prohibition of restrictive interventions in the waiver program. This information is located in the Hope Waiver Manual. All service providers are required to follow the policies and provisions of the program. In addition, BHDD will add this to the member's Bill of Rights requiring CMT's to train members about this on an annual basis.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Behavioral Health and Developmental Disabilities Division (BHDD) is responsible for detecting unauthorized use of seclusion. To detect any unauthorized use of seclusion, the case management team provides members with a Bill of Clients Rights which contains a signature section allowing members to indicate they were provided information regarding members rights (including the prohibition on seclusion), complaint procedures, and who to contact to report critical incidents. The member's signature is confirmation the member has been provided this information and understands their rights regarding seclusion.

In addition, BHDD's Quality Assurance Program Manager generates and reviews monthly utilization reports of all occurrences of emergency room and urgent care visits for waiver members by claim diagnosis and procedures billed. The purpose of this report is to detect unreported serious occurrences.

Program Officers review all Serious Occurrence Reports and progress notes to detect if there has been a possible use of seclusion and if further investigation is warranted. Further investigations may include communication with members, the case management teams, providers, and other individuals pertinent to uncover additional information as needed. In addition, Montana developed and implemented a process to review emergency room visits in order to assist in identifying unreported cases of abuse, neglect, and exploitation on a monthly basis. The Program Officer follows up if a Serious Occurrence Report was warranted but was not entered, and Adult Protective Services is contacted if appropriate.

The use of seclusion requires a serious occurrence report. Seclusion incidents are not currently captured as a separate category/sub category of incidents, but Program Officers can determine this from the incident narrative.

BHDD holds a monthly Oversight Committee meeting to review and discuss the management of serious occurrences. Members of the Oversight Committee include the Program Manager, Quality Assurance Program Manager, and the Program Officers. During the Oversight Committee meeting the following is reviewed:
(1) Outstanding serious occurrence report;
(2) Trends and patterns;
(3) Strategies and necessary training for prevention of future serious occurrences; and
(4) Potential unreported incidents.

The case management team is contractually responsible for education participating providers about the goals of the program as well as all program policies and rules governing the program. The case management team serves as a liaison between the providers and members, if necessary. BHDD currently has a process in place to inform service providers about the prohibition of restrictive interventions in the waiver program. This information is located in the Hope Waiver Manual.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of

seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The Montana Department of Public Health and Human Services, Quality Assurance Division is responsible for second-line monitoring to ensure the appropriate management of medication. The Quality Assurance Division oversees medication management for adult residential settings as part of licensure requirements. The Quality Assurance Division conducts on-site licensing surveys at application for a license, upon renewal of a license, annually, or at any time without prior notice when it is considered necessary. (Administrative Rules of Montana, Assisted Living Facilities, Title 37, Chapter 106, subchapter 28; Mental Health Center, Group Homes, Title 37, Chapter 106, subchapter 19) The Quality Assurance Division reviews the medication policies, procedures, and practices of each assisted living facility to ensure compliance with state and federal regulations.

Per the requirements in Administrative Rule, staff in licensed adult residential settings provide medication management for self-administered medication. They are responsible for keeping track of medication and ensuring the members take their medications as prescribed. All medication must be secured as required by the Department of Labor and Industry to restrict access. Medication management includes all medications prescribed to the member including over the counter medications. Monitoring is designed to record all medications for each member including the name of the drug, the dosage, and the directions for administering the medication to ensure the member is taking the medication as prescribed. The medication record must be uploaded into the members file monthly.

Montana statute establishes licensing requirements for Medication Aide I and II. This is managed through the Board of Nursing who established minimum requirements for course content, including competency evaluations, for medication administration. The Board of Nursing approves and maintains a list of approved training entities of medication administration courses.

Medication management includes all medications prescribed to the member including over the counter medications. Monitoring is designed to record all medications for each member including the name of the drug, the dosage, and the directions for administering the medication to ensure the member is taking the medication as prescribed. In addition, Montana is in the process of researching further monitoring and training opportunities.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful

practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Program Officers with the Behavioral Health and Developmental Disabilities Division review medication management during the initial review of the person-centered recovery plan and during subsequent evaluations. Case management teams monitor members ensuring they receive their medication as prescribed and report any mismanagement, harmful practices, or crimes to the appropriate authorities.

A member's case management team and private duty nursing provider are responsible for monitoring members who self-administer medications as part of wellness monitoring. A member's primary care provider or mental health provider are notified of issues/concerns. Staff in licensed assisted living facilities and group homes provide medication management. They are responsible for keeping track of medication and ensuring the members take their medication as prescribed.

Medication records are reviewed by the case management team each quarterly. Staff are required to report all medication errors to their respective management and to the case management team. The case management team must complete a serious occurrence report in the Quality Assurance Management System within 24hours of receiving the information or witnessing the occurrence. The individual entering the serious occurrence report into the Quality Assurance Management System is required to document the cause and effect of the incident, develop an action plan to address the problem, and document steps taken to prevent incidents from occurring in the future. The case management teams meet monthly with the private duty nurse to review the medication monitoring process, if an issue is identified, the case management teams are required to complete a serious occurrence report in the Quality Assurance Management System. The Program Offers review all medication incident reports within five working days and bring issues before the Oversight Committee to review and ensure remediation of identified medication monitoring problems. Quality improvement opportunities are also discussed during the Oversight Committee meetings.

Additional methods used to ensure medications are managed appropriately are:
(1) The point-of-sale system used by pharmacy providers, which has a set of built-in edits to inform the pharmacist of potential contraindicated effects such as drug-to-drug interaction and therapeutic duplication.
(2) Prior authorization requirements established by the Drug Utilization Review Board for the Department, which are based upon clinical criteria.

If the Program Officer finds concerning potentially harmful practices during the initial review of the Person Centered Recovery Plan or subsequent evaluations, they immediately report the information to the case management team to review the plan and communicate the concerns to the provider and establish what corrective measures will be put into place. The case management team ensures the process is corrected and employs training for the provider as needed. The case management teams also have monthly meeting with providers where Medication Management issues are discussed and providers are made aware of potential harmful practices. If the potentially harmful medication management practice is discovered through a Serious Occurrence Report (SOR), the Program Officers bring the incident to the bi-weekly Critical Incident Committee Meeting for further discussion and to ensure an appropriate corrective action plan was put in place.

SORS are entered into the Quality Assurance Management System (QAMS), if the incident meets critical incident criteria. The Critical Incident Review Committee completes an internal investigation for all critical incidents entered into QAMS monthly. The Critical Incident Review Committee investigates if policies were followed and whether notifications were made within appropriate timeframes.

Internal investigation of critical incidents includes determining if the incident is a result of a failure to follow federal regulation, Montana statute, the Administrative Rules of Montana, and/or the provider agencies' policy, if there was adequate staff present to ensure health and safety, and was the staff adequately trained in the components of the person's person-centered recover plan to ensure health and safety. Results of the internal investigation may be shared with the case management team, providers, or proper authorities.

Potentially harmful practices discovered during reviews or SOR's are tracked to establish if there are overall common root causes. Training needs and education opportunities as a result of findings are outlined at the Monthly Oversight Committee Meeting.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Licensed Practical Nurses and Registered Nurses administer medication as outlined in the Nurse Practice Act of Montana (Administrative Rules of Montana, Title 24, Chapter 159; Title 37, Chapter 8, Montana Code Annotated). Administration of medication by non-nurse staff is regulated by the Department of Labor and Industry, Board of Nursing (Administrative Rules of Montana, Title 24, Chapter 159, subchapter 9). An employee of an assisted living facility who, under the general supervision of a Montana licensed nurse, administers PRN and routine medication to residents of the assisted living facility are required to become licensed Medication Aide I. Accurate medication records are required for each resident of a Health Care Facility, including over-the-counter medication, for those residents whose self-administration requires monitoring and/or assistance by the facility staff.

iii. Medication Error Reporting. *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

The Department of Public Health and Human Services, Licensure Bureau, requires staff to complete a report form for all accidents/incidents causing injury to a resident and keep it in the residents file. In addition, records must be kept including:
(1) Name of medication, reason for use, dosage, route and date and time given;
(2) Name of the prescribing practitioner and their telephone number;
(3) Any adverse reaction, unexpected effects of medication or medication error, which must also be reported to the resident's practitioner;
(4) Allergies and sensitivities, if any;
(5) Resident specific parameters and instructions for PRN medications;
(6) Documentation of treatments with resident specific parameters;
(7) Documentation of doses missed or refused by resident and why;
(8) Initials of the individual monitoring and/or assisting with self-administration of medication; and
(9) Review date and name of reviewer.

In addition, staff are required to report all medication errors to their respective management and to the case management team. The case management team must complete a serious occurrence report in the Quality Assurance Management System within 24hours of receiving the information. The individual entering the serious occurrence report into the Quality Assurance Management System is required to document the cause and effect of the incident, develop an action plan to address the problem, and document steps taken to prevent incidents from occurring in the future.

(b) Specify the types of medication errors that providers are required to *record:*

(1) Missing medication;
(2) Doses refused or missed by the member with supporting documentation; and
(3) Any adverse reaction, unexpected effects, or medication errors.

(c) Specify the types of medication errors that providers must *report* to the state:

(1) Missing medication;
(2) Doses refused or missed by the member with supporting documentation; and
(3) Any adverse reaction, unexpected effects, or medication errors.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Montana Department of Public Health and Human Services, Quality Assurance Division is responsible for the oversight to ensure the appropriate administration of medication. The Quality Assurance Division oversees medication administration for adult residential settings as part of licensure requirements. The Quality Assurance Division conducts on-site licensing surveys at application for a license, upon renewal of a license, annually, or at any time without prior notice when it is considered necessary.

The Program Officers with the Behavioral Health and Developmental Disabilities Division review medication management during the initial review of the person-centered recovery plan and during subsequent evaluations. Case management teams monitor members ensuring they receive their medication as prescribed and report any mismanagement, harmful practices, or crimes to the appropriate authorities.

The Board of Nursing sets and enforces the standards of conduct for Licensed Practice Nurses and Registered Nurses. The Board's compliance, investigative, and legal staff process and investigate complaints of unprofessional conduct filed against licensees and license applicants. They also process and investigate unlicensed persons practicing a profession requiring a license.

All licensed service providers are required to follow the laws as set forth for the category of service they provide. If the Behavioral Health and Developmental Disabilities Division is made aware of issues that are present, a report is made to the appropriate licensing Board. A finding resulting in a negative action against the provider's license may result in the provider's Montana Medicaid Provider Identification Number to be suspended or terminated and may no longer bill Montana Medicaid and the Hope Waiver Program Services. The Department receives a report of all termed providers due to negative actions against their license.

Licensed agencies and facilities are required to employ individuals who hold an active license for the category of service they provide. Licensed agencies and facilities are required to report a Serious Occurrence Report if there was a critical incident occurring at the licensed agency or facility, at which time a corrective action plan is developed, and reviewed and approved by the Program Officer.

Problems may be identified by the Program Officer during Quality Assurance Reviews, by the case management team during monthly contact with the member, or at quarterly reviews. If the problem is discovered during Quality Assurance Review, the Program Officer issues a Quality Assurance Point which is reviewed by the case management team manager and reviewed with the case management team, at which time they develop a remediation action for the error. The remediation action is returned to the Program Manager to determine if it is satisfactory or if additional investigation or corrective actions should be implemented.

Data regarding medication errors and medication monitoring is acquired and identified through the Quality Assurance Review Process, Serious Occurrence Reporting from Quality Assurance Management System, and Emergency Room reporting gathered from paid claims data from MMIS.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-

assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number of members or their informal caregivers in representative sample who received information on how to identify/report instances of A/N/E/Unexplained Death. Numerator: Total members their informal caregivers who received information on how to identify/report instances of A/N/E/Unexplained Death. Denominator: Total number of waiver members in the representative sample.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and Percent of serious occurrence/critical incidents reported within 24 hours of receiving/witnessing the occurrence. Numerator: Number of serious occurrence/critical incidents reported within 24 hours of receiving/witnessing the occurrence. Denominator: Total number of serious occurrence/critical incidents reported.

Data Source (Select one):

Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent in reduction of critical incidents with an identified cause with the highest occurrence. Numerator: Number in reduction of critical incidents with an identified cause with the highest occurrence. Denominator: Total number of critical incidents with an identified cause with the highest occurrence.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of reports of abuse/neglect/exploitation/unexplained death incidents referred to appropriate investigative entities. Numerator: Number of reports of abuse/neglect/exploitation/unexplained death incident referred to appropriate investigative entities. Denominator: Total number of reports of abuse/neglect/exploitation/unexplained death incident referred.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of reoccurring critical incident causes for a member within 3 months where systemic interventions were provided. Numerator: Number of member's with reoccurring critical incident causes within 3 months where systemic interventions were provided. Denominator: Total number of reoccurring critical incident causes for a member within 3 months.

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number of substantiated abuse/neglect/exploitation/unexplained death incidents reviews completed by the investigated entities. Numerator: Number of substantiated A/N/E/unexplained death incidents reviews completed by the investigated entities. Denominator: Total number of substantiated A/N/E/unexplained death incidents reviews required to be completed by the investigated entities.

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

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
 # and % of newly enrolled providers received training informing them of having policies in place prohibiting use of restrictive interventions.Numerator: # of newly enrolled providers received training informing them to have policies in place prohibiting use of restrictive interventions.Denominator: Total # of newly enrolled providers required to receive training info on restrictive interventions.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of member's provided info regarding member's rights outlining prohibition of restraints/reporting a restraint incident. Numerator: # of member's who received info regarding member's rights outlining prohibition of restraints/reporting a restraint incident. Denominator: Total # of member's required to received info regarding member's rights outlining prohibition/reporting of restraints.

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and percent of members that were provided the opportunity to have annual physical exam. Numerator: Total number of members who were provided the opportunity to have annual physical exam. Denominator: Total number of members in the representative sample.

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

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

		95% Confidence Level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Behavioral Health and Developmental Disabilities Division (BHDD) uses information entered into the Quality Assurance Management System as the primary method for discovery for health and welfare assurance and performance measures. In addition, BHDD uses the Medicaid Management Information System (MMIS), to review claims for unreported cases of serious occurrences.

BHDD is responsible for oversight of the serious occurrence incident management process. BHDD's Program Officers review each Serious Occurrence Report within five business days to confirm agreement with the action plan or to ask clarifying questions, if necessary. Once confirmed, the Serious Occurrence Report is returned to the provider or case management team and monitored by the Community Program Officers. The Program Officers are responsible for ensuring the action plan is activated, identified issues are resolved, and compliance has occurred. Documentation of contact, ongoing monitoring activities, and outcomes are entered and stored in the Quality Assurance Management System. If the documentation does not clearly reflect the incident has been resolved, the Program Officers request follow up by the case management teams to gather information needed by the parties involved.

BHDD's Quality Assurance (QA) Program Manager generates monthly reports to monitor Serious Occurrence Reports entered into the Quality Assurance Management System. The QA Program Manager analyzes the Serious Occurrence Reports by incident type, incident response time, remediation outcomes, and timeliness. In addition, the BHDD’s QA Program Manager generates and reviews monthly utilization reports of all occurrences of Emergency Room and urgent care visits for waiver members by claim diagnosis and procedures billed. The purpose of this report is to detect unreported incidents.

BHDD holds a monthly Oversight Committee meeting to review and discuss the management of serious occurrences. Members of the Oversight Committee include the Program Manager, the Quality Assurance Program Manager, and the Program Officers. During the Oversight Committee meeting the following is reviewed:
(1) Outstanding Serious Occurrence Reports;
(2) Trends and patterns;
(3) Strategies for prevention of future serious occurrences; and
(4) Potential unreported incidents.

Members receive a brochure upon enrollment onto the waiver and during annual reviews which includes a help line. The brochure also includes:
(1) Contact information for Adult Protective Services for the regional offices;
(2) A description of Adult Protective Services;
(3) Where to report incidents of abuse, neglect, and exploitation;
(4) Descriptions of abuse, neglect, and exploitation.

Compliance with this performance measure requires the signature section of the service plan to indicate the member and/or family/guardian have been provided information regarding rights, complaint procedures, and have received information/education on how to report abuse, neglect, and exploitation and other serious occurrences.

Critical incidents are reported to BHDD via the web-based Quality Assurance Management System. Case management teams and waiver service providers are required to report serious occurrences within specific time frames. BHDD monitors serious occurrence reporting through the Quality Assurance Management System.

All follow up action steps taken must be documented in the members record. Documentation must include a description of any mandatory reporting to Adult Protective Services, referral to law enforcement, notification to ombudsman, or additional follow-up with the member. The Program Officers and QA Program Manager determine if adequate follow up was conducted and if all appropriate actions were taken and may require additional follow up or investigation, if needed.

Serious occurrences involving providers surveyed by licensure must be reported in the Quality Assurance Management System and referred to licensure to respond. A hotline is set up for complaints about quality of care, fraud, abuse, and misuse of personal property. Licensure evaluates the complaint and initiates an investigation if warranted. Incidents of unexplained death are investigated by the Adult Protective Services to determine if the death occurred due to a substantiated abuse, neglect, or exploitation.

BHDD examines data for specific trends to include individuals having multiple serious occurrence reports. Data is examined to identify members who have more than one serious occurrence reports in 30 days, more than three serious occurrence

reports in six months, and more than five serious occurrence reports in 12 months. Records of the reports and dates provided are retained in the Quality Assurance Management System.

BHDD examines data in the Quality Assurance Management System to determine when serious occurrences were preventable and whether resolutions were effective. Substantiated serious occurrences are reviewed by the Oversight Committee to determine if these incidents have been addressed appropriately. Any reduction of root causes or trends as a result of systemic intervention data are tracked and analyzed by the Oversight Committee on a quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Issues or problems identified during annual program evaluations will be directed to the administrator or director of the case management teams and reported in the member's annual report of findings. Case management teams deficient in completing accurate and required serious occurrence reports will receive technical assistance and/or training by the Behavioral Health and Developmental Disabilities Division (BHDD) staff. Case management teams are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the case management team's remediation action plan, BHDD reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies. In addition to annual data collection and analysis, BHDD's Program Officers and Program Manager remediates problems as they arise based on the severity of the problem or by nature of the compliance issue. For issues or problems arising at any other time throughout the year, technical assistance may be provided to case manager, supervisor, or administrator, and a confidential report will be documented in the waiver recipient care file when appropriate. BHDD reviews and tracks the on-going referrals and complaints to ensure a resolution is reached, and the member's health and safety has been maintained.

BHDD provides remediation training to the case management teams annually to assist with improving compliance with performance measures. The remediation process includes a standardized template for individual Corrective Action Plans (CAP) to ensure all of the essential elements, including a root-cause analysis, are addressed in the CAP. Time limited CAPs are required for each performance measure below the 86% CMS compliance standard. The CAP must also include a detailed account of actions to be taken, staff responsible for implementing the actions, time frames, and a date for completion. BHDD reviews the CAP and either accepts or requests additional remedial action. BHDD then follows up with each individual case management team quarterly to monitor the progress of the action items outlined in their CAP.

BHDD takes remedial action with waiver service providers and/or case management teams to address deficient practice in reporting and management of serious occurrences. This includes formal request for response, technical assistance, investigation, imposition of corrective action, termination of case management team contracts, and termination of waiver service providers. Case management teams deficient in completing accurate and required follow ups receive technical assistance and/or training by BHDD staff. Case management teams are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the case management team's remediation action plan, BHDD reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies.

In instances, where upon review of the complaint or occurrence report BHDD identifies individual provider issues, these issues are addressed directly with the provider and member/guardian. If trends or patterns are identified affecting multiple providers or members, BHDD will communicate a clarification or amend the rules/polices to resolve the issues. BHDD ensures the appropriate authority is notified of any unexplained deaths resulting from substantiated abuse, neglect, or exploitation.

BHDD utilizes this information to develop statewide trainings and determine the need for individual agency technical assistance for case management and service provider agencies. In addition, BHDD utilizes this information to identify problematic practices with individual case management teams and/or providers and to take additional action such as investigating, referring the agency to licensure for complaint investigation or directing the agency to take corrective action. If BHDD identifies problematic trends in the reports, they will require a written CAP by the case management teams and/or provider agencies to mitigate future occurrences.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

○ **No**

◉ **Yes**

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

The Department of Public Health and Human Services, as part of the MPATH Project, selected AssureCare to implement their MedCompass solution to satisfy the requirements of our Care Management module. The MedCompass includes a comprehensive Incident Management submission, tracking, resolution, and reporting solution. The Department expects the Incident Management solution to be implemented and operational in 2026.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Behavioral Health and Developmental Disabilities Division (BHDD) draws from multiple sources when determining the need for, and methods to, accomplish system design changes. This Quality Improvement Strategy encompasses all services provided in the Hope Waiver. Waiver specific requirements and assurances are included in the appendices.

Discovery and Remediation:
Using the Care Management System, Program Officers complete an annual desk review for each case management team administering the waiver. The Program Officers use a standardized tool, the Standards Review Form, to review the case management functions including: process regarding evaluation of need, service planning, member monitoring (contact), case reviews, complaint procedures, provision of member choice, waiver expenditures, etc. The information is also reviewed and analyzed in aggregate to track, illustrate state trends, and use for the basis for future remediation. Following completion of the annual program reviews, case management teams are notified of individual deficiencies. They are allowed 30 days to remediate deficiencies identified during the review process. The remediation must include a plan of correction with specific time frames describing the remedies for the issue and the steps the agency plans to take to reverse the trend. BHDD monitors progress of each case management team's corrective action plans.

BHDD also reviews all critical incident reports entered into the Quality Assurance Management System. The Program Officers determine if the critical incident was substantiated, adequate follow up was conducted, and all appropriate actions were taken. The Program Officers may require additional follow up or investigation within a specified time frame. The Program Manager's role is to monitor the discovery activities of the Program Officers, to evaluate their submitted information, and to participate in policy decisions addressing provider or system deficiencies. In addition, BHDD's Quality Assurance Program Manager pulls data from the Medicaid Management Information System (MMIS) for each member on a monthly basis to review for unreported serious occurrences.

In addition to the above-mentioned electronic discovery methods, BHDD also requires the use of standardized tracking tools. This includes the:
1) level of care assessment;
2) Hope Waiver, Home and Community Based Services Waiver, Evaluation and Level of Impairment form;
3) Strength Assessment; and
4) Standards Review form.
This allow BHDD to monitor the performance of the waiver and the associated waiver assurances in a more effective manner.

BHDD holds a monthly Oversight Committee meeting to review and discuss the management of the waiver. Members of the Oversight Committee include the Program Manager, Quality Assurance Program Manager, and the Program Officers. During the Oversight Committee meeting the following is reviewed:
1) Incident management;
2) Trends and patterns;
3) Identification of individual and systemic issues and strategies to mitigate; and
4) Potential training opportunities.

The Oversight Committee, along with the appropriate managerial staff, reviews and monitors the system to determine the need for design changes. Additional partnerships are formed as needed to identify and prioritize system design changes. These partnerships may include entities such as Adult Protective Services, the Quality Assurance Division, Licensure Bureau, the Department of Public Health and Human Services, Senior and Long-Term Care Division, the Montana Program for Automating and Transforming Health Care (MPATH), and others as applicable.

Prioritization:
BHDD relies on a variety of resources to prioritize changes. In addition to using information from annual reviews, analysis of performance measure data, and feedback from case managers, the BHDD factors in appropriation of funds, legislation and federal mandates, and department wide priorities. Quality improvement activities and results are reviewed and analyzed by the Treatment Bureau Chief, Program Supervisor, Program Manager, and the Quality Assurance Program Manager.

Implementation:
Prior to implementation of a system-level improvement, the Department ensures the following are in place, as appropriate:
1) A process to address the identified need for the system-level improvement;
2) Policy and instructions to support the newly created process;
3) Method to measure progress and monitor compliance with the system-level improvement activities including identifying the responsible parties;
4) Communication/training plan;
5) Evaluation plan to measure the success of the system-level improvement activities post-implementation; and
6) Implementation strategy.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☒ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The process used to monitor the effectiveness of system design changes will include systematic reviews of baseline data, reviews of remediation efforts, and analysis of results of performance measure data collected after remediation activities have been in place long enough to produce results.

Roles and Responsibilities: The Quality Assurance Program Manager and/or the Program Manager hold shared responsibility for monitoring and assessing the effectiveness of system design changes to determine if the desired effect has been achieved. This includes incorporation of feedback from waiver members, advocates, case management teams, and other stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Quality Assurance Program Manager and the Program Manger reviews the Quality Improvement Strategy and its deliverables with management on a quarterly basis and will provide updates to CMS when appropriate.
Evaluation of the Quality Improvement Strategy will take into account the following elements:
(1) Compliance with federal and state regulations and protocols;
(2) Effectiveness of the strategy in improving care processes and outcomes;
(3) Effectiveness of the performance measures used for discovery;
(4) Effectiveness of the projects undertaken for remediation; and
(5) Relevance of the strategy with current practices.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

Case management teams send the Participant Experience Surveys to members annually and the results are compiled by the BHDD and analyzed for trends.

The department is establishing a CAHPS survey which will collect data from Montana's HCBS programs. The survey is being completed in coordination with the state's Money Follows the Person program. The survey work is expected to occur in 2025 with data submitted to the programs mid-2025.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Pursuant to 2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards Subpart F – Audit Requirements §200.502 (i), Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered federal awards expended under this part unless a State requires the funds to be treated as federal awards expended because reimbursement is on a cost-reimbursement basis. Therefore, the Behavioral Health and Developmental Disabilities Division (BHDD) does not require an independent audit of waiver service providers.

Title XIX of the Social Security Act, federal regulations, and the Montana Medicaid State Plan has established record maintenance and retention requirements for Medicaid services. A case record/medical record or file must be maintained for each waiver member. Providers are required to complete the records within 90 days of the date the claim has been submitted for reimbursement and retain records documenting the services provided and support the claims submitted for a period of six years and three months. Records may be maintained for a period longer than six years when necessary for the resolution of any pending matters such as an ongoing audit or litigation. A record is not considered complete until it is signed and dated.

Mountain Pacific (MP) staff complete an annual review of waiver paid claims by member in addition to provider claims documentation. Member's files are selected randomly based on a 95% confidence level with a 5%+/-margin. Claims for each sample member are pulled for a full fiscal year. The claims are compared with the cost sheet and person-centered plan to ensure the waiver member is receiving the services identified on the cost sheet. MP provides BHDD with the annual review report which includes any non-compliance findings. The findings are reported on the 372 report and non-compliance less than 86% will be addressed through quality improvement plans.

Case management teams have instituted an internal control system requiring all completed paperwork to be checked for accuracy and compliance.

The fiscal intermediary, contracted by the Department of Public Health and Human Services, maintains documentation of provider qualifications to furnish specific waiver services submitted during the provider enrollment process and updated according to applicable licensure and survey requirements. This documentation includes copies of the Medicaid Provider Participation Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards. All providers are screened monthly against the exclusion lists. Providers are compared against the List of Excluded Individuals and Entities, the System for Award Management, the Medicare Exclusion Database, and the state Medicaid Termination file. Comparing providers against these lists allows the Department to determine if a provider has been excluded by the Office of the Inspector General, terminated by Medicare, or terminated from another state's Medicaid or Children's Health Insurance Program.

Claims are submitted to the Department's fiscal intermediary for reimbursement. Claims data is maintained through the Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits prior to payment.

Duties of providers include a requirement of documentation of care, in/out times, and confirmation care was provided per state rules and regulations. Additionally, there must be completion of appropriate service notes regarding service provision for each visit. Documentation shall contain services provided, date and time in and out, and a confirmation that care was provided as required in Administrative Rules of Montana 37.85.414. In order for personal care providers to render services, the provider agency must ensure individuals are appropriately trained and qualified.

The Surveillance and Utilization Review (SURS) Unit of the Quality Assurance Division, within the Department of Public Health and Human Services, is responsible for conducting the periodic independent audits of the waiver program under the provisions of the Single Audit Act and provides post-payment reviews of claims. The SURS monitors provider compliance with state and federal regulations and Department policies. Internal reviewers conduct post-payment reviews of provider claims submissions to ensure accuracy of provider billing and compliance with regulations and Department billing policies. Auditing under the Surveillance Utilization Review Unit, including the number and frequency of providers reviewed, percentage of claims reviewed, and the time period of the claims reviewed—varies with the review project conducted. Review projects range in size and focus (i.e. whether on provider type or service type) and can either be a claims data-only review, or include records submitted by providers. Montana's Medicaid over payment audits are regulated by Title 53, Chapter 6, Part 14, Montana Code Annotated. Montana uses a systematic statistical sampling for the audits. This includes setting parameters for determining a universe to review (i.e. timeframe/service). Montana then selects a systematic sample (i.e. every 10th claim line) from 100% of the universe.

If fraud is suspected, the provider is referred to the Medicaid Fraud Control Unit at the Department of Justice state agency for further investigation. If fraud is identified the provider can be sanctioned and discontinued as a Medicaid provider.

BHDD review the rates annually to ensure services remain consistent and are within our Montana Legislative appropriation. Proposed fee schedules are posted as part of the Administrative Rule of Montana process for public comment when fees are changed, added or deleted. Services are reimbursed according to fee schedule. The fee schedule identifies the maximum allowable rate. An annual review is completed to review information received through multiple sources including number of providers, feedback received from providers and members, member complaints, legislative appropriation, the state of Montana's Access Plan and outcomes from Legislative committee appropriations. In addition, claims history is reviewed of all providers for trends in the amount of services utilized and monitor the number of provider enrollments and compare previous state fiscal year to current year to determine whether there has been a significant reduction of providers. Montana will research trend if the overall provider network decreases by 10 percent.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

Performance Measure:
Number and percent of waiver claims in the representative sample paid according to the reimbursement methodology in the waiver Numerator: Number of waiver claims in the representative sample paid according to the reimbursement methodology in the waiver Denominator: Total number of paid waiver claims in the representative sample.

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

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

☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% Confidence Level with a +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Number and Percent of providers paid in accordance with the rate methodology in the approved waiver. Numerator: Number of providers paid in accordance with the rate methodology in the approved waiver. Denominator: Total number of paid claims.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

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

	Ongoing	*Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

The information gathered for the annual reporting of the performance measures serves as the primary method of discovery.

The state ensures claims are coded correctly through the following mechanisms:
(1) Rates are loaded with procedure code and modifier combinations, thus any use of incorrect coding results in a denied claim; and
(2) System edits exist to ensure only specific provider types are able to bill for waiver services;

Duties of providers include a requirement of documentation of care, in/out times, and confirmation care was provided per state rules and regulations. Additionally, there must be completion of appropriate service notes regarding service provision each visit. Documentation shall contain services provided, date and time in and out, and a confirmation care was provided. Such confirmation shall be according to agency policy.

All waiver services included in the member's service plan must be prior authorized by case managers.
Behavioral Health and Developmental Disabilities Division conducts quarterly audits of member records to ensure waiver

services are aligned with and address the member's identified needs,and cost sheets match services provided and paid.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

Behavioral Health and Developmental Disabilities Division (BHDD) is responsible for addressing individual problems as they are discovered. Methods for correcting problems discovered include working with the Program Officer, case management team, and directly with the provider to correct the issue, provider training, and referrals to other state agencies for audit.

If a discrepancy is discovered during the Quality Assurance Review or at any other point in time, the case management team will be notified. The Quality Assurance Program Manager meets with the Program Officer until the issue is resolved. Outcomes and trends are documented and discussed at the monthly Oversight Meeting.

BHDD provides ongoing training to waiver providers who are identified as having issues with accuracy of proper billing. BHDD meets with the provider until resolution has occurred. In addition, the state's fiscal agent holds two provider trainings each year. The trainings give the provider an opportunity to learn proper billing practices and to discuss any billing issues.

Areas of concern are identified at any point in time, the provider may be referred to the Audit and Compliance Bureau to conduct an independent audit of the provider, or the Surveillance Utilization Review Section to complete a medical record and billing audit.

If fraud is suspected, the provider is referred to the Medicaid Fraud Control Unit for further investigation. If fraud is identified the provider can be sanctioned and discontinued as a Medicaid provider.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Hope Waiver utilizes Fee-for-Service (FFS) and a negotiated market price for the Hyperbaric Oxygen Therapy service. Each rate has a unit designation and reimbursement is equal to the rate multiplied by the number of units utilized. The Hope Waiver FFS rate schedules are published and posted to the Departments website. There will be no interim rates, no prospective payments, and no cost settlements.

The Hope Waiver does not have a geographical (rural) differential currently. The Self-direction program may assist waiver participants living in rural areas to access providers in their areas. The case management team and the waiver participant develop the Person Centered Recovery Plan (PCRP). The cost sheet is made available to the member as the services are identified. The member is aware of the reimbursement rate for each of their services identified in the PCRP. For Personal Care services, there is a different rate methodology for self-directed. For BIA and Life Coach services, there is not a different rate methodology.

BHDD review the rates annually to ensure services remain consistent and are within our Montana Legislative appropriation. Proposed fee schedules are posted as part of the Administrative Rule of Montana process for public comment when fees are changed, added or deleted. Services are reimbursed according to fee schedule. The fee schedule identifies the maximum allowable rate. An annual review is completed to review information received through multiple sources including number of providers, feedback received from providers and members, member complaints, legislative appropriation, the state of Montana's Access Plan and outcomes from Legislative committee appropriations. In addition, claims history is reviewed of all providers for trends in the amount of services utilized and monitor the number of provider enrollments and compare previous state fiscal year to current year to determine whether there has been a significant reduction of providers. Montana will research trend if the overall provider network decreases by 10 percent.

The Hope Waiver Fee Schedules can be found at the following website:
https://medicaidprovider.mt.gov/88

In 2021-2022, the Department of Public Health and Human Services contracted a comprehensive rate study across Medicaid community services reimbursed by the Department, including its three operating 1915(c) waivers. The objectives of the rate models included in this study were to:
• Recognize reasonable and necessary costs of providers
• Standardize rates
• Reflect participant needs
• Increase transparency
• Facilitate regular updates
• Provide fiscal stability for providers and the state.

The rate study included a provider cost and wage survey, distributed to all providers delivering services under review. The division and its contractor worked with key stakeholders from December 2021 to August 2022 to conduct the rate study and develop proposed waiver program rates. Stakeholder involvement included the following workgroups:
• Rate Workgroup – Composed of small and large community providers who reviewed the survey design and materials, gave input on rate component assumptions, and developed related recommendations for consideration by the Steering Committee.
• Steering Committee – Composed of key state agency staff, the lieutenant governor, legislators, and consumer and provider representatives who reviewed and selected key rate assumptions based on materials developed by the contractor and recommendations from the Rate Workgroup.

Rates were developed through an independent rate build-up methodology based on cost and wage data from providers and other state and national data sources. The independent rate build-up methodology comprises direct care and indirect care components and uses assumptions about types of employees; wage rates; employee-related expenses (ERE); direct care staff productivity; occupancy and absence factors; supervision; staffing patterns; staff mileage and client transportation costs, along with general program support and administration costs. Some components vary between services while others are the same across the services. This rate determination methodology was used to calculate rates for the following services:
•Case Management
•Respite
•Consultative Clinical and Therapeutic services
• Adult Day Health
• Behavioral Intervention Assistant

• Homemaker chore
• Nutrition (Meals)
• Private duty nursing
• Personal assistant attendant-agency based and self-directed
• Residential habilitation
• Mental health group home
• Intensive mental health group home
• Assisted living/adult foster care
• Non-Medical Transportation-miles
• Life coach

Available funding is being applied across all studied rates using the same methodology. To reduce existing disparities in rates, this methodology increases rates by a percentage of the difference between current and benchmark rates. The department is able to fund about 69.5% of the gap between the current rate and the benchmark rate. Waiver services not subject to this rate determination method are services reimbursed at provider costs. These services include Environmental Accessibility Adaptations - Home Modifications, Community Transition Services, Personal Emergency Response Systems, and Specialized Medical Equipment and Supplies. Additionally, extended State Plan Waiver services are not subject to this rate determination method. They are reimbursed according to rates aligned with and published on Montana Medicaid's RBRVS professional services fee schedule and include Occupational Therapy, Physical Therapy, Speech Therapy, Psychological Services, and Nutritionist Services.

The following services were excluded from the Guidehouse rate review because the service is reimbursed at cost: environmental accessibility adaptations, health and wellness, pain and symptom management, personal emergency response-rental, specialized medical supplies and transportation trip.
Specialized medical equipment rate reimbursement aligns with state plan as follows: 75% of manufacturer suggested retail price.

All waiver services are preauthorized through a service authorization record in MMIS and are based on the person's Plan of Care. The member's cost plan identifies each service, the providers to deliver each service, and either the units identified as necessary or maximum cost allowable. Claims submitted for services not have the corresponding authorization record will be denied.

Public comment ran from May 1, 2023 to May 30, 2023. The Montana Department of Public Health and Human Services (DPHHS) has undertaken a robust public notice process in compliance with state and federal requirements. The Department complied notified Tribal Governments, Urban Indian Health Centers and Indian Health Services of the amendment on April 27, 2023. The Department posted notice, along with a summary of waiver changes, in the state's largest newspapers on April 30, 2023, and invited public comments and questions regarding its intent to submit the amendment. The amendment, summary of changes, and information regarding public comments was posted on the Behavioral Health and Disability Determination Divisions website. All notices contained the following information: "Questions and comments can be submitted from May 1, 2023 to May 30, 2023, addressed to: Mary Eve Kulawik, Medicaid State Plan Amendment and Waiver Coordinator, at (406) 444-2584 or mkulawik@mt.gov; or Director's Office, PO Box 4210, Helena, MT 59604-4210." The Department also engaged stakeholders via regular virtual meetings to provide feedback. Finally, electronic mail requesting public input was sent to Montana Health Coalition Members, Ad Hoc Members, and Interested Parties. The Department received no comments.

The process for any Medicaid rates are the responsibility of the Legislative budget sub-committee. If they approve, they will present to the overall Legislative body for inclusion and approval in the State budget. The Chief Financial Medicaid Officer within DPHHS works to create an overall budget to present to the Legislative budget sub-committee for approval.

continued in Main Module B (Optional)

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Waiver service providers bill Montana Medicaid through the Montana Medicaid Information System (MMIS). Payments are issued directly to the providers; no funds are retained by the Department or by the State. All services are prior authorized and all claims are paid through the MMIS.

The MMIS has edits in place to ensure all services are allowable and reimbursed at the appropriate rate. Providers must enroll as a waiver provider in MMIS. Each provider has a charge file of the services (procedure codes) they are approved to provide. These files are updated annually with the appropriate fiscal year reimbursement rate. BHDD staff provides the information to the fiscal intermediary for updating. MMIS contains edits to ensures the member is eligible for services billed. If all is appropriate, the claim is paid. If there is an error anywhere in this process, the claim is denied.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Montana implemented a EVV solution on 09/18/2023. The EVV solution will be integrated into the MMIS system as an integral part of assuring pre-payment validations occur. The system meets the three essential tests of pre-payment validation. There are a series of validations for payments.

First, this integration will establish eligibility by determining if an open waiver span exists. This information is received from the MMIS eligibility system. If the span does not exist, the claim will not be created.

Second, services approved in the plan of care require a prior authorization to be entered and active in the MMIS system. A prior authorization for the service must exist for the appropriate days of services or the service is deemed outside the scope of the plan of care. The claim will not be created.

Third, Montana's EVV system is a cellular check in /check out system. The direct care worker must complete the processes, including indicating tasks are completed and signed off by the member or an approved member representative. When a check in or a log-out is not present in the system, the claim will not advance for payment. When cellular coverage is not available, the offline data is held until such time the visit can be uploaded.

The Hope Waiver has the following services covered under EVV:
Behavioral Intervention Assistant (BIA)
Respite Care
Personal Assistance Attendant
Personal Assistance Attendant- Self-Directed
Private Duty Nursing, RN
Private Duty Nursing, LPN

Billing validation is accomplished primarily by the Department of Public Health and Human Service's Medicaid Management Information System (MMIS). MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits prior to payment. MMIS has a member eligibility system verifying eligibility for Medicaid and the waiver. Electronic eligibility files are uploaded into the MMIS daily to ensure updated verification of eligibility. Claims submitted for members who are not eligible on the date of service are denied.

All waiver services included in the member's service plan must be prior authorized by case managers. Case managers monitor service provision to ensure services are being provided according to the service plan. Should a discrepancy occur between a provider's claim, what the member reports, or should the member report the provider is not providing services according to the service plan, the case manager reports the information to the Behavioral Health and Developmental Disabilities Division (BHDD) for investigation.

The Quality Assurance Reviews also verifies payments for services were made in accordance with the Person-Centered Recovery Plan and no Hope Waiver services were paid for a member who was discharged from the waiver.

Case management teams check in with each member on a monthly basis to determine services are being provided appropriately, as well a meets monthly with providers to discuss the delivery of services.

Recoupments for overpayments are achieved one of two ways. If it is discovered a provider was paid for a service or services in error, BHDD may contact the provider in writing to indicate a payment was made in error and an overpayment is due, or BHDD can forward the information to the Surveillance Utilization & Review Section (SURS) to request reimbursement from the provider.
The process includes:
1) Identifying the specific claims paid in error
2) Communicating the error to the provider and requesting clarification or additional documentation if appropriate, and
3) Requesting the provider either adjust the error claim or remit a check for the amount of the recoupment. This request is made in writing and outlines appropriate ARMS allowing for recoupment, and the provider's due process rights.
B. Inappropriate payments are removed from FFP via our Fiscal Bureau if within the designated timeframe allowed by federal regulation via the use of CMS Form 64.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and*

providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

- ☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***
- ☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***
- ☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

(1) Nursing facilities that receive county tax dollars may provide Respite Services to members who are on the waiver.
(2) Local city-county health departments that receive city or county tax dollars may provide direct nursing services to waiver members.
(3) Community Mental Health Centers that receive county tax dollars may provide professional mental health services to members on the waiver.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Hope Waiver qualified service providers are designated as OHCDS in cases where the enrolled provider subcontracts with other entities (persons or agencies) for the provision of services not provided by staff employed by the agency. Any person or agency providing services under a subcontract must meet the Hope Waiver qualified provider standards for the provision of the service. It is the responsibility of the enrolled Hope Waiver provider to ensure the QP standards for the subcontracted service are met and documentation is maintained by the agency with the OHCDS designation to support this requirement.

(a) Entities are designated as OHCDS. Providers are designated as OHCDS in cases where the enrolled provider subcontracts with other entities (persons or agencies) for the provision of services not provided by staff employed by the agency. Any person or agency providing services under a subcontract must meet the Hope Waiver qualified provider standards for the provision of the service. It is the responsibility of the enrolled Hope Waiver provider to ensure the qualified provider standards for the subcontracted service are met and documentation is maintained by the agency with the OHCDS designation to support this requirement.
(b) Providers of waiver services may choose to bill the Hope Waiver directly if they are an enrolled Hope Waiver provider. The potential service provider would complete an application through MMIS. After the required application and documentation has been reviewed and approved the applicant would achieve qualified provider status.
(c) Individuals are free to request the services of any qualified provider, as outlined in previous sections. Case managers are responsible for providing information to individuals and families regarding available service providers as part of the planning process. Provider agencies currently subcontract with various providers of professional and therapy services, in response to the expressed desires of the individual and/or family.
(d) Claims break out procedure codes which allow the reporting of the delivery of all waiver services by waiver service category. This information is a critical piece of the paid claims history and audit trail, and is subject to review by independent, state, and federal auditors.
(e) The provider agency designated as an Organized Health Care Delivery System (OHCDS) is accountable for maintaining documentation verifying the credentials of subcontracted staff.
(f) Financial accountability is maintained as follows: Providers may subcontract for the delivery of waiver services if the enrolled Hope Waiver provider has been designated as an Organized Health Care Delivery System in their enrollment addendum. In this case, the enrolled Hope Waiver provider has the option of reimbursing another waiver service provider, at a rate equal to or less than the approved Medicaid rate. There can be no Medicaid payment made to the provider issuing the subcontract for submitting claims or processing payment, maintenance of documentation, or verification of credentials of the subcontracting entity, when the subcontracted entity bills at the Medicaid rate. The enrolled Hope Waiver provider is responsible for ensuring the subcontracted service is delivered in accordance with the plan of care, the service authorization, and the applicable qualified provider standards for the service. The enrolled Hope Waiver provider issuing the subcontract is responsible for maintenance of a "funding and service delivery paper trail", enabling auditors and Hope Waiver reviewers to verify the delivery of services in accordance with the aforementioned requirements. The Hope Waiver QA financial review occurs annually. The additional assurance of individual/unpaid caregiver survey questions linked to the delivery of services outlined in the plan of care, the service authorization and the sampled claims reduces the potential for fraudulent billing and the misuse of Medicaid funds.

The Performance Measure and Quality Assurance review process reviews the qualified provider documentation for staff providing the services outlined in the plan of care and the service authorization. The Hope Waiver quality assurance personnel may choose to verify the professional licensure or certification status at the Montana Department of Labor website, in addition to reviewing the certification or licensure records of subcontracted staff maintained by the provider agency designated as an OHCDS.

Providers of waiver services may choose to bill the Hope Wavier directly if they are an enrolled Hope Waiver provider. The potential service provider would complete an application through MMIS. After the required application and documentation has been reviewed and approved the applicant would achieve qualified provider status.
Individuals are free to request the services of any qualified provider, as outlined in previous sections. Case managers are responsible for providing information to individuals and families regarding available service providers as part of the planning and pre-planning meeting process.

Claims break out procedure codes which allow the reporting of the delivery of all waiver services by waiver service category. This information is a critical piece of the paid claims history and audit trail, and is subject to review by independent, state, and federal auditors.
The provider subcontracting shall have written agreements specifying the duties, responsibilities, and compensation of the subcontractor and must maintaining documentation verifying the credentials of subcontracted staff.
Providers may subcontract for the delivery of waiver services if the enrolled Hope Waiver provider has been designated as an Organized Health Care Delivery System. The enrolled Hope Wavier provider is responsible for ensuring the subcontracted service is delivered in accordance with the plan of care, the service authorization, and the applicable qualified provider standards for the service. The enrolled Hope Waiver provider issuing the subcontract is responsible for maintenance of a "funding and service delivery paper trail", enabling auditors and Hope Waiver reviewers to verify the delivery of services in accordance with the aforementioned requirements.

Adding services provided by an OHCDS provides additional options for members to receive necessary services where provider's are experiencing shortages in resources. The additional service options will expand the number of providers, increase access to the community and the frequency of services provided to members throughout the state.
Execute and hold Medicaid provider agreement through being deemed by the State to function as an OHCDS or as authorized under a written agreement with the Department. Hope Waiver qualified service providers are designated as OHCDS in cases where the enrolled provider subcontracts with other entities (persons or agencies) for the provision of services not provided by staff employed by the agency. Any person or agency providing services under a subcontract must meet the Hope Waiver qualified provider standards for the provision of the service. It is the responsibility of the enrolled Hope Waiver provider to ensure the QP standards for the subcontracted service are met and documentation is maintained by the agency with the OHCDS designation to support this requirement.

Financial accountability is maintained as follows: Providers may subcontract for the delivery of waiver services if the enrolled Hope Waiver provider has been designated as an Organized Health Care Delivery System in their enrollment addendum. In this case, the enrolled Hope Waiver provider has the option of reimbursing another waiver service provider, at a rate equal to or less than the approved Medicaid rate. There can be no Medicaid payment made to the provider issuing the subcontract for submitting claims or processing payment, maintenance of documentation, or verification of credentials of the subcontracting entity, when the subcontracted entity bills at the Medicaid rate. The enrolled Hope Waiver provider is responsible for ensuring the subcontracted service is delivered in accordance with the plan of care, the service authorization, and the applicable qualified provider standards for the service. The enrolled Hope Waiver provider issuing the subcontract is responsible for maintenance of a "funding and service delivery paper trail", enabling auditors and Hope Waiver reviewers to verify the delivery of services in accordance with the aforementioned requirements. The Hope Waiver QA financial review occurs annually and OHCDS' are included in the review and random sample. The additional assurance of individual/unpaid caregiver survey questions linked to the delivery of services outlined in the plan of care, the service authorization and the sampled claims reduces the potential for fraudulent billing and the misuse of Medicaid funds

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The Department of Public Health and Human Services sets reimbursement for room and board in residential settings equitable to the amount utilized when determining Medicaid eligibility. Upon admission, providers are notified that the waiver can not cover the cost of room and board for the member.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii*

through I-7-a-iv):

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	65149.21	16923.30	82072.51	59586.99	34933.08	94520.07	12447.56
2	63187.20	17430.99	80618.19	61374.59	35981.07	97355.66	16737.47
3	57537.70	17953.91	75491.61	63215.82	37060.50	100276.32	24784.71
4	60413.68	18492.52	78906.20	65112.29	38172.31	103284.60	24378.40
5	63399.37	19047.29	82446.66	67065.65	39317.47	106383.12	23936.46

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(1 of 9)*

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	600	600
Year 2	650	650
Year 3	750	750
Year 4	750	750
Year 5	750	750

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(2 of 9)*

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Behavioral Health and Developmental Disabilities Division (BHDD) estimated the average length of stay based on the Hope Waiver by reviewing historical data on the 372 reports for the past three years and determined this was 263.

Montana's Medicaid Management Information System (MMIS) was used to calculate data for the 372 reports.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

For each individual service, the Behavioral Health and Developmental Disabilities Division (BHDD) estimated the number of members utilizing each service, the number of units per user, the average cost per unit and the total cost of the service. To estimate these factors the Department examined historical growth rates and the fraction of the total population utilizing each service.

State FY 2024 data was used as the baseline to determine utilization of billed/paid services and estimated number of users per service to determine cost. This includes the applicable rates from the Guidehouse rate study. For services in the SFY24 underutilized or not utilized, the baseline was estimated based on an average of the most recent utilized time frames. The fraction of growth rates source of data is 372 waiver reports which include number of utilizers of each service and total of waiver members. BHDD divides service utilizers into total waiver enrollments to calculate fraction of total population using services.

An estimated 2% provider rate increase was factored into Waiver Years 2, 3, 4, and 5. The percentage of provider rate increase was determined by historical legislative provider rate increases. In addition, a 3% increase was estimated for projected increases in the population served.

FY24 paid claims data from Montana's Medicaid Management Information System (MMIS) was used to calculate Factor D.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

To calculate the Medicaid State Plan service costs associated with Hope Waiver members, Behavioral Health and Developmental Disabilities Division (BHDD) analyzed historical D' values. FY 2024 was used as the baseline and an estimated 2% annual increase was factored in for waiver years 2, 3, 4, and 3% reflects projected increases in population served. This includes the applicable rates from the Guidehouse rate study.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

To calculate nursing facility costs, Behavioral Health and Developmental Disabilities Division (BHDD) examined utilization and average per user mental health nursing facility costs (Montana Mental Health Nursing Care Center), and traditional nursing facility costs. FY 2024 was used as the baseline and an estimated 2% annual increase was factored in for waiver years 2, 3, 4, and 5. This includes the applicable rates from the Guidehouse rate study. The increase was only applied to traditional nursing facility cost as mental health nursing care cost is a negotiated rate.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

When determining the Medicaid State Plan costs for nursing facility clients, FY 2024 was used as the baseline and a 2% annual increase was factored in for waiver years 2, 3, 4, and 5. This includes the applicable rates from the Guidehouse rate study.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health	
Case Management	
Residential Habilitation	
Respite	
Supported Employment	
Behavioral Intervention Assistant	
Community Transition	
Consultative Clinical and Therapeutic Services	
Environmental Accessibility Adaptations	
Health and Wellness	
Homemaker Chore	
Life Coach	
Meals	
Non-Medical Transportation	
Pain and Symptom Management	
Personal Assistance Service	
Personal Emergency Response System	
Private Duty Nursing	
Specialized Medical Equipment and Supplies	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Health Total:							***53486.16***
Adult Day Health	☐	*15 min*	*7*	*2418.00*	*3.16*	***53486.16***	

GRAND TOTAL:	***39089527.46***
Total: Services included in capitation:	
Total: Services not included in capitation:	*39089527.46*
Total Estimated Unduplicated Participants:	***600***
Factor D (Divide total by number of participants):	***65149.21***
Services included in capitation:	
Services not included in capitation:	*65149.21*
Average Length of Stay on the Waiver:	*279*

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							**2888844.00**
Case Management, Daily	☐	day	578	340.00	14.70	**2888844.00**	
Residential Habilitation Total:							**23174677.60**
Specialized Residential Habilitation	☐	day	194	365.00	124.75	**8833547.50**	
Residential Habilitation	☐	day	166	341.00	253.35	**14341130.10**	
Respite Total:							**1589.28**
Respite Care, Per Diem	☐	day	2	3.00	192.64	**1155.84**	
Respite	☐	15 min	2	36.00	6.02	**433.44**	
Supported Employment Total:							**287.40**
Supported Employment	☐	15 minute	2	10.00	14.37	**287.40**	
Behavioral Intervention Assistant Total:							**8353144.80**
Behavioral Intervention Assistant	☐	15 min	312	2135.00	12.54	**8353144.80**	
Community Transition Total:							**8721.20**
Community Transition	☐	service	2	2.00	2180.30	**8721.20**	
Consultative Clinical and Therapeutic Services Total:							**230245.80**
Consultative Clinical and Therapeutic Services	☐	service	15	38.00	403.94	**230245.80**	
Environmental Accessibility Adaptations Total:							**4360.60**
Environmental Accessibility Adaptations	☐	service	1	1.00	4360.60	**4360.60**	
Health and Wellness Total:							**475230.60**
Health and Wellness	☐	service	78	69.00	88.30	**475230.60**	

GRAND TOTAL:	**39089527.46**
Total: Services included in capitation:	
Total: Services not included in capitation:	39089527.46
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**65149.21**
Services included in capitation:	
Services not included in capitation:	65149.21
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Chore Total:							**17876.16**
Homemaker Chore	☐	per job	6	9.00	331.04	**17876.16**	
Life Coach Total:							**2160360.00**
Life Coach	☐	15 min	240	706.00	12.75	**2160360.00**	
Meals Total:							**308783.28**
Meals	☐	meal	104	331.00	8.97	**308783.28**	
Non-Medical Transportation Total:							**159107.24**
Non-Medical Transportation, per mile	☐	mile	262	818.00	0.59	**126446.44**	
Non-Medical Transportation	☐	trip	8	274.00	14.90	**32660.80**	
Pain and Symptom Management Total:							**33921.36**
Pain and Symptom Management	☐	service	22	18.00	85.66	**33921.36**	
Personal Assistance Service Total:							**929796.14**
Personal Assistance Services	☐	15 min	91	1282.00	7.97	**929796.14**	
Personal Emergency Response System Total:							**23468.64**
Personal Emergency Response System	☐	monthly	39	8.00	75.22	**23468.64**	
Private Duty Nursing Total:							**180595.50**
PAS Nurse Supervision	☐	15 min	40	160.00	14.12	**90368.00**	
RN Supervision	☐	15 min	55	85.00	19.30	**90227.50**	
Specialized Medical Equipment and Supplies Total:							**85031.70**
Specialized	☐					**45786.30**	

GRAND TOTAL:	**39089527.46**
Total: Services included in capitation:	
Total: Services not included in capitation:	39089527.46
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**65149.21**
Services included in capitation:	
Services not included in capitation:	65149.21
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Equipment		item	21	1.00	2180.30		
Specialized Medical Supply	☐	item	18	1.00	2180.30	39245.40	

GRAND TOTAL:	39089527.46
Total: Services included in capitation:	
Total: Services not included in capitation:	39089527.46
Total Estimated Unduplicated Participants:	600
Factor D (Divide total by number of participants):	65149.21
Services included in capitation:	
Services not included in capitation:	65149.21
Average Length of Stay on the Waiver:	279

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							54501.72
Adult Day Health	☐	15 min	7	2418.00	3.22	54501.72	
Case Management Total:							3032477.00
Case Management, Daily	☐	day	595	340.00	14.99	3032477.00	
Residential Habilitation Total:							24357978.62
Specialized Residential Habilitation	☐	day	200	365.00	127.25	9289250.00	
Residential Habilitation	☐	day	171	341.00	258.42	15068728.62	
Respite Total:							1621.02
Respite Care, Per Diem	☐	day				1178.94	

GRAND TOTAL:	41071681.61
Total: Services included in capitation:	
Total: Services not included in capitation:	41071681.61
Total Estimated Unduplicated Participants:	650
Factor D (Divide total by number of participants):	63187.20
Services included in capitation:	
Services not included in capitation:	63187.20
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			2	3.00	196.49		
Respite	☐	15 minute	2	36.00	6.14	442.08	
Supported Employment Total:							293.20
Supported Employment	☐	15 minute	2	10.00	14.66	293.20	
Behavioral Intervention Assistant Total:							8765434.65
Behavioral Intervention Assistant	☐	15 min	321	2135.00	12.79	8765434.65	
Community Transition Total:							8895.64
Community Transition	☐	service	2	2.00	2223.91	8895.64	
Consultative Clinical and Therapeutic Services Total:							250508.16
Consultative Clinical and Therapeutic Services	☐	service	16	38.00	412.02	250508.16	
Environmental Accessibility Adaptations Total:							4447.81
Environmental Accessibility Adaptations	☐	service	1	1.00	4447.81	4447.81	
Health and Wellness Total:							497186.40
Health and Wellness	☐	service	80	69.00	90.07	497186.40	
Homemaker Chore Total:							18233.64
Homemaker Chore	☐	per job	6	9.00	337.66	18233.64	
Life Coach Total:							2268709.82
Life Coach	☐	15 min	247	706.00	13.01	2268709.82	
Meals Total:							324065.55
Meals	☐	meal	107	331.00	9.15	324065.55	
Non-Medical Transportation							165834.40

GRAND TOTAL:	41071681.61
Total: Services included in capitation:	
Total: Services not included in capitation:	41071681.61
Total Estimated Unduplicated Participants:	650
Factor D (Divide total by number of participants):	63187.20
Services included in capitation:	
Services not included in capitation:	63187.20
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Non-Medical Transportation, per mile	☐	mile	270	818.00	0.60	**132516.00**	
Non-Medical Transportation	☐	trip	8	274.00	15.20	**33318.40**	
Pain and Symptom Management Total:							**36171.18**
Pain and Symptom Management	☐	service	23	18.00	87.37	**36171.18**	
Personal Assistance Service Total:							**979730.04**
Personal Assistance Services	☐	15 min	94	1282.00	8.13	**979730.04**	
Personal Emergency Response System Total:							**24550.40**
Personal Emergency Response System	☐	monthly	40	8.00	76.72	**24550.40**	
Private Duty Nursing Total:							**189862.05**
PAS Nurse Supervision	☐	15 min	41	160.00	14.40	**94464.00**	
RN Supervision	☐	15 min	57	85.00	19.69	**95398.05**	
Specialized Medical Equipment and Supplies Total:							**91180.31**
Specialized Medical Equipment	☐	item	22	1.00	2223.91	**48926.02**	
Specialized Medical Supply	☐	item	19	1.00	2223.91	**42254.29**	

GRAND TOTAL:	**41071681.61**
Total: Services included in capitation:	
Total: Services not included in capitation:	41071681.61
Total Estimated Unduplicated Participants:	**650**
Factor D (Divide total by number of participants):	**63187.20**
Services included in capitation:	
Services not included in capitation:	63187.20
Average Length of Stay on the Waiver:	279

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box*

next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**55517.28**
Adult Day Health	☐	15 min	7	2418.00	3.28	**55517.28**	
Case Management Total:							**3186741.80**
Case Management, Daily	☐	day	613	340.00	15.29	**3186741.80**	
Residential Habilitation Total:							**25579279.44**
Specialized Residential Habilitation	☐	day	206	365.00	129.80	**9759662.00**	
Residential Habilitation	☐	day	176	341.00	263.59	**15819617.44**	
Respite Total:							**1653.24**
Respite Care, Per Diem	☐	day	2	3.00	200.42	**1202.52**	
Respite	☐	15 minute	2	36.00	6.26	**450.72**	
Supported Employment Total:							**299.00**
Supported Employment	☐	15 minute	2	10.00	14.95	**299.00**	
Behavioral Intervention Assistant Total:							**9222239.25**
Behavioral Intervention Assistant	☐	15 min	331	2135.00	13.05	**9222239.25**	
Community Transition Total:							**9073.56**
Community Transition	☐	service	2	2.00	2268.39	**9073.56**	
Consultative Clinical and Therapeutic Services Total:							**271487.96**
Consultative Clinical and Therapeutic Services	☐	service	17	38.00	420.26	**271487.96**	

GRAND TOTAL:	**43153273.39**
Total: Services included in capitation:	
Total: Services not included in capitation:	43153273.39
Total Estimated Unduplicated Participants:	**750**
Factor D (Divide total by number of participants):	**57537.70**
Services included in capitation:	
Services not included in capitation:	57537.70
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:							**4536.77**
Environmental Accessibility Adaptations	☐	service	1	1.00	4536.77	**4536.77**	
Health and Wellness Total:							**519800.46**
Health and Wellness	☐	service	82	69.00	91.87	**519800.46**	
Homemaker Chore Total:							**18598.14**
Homemaker Chore	☐	per job	6	9.00	344.41	**18598.14**	
Life Coach Total:							**2379629.48**
Life Coach	☐	15 min	254	706.00	13.27	**2379629.48**	
Meals Total:							**339705.30**
Meals	☐	meal	110	331.00	9.33	**339705.30**	
Non-Medical Transportation Total:							**172692.44**
Non-Medical Transportation, per mile	☐	mile	278	818.00	0.61	**138716.44**	
Non-Medical Transportation	☐	trip	8	274.00	15.50	**33976.00**	
Pain and Symptom Management Total:							**38499.84**
Pain and Symptom Management	☐	service	24	18.00	89.12	**38499.84**	
Personal Assistance Service Total:							**1030894.66**
Personal Assistance Services	☐	15 minute	97	1282.00	8.29	**1030894.66**	
Personal Emergency Response System Total:							**25666.00**
Personal Emergency Response System	☐	monthly	41	8.00	78.25	**25666.00**	
Private Duty Nursing Total:							**199418.00**

GRAND TOTAL:	**43153273.39**
Total: Services included in capitation:	
Total: Services not included in capitation:	43153273.39
Total Estimated Unduplicated Participants:	**750**
Factor D (Divide total by number of participants):	**57537.70**
Services included in capitation:	
Services not included in capitation:	57537.70
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PAS Nurse Supervision	☐	15 min	42	160.00	14.69	98716.80	
RN Supervision	☐	15 min	59	85.00	20.08	100701.20	
Specialized Medical Equipment and Supplies Total:							97540.77
Specialized Medical Equipment	☐	item	23	1.00	2268.39	52172.97	
Specialized Medical Supply	☐	item	20	1.00	2268.39	45367.80	

GRAND TOTAL:	43153273.39
Total: Services included in capitation:	
Total: Services not included in capitation:	43153273.39
Total Estimated Unduplicated Participants:	750
Factor D (Divide total by number of participants):	57537.70
Services included in capitation:	
Services not included in capitation:	57537.70
Average Length of Stay on the Waiver:	279

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							56702.10
Adult Day Health	☐	15 min	7	2418.00	3.35	56702.10	
Case Management Total:							3346824.00
Case Management, Daily	☐	day	631	340.00	15.60	3346824.00	
Residential Habilitation Total:							26839420.06

GRAND TOTAL:	45310257.50
Total: Services included in capitation:	
Total: Services not included in capitation:	45310257.50
Total Estimated Unduplicated Participants:	750
Factor D (Divide total by number of participants):	60413.68
Services included in capitation:	
Services not included in capitation:	60413.70
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Residential Habilitation	☐	day	212	365.00	132.40	10245112.00	
Residential Habilitation	☐	day	181	341.00	268.86	16594308.06	
Respite Total:							1686.66
Respite Care, Per Diem	☐	day	2	3.00	204.43	1226.58	
Respite	☐	15 minute	2	36.00	6.39	460.08	
Supported Employment Total:							305.00
Supported Employment	☐	15 minute	2	10.00	15.25	305.00	
Behavioral Intervention Assistant Total:							9690145.85
Behavioral Intervention Assistant	☐	15 min	341	2135.00	13.31	9690145.85	
Community Transition Total:							9255.04
Community Transition	☐	service	2	2.00	2313.76	9255.04	
Consultative Clinical and Therapeutic Services Total:							293210.28
Consultative Clinical and Therapeutic Services	☐	service	18	38.00	428.67	293210.28	
Environmental Accessibility Adaptations Total:							4627.51
Environmental Accessibility Adaptations	☐	service	1	1.00	4627.51	4627.51	
Health and Wellness Total:							543143.16
Health and Wellness	☐	service	84	69.00	93.71	543143.16	
Homemaker Chore Total:							18970.20
Homemaker Chore	☐	job	6	9.00	351.30	18970.20	
Life Coach Total:							2504520.88
Life Coach	☐					2504520.88	

GRAND TOTAL:	**45310257.50**
Total: Services included in capitation:	
Total: Services not included in capitation:	45310257.50
Total Estimated Unduplicated Participants:	**750**
Factor D (Divide total by number of participants):	**60413.68**
Services included in capitation:	
Services not included in capitation:	60413.70
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 min	262	706.00	13.54		
Meals Total:							**356076.56**
Meals	☐	meal	113	331.00	9.52	**356076.56**	
Non-Medical Transportation Total:							**179703.28**
Non-Medical Transportation, per mile	☐	mile	286	818.00	0.62	**145047.76**	
Non-Medical Transportation	☐	trip	8	274.00	15.81	**34655.52**	
Pain and Symptom Management Total:							**40905.00**
Pain and Symptom Management	☐	service	25	18.00	90.90	**40905.00**	
Personal Assistance Service Total:							**1084572.00**
Personal Assistance Services	☐	15 min	100	1282.00	8.46	**1084572.00**	
Personal Emergency Response System Total:							**26819.52**
Personal Emergency Response System	☐	monthly	42	8.00	79.82	**26819.52**	
Private Duty Nursing Total:							**209251.20**
PAS Nurse Supervision	☐	15 min	43	160.00	14.98	**103062.40**	
RN Supervision	☐	15 min	61	85.00	20.48	**106188.80**	
Specialized Medical Equipment and Supplies Total:							**104119.20**
Specialized Medical Equipment	☐	item	24	1.00	2313.76	**55530.24**	
Specialized Medical Supply	☐	item	21	1.00	2313.76	**48588.96**	

GRAND TOTAL:	**45310257.50**
Total: Services included in capitation:	
Total: Services not included in capitation:	*45310257.50*
Total Estimated Unduplicated Participants:	**750**
Factor D (Divide total by number of participants):	**60413.68**
Services included in capitation:	
Services not included in capitation:	*60413.70*
Average Length of Stay on the Waiver:	279

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**57886.92**
Adult Day Health	☐	15 min	7	2418.00	3.42	**57886.92**	
Case Management Total:							**3516110.00**
Case Management, Daily	☐	day	650	340.00	15.91	**3516110.00**	
Residential Habilitation Total:							**28139874.74**
Specialized Residential Habilitation	☐	day	218	365.00	135.05	**10745928.50**	
Residential Habilitation	☐	day	186	341.00	274.24	**17393946.24**	
Respite Total:							**1720.56**
Respite Care, Per Diem	☐	day	2	3.00	208.52	**1251.12**	
Respite	☐	15 minute	2	36.00	6.52	**469.44**	
Supported Employment Total:							**311.20**
Supported Employment	☐	15 minute	2	10.00	15.56	**311.20**	
Behavioral Intervention Assistant Total:							**10176648.30**
Behavioral Intervention Assistant	☐	15 min	351	2135.00	13.58	**10176648.30**	
Community Transition Total:							**9440.16**
Community Transition	☐	service	2	2.00	2360.04	**9440.16**	

GRAND TOTAL:	**47549529.85**
Total: Services included in capitation:	
Total: Services not included in capitation:	47549529.85
Total Estimated Unduplicated Participants:	**750**
Factor D (Divide total by number of participants):	**63399.37**
Services included in capitation:	
Services not included in capitation:	63399.37
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services Total:							**315687.28**
Consultative Clinical and Therapeutic Services	☐	service	19	38.00	437.24	**315687.28**	
Environmental Accessibility Adaptations Total:							**4720.06**
Environmental Accessibility Adaptations	☐	service	1	1.00	4720.06	**4720.06**	
Health and Wellness Total:							**573766.74**
Health and Wellness	☐	service	87	69.00	95.58	**573766.74**	
Homemaker Chore Total:							**19376.82**
Homemaker Chore	☐	per job	6	9.00	358.83	**19376.82**	
Life Coach Total:							**2632462.20**
Life Coach	☐	15 min	270	706.00	13.81	**2632462.20**	
Meals Total:							**372825.16**
Meals	☐	meal	116	331.00	9.71	**372825.16**	
Non-Medical Transportation Total:							**187382.26**
Non-Medical Transportation, per mile	☐	mile	295	818.00	0.63	**152025.30**	
Non-Medical Transportation	☐	trip	8	274.00	16.13	**35356.96**	
Pain and Symptom Management Total:							**43392.96**
Pain and Symptom Management	☐	service	26	18.00	92.72	**43392.96**	
Personal Assistance Service Total:							**1139556.98**
Personal Assistance Services	☐	15 min	103	1282.00	8.63	**1139556.98**	
Personal Emergency							**28008.48**

GRAND TOTAL:	**47549529.85**
Total: Services included in capitation:	
Total: Services not included in capitation:	47549529.85
Total Estimated Unduplicated Participants:	**750**
Factor D (Divide total by number of participants):	**63399.37**
Services included in capitation:	
Services not included in capitation:	63399.37
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response System Total:							
Personal Emergency Response System	☐	monthly	43	8.00	81.42	**28008.48**	
Private Duty Nursing Total:							**219437.15**
PAS Nurse Supervision	☐	15 min	44	160.00	15.28	**107571.20**	
RN Supervision	☐	15 min	63	85.00	20.89	**111865.95**	
Specialized Medical Equipment and Supplies Total:							**110921.88**
Specialized Medical Equipment	☐	item	25	1.00	2360.04	**59001.00**	
Specialized Medical Supply	☐	item	22	1.00	2360.04	**51920.88**	

GRAND TOTAL:	**47549529.85**
Total: Services included in capitation:	
Total: Services not included in capitation:	47549529.85
Total Estimated Unduplicated Participants:	**750**
Factor D (Divide total by number of participants):	**63399.37**
Services included in capitation:	
Services not included in capitation:	63399.37
Average Length of Stay on the Waiver:	279