

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:

Behavioral Health Severe and Disabling Mental Illness Home and Community Based Services

C. Waiver Number: MT.0455

Original Base Waiver Number: MT.0455.

D. Amendment Number: MT.0455.R02.05

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

02/11/19

Approved Effective Date: 02/11/19

Approved Effective Date of Waiver being Amended: 07/01/15

2. Purpose(s) of Amendment

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

DPHHS has determined that an increase to the PDN fees is necessary to serve high-needs Montana Medicaid members in the least costly setting. According to the Montana Medicaid 2017 Access Monitoring Plan, one PDN provider withdrew as a Medicaid provider between state fiscal years 2016 and 2017, leaving four providers available to serve Montana's Medicaid population. In 2018, one of the four remaining providers notified the Department that it could no longer provide PDN at the reimbursement rate currently paid by the Medicaid program, and that it would discontinue services within three months.

In response, DPHHS analyzed the Medicaid population served, the number of PDN agencies across the state, the existing labor market for nurses, the cost of providing PDN benefits to Medicaid members, and the higher level of care costs avoided by providing the PDN benefit.

When this amendment is effective, the Department will reimburse private duty nursing providers at the rates of \$8.95 per 15 minutes of care by a licensed practical nurse (LPN), \$11.28 per 15 minutes by a registered nurse (RN) and \$15.31 per 15 minutes of care by a registered nurse (RN) supervisor. The rates are currently \$7.38 for LPN services, \$8.69 for RN services and \$11.79 for RN Supervision services.

The private duty nursing rate calculation included the following steps: 1) determine the number of PDN providers across the state and how the number of providers impacts access, 2) review entry level nursing salaries in a cross cutting sample of hospitals across the state, 3) estimate the employment and provider agency costs in addition to salaries, and 4) calculate a rate that would reasonably cover employing nurses at a minimally competitive entry salary level.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	<input type="text"/>
Appendix A Waiver Administration and Operation	<input type="text"/>
Appendix B Participant Access and Eligibility	<input type="text"/>
Appendix C Participant Services	<input type="text"/>
Appendix D Participant Centered Service Planning and Delivery	<input type="text"/>
Appendix E Participant Direction of Services	<input type="text"/>
Appendix F Participant Rights	<input type="text"/>
Appendix G Participant Safeguards	<input type="text"/>

Component of the Approved Waiver	Subsection(s)
Appendix H	
Appendix I Financial Accountability	2a.
Appendix J Cost-Neutrality Demonstration	J-1, J-2c.i., J-2 d. wy4 and wy5

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

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

Increase rate for Private Duty Nursing services.

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

1. Request Information (1 of 3)

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

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

Behavioral Health Severe and Disabling Mental Illness Home and Community Based Services

C. Type of Request: amendment

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

3 years 5 years

Original Base Waiver Number: MT.0455

Waiver Number: MT.0455.R02.05

Draft ID: MT.013.02.06

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/15

Approved Effective Date of Waiver being Amended: 07/01/15

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

Inpatient psychiatric facility for individuals age 21 and under as provided 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 §1915(a)(1)(a) of the Act and described in Appendix I**Waiver(s) authorized under §1915(b) of the Act.**

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

1915b selective contracting case management providers has been submitted on April 6, 2018.
RFP has been released, set to close on April 6, 2018.

Specify the §1915(b) authorities under which this program operates (check each that applies):**§1915(b)(1) (mandated enrollment to managed care)****§1915(b)(2) (central broker)****§1915(b)(3) (employ cost savings to furnish additional services)****§1915(b)(4) (selective contracting/limit number of providers)****A program operated under §1932(a) of the Act.**

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

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare. Check if applicable:

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

2. Brief Waiver Description

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

The Behavioral Health Waiver for Adults with Severe Disabling Mental Illness (SDMI Waiver) is designed to provide a member with SDMI a choice of receiving long term care services in a community setting as an alternative to receiving long term care services in a nursing home setting. The member with SDMI must meet nursing home level of care.

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

Concurrently, another goal includes providing quality care while maintaining financial accountability. SDMI Waiver providers will be enrolled Montana Medicaid providers and all payments will occur through the 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 SDMI Waiver.

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

- Conducting quality assurance reviews;
- Conducting satisfaction surveys with waiver members;
- Completing regular audits of SDMI Waiver providers records for compliance;
- Providing training/education to all waiver providers; and
- Monitoring all waiver expenditures.

The SDMI Waiver will be available statewide.

The package of services to be included in the SDMI waiver are: Adult Day Health, Case Management, Personal Assistance and Specially Trained Attendant Care, Habilitation and Residential Habilitation as a sub-category, Homemaking, Peer Support, Respite Care, Consultative Clinical and Therapeutic services including extended Mental Health Services, Nursing Services, Personal Emergency Response Systems, Specialized Medical Equipment and Supplies, Non-Medical Transportation, Community Transition, Pain and Symptom Management, Environmental Accessibility Adaptations, Health and Wellness which includes Illness Management and Recovery; and Wellness Recovery Action Plan, and Life Coach. Services are reimbursed fee for service; there is no managed mental health plan.

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

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- | |
|--|
| <p>Yes. This waiver provides participant direction opportunities. Appendix E is required.</p> <p>No. This waiver does not provide participant direction opportunities. Appendix E is not required.</p> |
|--|
- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

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

Geographic Limitation. A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver

and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

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

Public notice was published on June 13, 2018 and posted on our website. No public comment has been received as of 7/13/2018.

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:

Fox

First Name:

Jennifer

Title:

Medicaid Mental Health Program Manager

Agency:

Montana Department of Public Health and Human Services Addictive and Mental Disorder

Address:

PO Box 202905

Address 2:

100 North Park Avenue, Suite 300

City:

Helena

State:

Montana

Zip:

Phone:**Ext:** **TTY****Fax:****E-mail:**

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

Last Name:**First Name:****Title:****Agency:****Address:****Address 2:****City:****State:****Montana****Zip:****Phone:****Ext:** **TTY****Fax:****E-mail:**

8. Authorizing Signature

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

Signature:

02/21/2020

State Medicaid Director or Designee

Submission Date:

Feb 7, 2019

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

Last Name:

Kulawik

First Name:

Mary Eve

Title:

Mdeicaid Analyst

Agency:

MT DPHHS

Address:

PO Box 4210

Address 2:

City:

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State:

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59604

Phone:

(406) 444-2584

Ext:

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Attachments

mkulawik@mt.gov

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

- 1) Add references to a new 1915(b)(4) waiver to allow 1915(c) SDMI Waiver members to be served by a single waiver case management provider in a service area;
- 2) The 1915(c) SDMI Waiver will be available statewide;
- 3) Services being removed from the waiver, Substance Use Disorder and Occupational Therapy, are provided in the State Plan at the same amount, scope, duration and frequency as they were provided in the waiver program. ;
- 4) Technical revisions to quality assurance measures and quality improvement development.
- 5) Transition from current case management to case management under the 1915 (b) will be overseen directly by Central Office. Case management transition for members receiving services under a new case management provider will include; Meetings between current case management teams and new case management teams to ensure a warm hand off, system oversight so members files are visible to the correct team in the correct area, ensure that new case management contracts are upheld and on track through a single point of contact. Affected members will be notified of the case management change via letter from the Department with Fair Hearing information attached; and
- 6) Upon approval from CMS, affected members will be notified of the case management change via letter from the Department with fair hearing information attached. Notification will also be posted on the Department's website.

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

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

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

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

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

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

Rule Overview

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

What does the new Rule Means

As indicated in the informational summary that accompanied Montana's statewide HCBS transition plan, the overarching theme of the rule is: "The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS."

The rule also requires that the setting:

- Is selected by the individual from options that include non-disability specific settings and options for private units. Individuals must also have choice regarding the services they receive and by whom the services are provided.
- Ensures the individual right of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes independence and autonomy in making life choices without regimenting such things as daily activities, physical environment, and with whom the individual interacts.

When a residential setting is owned or controlled by a service provider, additional requirements must be met:

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

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

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

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

Public Input

A public meeting was held to discuss the SDMI Waiver renewal and the transition plan on February 26, 2015, from 9:00 am to 10:30 am, at the Sanders Auditorium, 111 N. Sanders Avenue, Helena, Montana. The public meeting could also be accessed by webinar at <https://hhsmt.webex.com/hhsmt> and a toll free number. The renewal application to be effective July 1, 2015 notified in writing all federally recognized Tribal Governments, Montana Health Coalition and interested parties on February 18, 2015. Public notices were printed, February 15, 2015, in three of the major daily newspapers for Montana. Letters were sent to Mental

Health Advisory Council, Local Advisory Councils, Service Area Authorities, Mental Health Centers, waiver participants and providers on February 19, 2015. The application is available through the Addictive and Mental Disorders Division website or upon request a hard copy will be made available. A public meeting was held on February 26, 2015, to discuss the SDMI waiver renewal and transition plan. The renewal application and transition plan were made available for review February 21, 2015, at the AMDD website. A public comment form was included on this website to offer the public another convenient way to comment. The State, upon request, made hard copies available of the renewal application and transition plan. A second public notice was sent to the federally recognized Tribal Governments, Montana Health Coalition and interested parties on February 27, 2015. Letters were sent to the Mental Health Advisory Council, Local Advisory Councils, Service Area Authorities, Mental Health Centers, waiver participants, and providers on February 27, 2015. The second notice included the addition of peer services, replacing Consultation with Consultative Clinical and Therapeutic Services, and additional service that may be deleted or reduce in utilization is day habilitation. The public comment period was February 21 through March 24, 2015. The public comment period was extended through March 30, 2015. Public comments were summarized and addressed. There were no waiver specific comments on the transition plan. The comments primarily focused on services and geographic areas.

The full waiver Transition Plan was available on the web site for review and ability to download. The public notice, Tribal Consultation letter, Montana Health Coalition letter, Mental Health Centers, Mental Health Oversight Advisory Council, Local Advisory Councils, Service Area Authorities, providers, interested parties, and member letters all stated "hard copy of application and transition plan is available upon request." In addition, hard copies were made available during the public meeting. The case management teams and Community Program Officers had the electronic copy of the transition plan and were requested to make hard copies available when requested by agencies and waiver members.

Assessment

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

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

Other planned avenues for assessment include:

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

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

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

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

The Department will be developing a member experience survey that will be distributed to members, stakeholders, advocates, providers and interested parties for review and comments in the ongoing public notice process. The member survey will have the similar questions recommended by CMS for their perspective of the settings. This is a survey being developed by the state to determine the Waiver participants' satisfaction and perception of their current HCB setting.

Remediation

DPHHS will take a series of steps to guide providers in making the transition to full compliance with HCBS settings, such as

informational letters, updates to the Administrative Rules of Montana and provider manuals, and other targeted communications.

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

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

Program Administration

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

Upon conducting the compliance assessment, if the Department determines that existing standards meet the federal settings requirements and the State's oversight process is adequate to ensure ongoing compliance, the State will describe the process that it used for conducting the compliance assessment and the outcomes of that assessment.

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

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

The state will be working closely with the provider that will need to come into compliance or is unable to come into compliance. The waiver member and family will have clear communication from the state and case management teams of the provider's corrective plan and their timelines outlined in the corrective plan. The member and family will be made fully aware during this process. If a member needs to be transitioned from a setting that is determined non-compliant a transition plan will be developed beginning July 1, 2017, with the final transition completed by March 17, 2019.

AMDD has completed a high level assessment of the settings. AMDD believes the majority of the settings will meet compliance with some modifications. The settings being utilized and reviewed in the waiver are: Residential Habilitation including respite care, Supported Living, prevocational and supported employment. We will be meeting with our specific providers to discuss the HCB setting rule and the possible implications they may have. In addition, it will be an opportunity to hear their concerns. The Program Manager and CPOs will meet in March 2015 to discuss the avenues we can utilize to educate providers and waiver participants. AMDD is working collaboratively with the other DPHHS Divisions to develop a provider and member experience survey. The draft will be put on the website for review and comment. We will hold meetings with providers, stakeholders and members to discuss the survey and receive their comments. After completion of the public comment period we will finalize the surveys based on the comments received.

AMDD and Department will review the provider self-assessments and the member experience assessments. The member experience assessments will help validate the provider assessments. A random selection of providers will be selected for on-site reviews. The Department will have this process be as transparent as possible with opportunity to comment on the process and documents. The Department has begun discussions with Quality Assurance Division on the new HCB settings and how we can work together on educating current providers as well as agencies applying as a new provider. We will also meet with fiscal intermediary contractor for the Department, to discuss the regulations and the part that they may play in providing education to new providers.

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

The settings that are presumed compliant with the setting rule, where individuals reside and where the individual receives waiver services, are individual apartments and homes. This is a person's private home that the individual owns or rents. The individuals who hold a lease to the apartment rented, has control over their residence within the confines of the lease and they maintain control over their apartment (such as decorating, cleaning). Determination was made by apartments or homes that are rented to any individual. They are not homes or apartment complexes that are reserved for persons with disabilities. The settings meet the requirements of 441.301(c)(4)-(5). The settings do not tend to isolate individuals from the community.

The state Medicaid agency will incorporate the settings requirements in the licensing reviews. The Community Program Officers will do site visits when the individuals residing in the setting or the case management teams have expressed concerns. Any new entity applying for licensure will be provided education and materials on the setting requirements for those settings who want to be Medicaid providers.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

Addictive and Mental Disorders Division

(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.

(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:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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.:*

DPHHS or the contracted entity, which is currently the Quality Improvement Organization, the contracted Entity or DPHHS, will conduct the level of care assessments, including Level I activity. As appropriate, the contracted entity will refer members to the waiver case management teams (CMT).

Community Mental Health Centers or private therapist will complete the Level II screens for members who are identified by the contracted entity or DPHHS as having severe and disabling mental illness and have had inpatient psychiatric admission within the last two years. The Level II screen will determine if active treatment is necessary. Community Mental Health Centers or private therapist, will determine if SDMI criteria are met and advise the contracted entity or DPHHS.

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

CMTs will enroll members in the SDMI Waiver and provide case management services. CMTs will work within the communities to identify potential providers of waiver services appropriate to meet the needs of members in the waiver. The enrolled members will select their providers of their waiver services.

Case management services are provided through the 1915b waiver restricting case management services to a contracted provider. The CMTs do not provide any other services except case management. Each member chooses their providers for waiver services. This choice is documented in each file. Community Program Officers (CPOs) will work within the communities to identify potential providers of waiver services appropriate to meet the needs of members in the waiver. The case management agencies will not provide other direct waiver services. Other protections include: yearly waiver member satisfaction surveys by various methods, the freedom of choice documentation, and all providers have policies outlining the corporate/dispute resolution procedure.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

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

Check each that applies:

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

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

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

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

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Appendix A: Waiver Administration and Operation

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

Department of Public Health and Human Services, Addictive and Mental Disorders Division will be responsible for assessing the performance of contracted entities.

Appendix A: Waiver Administration and Operation

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

Participant waiver enrollment – quarterly and annually the case management entity is audited (including and annual onsite review) by the state to ensure enrollment of members into the waiver meets all standards related to the criteria that must be met for a member to be enrolled in the waiver.

Level of Care - The LOC contractor submits a management report to the Central Office on a quarterly basis. The report captures data on the date of level of care assessments and days elapsed between the request for level of care determination and the date the letter was sent to the applicant notifying him/her the outcome of the level of care determination. Central Office will monitor the report to ensure that reassessments and information regarding level of care determination is provided in a timely manner. Central Office reviews a representative sample member level of care determinations to ensure accuracy and consistency in their application of the level of care tool. These reviews will occur annually. Central Office staff will be available for consultation of level of care denials when necessary. If a member is found to not meet level of care, this potential denial is reviewed by the physician on the contractor's staff for accuracy. Notice of the denial is sent to the member including fair hearing process information. In addition, the contractor completes internal audits to review their system processes and effectiveness as a contractor. This information is shared with the state in the form of a Service Auditor's Report.

Review of Participant Service Plan-each Person-Centered Recovery Plan (PCRP) is entered into the care management system and must be reviewed and approved by the community program officer at the state level within 30 days.

Prior authorization of waiver services - Services entered into the care management system are reviewed by the community program office at initial intake and annual review when the PCRP is reviewed. Any service plan that the annual cost is over \$24,000, the service plan must be reviewed by the community program officer. If a service plan exceeds \$24,000 in the electronic Care Management System, an alert is sent to the community program officer triggering a review of the service plan at the central office to assure services are appropriate. Community program officers also complete quarterly desk audits reviewing services prior authorized in the care management system to services billed to MMIS.

Qualified provider enrollment and execution of Medicaid provider agreements. The contractor will assist providers of waiver services with enrollment. In addition, the contractor is responsible for verification of providers. MMIS Contract Manager in the Director's Office directly oversees the Conduent contract. Conduent provides a report monthly to the Department which includes the contract requirements. In addition, Conduent and the Department have monthly status meetings. Conduent submits all SDMI HCBS provider enrollments to AMDD Central Office for approval. This includes a report on criminal convictions, whether providers have been sanctioned, debarred or excluded for Medicare and whether there has been an action. Conduent generates a spreadsheet indicating provider enrollment by provider type. Conduent submits a monthly Report Card that summarizes internal monitoring Conduent does over the system and processes (i.e. recipient subsystem, provider enrollment, claims processing and documents, verify changes requested for codes were made appropriately). 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.

Quality assurance and quality improvement activities - 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 state. Case management teams will submit annual report cards to the state as well as monthly utilization reports. These will ensure that quality assurance measures are met in accordance with performance measures. Teams will receive on-site reviews every year. Teams are also monitored on an on-going basis by Community Program Officers and HCBS Program managers via quality assurance performance notices completed monthly, quarterly, and annually based on the standard being reviewed. The state's community program officers (CPOs) oversee ongoing monitoring via annual review, desk audits and bi-weekly meetings with their assigned teams/s. Individual or systemic issue identified will be discussed during the monthly Quality Assurance Committee meeting. A Quality Assurance Performance (QAP) sheet will be issued for the deficiency. The QAP is a written understanding of the identified area of noncompliance there is agreement in terms of steps that need to be taken to correct deficiencies, and that correction of the findings or deficiency is completed before the QAP can be considered accepted or "closed". The CPO will follow up on the on the QAP, the QAP will not be considered closed until the Program Manager signs off on the QAP. The results are compiled and maintained in the central state office.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities

that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

The Number and Percent of case management files that follow the protocols described in policies and procedures. Numerator is number of files in which documentation indicates the case management team followed protocols as defined in the quality review. Denominator is the total number of files reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95.5 % +/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div>On-site reviews preformed on even fiscal years.</div>
	Other Specify: <div></div>	

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95.5 % +/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div>Off site review preformed on odd fiscal years.</div>
	Other Specify: <div></div>	

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: <div></div>	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):

Performance Measure:

The number/percent of HCBS SDMI waiver providers enrolled by the fiscal agent contractor are in compliance with licensure and program appropriate credentials. The numerator is the number of SDMI waiver providers enrolled by the fiscal agent contractor are in compliance with licensure and program appropriate credentials. The denominator is the total number of enrolled HCBS SDMI waiver providers.

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 = <div>95.5% confidence level +/- 5%</div>
Other Specify: <div>fiscal agent</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

The number and percent of the Level II evaluations completed within 10 days from the request by the contracted entity currently Mountain Pacific Quality Health (MPQH). Numerator is the number of Level II evaluations completed within the 10-day time frame. Denominator is the total number of Level II evaluations requested by the contracted entity currently Mountain Pacific Quality Health (MPQH).

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

The contracted entity- MPQH/PASRR contractor		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

	Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin: 5px 0;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin: 5px 0;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin: 5px 0;"></div>

Performance Measure:

he number/percent of new members who were enrolled in the HCBS SDMI waiver were enrolled appropriately. Numerator: Number of new members enrolled in the HCBS SDMI waiver who were enrolled appropriately. Denominator: Total number of new members enrolled in the HCBS SDMI Waiver.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Interval = 95.5% confidence level +/- 5%
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify: On-site reviews preformed on even fiscal years.
	Other Specify: 	

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95.5 % +/- 5%;
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and	Other

	Ongoing	Specify: Off-site reviews performed on odd fiscal years.
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number/percent of services requiring prior authorization were authorized per HCBS SDMI waiver requirements. Numerator: Number of services requiring prior authorization were authorized per HCBS SDMI waiver requirements. Denominator: Total number of services requiring prior authorization.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95.5% confidence level +/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div>On-site reviews performed on even fiscal years.</div>
	Other Specify: <div></div>	

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95.5 % +/- 5%</div>

Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/> Off-site reviews performed on odd fiscal years.
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

Number/percent of monthly reports submitted to the state Medicaid agency by LOC contractor that demonstrate compliance with contractual mandates. The numerator is the number of reports submitted to SMA by the LOC contractor demonstrate compliance with contractual mandates. The denominator is the total number of reports mandated by the SMA.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95.5 % +/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div>On-site reviews preformed on even fiscal years.</div>
	Other Specify: <div></div>	

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

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

		Sample Confidence Interval = <div>95.5 % +/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div>Off-site reviews performed on eodd fiscal years.</div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

--

b. Methods for Remediation/Fixing Individual Problems

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

Addictive and Mental Disorders Division (AMDD) has total oversight over the waiver. The AMDD Central Office and the CPOs act at the local and statewide level to provide routine and ongoing waiver oversight of the waiver program quality measures and waiver providers. At the local level the CPO, in their Quality Assurance reviews, provide ongoing oversight of the SDMI waiver members and providers. Training is provided to members and providers, as needed, for policy/program changes and when issues are identified.

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

Remediation - The CPOs will review 100% of the waiver member files. Reviews include examination of case notes, PRCP (with amendments and changes), Level of Care determination, Level of Care re-evaluation documentation, prior authorization for services and support, monthly expenditures, Cost Sheet, admittance form, serious occurrence reports (SOR), and documentation of training. The CPO will respond to any immediate concerns. Data collected in the review will result in a report that will be submitted to the Case Management Agency and to AMDD. After case management teams have provided their responses to how issues identified in the review will be corrected/addressed, data collected from all the case management reviews is compiled by CPOs and central office to analyze for trends and areas of improvement.

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	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 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.

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Appendix B: Participant Access and Eligibility**B-1: Specification of the Waiver Target Group(s)**

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Physical)		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Other)		<input type="checkbox"/>	<input type="checkbox"/>
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury		<input type="checkbox"/>	<input type="checkbox"/>
		HIV/AIDS		<input type="checkbox"/>	<input type="checkbox"/>
		Medically Fragile		<input type="checkbox"/>	<input type="checkbox"/>
		Technology Dependent		<input type="checkbox"/>	<input type="checkbox"/>
Intellectual Disability or Developmental Disability, or Both					
		Autism		<input type="checkbox"/>	<input type="checkbox"/>
		Developmental Disability		<input type="checkbox"/>	<input type="checkbox"/>
		Intellectual Disability		<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness					
		Mental Illness	18	<input type="checkbox"/>	<input type="checkbox"/>
		Serious Emotional Disturbance		<input type="checkbox"/>	<input type="checkbox"/>

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

"Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the following criteria:

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

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

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

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	275
Year 2	330
Year 3	357
Year 4	357
Year 5	357

- 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	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

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 Money follows the Person individuals	<input type="checkbox"/>
Money Follows the Person	<input type="checkbox"/>

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 Money follows the Person individuals

Purpose *(describe)*:

As of 1/12/2018, 18 SDMI Waiver members have transitioned using the MFP grant. SDMI Waiver has been allocated 23 slots through the end of the grant. SDMI continues to utilize the MFP grant and transition members that meet the MFP grant guidelines.

Describe how the amount of reserved capacity was determined:

The MFP stakeholder group reviewed the number of members in nursing facilities that may qualify for the SDMI Waiver. A number of members who have a severe disabling mental illness are residents of the MNCC which is an IMD. The focus for members transitioning from MNCC will be those members who are 65 and older. Due to the MFP regulations regarding Medicaid eligibility this limits the transition from this facility. The estimation for transition to the SDMI Waiver was set at 30 over the six year grant period. The grant began transitioning members in May 2014 with the first member for the SDMI Waiver in August 2014. The estimate for reserved capacity is conservative based on limited experience in transition.

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	15
Year 4	20
Year 5	25

Appendix B: Participant Access and Eligibility**B-3: Number of Individuals Served (2 of 4)**

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

Money Follows the Person

Purpose (describe):

The Money follows the Person (MFP) grant currently has two members who have a severe disabling mental illness. These members will complete a full year with MFP August 2015 and May 2016 and transition to the SDMI Waiver. The MFP grant is currently working with another member to transfer from the nursing home to the program. The state will reserve three slots for these members in Waiver Year One of this renewal.

Describe how the amount of reserved capacity was determined:

The MFP stakeholder group reviewed the number of members in nursing facilities that may qualify for the SDMI Waiver. A number of members who have a severe disabling mental illness are residents of the Montana Nursing Care Center (MNCC) which is an Institution for Mental Disease (IMD). The focus for members transitioning from MNCC will be those members who are 65 and older. Due to the MFP regulations regarding Medicaid eligibility this limits the transition from this facility. The estimation for transition to the SDMI Waiver was set at 30 over the six year grant period. The grant began transitioning members in May 2014 with the first member for the SDMI Waiver in August 2014. The estimate for reserved capacity is conservative based on limited experience in transition.

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

Waiver Year	Capacity Reserved
Year 1	3

Waiver Year	Capacity Reserved
Year 2	8
Year 3	15
Year 4	20
Year 5	25

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:

- a) The CMTs are allocated unduplicated number of members to serve for the year. These teams are regional entities. Central office AMDD shifts additional numbers to CMT as available.
- b) The allocation capacity was determined through historical trends. This is evaluated quarterly by the AMDD to determine if the geographical sites are at capacity and the number on the wait list in each site.
- c) If a member on the waiver wait list is interested in moving to another geographical site they are placed on both wait lists. (The wait list in their current location and the location they are willing/want to relocate.) Any unused capacity is reallocated based on number on wait list and the acuity of members on the wait list.

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

Member must:

- Be Medicaid eligible;
- Meet SDMI criteria;
- Be age 18 or older;
- Meet nursing facility level of care;
- Choose to receive waiver services; and
- Meet capacity within the waiver.

Entrance into the waiver will be on a first-come, first-served basis for those who meet the above-listed criteria. Once a waiting list has been established, the CMTs will use the Wait List Criteria Tool within 30 days of the referral and then every 90 days. The Wait List Criteria Tool scores members eligible for the waiver according to criteria, including cognitive impairment, risk of medical and/psychiatric deterioration without services, risk of institutional placement or death, need for supervision, need for formal paid services, assessment of informal supports, assessment of relief needed for primary caregiver, need for adaptive aides, and assessment of health and safety issue that place the member at risk. The case managers will manage the waitlist, which will be reviewed by AMDD of DPHHS through access to the electronic case management program.

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

The CMT is required to contact a member, who is eligible for the waiver and has been referred to the waiver, within 5 days of the referral and complete an initial in-person assessment within 30 days. The CMT use a Wait List Criteria Tool to determine the need of the member. The CMT refer the member to other services that may assist the member until they can be placed on the waiver. AMDD monitors and reviews the waitlist quarterly to determine if any unused capacity can be reallocated. The CMT administer the waitlist by the use of the Wait List Criteria Tool, wait list policy and AMDD oversees the wait list.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

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

No

Yes

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

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

Low income families with children as provided in §1931 of the Act

SSI recipients

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

Optional state supplement recipients

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

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

PICKLE, DAC, ACA Adult Medicaid

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage: **A dollar amount which is lower than 300%.**Specify dollar amount: **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)****Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)****Medically needy without spend down in 209(b) States (42 CFR §435.330)****Aged and disabled individuals who have income at:***Select one:***100% of FPL****% of FPL, which is lower than 100%.**Specify percentage amount: **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)***Specify:*

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

- b. Regular Post-Eligibility Treatment of Income: SSI State.**

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (4 of 7)**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

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

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

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (5 of 7)**

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (6 of 7)**

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (7 of 7)**

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

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

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Contracted entity or DPHHS completes initial Level of care evaluations. Level of care reevaluations are completed by the CMT yearly at the member's annual review. Case Management service is provided through a 1915 (b) Waiver.

Other

Specify:

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

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

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

(if applicable), including the instrument/tool utilized.

The contacted agency or DPHHS will complete a Level of care screening including a Functional Assessment. The contacted agency or DPHHS will complete a Level of care screening including a Functional Assessment which includes an assessment of ADL/IADL, home environment/Assistive devices, and social support/economic status to determine if the member meets level of care requirements for enrollment into the waiver. Preadmission determination and functional assessment involves telephone interviews based on established protocols. A Level I screen will also be completed to determine if the member has Mental Retardation or Mental Illness as part of PASRR requirements. Community Mental Health Centers/private therapist will complete Level II screens to determine if a member with Mental Illness identified through the Level I screen requires active treatment. Active treatment in Montana is provided by inpatient care at:

- A) Local community hospitals with psychiatric units.
 - B) Montana State Hospital (MSH); or
 - C) Montana Mental Health Nursing Care Center (MMHNCC).
- MSH and MMHNCC are IMDs.

- 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:

The initial level of care screening is completed by the contacted agency or DPHHS. The initial level of care screening is performed to evaluate the medical, psychological and social needs of a member. The Functional Assessment is a review of impairments in walking, bathing, grooming, dressing, toileting, transferring, feeding, bladder incontinence, bowel incontinence, special sense impairments (such as speech or hearing), mental, and behavioral dysfunctions. Nursing facility or waiver level of care is authorized if the member's needs are greater than personal level of care. The reevaluation level of care process is the same except the CMTs perform the level of care reevaluation at the waiver member's annual review.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

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

The qualifications are different.

Specify the qualifications:

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

Re-evaluation timeliness is a standard of care included in the annual CMT review. The Department is also able to generate reports from the Care Management system for monthly review.

Montana's Care Management system allows case management teams (CMT) pull monthly tickler reports that contain the members that have an annual plan of care/level of care due. The QA staff run this report monthly for review.

A Quality Assurance Performance (QAP) sheet is issued for discovered deficiency. The QAP is a written understanding of the identified area of noncompliance there is agreement in terms of steps that need to be taken to correct discovered deficiency, and that correction of the findings or deficiency is completed before the QAP can be considered accepted or "closed". The CPO follows up on the QAP, the QAP is not considered closed until the program manager signs off on the QAP. The results are compiled and maintained in the central office.

- 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 contracted entity or DPHHS will maintain all evaluations and CMTs will maintain reevaluations for a minimum of three years as required in 45 CFR §74.53.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number of applicants who received a LOC determination indicating need for institutional level of care prior to receipt of services. Numerator is the number of applicants who received a LOC determination indicating need for institutional level of care prior to receipt of services. Denominator is the 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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Contracted entity currently MPQH.</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 200px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 200px; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

The percent of enrolled waiver members whose LOCs are reevaluated annually.

Numerator - The number of enrolled members whose LOCs are reevaluated annually. Denominator - All enrolled waiver members.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Monthly reports from Case Management teams.

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Care Management Contractor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

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:

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

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other	Annually	Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Report to the AMDD provided by the contracted entity or DPHHS.

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 = <input type="text"/>
Other Specify: <input type="text"/> Contracted entity or DPHHS.	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of members who received a LOC denial and were provided information and access to the fair hearing process. Numerator is number of members who received a LOC denial and were provided information and access to the fair hearing process; Denominator is number of individuals who received a LOC denial.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other

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

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

The contracted entity or DPHHS will submit a management report to Mental Health Service Bureau (MHSB) on a monthly basis. This report will capture data on the LOC evaluations completed prior to the receipt of waiver services, members notified of the LOC determinations within the state required timeframes. CPOs will review Level of Care determinations and re-determinations as part of their annual QA reviews. All persons denied are notified in writing of the denial and process of requesting a Fair Hearing.

b. Methods for Remediation/Fixing Individual Problems

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

The LOC Quality Assurance Review spreadsheets specific to HCBS SDMI waiver quality assurance personnel performance measures are maintained in an electronic file by the waiver program manager. Problems noted in the performance of activities related to the level of care process would result in the contractor's regional manager follow up with their assigned staff in addressing specific problems as they arise. Follow up occurs at the HCBS SDMI Waiver central office level, as needed. The Quality Assurance Observation sheet is used to address problems in a timely manner.

The Oversight Committee, which includes CPOs, program analyst, program manager and supervisor, meet monthly. Topics discussed during Oversight Committee meetings include health and wellness, waitlist monitoring, training, systemic issues and provider issues. CPOs attend monthly meetings with providers hosted by CMTs, and meet biweekly with CMTs. CPOs bring information to the Oversight Committee. Individual or systemic issues identified are discussed during the monthly meeting oversight meeting. A Quality Assurance Performance (QAP) sheet is issued for discovered deficiency. The QAP is a written understanding of the identified area of noncompliance there is agreement in terms of steps that need to be taken to correct deficiencies, and that correction of the findings or deficiency is completed before the QAP can be considered accepted or "closed". The CPO follows up on the on the QAP, the QAP is not be considered closed until the program manager signs off on the QAP. The results are compiled and maintained in the state's central office.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

During the preadmission screening determination, the contracted entity or DPHHS 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 contracted entity or DPHHS.

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 contracted entity or DPHHS will maintain the Screening Determination Form, including all documentation regarding freedom of choice, for a minimum of three years.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting

Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State will make reasonable accommodation upon request. Accommodations for foreign translators will be arranged through 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. The State will utilize other resources including, but not limited to, the Special Needs Center or family members. 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		
Statutory Service	Homemaker		
Statutory Service	Prevocational Services		
Statutory Service	Residential Habilitation		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Other Service	Community Transition		
Other Service	Consultative Clinical and Therapeutic Services		
Other Service	Environmental Accessibility Adaptations		
Other Service	Habilitation Aide		
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	Peer Support		
Other Service	Personal Assistance Attendant		
Other Service	Personal Emergency Response System		
Other Service	Private Duty Nursing/ Registered Nurse Supervision		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Specially Trained Attendant		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

--

HCBS Taxonomy:**Category 1:**

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

--

Sub-Category 2:

--

Category 3:

--

Sub-Category 3:

--

Service Definition (Scope):**Category 4:**

--

Sub-Category 4:

--

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

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

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

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

--

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Provider

Appendix C: Participant Services

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

Service Type: Statutory Service**Service Name: Adult Day Health**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:**Service:****Alternate Service Title (if any):****HCBS Taxonomy:**

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

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

Case Management entails:

Development and review of the PCRP with the member

Reevaluation of the Person Centered Recovery Plan (PCRP) including a functional assessment and appropriateness of services in the PCRP

Coordination of services

Linking members to other programs

Monitoring implementation of PCRP

Ensuring health and safety

Addressing problems with respect to services and providers

Responding to crises

Being financially accountable for waiver expenditures for members on the waiver

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

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

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

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by (check each that applies):****Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Case Management Providers

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service**

Service Name: Case Management

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:**Service:****Alternate Service Title (if any):****HCBS Taxonomy:**

Category 1:

08 Home-Based Services

Sub-Category 1:

08050 homemaker

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

Homemaker services consist of general household activities. Homemaker services are provided to members unable to manage their own homes. Homemaker services do not include personal care services available under State Plan Medicaid.

Homemaker activities include tasks related to household management. This may include assisting with boxing, unpacking and organizing household items. In addition the service provides general housecleaning and meal preparation, as well as teaching services that improve a member's skills in household management and social functioning.

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

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Homemaker****Provider Category:**

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

Medicare Certified.

Other Standard (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and license renewal

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

PAS Provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications
Entity Responsible for Verification:

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Homemaker Provider

Provider Qualifications
License (specify):**Certificate (specify):****Other Standard (specify):**

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications
Entity Responsible for Verification:

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Prevocational Services are habilitative activities that foster employability for a HCBS member. Prevocational Services:

Are aimed at preparing a member for paid or unpaid employment;

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

Are provided to members who may or may not join the general work force (excluding supported employment programs). Prevocational services are the initial step in developing employment skills and should be used as a pathway to competitive employment.

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

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

The service will be provided for a period of 90 days. At that time, the CMT will review the outcomes determined in the PCRPP with the member and the provider. If it appears the outcomes will be achieved within the next quarter the PCRPP will reflect this and reviewed quarterly. At the end of 9 months if the outcomes are not achieved the service will be discontinued. The member can request additional units but will need to demonstrate progress toward the achievement of the outcomes.

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. In the case of extensive needs, a member's PCRPP will include additional waiver services.

The outcomes achieved will be determined based on the member's PCRPP. Prevocational services are the initial step in developing employment skills and should be used as a pathway to competitive employment.

Must not be provided if they are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Education of the Handicapped Act. The CMT under the Rehabilitation Act of 1973 or P.L. 94-142. This documentation may be obtained from the Rehabilitation Services Program, DPHHS. This service will not duplicate or replace services required to be provided by the school under the IDEA.

Prevocational services are provided to either an individual or a group. There is not a limit to a group size, however, the group would typically be provided to a group of three to six individuals. The state does not deem differentiation of the prevocational service rate between a group vs. an individual as a fiscal concern due to low utilization

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions; have the ability to provide services in accordance with a Support Plan; have completed minimum training based on State training guidelines; have necessary ability to perform the required job tasks; and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Conduent.

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02013 group living, other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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

Adult residential care is provided in an adult foster home, group home, or assisted facility.

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

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

Retainer days

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

Retainer days are days on which the 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 PCRP 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

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	Group Home
Agency	Adult Foster Care
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License (specify):**Group Home License**

The group home must maintain staffing at least eight hours daily. Additional staffing and supervision is dictated by the needs of the group home residents. They ensure 24 hour a day emergency mental health care through the mental health center or other contracted entities.

Groups homes can be licensed up to 12 individuals if the applicable zoning laws allow. Most zoning laws across Montana limit group homes to 8 individuals.

Assisted living facilities and Mental Health Group Homes are both licensed as health care facilities – MCA 50-5-204. Issuance and renewal of licenses -- inspections. (1) After receipt of a new application and notice that the facility is ready to be inspected, the department or its authorized agent shall conduct an initial inspection of the facility within 45 days.

(2) After receipt of an application for renewal of a license, the department or its authorized agent shall inspect the facility without prior notice to the operator or staff.

(3) If the department determines that the facility meets minimum standards and the proposed or existing staff is qualified, the department shall issue a license for a period of 1 to 3 years in duration.

(4) according to ARM 37.106.1938

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

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/Quality Assurance Division
State Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and renewal of license.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Adult Foster Care

Provider Qualifications

License (specify):

Adult Foster Home

Adult Foster Care licenses (ARM 37.100.121- 1) The department may issue a license for a period of one to three years in duration for an AFCH, under ARM 37.100.121, to any license applicant meeting all of the requirements established by these rules and the governing statutes.

Certificate (specify):

Other Standard (specify):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Adult Foster Care is licensed through the QAD, Licensing Bureau. To apply for license the prospective provider needs to supply to Licensing Bureau the following: floor plan indicating square footage of rooms; fire safety checklist; grievance policy; resident payment refunds policy; written placement agreement; accident/sudden illness report form; communicable disease policy; personal statement of health for staff and family residence over 18 years of age; release of information for each employee and each family member in residence over 18 years of age; and submit to a background check for each employee and family residence over 18 years of age. The QAD Licensing Bureau schedules an onsite visit within 45 working days from receipt of last document received. For Adult Foster Care Homes (AFCH) licensed to serve persons with severe disabling mental illness must contract with a licensed mental health center that has an adult foster care endorsement or have a formal working relationship with a case management team providing mental health services to the resident. For those AFCH providers contracting with a mental health center must participate in residents' treatment planning. The providers and staff must be at least 18 years of age or older. They must be in good physical and mental health. The provider must maintain a current CPR/First Aid Certification and staff must obtain a current CPR/First Aid Certification within 30 days of employment.

Frequency of Verification:

Upon enrollment and renewal of license.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License (specify):

Assisted Living Facility

Assisted living facilities and Mental Health Group Homes are both licensed as health care facilities – MCA 50-5-204. Issuance and renewal of licenses -- inspections. (1) After receipt of a new application and notice that the facility is ready to be inspected, the department or its authorized agent shall conduct an initial inspection of the facility within 45 days.

(2) After receipt of an application for renewal of a license, the department or its authorized agent shall inspect the facility without prior notice to the operator or staff.

(3) If the department determines that the facility meets minimum standards and the proposed or existing staff is qualified, the department shall issue a license for a period of 1 to 3 years in duration.

(4) Administrative Rules of Montana 7.90.428 and 37.106.2801 (QAD)

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

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services (Quality Assurance Division)/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and renewal of license.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

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

Respite care is temporary, short-term care provided to members in need of supportive care to relieve those persons who normally provide the care. Respite care is only utilized to relieve a non-paid caregiver. Respite care may include payment for room and board in adult residential facilities or nursing homes. 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.

When respite care is provided, the provision of, or payment for other duplicative services under the waiver is precluded (e.g., payment for respite when member is in Adult Day Care).

If a member requires assistance with activities of daily living during the respite hours, a personal assistant should be used under State Plan or Home and Community Based Services Personal Assistance Services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:**Service Delivery Method (check each that applies):****Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by (check each that applies):****Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

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

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

PAS Provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Homemaker Provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications**License (specify):**

ARM 37.106.601 - 37.106.650

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and renewal of license

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Residential Facility

Provider Qualifications**License** (*specify*):

Administrative Rules of Montana 7.90.428 and 37.106.2801 (QAD)
 Licensed in the State of Montana

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

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and renewal of license

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

03 Supported Employment

Sub-Category 1:

03021 ongoing supported employment, individual

Category 2:

03 Supported Employment

Sub-Category 2:

03022 ongoing supported employment, group

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

Supported employment includes activities needed to sustain paid work by members; including supervision and training for members for whom unsupported or competitive employment at or above the minimum wage is unlikely, persons receiving these services would not be successful in achieving a competitive wage IF NOT for the supported employment services. Supported employment is conducted in a variety of settings. Supported employment may include group community employment such as crews, or individual community employment. The supported employment is provided in community settings. The crew may provide janitorial services in the community or an individual in an office setting. Supported employment services are provided to either an individual or a group. There is not a limit to a group size, however, the group would typically be provided to a group of three to six individuals. The state does not deem differentiation of the supported employment service rate between a group vs. an individual as a fiscal concern due to low utilization.

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. In the case of extensive needs, a member's PCRP will include additional waiver services.

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

Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142. Documentation will be maintained in the file of each member receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142. This documentation may be obtained from with the Rehabilitation Services Program, Department of Public Health and Human Services.

Transportation may be provided between the 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.

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.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by (check each that applies):****Legally Responsible Person****Relative**

Legal Guardian**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Living Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Supported Employment****Provider Category:**

Agency

Provider Type:

Supported Living Provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:**Category 1:**

16 Community Transition Services

Sub-Category 1:

16010 community transition services

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

Community Transition services are non-recurring set-up expenses for members who are transitioning from an institutional or another provider-operated living arrangement 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 and are not limited to but may include: security deposits that are required to obtain a lease on an apartment or home; essential household furnishings required, including furniture, window coverings, food preparation items and bed/bath linens and moving expenses; usual and customary set up fees or deposits for utility or service access, including telephone, electricity, heating and water; activities to assess need, arrange for and procure resources.

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

Community Transition Services do not include monthly rental or mortgage expenses, regular utility charges, and/or household appliances or items that are intended for purely diversion/recreational purposes. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the PCRP development process, clearly identified in the PCRP and the member is unable to meet such expense or when the services cannot be obtained from other sources.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Providers

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service**Service Name: Community Transition****Provider Category:**

Agency

Provider Type:

Case Management Providers

Provider Qualifications**License (specify):**

ARM 37.90.425

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

DPHHS

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10090 other mental health and behavioral services

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

These are services that assist unpaid and/or paid caregivers in carrying out individual PCRP and are necessary to improve the member's independence and inclusion in the community. Members with complex mental health or behavioral issues would benefit from a more clinical approach and specialized interventions. Members identified by direct care staff, CMTs and Community Program Officers(CPO) as having difficulty with the member's behavior. These members typically have a high turnover in staff due to their behavior. This service would identify behavior interventions, training, and other means to support the member's PCRP. Consultation activities are provided by professionals in psychiatry, psychology, neuro-psychology, behavior management, or others specializing in specific intervention modalities.

This service may include:

- 1) Clinical evaluations by these professionals;
- 2) Development by a supplemental home/community treatment plan which is incorporated into the member's PCRP;
- 3) Training and technical assistance to implement the treatment;
- 4) Monitoring the treatment and interventions; and
- 5) One-on-One consultation and support for paid and non-paid caregivers.

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

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

The state plan service is provided in a Mental Health Center or office setting. The state plan does not provide for training of the staff on an identified individual behavioral intervention. This service can be provided in the home setting. The provider for Consultative Clinical and Therapeutic services trains the other providers on therapeutic interventions identified in the PCRP who are working with the waiver member.

The service will be provided in the home or in the community dependent on the PCRP.

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. In addition, this service will not be provided to children eligible under EPSDT as the state is required to provide this service to these children through EPSDT.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Consultative Clinical and Therapeutic Services

Provider Category:

Individual

Provider Type:

Psychiatrist, Psychologist, Neuro-Psychiatrist, Rehabilitation Counselor, Professional Counselor

Provider Qualifications

License (specify):

As required by state law by the Board of Medical Examiners or the Professional Licensing Bureau

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and renewal of license

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Consultative Clinical and Therapeutic Services

Provider Category:

Agency

Provider Type:

Psychiatrist, Psychologist, Neuro-Psychiatrist, Rehabilitation Counselor, Professional Counselor

Provider Qualifications

License (specify):

As required by state law by the Board of Medical Examiners or the Professional Licensing Bureau

Certificate (specify):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Those physical adaptations to the home required for the member's PCRP, which are necessary to ensure the health, safety and welfare of the member; or which enable the member to function with greater independence in the home and without which the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies, which are necessary for the welfare of the member, but shall exclude 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.

HCBS SDMI Waiver may supplement environmental accessibility adaptation services only when a member's needs exceed the limits of the state plan program. In the case of extensive needs, a member's PCRP will include additional waiver services

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

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

The services under the Behavioral Health Severe and Disabling Mental Illness Home and Community-Based Services Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Construction Company, Building Contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Construction Company, Building Contractor

Provider Qualifications

License (*specify*):

Contractor License through business and labor

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Habilitation Aide

Provider Category:

Agency

Provider Type:

PAS Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Habilitation Aide

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

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

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Health and wellness offers waiver members opportunities to engage in recreational, health promoting and wellness/recovery activities within their community.

The service includes:

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

The Wellness Recovery and Action Plan (WRAP) components are individualized to the member. With the assistance from a facilitator they identify what their wellness tools and activities needed for their recovery (what assists the member in their own recovery with mental illness); identification of the individual “triggers” that interfere in their recovery; identification of those activities and behaviors if not addressed immediately may lead to a psychiatric crisis; identification of what assists the member when they are in crisis (i.e. good sleep, good nutrition, counseling, having a friend provide support, or admission in a crisis stabilization unit); and identification when the crisis is subsiding and what the member is at “baseline” (people’s baseline is different and the crisis responders need to be able to identify what that baseline is for the member). A crisis plan is developed and provided to persons identified by the individual. WRAP is crucial for the member to remain in the community and not be institutionalized.

Illness Management and Recovery (IMR) is an evidence based practice identified by Substance Abuse Mental Health Services Administration (SAMHSA). IMR components are recovery strategies; practical facts about mental illness; helps understand stress-vulnerability model of mental illness; guidelines on how to use medication effectively; how to reduce relapse; coping with stress; coping with problems and symptoms; how to get your needs met in the mental health system; and, effects of alcohol and drugs on mental illness. This provides education in the member’s mental illness and their individual living situations. It identifies the recovery strategies and barriers to their recovery. IMR educates the member on mental illness, recovery and prevention or early intervention of relapse. This service assists the individual to integrate in the community and help prevent institutionalization.

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

Any activities provided under this service must be tied to recovery goals in the PCRP and necessary to avoid institutionalization.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Living Centers
Agency	Wellness/Recovery Classes/Health Clubs/Fitness Centers

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Health and Wellness**

Provider Category:

Agency

Provider Type:

Independent Living Centers

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Montana Centers for Independent Living are non-residential, consumer-controlled, community-based, private, non-profit organizations that provide 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.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services

Frequency of Verification:

every two years

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Health and Wellness**

Provider Category:

Agency

Provider Type:

Wellness/Recovery Classes/Health Clubs/Fitness Centers

Provider Qualifications**License (specify):**

As required by state law.

Certificate (*specify*):

All wellness and recovery classes require a certificate of training from the trainers.

Other Standard (*specify*):

Health Clubs are enrolled Medicaid providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Homemaker Chore

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08060 chore

Category 2:

08 Home-Based Services

Sub-Category 2:

08050 homemaker

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Homemaker Chore

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Medicare Certified

Other Standard (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Homemaker Chore

Provider Category:

Agency

Provider Type:

PAS Provider

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Homemaker Chore

Provider Category:

Agency

Provider Type:

Homemaker Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Life Coach

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

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

Life Coach assists the waiver member in developing independent living skills such as accessing community resources, budgeting, money management, and behavioral support. The service is delivered in the community and the member's home. The Life Coach will assist the member with a therapeutic behavioral support plan if put in place by qualified professionals; work on needed independent living skills identified in the PCRP and will provide appropriate training of the identified skills; provide money management services; and budgeting assistance and navigation of public services (for example social security, public assistance, housing, human resource development councils, Bureau of Indian Affairs). This service includes the navigation of public and social services. The Life Coach is not required to be certified as a Peer Support Specialist. The Life Coach will have the training necessary to provide the support as identified in the PCRP.

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

The amount of this service approved and provided may vary on the needs of the member and as identified within the PCRP.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by (check each that applies):****Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Independent Living Centers
Agency	PAS Provider
Agency	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:****Provider Type:**

Independent Living Centers

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Life Coach****Provider Category:**

Agency

Provider Type:

PAS Provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Life Coach

Provider Category:

Agency

Provider Type:

Other Entities Approved by the Department

Provider Qualifications**License (specify):**

Certificate (specify):

Certification of Peer Support Training as approved by Department

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years after

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

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

Service Title:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):**Category 4:**

Sub-Category 4:

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.

Some individuals need special assistance with their diets and the special meals service can help ensure that 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.

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

Service Delivery Method (check each that applies):
☐ Participant-directed as specified in Appendix E

☐ Provider managed
Specify whether the service may be provided by (check each that applies):
☐ Legally Responsible Person

☐ Relative

☐ Legal Guardian
Provider Specifications:

Provider Category	Provider Type Title
Agency	Area Agency on Aging
Agency	Retirement Homes

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Meals

Provider Category:

Agency

Provider Type:

Area Agency on Aging

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Montana's Area Agencies on Aging are public or private non-profit agencies, designated by the Aging Services Bureau, to address the needs and concerns of older Montanans at the local level. Every Area Agency on Aging is required to have an advisory council, comprised primarily of older persons, to review and comment on all programs affecting the elderly at the community level. More than 100 advisory council members work in partnership with Montana's Area Agencies on Aging.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services
Fiscal Fiduciary

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Meals

Provider Category:

Agency

Provider Type:

Retirement Homes

Provider Qualifications**License** (*specify*):

Retirement Homes must comply with local and state building and fire codes. Each bedroom in a retirement home must include floor to ceiling walls; one door which can be closed to allow privacy; at least one operable window; and access to a bathroom without entering another resident's room. Retirement homes are licensed through the QAD, Licensing and Certification Bureau. A health care facility surveyor will conduct a site visit during a provisional license period to assess facility compliance with regulations.

Certificate (*specify*):
Other Standard (*specify*):
Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services
Fiscal Fiduciary

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

HCBS Taxonomy:**Category 1:**

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

Category 2:

Sub-Category 2:

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

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

Non medical transportation Services must meet the following criteria:

Be provided only after volunteer or other publicly funded transportation programs have been exhausted or determined to be inappropriate; and

Be provided by the most cost effective mode.

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

Non-medical transportation services offered in this waiver are limited based on the member's assessed need for services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Accessible Transportation Providers
Agency	PAS Providers
Individual	Taxi Cabs

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Accessible Transportation Providers

Provider Qualifications

License (specify):

Must meet all pertinent state laws and regulations.

Certificate (specify):

Other Standard (*specify*):

Non medical transportation providers must provide proof of a valid Montanas drivers license; adequate automobile insurance; and assurance that the vehicle is in compliance with all applicable federal, state and local laws and regulations.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Fiscal Intermediary Contractor

Frequency of Verification:

As required by law; Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

PAS Providers

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Non medical transportation providers must provide proof of a valid Montana's driver's license; adequate automobile insurance; and assurance that the vehicle is in compliance with all applicable federal, state and local laws and regulations.
The agency is responsible to hire qualified staff and follow all state and federal labor laws.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Non-Medical Transportation****Provider Category:**

Individual

Provider Type:

Taxi Cabs

Provider Qualifications**License (specify):**

Must meet all pertinent state laws and regulations

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

Non medical transportation providers must provide proof of a valid Montanas drivers license; adequate automobile insurance; and assurance that the vehicle is in compliance with all applicable federal, state and local laws and regulations.

The agency is responsible to hire qualified staff and follow all state and federal labor laws and meet the states definition as an independent contractor.

Verification of Provider Qualifications**Entity Responsible for Verification:**

State/Fiscal Intermediary Contractor

Frequency of Verification:

As required by law; Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Pain and Symptom Management

HCBS Taxonomy:**Category 1:**

17 Other Services

Sub-Category 1:

17990 other

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

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

Clinical practice guidelines for the American Pain Society and the American College of Physicians (1999) recommend that physicians consider using alternative therapies including massage therapy, acupuncture, and chiropractic when patients with chronic low-back pain do not respond to conventional treatment. Massage therapy has also been shown to help regulate blood sugars in patients with diabetes, reduce pain in patients with rheumatoid arthritis and fibromyalgia, lower blood pressure in cardiac patients and improve mood and sleep in waiver members. Without this service many would become institutionalized due to their chronic pain and poor physical health.

A growing body of research supports massage therapy for health and wellness. Massage therapy is increasingly being offered along with conventional treatments for a variety of medical conditions. It has been shown to be effective in reducing stress, anxiety, and pain and improving mood, mobility and cardiovascular health. Massage therapy helps support an individual's health and independence and prevent institutionalization.

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. This service will not be provided to children eligible under EPSDT as the state is required to provide this service to these children through EPSDT.

The services under the Behavioral Health Severe and Disabling Mental Illness Home and Community-Based Services Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative**Legal Guardian****Provider Specifications:**

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

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Pain and Symptom Management****Provider Category:**

Agency

Provider Type:

Massage Therapists, Chiropractors, Acupuncturists, Specialized RN

Provider Qualifications**License (specify):**

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

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

State/Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and upon license renewal

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Pain and Symptom Management****Provider Category:**

Agency

Provider Type:**Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Pain and Symptom Management****Provider Category:****Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:**

Frequency of Verification:

Upon enrollment and every two years thereafter

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Peer Support

HCBS Taxonomy:**Category 1:**

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10050 peer specialist

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

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

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

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

--

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Other Individuals Approved by DLI
Agency	PAS Provider
Agency	Mental Health Centers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Peer Support

Provider Category:

Agency

Provider Type:

Other Individuals Approved by DLI

Provider Qualifications

License (*specify*):

--

Certificate (*specify*):

ARM 24.219.912 Certification of Peer Support Training as approved by DLI.
--

Other Standard (*specify*):

--

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/ Fiscal Intermediary Contractor
--

Frequency of Verification:

Upon enrollment and renewal of certification
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Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Peer Support

Provider Category:

Agency

Provider Type:

PAS Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Specially Trained assistants who assist waiver participants with a severe disabling mental illness must receive a minimum of 20 additional hours in mental health and recovery specific training.

Training and certification provided or approved by the Community Program Officer (CPO). Assistants who assist consumers with physical disabilities must receive an additional four hours of disability-specific training approved by the CPO. It is the responsibility of the provider agency to ensure assistants are appropriately trained under agency-based services.

Individuals who provide peer support services have lived experience with mental illness and mental health services are well grounded in their recovery process and have completed a Peer certification course approved by the Department. At a minimum, the following core competency areas include: ethics and boundaries; HIPAA; Confidentiality and Mandatory Reporting; and role of peer support and recovery for a minimum of 30 hours. Must have 10 hours of annual continuing education.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services / Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Support

Provider Category:

Provider Type:

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications
Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

HCBS Taxonomy:
Category 1:

Sub-Category 1:

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

Personal Assistance Attendant under the HCBS Program may include supervision for health and safety reasons, socialization, escort and transportation for non-medical reasons, specially trained attendants for members with mental health needs, or an extension of State Plan personal assistance services. Socialization is available to those members who require personal assistance to access the community, rather than just assistance with the access (social restorative). Specially trained personal assistance services are provided by attendants who have been specially trained to meet the unique needs of the HCBS member. The service is more clearly defined as a tier of personal assistance and provides increased training and higher rate of reimbursement. It is the responsibility of the provider agency to ensure that assistants are appropriately trained under agency based services. Areas of special training include knowledge and understanding of serious mental illness and the needs of members with mental illness. All personal assistance service attendants are supervised by registered nurses.

Senior and Long Term Care Division, Department of Public Health and Human Services, has developed a manual for personal assistance provider agencies that outlines all policies and procedures relating to the Personal Assistance Services Program. This manual should be referred to for policy information.

A shared delivery system in personal assistance is defined as a system where services are provided within the apartment complex. The members living in the complex share the service providers. This is reimbursed in 15 minute unit increments:

Shared service delivery is possible in accessible space apartment living complexes (a complex that is 100% accessible) , however, not all of them provide this service at this time. Members have freedom of choice of service providers.

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

Services provided under the waiver exceed or differ in scope from those available under the State Plan. State Plan services must be accessed first.

Personal Assistance services are not allowed for a resident residing in adult residential setting. Services under this definition are not duplicative of the non medical transportation service.

Retainer Days

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

The CMT tracks these days through their electronic case management system. This is reviewed by the state during the annual on-site quality assurance review.

The services under the Behavioral Health Severe and Disabling Mental Illness Home and Community-Based Services Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Assistance Attendant

Provider Category:

Agency

Provider Type:

PAS Provider

Provider Qualifications

License *(specify):*

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

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Personal Assistance Attendant****Provider Category:****Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14010 personal emergency response system (PERS)

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

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.

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

ARM 37.90.448

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	PERS Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

PERS Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Duty Nursing/ Registered Nurse Supervision

HCBS Taxonomy:**Category 1:**

05 Nursing

Sub-Category 1:

05010 private duty nursing

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

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 that is 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 PCRP, 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 problem, is not allowable. General statements such as a monitor health needs are not considered sufficient documentation for the service. PDN is not a state plan service for adults.

The RN or LPN must be from a home health agency or an independent agency. The member and the CMT will have input in the amount and degree of supervision required and the projected cost.

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

This service will not duplicate or replace services available under the Home Health state plan. This service will not be provided to Children eligible under EPSDT as the state is required to provide this service to these children through EPSDT.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency or Private Duty Nursing Agency
Individual	Licensed Registered Nurse and Licensed Practical Nurse

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Private Duty Nursing/ Registered Nurse Supervision****Provider Category:**

Agency

Provider Type:

Home Health Agency or Private Duty Nursing Agency

Provider Qualifications**License (specify):**

Registered Nurse or Licensed Practical Nurse according to ARM 8.32.401 et. Seq.

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

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Private Duty Nursing/ Registered Nurse Supervision****Provider Category:**

Individual

Provider Type:

Licensed Registered Nurse and Licensed Practical Nurse

Provider Qualifications**License (specify):**

Licensed Registered Nurse or Licensed Practical Nurse according to ARM 8.32.401 et. Seq.

Certificate (specify):

Other Standard (*specify*):

Meets the state's definition as an independent contractor.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and upon license renewal

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14032 supplies

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Specialized Medical Equipment and Supplies include devices, controls, or appliances, specified in the PCRP, 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 the provision of service animals as well as items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any Medical Equipment and Supplies furnished under the state plan and shall exclude those items that are not of direct medical or remedial benefit to the 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. Any specialized medical equipment and/or supply over \$500 must have a prior authorization submitted through CaseWave and be reviewed by the prior authorization committee that consists of CPO's, MMIS analyst, and program manager prior to service being rendered.

HCBS SDMI Waiver may supplement environmental accessibility adaptation services only when a member's needs exceed the limits of the state plan program. In the case of extensive needs, a member's PCRP will include additional waiver services.

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

Specialized Medical Equipment and Supplies will be limited to a one-time purchase with the exception of supplies not covered by State plan services. The Addictive and Mental Disorders Division, at its discretion, may authorize an exception to this. Purchases in excess of \$500 must receive prior authorization from the CPO. Specialized Medical Equipment and Supplies will not pay for vehicles, vehicle licenses or insurance. Any equipment or supply covered under the State Plan must be used prior to the waiver.

The services under the Behavioral Health Severe and Disabling Mental Illness Home and Community-Based Services Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Providers/Retailers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Providers/Retailers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

Frequency of Verification:

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

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

Service Title:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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

When a member's needs exceed the scope of service provided by personal assistance attendant and specially trained attendant may be utilized. Specially Trained Attendants are recovery oriented aides who possess the skills to assist the member with their ADL/IADLs. In addition to this, they will help the member with:

- 1.A therapeutic behavioral support plan if put in place by qualified professionals.
 - 2.A program to work on needed independence skills identified in the Person-Centered Recovery Plan.
- The Specially Trained Attendant will provide appropriate training of the identified skills.

Montana avoids duplication of services by assuring members meet one of the following qualifications for specially trained attendant services:

- 1.Person with a Brain Injury whose needs cannot be met by standard personal assistance services(PAS);
- 2.Person with a severe physical disability whose needs cannot be met by standard PAS; and
- 3.Person with a severe disabling mental illness whose needs can't be met by standard PAS.

A shared delivery system in personal assistance is a which is defined a system where services are provided within the apartment complex. The members living in the complex share the service providers. This is reimbursed in 15 minute unit increments:

Shared service delivery is possible in accessible space apartment living complexes (a complex that is 100% accessible) ,however, not all of them provide this service at this time. Members utilizing shared delivery still retain the right to choose their provider.

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

Services provided under the waiver exceed or differ in scope from those available under the State Plan. State Plan services must be accessed first.

Personal Assistance services are not allowed for a resident residing in adult residential setting.

Services under this definition are not duplicative of the non medical transportation service.

Retainer Days

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

The CMT tracks these days through their electronic case management system. This is reviewed by the state during the annual on-site quality assurance review.

The services under the Behavioral Health Severe and Disabling Mental Illness Home and Community-Based Services Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person**Relative****Legal Guardian****Provider Specifications:**

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

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specially Trained Attendant****Provider Category:**

Agency

Provider Type:

PAS Provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specially Trained Attendant****Provider Category:**

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Medicare Certified

Other Standard (*specify*):

Direct Care Staff: must be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports and to follow verbal and written instructions. Have the ability to provide services in accordance with a Support Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks, and have interpersonal skills needed to effectively interact with persons with mental illness.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Human Services/ Fiscal Intermediary Contractor

Frequency of Verification:

Upon enrollment and every two years

Appendix C: Participant Services

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

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

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

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

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

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

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

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

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

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

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

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

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

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

Appendix C: Participant Services

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

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

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

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

Appendix C: Participant Services

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

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

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

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

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

Self-directed

Agency-operated

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

The state does not make payment to relatives/legal guardians for furnishing waiver services.

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

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

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

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

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All potential SDMI Waiver providers may become Medicaid providers as long as they meet the provider qualifications. 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 states 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:

<http://medicaidprovider.hhs.mt.gov/enrollmenttutorial/CONTENTS.html>

<https://mtaccesstohealth.acs-shc.com/mt/general/providerEnrollmentHome.do>

The enrollment application must be completed in its entirety before the Contractor is able to process the enrollment application. This is the same process for enrollment of any Montana Medicaid provider. As specified in the contract between the Department and the Contractor, Contractor will forward all completed enrollment applications to the AMDD, Department of Public Health and Human Services, for approval, procedure codes and rates. AMDD will act upon the completed enrollment application within five working days of receipt and return it to the Fiscal Intermediary for action.

The CMTs 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 Departments web site to assist potential providers who are seeking information about Montana Medicaid and programs.

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

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

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

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

Performance Measure:

Number/percent of providers required to be licensed or certified that were verified to continually meet state licensure/certification standards. The numerator is the number of providers required to be licensed or certified that were verified to continually meet state licensure/certification standards. The denominator is the total number of providers that require a license or certification.

Data Source (Select one):

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 = <input type="text"/>
Other Specify: <input type="text" value="Quality Assurance"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div> Quality Assurance Division - Licensing Bureau Review for compliance of Licensing Standards. </div>	Annually
	Continuously and Ongoing
	Other Specify: <div> SLTC Division reviews every three years or sooner if concerns were identified in previous review. AMDD will receive written summary of review, including corrective action requested. </div>

Performance Measure:

Number/percent of new providers required to be licensed/certified that were verified to initially meet state licensure/certification standards. The numerator is the number of new providers required to be licensed or certified that were verified to initially meet state licensure/certification standards. The denominator is the total number of new providers that require a license or certification.

Data Source (Select one):**Provider performance monitoring**

If 'Other' is selected, specify:

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

		Confidence Interval = <input type="text"/>
Other Specify: <div>Quality Assurance Division - Licensing Bureau Review for compliance of Licensing Standards.</div>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>Quality Assurance Division - Licensing Bureau Review for compliance of Licensing Standards.</div>	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 monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

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

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

Performance Measure:

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

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/> State's fiscal intermediary contractor	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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/percent of new waiver providers who received state approved waiver certification. The numerator is the number of new waiver providers who received state approved waiver certification. The denominator is the total number of new waiver providers.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">QAD and Department of Labor</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

Number/percent of existing waiver providers who maintain state approved training requirements during their certification period. The numerator is the total number of existing waiver providers (by type) who meet training requirements during the certification period.

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 period.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Providers that do not have the required qualifications, license, or certifications for the specific HCBS service cannot be enrolled as a HCBS provider for that service. If a provider's license/certification has been revoked, that agency/individual will no longer be allowed to provide the service. Repayment procedures will be initiated for payment for services provided after the license/certification expiration date. Members will be given a new choice of providers if available and assisted in the transition process.

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

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 hardcopy of the Licensee Lookup System indicates any adverse action or information regarding the enrolled provider and may prevent that individual or agency from being enrolled as a SDMI waiver provider. When a provider 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 insure 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 corrections is due 30 days from receipt of letter. The Program will 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 Department will suspend the provider from receiving new referrals or cease all program operations. The provider will no longer provide services until the matter has been resolved. The Department can remove a provider when the provider continuously does not meet the standards.

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: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

Applicable - The state imposes additional limits on the amount of waiver services.

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

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

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

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

Furnish the information specified above.

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Please refer to Attachment #2 HCB Settings Waiver Transition Plan for further information.

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 (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

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

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

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

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) A PCRP is a written plan developed by the member and the CMT to assess the member's status and needs. The PCRP outlines the services that will be provided to meet his/her identified needs as well as the cost of those services. An initial plan must be developed at the time of the member's enrollment. The initial enrollment date is the date the member begins receiving services under the SDMI Waiver. This date will be entered in the upper left corner of the Plan of Care form and will be entered into the case notes. The CMT will notify Eligibility Staff of the Department whenever a Medicaid member is being admitted in the SDMI Waiver program. The member must sign the PCRP. The CPO must approve the initial PCRP and each annual PCRP.

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

(d)(e) Each PCRP shall include at least the following components:

Diagnosis, symptoms, complaints and complications indicating the need for services;

A description of the functional level;

Specific short-term objectives and long-term goals, including discharge potential or plan;

Member's desired outcome;

A description of risk factors and special procedures recommended for the health and safety of the member;

Discharge plan;

Any orders for the following:

Medication;

Treatments, Including Mental Health Regime;

Restorative and Rehabilitative Services;

Activities;

Therapies;

Social services; and

Diet;

The specific services to be provided, the frequency of services and the types of providers;

A psychosocial summary describing the member's social, emotional, mental and financial situation attached to the initial PCRP;

Formal and informal supports;

Crisis plan;

A cost sheet which projects the annualized costs of HCBS; and

Signatures of all individuals who participated in development of the PCRP including the member and/or representative and CMT (CMTs will maintain the listing of waiver providers from which the member chooses for his/her identified needs). Signatures by the member on the PCRP acknowledges freedom of choice providers. This is an area the CPOs monitor during their annual QA reviews, further detailed in Appendix H.

(f) All PCRPs are subject to review by the Department. The Department has delegated the review function to the CPO. The CPO is responsible for reviewing all portions of the plan utilizing the criteria outlined below. Review of the PCRP will be based on the following:

Completeness of PCRP which includes all necessary services being listed in terms of amount, frequency and planned provider(s) including assurances of freedom of choice of waiver providers (from the listing of waiver providers maintained by the CMT);

Consistency of the PCRP with screening information regarding needs;

Thoroughness of the crisis plan;

Presence of appropriate signatures; and

Cost-effectiveness of PCRP.

(g) Subsequent PCRPs must be completed at least annually or when the member's condition warrants it. The PCRP is reviewed. The PCRP must provide documentation of the plan's costs. It will include all HCBS to be provided, the frequency, amount and projected annualized cost of the services. The PCRP will list the non-waiver services to be

utilized by the member. The CMT will make all necessary referrals for non-waiver services for the member and the member has free choice of providers. The CMT will prepare the cost sheet after the PCRP has been developed. The CMT must explain the cost sheet to the member and/or representative. CMT will complete final cost plan upon return to office and document mailing of form to the member and/or representative. The PCRP and cost sheet will be updated as needs change throughout the PCRP year. A new cost sheet must also be completed at each annual review and update of the PCRP. The CMT will review the PCRP and cost sheet with the member at quarterly reevaluations every three months with the member.

(h) The member is provided a list of services available under the waiver by the CMTs. The services are reviewed with the member when developing the PCRP.

(i) The member and CMT identify the services and the providers for each of the services through the PCRP. The agencies identified in the PCRP are notified of the referral to their agency. The agency will contact the member to schedule an appointment and do an intake for services with the member. If the member is on Community First Choice/Personal Assistance Services the agency, may be participating in the development of the PCRP, if the member chooses their participation. Ultimately, the CMTs are responsible for implementing the PCRP. The teams meet with provider agencies once a month to discuss waiver members and the delivery of their services. Any difficulties identified are discussed and addressed at this time. The member is contacted monthly by the CMT. Any issues with the PCRP and the delivery and implementation of services is discussed at this time. The CMT has a scheduled face to face meeting with the member every three months. The services and PCRP are reviewed at this time.

(j) As described above, the CMT monitors and oversees the implementation of the PCRP. The CPOs provide oversight with the CMTs and discuss the members and the PCRP during their scheduled meetings with the CMTs.

(k) Interim (initial) PCRPs are developed to initiate the services. The CMTs meet with the member at the time of admission to the waiver. The CMTs can develop an interim (initial) PCRP within 10 days of admission. The annual PCRP needs to be completed no later than 30 days from the initial plan. The member is required to sign the interim and the annual PCRP.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Training and information will be provided to every member to prepare them for playing a greater role in the support and service planning and delivery process. The training and information will cover health and safety factors, emergency back up planning created by the member, and risk identification, assessment, and management. Members will conduct a self-assessment as part of the planning and implementation process. If the member's mental condition has decompensated, family members and other supports will be afforded the opportunity for training and information, if approved by the member, and allowed to participate with the self assessment. Member created back up plans and risk identification and management are included in the PCRP. Member created emergency back up plans will be defined and planned for on an individual basis. The emergency back up plan may include an assessment of critical services and a back up strategy for each identified critical service. Back up may include:

1. Member created backup incorporated into the plan;
2. Informal backup (for example, family, friends, and neighbors);
3. Enrolled Medicaid provider network (for example, personal assistant agencies); and
4. System level (local emergency response). Back up services may be included and paid for by the waiver program.

As part of the quality assurance, the program manager reviews 100% of the service and support plans, emergency backup, and risk management procedures to ensure they were developed timely through system reports.

Appendix D: Participant-Centered Planning and Service Delivery

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

During the development of the PCRP, the member will select providers from a list prepared by the CMT. The CMT will maintain the list of waiver providers, the lists may vary per geographic area. The member will choose providers from the list and signatures by the member on the PCRP acknowledging freedom of choice of waiver providers. If the member is unsatisfied with the available agencies, the CMT or the member may solicit other providers for the service who would be required to enroll as a Medicaid provider. CMTs discuss at quarterly face to face meetings with the member selected services are being provided as outlined in the PCRP. If selected services are not being provided, CMTs will support the member in finding a new provider or assisting the member in getting services authorized by current service provider adequately provided.

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 CMT is responsible for the development of the PCRP with waiver members. All PCRP are subject to review by the Department. The Department has delegated the review function to the CPOs. CPOs will be charged with the role of regular review and monitoring of planning, documentation, quality, and delivery of services to SDMI Waiver service members. The CPO will approve the initial PCRP for persons enrolling into the SDMI Waiver. Yearly the Department will conduct SDMI Waiver member customer satisfaction surveys to ensure members feel they are in charge of their PCRP development; members agreed to all the services outlined in their PCRP; members had freedom of choice of services providers; and members signed their PCRP and retained copies for their files.

Customer satisfaction surveys will be sent to 100% of waiver members annually.

Appendix H Quality Management Strategy, provides additional details.

Appendix D: Participant-Centered Planning and Service Delivery

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

--

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The case management team (CMT) has direct contact with the member via monthly monitoring calls and mandatory quarterly face-to-face contact. During quarterly face-to-face contact the CMT reviews and updates the service plan with the member as needed.

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 state. Case management teams submit annual report cards to the state as well as monthly utilization reports to ensure that quality assurance measures are met in accordance with performance measures. Teams receive on-site reviews every year and are monitored on an on-going basis by community program officers (CPOs) and HCBS program managers via quality assurance performance notices completed monthly, quarterly, and annually depending on the standard being reviewed.

CMT review and update service plans during quarterly face-to-face contact with member. CMT's review service plans quarterly to ensure members are receiving services according to the service plan and assess over/underutilization of services authorized in the service plan during this quarterly review.

The Care Management System has a trigger if a member's cost sheet exceeds \$24,000 central office reviews to ensure members are receiving services according to the service plan and assess over/underutilization of services prior to updated service plan being approved by the CMT. If the member's service plan does not exceed \$24,000, during annual review all service plan are reviewed by community program officers to ensure members are receiving services according to the service plan and assess over/underutilization of services.

The state's CPOs oversee ongoing monitoring via annual review, desk audits and bi-weekly meetings with their assigned team or teams. Individual or systemic issues identified are discussed during the monthly oversight meeting between CPOs, HCBS program manager, program analyst and supervisor. A Quality Assurance Performance (QAP) sheet is issued for the deficiency. The QAP is a written understanding of the identified area of noncompliance there is agreement in terms of steps that need to be taken to correct deficiencies, and that correction of the findings or deficiency is completed before the QAP can be considered accepted or "closed". The CPO follows up on the on the QAP, the QAP is not be considered closed until the program manager signs off on the QAP. The results are compiled and maintained in the state's central office and tracked to identify trends for quality improvement.

The state monitors services furnished in accordance with the service plan through a quarterly desk audit completed by CPOs. The desk audit compares services authorized in the service plan to services billed through the MMIS. If a deficiency is discovered a QAP is issued following the above steps.

CPOs attend monthly provider meetings per service area. Case management teams arrange the provider meetings inviting providers through their service area to attend and discussing access to waiver services, more than one provider per area so members can exercise free choice, services are available to meet the needs of members and member health and welfare. Monthly provider meetings are discussed with central office during monthly oversight meeting. If a deficiency is discovered a QAP is issued following the above steps.

All initial and annual service plan are reviewed by CPOs. Each initial and annual service plan CPOs review if services were furnished in accordance with the service plan, participant access to waiver services, participants exercise free choice of provider, services meet participants needs, effectiveness of back up plans, participant health and welfare, and participant access to non-waiver services. If a deficiency is discovered a QAP is issued following the above steps.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

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

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

Performance Measure:

Percent of PCRPs that include services and supports that align with the members assessed needs. Numerator is the number of PCRPs that include services and supports aligned with the members assessed needs. Denominator is all PCRPs.

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 = <div></div>
Other	Annually	Stratified

Specify: Data is entered into Care Management system by Case Management teams for state to access quarterly reports.		Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: Data is entered into Care Management system by Case Management teams for state to access quarterly reports.	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

Percent of PCRPs that include personal goals in the PCRPs. Numerator is the number of PCRPs that include personal goals. Denominator is all PCRPs.

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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Data is entered into Care Management system by Case Management teams for state to access quarterly reports. </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 10px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 10px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 10px;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Data is entered into Care Management system by Case Management teams for state to access quarterly reports. </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

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

Performance Measures

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

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

Performance Measure:

Percent of PCRP's that include personal goals in the PCRP. Numerator is the number of PCRP's that include personal goals. Denominator is all PCRP's

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/> CMT enters into the Care Management system.	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

Performance Measure:

Number and percent of members with annual service plans reviewed meet the standards set forth by the state's policies. Numerator: The number of member's annual service plans reviewed meet the standards set forth by the state's policies.
Denominator: The total number of members with annual service plans reviewed.

Data Source (Select one):**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">Care Management system reports</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.*

Performance Measures

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

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

Performance Measure:

Number/percent of members' service plans that were updated/revised at least annually or as warranted by changes in the members' needs. The numerator is the number of reviewed members' service plans that were updated/revised annually or sooner if needed. The denominator is the total number of service plans.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Data is entered into Care Management system by Case Management teams for state to access quarterly reports. </div>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

The percentage of PCRPs that are reviewed annually with the member and updated at annual review. Numerator is the number of PCRPs reviewed annually with the member and updated at annual review. Denominator is the number of PCRPs

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">Data is entered into Care Management system by Case Management teams for state to access quarterly reports.</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> Data is entered into Care Management system by Case Management teams for state to access quarterly reports. </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

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

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

Performance Measure:

Percent of members who receive services in the type, amount, frequency, scope, and duration specified in the PCRP. Numerator is the number of members who receive services in the type, amount, frequency, scope, and duration specified in the PCRP.

Denominator is the total number of members.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Done primarily through the desk audits by CPO. This will also be discussed at least monthly during staffing with CMT.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

Percent of members who were afforded a choice of provider. Numerator is the number of members who were afforded a choice of providers. Denominator is the total number of members.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Checklist with all providers available included in consumer file documenting providers chosen by consumer and signed.

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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	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):
	<div data-bbox="868 304 1262 383" style="border: 1px solid black; height: 35px; width: 100%;"></div>

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

The CPO will conduct a review of a minimum of 100% of the case files for members. The review will:

- *determine if the PCRCP is completed and comprehensively addresses the member's need for waiver services, health care and other services in accordance with the member's preference and goals;
- * determine if plan development followed PCRCP procedure and if the plan meets program policy;
- * included indicators to assess the completeness of members's records, changes in needs; and involvement in updating the PCRCP as necessary;
- * assure documentation of choice between waiver services and institutional care;
- * assure documentation of freedom of choice among qualified providers.

PCRCP reviews will occur as part of the annual file review. The initial PCRCP approval is required from the CPO with 30 days of signature from member. Annual PCRCP approval is required by the CPO. The MHSB and CPO will utilize the Quality Review checklist to assess for a comprehensive plan that addresses member's goals and objectives, health and safety, service needs, expenditures that are appropriate and allowable, correct procedure codes, viable emergency backup plan, health care professional sign off, risk assessment and agreement (if necessary), and appropriate signatures for the PCRCP, including the member. The PCRCP will be strength based and member choice. The CPO will address any errors or missing information with the case management team prior to approval of the PCRCP.

Completed member files will be maintained by the case management agency. The file contains: CMT notes, PCRCP (with amendments and changes), Level of Care determination, SDMI determination, Level II results (if appropriate), Level of Care reassessment documentation of prior authorization of services and supports, admittance form, serious occurrence reports, health care professional sign off form, and documentation of freedom of choice for qualified providers.

b. Methods for Remediation/Fixing Individual Problems

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

Initial PCRP approval is required by the CPO. Annual PCRP approval is required by the CPO. The MHSB and CPO will utilize the Quality Review checklist to assess for a comprehensive plan that addresses member goals and objectives, health and safety, service needs, expenditures that are appropriate and allowable, correct procedure codes, viable emergency backup plan, health care professional sign off, risk assessment and agreement (if necessary), and appropriate signatures for the PCRP, including the member. The PCRP will be strength based and member choice. The CPO will address any errors or missing information with the CMT prior to approval of the PCRP. The CPO, on an ongoing basis, will address any errors or missing information with the case management agency. Data collected in the review will be provided in a report submitted to the MHSB and provider. Providers are required to respond to the report with resolution efforts according to the specified time frames. All responses to the review must be resolved and returned to the MHSB and CPO prior to closure of the review.

Discovery - AMDD will conduct a review of 100% of case files. The review will: determine if the PCRP is complete and comprehensively addresses the member's need for services, recovery, health care and other services in accordance with the preferences and personal goals; determine if PCRP followed AMDD policies and procedures; include indicators to assess the completeness of waiver records, changes in needs, and involvement in the development and update of the PCRP; assure documentation of choice between waiver services and institutional care; and assure documentation of freedom of choice among qualified providers.

The initial PCRP will occur within 10 days of enrollment in waiver program. This timeframe is necessary for members who have a difficulty trusting a new CMT to share their needs and goals. The annual PCRP review must be completed within 30 days after the initial PCRP. The CPO will review the assessment and PCRP. The review process will include a review of the biopsychosocial, goals, health and safety, service and recovery needs, expenditures that are appropriate and allowable, correct procedure codes, viable psychiatric and medical emergency plan, health care professional sign off, member sign off, and other appropriate signatures for PCRP. The CPO will address any errors or missing information with the CMT for correction prior to approval of the PCRP.

Complete member files will be maintained by the CMTs. The files will consist of: CMT notes, PCRP(including amendments and updates), Level of Care determinations and reassessment documentation, prior authorizations for services and supports, admittance form, serious occurrence reports, and health care professional sign off form. The CMTs generate a monthly management report to AMDD. Data includes type of housing and estimated monthly utilization of services.

Every year the Department will send member satisfaction surveys to 100% of members. The results will be used for quality assurance.

Remediation – If a PCRP does not assure that health and safety needs are met, the CPO will work with the CMT to make appropriate adjustments to the PCRP in order to receive the necessary approval. When a PCRP is not developed in accordance with program policy and procedure the CPO will work with the CMT to take appropriate corrective action. The CPO will respond to any immediate concerns related to the health and safety of the member.

Data collected in the review will result in a report that will be submitted to the CMT and to AMDD. The CMT is required to respond to all identified quality assurance recommendations with corrective plan within 30 days from receipt of letter. The provider can request an extension from AMDD if there sufficient reason for the delay. If AMDD does not grant the extension, the provider will be suspended from providing services which could lead to disenrollment and loss of service. All corrective actions from the quality improvement recommendations must be approved by the program manager and CPO prior to closure of the review.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

Applicability (*from Application Section 3, Components of the Waiver Request*):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (*select one*):

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Members may self-direct some of their services as well as access traditional agency based delivered services as needed. They are provided the opportunity to select and manage staff who perform personal assistance type services using employer authority.

Upon intake into the waiver, CMTs will inform every member about participant direction of services option. If a member indicates interest in the program Addictive and Mental Disorders Division (AMDD) will provide an orientation guide about the participant direction of services opportunity in the waiver. Members will have the opportunity to select either the traditional waiver or the participant direction option. The contracted entity's, currently Mountain Pacific Quality Health (MPQH), nurse will do a capacity interview over the phone with the member who would be interested in participant direction services. The nurse will interview the member to determine the functional capability of the member. The CMT will provide a brochure describing participant direction services and the waiver member's responsibilities.

Members will be able to choose from several agencies providing personal assistance type services, ensuring members are successful with participant 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 that includes mandatory agency training and payroll, and 4) assist with monitoring health and welfare. The CMTs will: 1) assist to develop an emergency backup plan, 2) identify risks or potential risks and develop a plan to manage those risks, and 3) assist with monitoring health and safety.

The member will select the agency that will assist them in participant direction service. The agencies will advertise, and assist the member in the interview process of selecting the worker. The worker will be an employee of the agency. The agency will train the worker. The CMT will assist the member in developing back up plans such as when a worker does not arrive at the scheduled time. Assist in reviewing the risks to participant direction services and developing plans to mitigate those risks.

The entities that will provide support for the member and the worker are the personal assistance agencies, supported living providers, and home health agencies.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.
Select one:

Participant: Employer Authority. As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

To be eligible for the program the individual must meet all the following criteria:

- a. Be full Medicaid eligible and meet nursing facility level of care criteria
- b. Demonstrate a medical and functional need for assistance with activities of daily living, which is substantiated by symptoms and a medical diagnosis
- c. Have the ability to direct services authorized by a Health Care Professional
- d. Have services authorized by Mountain Pacific Quality Health (MPQH)
- e. Meet capacity to direct self-direct services or have a personal representative meet capacity to direct services.
- f. Be capable of assuming the management responsibilities of self-direct services. This includes being capable of making choices about activities of daily living, understand the impact of these choices, and assume responsibility for the choices, or have their personal representative assist them in making choices and directing their activities
- g. 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 current and potential members about the benefits and potential liabilities of participant direction of services. AMDD has developed a brochure that will describe the responsibilities of the agency, member, worker, and the CMT; description of the advantages and disadvantages to participant direction services; frequently asked questions; and resources for participant direction services. The brochure has been developed by the state and will be provided to the contracted entity, CMTs, CPOs, personal assistance agencies, supported living providers and home health agencies. This information will be included in the admission packets provided by the CMTs.

Community First Choice/Personal Assistance Services currently provides the option for participant direction services under state plan services. The contracted entity does the functional assessment for the program and a nurse conducts a home visit to determine the level of functioning. The CMT will discuss participant direction services at the time of the admission to the waiver. When a member decides to participate in participant direction services CMT will provide skill assessment and training related to participant direction service. This will be done prior to enrollment in the program.

At any point during the outreach stages a member is free to opt out of the participant directed services and select to receive the personal assistance type services via the traditional agency based model.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A personal representative will be required for any potential enrollee who has impaired judgment as identified on the assessment tool used by the contracted entity 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 potential enrollee, the contracted entity, a case manager, and AMDD may request a personal representative be appointed. A personal representative may be a legal guardian, or other legally appointed personal representative, an income payee, a family member or friend. The personal representative must be willing and able to fulfill the responsibilities as outlined in the Personal Representative Agreement and must demonstrate:

- 1) A strong personal commitment to the 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) Demonstrate knowledge of the member's preferences;
- 4) Agree to predetermined frequency of contact with member;
- 5) Be willing and capable of complying with all criteria and responsibilities of consumers;
- 6) Be at least 18 years of age; and
- 7) Obtain the approval from the potential enrollee and/or a consensus from other family members to serve in this capacity if applicable.

A personal representative may not be paid for this service nor be a paid worker or paid to provide any other waiver services to the member. The overall management of personal representatives will assist AMDD to assure health and safety of each member in participant direction. Each personal representative will be required to complete and sign a Personal Representative Agreement and an Authorized Personal Representative Designation Form and participate in PCRP development and reviews.

The non-legal representative will be under the careful scrutiny of the CMT, AMDD and contracted entity. 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
Specially Trained Attendant		
Personal Assistance Attendant		

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
Specialized Medical Equipment and Supplies	
Specially Trained Attendant	
Habilitation Aide	
Case Management	
Supported Employment	
Residential Habilitation	
Non-Medical Transportation	
Homemaker	
Pain and Symptom Management	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Life Coach	
Community Transition	
Personal Emergency Response System	
Environmental Accessibility Adaptations	
Peer Support	
Private Duty Nursing/ Registered Nurse Supervision	
Health and Wellness	
Homemaker Chore	
Consultative Clinical and Therapeutic Services	
Respite	
Meals	
Personal Assistance Attendant	
Adult Day Health	
Prevocational Services	

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 managed model. The member will notify the agency of their intention. The CMT will coordinate services to ensure that no break in vital services and timely revision of the PCRCP occurs. The reason for the voluntary termination will be documented.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

When the quality management system identifies an instance where the participant direction 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 traditional provider managed service delivery. This could occur due to failure to follow the participant direction policies or failure to participate in the planning of their services. CMT, in collaboration with the agency, ensure that no break in vital services and a timely revision of the PCRCP occurs. The member may appeal this decision by requesting a fair hearing through the Department's Fair Hearing process.

The fair hearing rights will be included in the guide provided to every member participating in the program. When the member is terminated from participant 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	20	
Year 3	50	
Year 4	55	
Year 5	60	

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 workers who provide waiver services. 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 Personal Assistance Agencies are the agencies of choice that serve as co-employers of member selected staff.

The mechanism in place to ensure that members maintain authority and control is the CMTs mandatory monthly contact with the member and with the providers. The CMTs will ascertain if the member is maintaining authority and control over their employees.

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.

A member will be notified of the fair hearing process by eligibility staff when they complete the Medicaid application process. A member will also be notified of the fair hearing process by the contracted entity when the member receive the choice of waiver or institutional services during level of care assessment process. The member will be notified of the fair hearing process by the CMT when information is provided on choice of provider of service or when there is an adverse action such as a denial, reduction, suspension or termination of services. CMT will also specify that the member will continue to receive waiver services during the period while the appeal is under consideration. CMT will provide information regarding the fair hearing process on an on-going basis through their routine involvement with the member.

Resources available to a member in the fair hearing process include the Mental Health Ombudsman, Montana Disability Rights Program and personal attorneys of the member and/or family. All notification that a member received of the fair hearing process will be kept in the respective agency files.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:***No. This Appendix does not apply****Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver****b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:
c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Appendix G: Participant Safeguards**Appendix G-1: Response to Critical Events or Incidents****a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:***Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)***No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

AMDD has established a system of reporting and monitoring serious incidents that involve member served by AMDD in order to identify, manage and mitigate overall risk to the member.

A “serious occurrence” means a significant event involving a member, which affects the health, welfare or safety of the member served under the circumstances listed below. Many members accessing waiver services are vulnerable to abuse or neglect. All persons employed by an agency participating in HCBS are mandated by law to report any instances or suspected instances of abuse or neglect to Adult and Protection Services (APS). They are also required to complete a Serious Occurrence Report (SOR). The SOR can be electronically submitted.

The state requires all Serious Occurrences to be reported to the state within five business days. A SOR must be completed anytime an individual’s life, health, or safety has been put at risk. This includes all reports that meet the guidelines for suspected abuse, neglect or exploitation (MCA 52-3-803) submitted to Adult Protective Services. All designated service providers are mandated to complete a SOR utilizing the QAMS database within five business days of receiving information or witnessing the incident. The provider agency must document cause and effect of the incident and the action plan to correct or prevent incidents from occurring in the future.

The following is a list of incidents necessitating a Serious Occurrence Report:

1. Suspected or known physical, emotional, sexual, financial or verbal abuse;
2. Neglect of the individual, self-neglect or neglect by a paid caregiver;
3. Sexual harassment by an agency employee or individual;
4. Any injury that results in hospital emergency room or equivalent level of treatment. The injury may be either observed or discovered. A SOR would be required for any injury that occurred within the last 90 days;
5. An unsafe or unsanitary working or living environment which puts the worker and/or individual at risk;
6. Any event that is reported to Adult Protective Services, Law Enforcement, the Ombudsman Program or QAD/Licensing, Drug Utilization Review Board;
7. Referrals to the Medicaid Fraud Unit;
8. Psychiatric Emergency: Admission of an individual 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 an individual actually takes and these results in hospital emergency room or equivalent level of treatment or hospital admission; or
10. Suicide resulting in death, suicide attempt or suicide threat.

All CMTs and service providers are mandated to immediately refer all suspected abuse, neglect or exploitation to APS. CMTs and service providers must complete the SOR and notify the CPO within ten working days of their referral to APS or CPS. The provider agency must document cause and effect of the incident and the action plan to correct or prevent incidents from occurring in the future. Reporting of Critical Incidents are through the web based reporting system, Quality Assurance Management System (QAMS).

The CPO will review the SOR and return it to the provider, with any responses, within 10 working days. The provider completing the report will include the appropriate case management team as the secondary provider on the SOR.

The CPO is responsible for ensuring an appropriate response by the provider agency. The designated state agency (e.g. APS or CPS) will monitor the provider agency to ensure the corrective action plan was activated and identified issues resolved. The CPO will obtain copies of documentation to ensure compliance has occurred. CPO will monitor the corrective plan of action and sign off on the SOR as approval of action plan and closed the SOR as resolved.

Documentation of contact, including method and time, are entered in the quality assurance management system. The provider, along with the state’s Community Program Officers, monitor the time frames to insure deadlines are met.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information on identifying, addressing, and protecting someone from abuse, neglect, and exploitation and how to notify the appropriate authorities will be provided to members during the development of the PCR. The CMTs will continue to provide this information at the annual renewal of the PCR. Members can access information on the Department website. Information on incident management, abuse, neglect and exploitation and consumer protection will be covered as special training topics by the MHSB in the Central Office for the CPOs. Training and education for the CPOs will occur on an annual basis or as changes in policies are made.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Investigations involving Abuse, Neglect and Exploitation and/or criminal activity:

Reports of abuse, neglect and exploitation are made to APS or CPS for evaluation, reporting, and investigation. APS are emergency intervention activities which may include: investigating complaints, coordinating family and community support resources, strengthening current living situations, developing and protecting personal financial resources and facilitating legal intervention. All reports come through a centralized intake hotline where trained staff assess the situation and send a report to field staff. Local APS or CPS social workers evaluate, assess, prioritize and follow-up on all cases within their jurisdiction.

APS is the investigation unit for all reports of Abuse, Neglect or Exploitation for the State of Montana (DPHHS) for disabled adults and individuals over 60. APS does not rely on any one person 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. APS follows strict protocol on investigations and collaborates with Department of Justice, Law Enforcement, FBI, Medicaid Fraud etc. If a conflict arises, APS will work with outside investigative agencies to mitigate conflicts. APS does obtain any investigation a provider may have done, but does not rely on these; they are only a part of the evidence that is gathered. APS keeps data on all reports of Abuse, Neglect and Exploitation. State of Montana employees and contractor(s) including Law Enforcement are all mandated reporters to APS. State programs such as AMDD will be notified of all intent to investigate and the outcome. APS partners with Medicaid Fraud Control Unit when to address issues of Medicaid fraud. Montana uses preponderance of the evidence.

APS, Medicaid providers and CPOs make referrals, when necessary, to local law enforcement or other entities. Referrals to local law enforcement include illegal activities, theft, embezzlement and incidents involving significant abuse.

Investigations outside the scope of APS, and local law enforcement:

Incidents and events outside the scope of APS, or local law enforcement authority are reported to the pertinent provider agency. The agency investigates the incident and provides follow-up, when needed. The provider agency documents the scope of the incident, the incidents cause and effect, and work with the member to develop an action plan to correct or prevent the incident from reoccurring in the future. This information is captured on a SOR. A copy of the SOR must be provided to the CPO within 10 days. The CPO will follow up on the SOR to ensure that the incidents are being addressed and resolved as they occur and during the quality assurance reviews. The CPO is responsible for insuring an appropriate and timely response is provided by the provider agency. On the SOR form there is a section where the CPO may comment on the incident and mark any follow-up action taken, including providing training, case conference, and/or sanctions.

All referrals where there is suspected abuse, neglect, exploitation or other unlawful activity will be immediately reported to the appropriate authority. The CMT will be made aware of the referrals through their interactions with members and families and provider agencies. The CMT will follow up with the appropriate authority to ensure the health and safety of members. The authority responsible for the investigation may not be able to share the investigation results with CMT due to confidentiality of the investigation. The CMT and CPOs will be monitoring the services provided to members and making necessary changes within the PCRPP as well as working with the waiver providers, should the investigation involve providers. The CMT will apprise the CPOs of all serious events. The CPO will be responsible for tracking serious events and bringing situations to the attention of the Program Manager and AMDD. The Program Manager will ensure there is adequate training and monitoring of specific providers in the event there appears to be a common pattern being established in any of the waiver sites. Provider/CMT (primary) has 10 working days to report the event once it is discovered. The incident details are entered into the quality assurance management system. The secondary provider has 5 working days to review and respond to the SOR once received. The respondent is responsible for notifying the CPO/RPO of any action taken, investigate the incident and enter corrective action items in the system. The CPO/RPO reviews the report to ensure appropriate.

Upon closure of the SOR, the case manager or provider provides the results to the member or the member's family/legal representative.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department and AMDD Central Office is responsible for overseeing the operation of the serious occurrence incident management system. All critical events or incidents involving a member warrant a SOR that is sent to the local CPO who oversees the incident management process and ensures appropriate reporting and follow-up occurs at the local level. The QAMS is the system for all SOR reporting. The Program Manager will pull reports from QAMS for the purpose of analyzing and reviewing the SORs.

The Program Manager will have monthly meetings with the CPOs to discuss the management of critical incidents and events. Program Manager will meet more frequently with individual CPOs, as warranted.

At a minimum, AMDD, CMTs and CPOs will meet annually to discuss the management of critical incidents and events. Training from APS, CPS and law enforcement staff may be included in the annual meetings to provide in-services training to CMTs and CPOs.

All critical events or incidents involving a member warrant a Serious Occurrence Report (SOR) to be entered into the quality assurance management system (QAMS) database and submitted to the local CPO who oversees the incident management process and ensures that appropriate reporting and follow-up occurs at the local level. The CPO will enter follow up and resolution activities related to the SOR into the QAMS database. The CPO will use the QAMS database to generate a quarterly SOR Report and submit it to the AMDD Central Office. The QAMS database and summative reports will capture information on incident type, member characteristics, incident response time, and remediation outcomes and timeliness.

(The CPO is not required to do any analysis?)

The quarterly SOR report will be analyzed and reviewed at the AMDD Central Office QA meetings. Central Office staff will use the reports to track trends and patterns in serious occurrence reporting. During the QA meetings prevention strategies will be developed to respond to patterns and trends. The Central Office staff will also work to establish benchmarks for incident management activity and develop strategies to achieve positive outcomes.

As necessary, APS and Central Office Staff will work together to develop and implement strategies for prevention using reports from their respective databases.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Department and AMDD are responsible for detecting unauthorized use of restraints or seclusion. AMDD staff performs routine quality assurance reviews of members and standards for member satisfaction. AMDD staff provides ongoing training with providers to assure health, safety and welfare. AMDD operates a SOR system as a part of the overall quality management of the waiver. SORs are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the QA reviews of providers to assure appropriate reporting and resolution of incidents. Any unauthorized use of restraints and restrictive interventions will be reported to the QAD for investigation and to AMDD.

The use of restraints is a reportable incident via the SOR process. Restraints are not currently captured as a separate category/sub category of incidents but CPOs can determine this from the incident narrative.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. (*Select one*):

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Department and AMDD are responsible for detecting unauthorized use of restrictive interventions. AMDD staff performs routine quality assurance reviews of members and standards for member satisfaction. AMDD staff provides ongoing training with providers to assure health, safety and welfare. The Division operates a SOR system as a part of the quality management of the waiver. SORs are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are reviewed as a standard in the QA reviews of providers to assure appropriate reporting and resolution of incidents. Any unauthorized use of restraints and restrictive interventions will be reported to the QAD for investigation and to AMDD.

The use of restrictive interventions is a reportable incident via the SOR process. Restrictive interventions are not currently captured as a separate category/sub category of incidents but CPOs can determine this from the incident narrative.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Department and AMDD are responsible for detecting unauthorized use of seclusion. AMDD staff performs routine quality assurance review of Members and standards for member satisfaction. AMDD staff provides ongoing training with providers and members to assure health, safety and welfare. AMDD operates a SOR system as a part of the overall quality management of the waiver. SORs are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the QA reviews of providers to assure appropriate reporting and resolution of incidents. Any unauthorized use of restraints and restrictive interventions will be reported to the QAD for investigation and to AMDD.

Seclusion is a reportable incident via the SOR process. Seclusion incidents are not currently captured as a separate category/sub category of incidents but CPOs can determine this from the incident narrative.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:**No. This Appendix is not applicable** (*do not complete the remaining items*)**Yes. This Appendix applies** (*complete the remaining items*)**b. Medication Management and Follow-Up****i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Staff in licensed assisted living facilities and licensed group homes provide medication management for self-administered medication. They are responsible for keeping track of medication and ensuring the members take their medications as prescribed. Medication is kept in a locked box or cabinet thus restricting access by other residents. Assisted living facilities utilize a bubble pack filled by a pharmacy whenever possible. Group homes always utilize a bubble pack system. In addition, group home staff are required to take a test and be certified to manage and assist with self-administered medication. Staff in licensed assisted living facilities and licensed group homes will refer all medication errors to their respective management and complete the SOR. Management will work with the CMTs where waiver members are involved.

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 will be 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 is secured as required by the Department of Labor and Industry to restrict access by residents.

The private duty nurse will meet monthly with the CMT to review. Information reviewed monthly includes – vital signs, pain scale if applicable, side effects/interactions, allergies, medication adherence issues/incidents, nurse's recommendation, follow up with physician or mental health provider if required, each medication, prescription dates, dosage, frequency, and issues if applicable. Medication monitoring may be discontinued at the CMT's discretion if the member has not had any adverse medication issues for one year. Medication monitoring may be resumed if warranted. Monitoring is not focused on certain medication types.

When incidents have been identified with medications, a Serious Occurrence Report is entered in the state's quality assurance management system. Issues are discussed with the quality assurance committee and if concerns are identified with medication management practices, the committee will immediately bring the issue to licensure to determine the best course of action based on the level of severity of the infraction.

The QAD, Licensing Bureau, is responsible for the issuance of licenses to assisted living facilities and group homes. Annual reviews are completed to ensure compliance in the area of medication regimens. Reviews may occur more frequently if warranted.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Department, QAD, Licensing Bureau, ensures the appropriate management of medication during quality assurance reviews. The point-of-sale system used by pharmacy providers has a set of built-in edits to inform the pharmacist of potential contraindicated effects such as drug-to-drug interaction and therapeutic duplications. There is also a prior authorization process based on clinical criteria established the Drug Utilization Review Board for the Department. Through periodic reviews, CMTs will monitor members ensuring they receive their medication as prescribed and will report any mismanagement, harmful practices or crimes to the appropriate authorities. CMTs will be required to complete necessary documentation to report any serious occurrences. Oversight and follow-up are the responsibility of the QAD, Licensing Bureau.

The state monitors medication management in multiple ways. One that was described in areas above include incidents reported in the quality assurance system but medication management is also a component that is reviewed by the CPO in the initial review and at the re-evaluation annual review to identify issues/concerns.

The case management teams meet monthly with the PDN to review the medication monitoring process, if an issue is identified, the incident will be entered in to the quality assurance management system. The state's quality assurance management system contains information entered regarding issues with medication monitoring to identify potentially harmful practices. The CPOs review all medication incident reports as soon as possible (within 10 working days) and brings issues before the Department's quality assurance committee to review and ensure remediation of identified medication monitoring problems as well as discuss the best course of action for quality improvement.

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.

Staff in licensed assisted living facilities and group homes provide medication management. Medication is secured as required by the Department of Labor and Industry to restrict access by residents. Per licensure, assisted living/group home staff assist with self-administration of medications and complete the MAR documentation. LPN or RN's have oversight.

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:

SORs must be submitted to the CPO whenever there is an issue concerning missing or spilled medications, wrong dose, wrong medication, wrong time, or surplus medication. This is also reported to the nurse supervisor of the personal assistance or home health agency.

Medication Serious Occurrence Reports are used for all members enrolled in the waiver not just those in assisted living or group homes

(b) Specify the types of medication errors that providers are required to *record*:

Missing medication

(c) Specify the types of medication errors that providers must *report* to the state:

Missing medication

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The State Medicaid Agency is responsible for monitoring the performance of waiver providers in the self-administration of medications to members on the waiver. Licensed facilities are monitored by the Department Licensing Bureau. CMTs, during their review processes or as necessary, evaluate the self-administration of medication by waiver providers.

Licensing verification is completed by the state's fiscal agent when the provider enrolls as a Medicaid provider. MMIS Contract Manager in the Director's Office directly oversees the Conduent contract. Conduent provides a report monthly to the Department which includes the contract requirements. In addition, Conduent and the Department have monthly status meetings.

In addition to reviews completed by the licensure bureau. 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 state. The CPOs review all medication incident reports as soon as possible (within 10 working days) and brings issues before the Department's quality assurance committee to review and ensure remediation of identified medication monitoring problems.

In addition to the methods for gathering data described above, the SDMI HCBS quality assurance committee representative attends monthly tri-divisional meetings where medication management patterns/trends and remediation efforts are discussed with multiple HCBS waiver managers within Montana to collaborate on best practices and improvement strategies.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:

Percent of reports of abuse, neglect, and exploitation investigated within stipulated time frames. Numerator is the number of abuse, neglect and exploitation reports investigated within stipulated time frames. Denominator is the total number of reports.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

Percent of reports of abuse, neglect, and exploitation that were resolved within stipulated time frames. Numerator is the number of abuse, neglect and exploitation reports that were resolved within stipulated time frames. Denominator is the total number of reports.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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<i>(check each that applies):</i>		
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Providers/CMTs</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	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: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

Percentage of SORs (report by type of SOR) reported with the required timeframe.

Numerator is the number of SORs reported by type within time frame. Denominator is the total number of SORs received.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

c. Sub-assurance: *The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of incidents involving restrictive interventions including seclusion that are reviewed by the Department. Numerator: number of incidents involving restrictive interventions including seclusion reviewed by the Department. Denominator: total number of incidents involving restrictive interventions.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

The number and percent of waiver members receiving annual physical exam.

Numerator - number of members who receive annual physical exams. Denominator - total number of waiver members.

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

The CPO will review all SOR on an ongoing basis. They will review for incident types, response time and remediation activities. AMDD Central Office staff will review SORs and CPO response on a quarterly basis.

The medication monitoring will be for those persons who self-administer their medications. The CMTs will require a RN or LPN to visit persons who are self-administering their medications and do not have any other persons monitoring their use. They will check on their use of medication. This will be done by reviewing the prescriptions and tallying the amount of medication remaining. The RN or LPN will meet monthly with the CMT to discuss the monthly medication monitoring. Any missing doses or more doses remaining than prescription notes will be documented and the RN or LPN will discuss with CMT, member and doctor. If it is determined the person cannot self-administer their medication the RN or LPN will set up a process of distributing medication. If a member is compliant with medication management without incidence of self-administering their medication the monitoring can discontinue. This can start up again if warranted.

b. Methods for Remediation/Fixing Individual Problems

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

As part of the ongoing review of SORs, the CPO, when necessary, will take immediate and appropriate action to remediate situations when the health, safety or welfare of a member has not been safeguarded. The quarterly SOR report will be analyzed and reviewed by Program Manager. The Program Manager will review SORs by type, agency and waiver site. This will allow the Program Manager to identify patterns and trends. All SORs are electronic through QAMS and a report is generated through the QAMS. Prevention and training strategies will be developed to respond to patterns and trends identified by the CPOs, CMTs and AMDD. The Program Manager and CPOs meet monthly and review the reports quarterly. As necessary, APS and AMDD will work together to develop and implement strategies for prevention.

Discovery The CPO will review all SORs on an ongoing basis. They will review for incident type, response time by CMT and remediation activities. The Program Manager will receive copies of all SOR and the results of the review by CPO. The Program Manager will review the SOR for response time and resolution by CMT and CPO. The SOR quarterly report, including the breakdown of types of SORs, is available through the QAMS by the Program Manager to identify any trends. Training for waiver providers will be identified based on those trends. All CMT will receive program manual detailing the policies and procedures of the programs. Training of providers and CMT will specifically address information on how to identify and report abuse, neglect and exploitation.

Remediation As part of the ongoing review of SORs the CPO, when necessary when there is imminent risk of harm, will take immediate and appropriate action to remediate situations when the health or welfare of a member has not been safeguarded. The Program Manager will track the timeliness and resolution of SORs against AMDD policies and procedures. The quarterly report developed by the Program Manager will be analyzed and reviewed program manager. Based on this review, prevention strategies will be developed by AMDD to respond to patterns and trends. As necessary, APS and AMDD will work together to develop and implement strategies for prevention. When the Program Manager determines the SORs identify systemic issues, the program manager will recommend strategies to prevent further incidences. The strategies would be dependent on the issue identified but could involve several responses from AMDD including additional training, rule changes or referral to another agency such as law enforcement, as examples. If the SORs are provider related issue initially training would be required or disciplinary action requested if the occurrence was imminently jeopardizing and members health or safety. The CPO will also be responsible for follow-up with individual providers regarding an SOR related issue. The CPO would request the provider address the issue and comply with recommended follow-up from the SOR. The time frame for compliance would be negotiated with the provider and CPO. If the change in provider behavior is not acceptable, AMDD would stop using the provider and refer to QAD for potential sanctions. If the SOR is identified as a member issue the CMT and CPO will discuss the issue with the member and determine a corrective plan for the member and the time line. Again, this will be monitored closely for resolution within the time line. Dependent on the issue, the plan could be education, counseling or referral to another entity. The member will be an active participant in the corrective plan and any decisions determined necessary to resolve the issues. Unfortunately, when a member is abusive to providers the behavior does need to change or providers will refuse to serve the member. It is imperative that this resolved before it gets to this point, which could result in the waiver unable to serve the member in the community.

The medication monitoring will be documented in progress notes. Medication monitoring will be added to the annual quality assurance review. The quality assurance review team will review the progress notes to ensure monthly visits. If monthly visits are missed the CMT will be written up. They will be required to develop a system to ensure each person is reviewed monthly for medication monitoring. When a person has no difficulty with medication self administering, the medication monitoring will discontinue. If an issue arises the monthly medication monitoring would resume.

ii. Remediation Data Aggregation

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

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Quality Management Strategy for the SDMI Waiver is: AMDD will conduct comprehensive evaluations of services to HCBS members to meet the Divisions quality assurance requirements. AMDD staff will perform announced quality assurance reviews. The purpose of the review is to ensure that optimal services are being provided to members and that program rules and policies are being followed. Quality assurance results will be utilized to improve the programs and services.

State staff make up the Quality Assurance Committee including CPOs, Program Manager, Program Supervisor, and Program Specialist.

Providers and CMTs keep state staff informed of effectiveness of design changes at state-wide meetings quarterly or during the monthly individual case management team calls with the CPO.

Member feedback through surveys/advocates such as mental health ombudsman, Mental Health Oversight Advisory Council, Service Area Authorities and Mental Health Local Advisory Councils.

In General

The Quality Management (QM) process will involve a strategy to ensure that individual members have access to and are receiving the appropriate services to meet their needs. This will require ongoing development and utilization of individual quality standards, and working with case management teams to evaluate individualized personal outcomes and goals.

The QM process will also involve a strategy designed to collect and review data gathered from providers and individual members on quality assurance measures. Provider standards and quality indicators are used to ensure that quality assurances are met. At the Division level in central office, the Program manager will identify trends and systemic issues and provide remediation, as necessary. Each of the Waiver assurances and other federal requirements will be addressed below at varying levels of responsibility, beginning with the CPOs. Their responsibilities will be the utilization of discovery and monitoring methods, through reviews of member clinical records, specifically to include

PCRPs, comparison with up-to-date documentation of service claims paid, and interviews with staff and annual member surveys to evaluate areas of strength and weakness in the overall program. The Program managers role will be to monitor the discovery activities of the CPOs; to evaluate their submitted information; and to participate in policy decisions that address provider or system deficiencies. Recovery markers have been established as performance/outcome indicators. These include the domains of Employment; Level of Symptom Interference; Housing; Substance Abuse (stages of change and level of use). Each domain contains items that will be scored and submitted quarterly through a secure web based application by case managers to the State Mental Health Authority for analysis, and review. All reports will contain only summarized data to ensure member confidentiality. The State Mental Health Authority currently administers an annual nationally standardized Consumer Satisfaction Survey that measures Access to services; Quality and Appropriateness of services; Member Satisfaction with services; member perspective on Outcomes; and member Participation in Treatment Planning. This survey will be modified where appropriate to obtain optimal feedback from members regarding the waiver service program.

Additionally, all CMT Providers are required to conduct internal audits of their records to ensure the members files include the necessary documentation to support the consumers identified needs. The PCRPs must be accurate and complete; services must be aligned to address the identified needs; the cost sheet must match the services provided; and all required information must be included in the file. The qualifications of the CMTs will be reviewed to ensure compliance. Areas of concern that may lead into suspected overpayments will be referred to the Audit and Compliance Bureau.

Long Term Care Division (SLTC) reviews Personal Assistance agencies a minimum of every three years. The summary reports will be shared with AMDD. All corrective action plans from providers will be reviewed by AMDD. Should any of the areas of deficiency involve members from the SDMI waiver the appropriate CPO and Program Manager will be contacted to review the deficiency and corrective plan. The Quality Assurance Division reviews all facilities. The SLTC Ombudsman office will contact the appropriate CPO and Program Manager when a concern is registered with their office. The member satisfaction surveys will include a section on their

waiver services other than the CMTs. This information will be reviewed by the CPO and Program Manager. Should there be any issues related to Health and Safety these will be addressed immediately with the agency. CPOs review all PCRPs and the services provided to members.

ii. System Improvement Activities

Responsible Party (<i>check each that applies</i>):	Frequency of Monitoring and Analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div></div>	Other Specify: <div></div>

b. System Design Changes

- i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The review of the effectiveness of the system design changes will be overseen by the Program Manager. The Program Manager will gather information from CPOs, CMTs, member surveys, provider input and other discovery methods. A review will take place at a minimum annually or as issues arise. The review will evaluate the effectiveness, efficiency, and appropriateness of the quality management system design identifying changes as needed.

The program Manager will review summaries of information on trends, patterns and areas of concern. As issues arise they will be prioritized and strategies developed to address the issues. The CPO will identify trends and systemic issues and provide assessment information to the Program manager at a minimum quarterly. The Program Manager will perform QA functions through ongoing review of discovery information; monitoring QA annual onsite reviews and quarterly desk audits. CMTs will keep state staff informed of effectiveness of design changes at monthly state wide meetings.

Central office staff and CPOs meet monthly to discuss any issues with staff, waiver members and CMTs, review of policies and procedures and service utilization. CPOs have monthly meetings with CMTs to discuss issues with providers, members, review PCRPs, cost sheets and any other issues. CMTs meet monthly with providers to discuss issues with providers, members, and staffing issues. CMTs inform CPOs of any issues that arise at these monthly meetings.

- ii.** Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Central office and CPOs meet monthly. CPOs meet monthly with CMTs. CMTs meet monthly with providers.
State Roles and Responsibilities

1. LOC Monitoring:

The state monitors LOC at initial intake and member's annual review through the state's annual review QA process. The contracted entity will complete the initial LOC review. Annual LOC is completed by the CMT at member's annual review. If the CMT has concern that the member does not meet LOC, the CMT will request a LOC reevaluation be completed by the contracted entity. If the CMT finds at annual review the member does not meet LOC, the CMT will request a LOC reevaluation be completed by the contracted entity.

2. Person Centered Recovery Plan:

- a) Services will be delivered in accordance with the PCRP, including the type, scope, amount, duration, and frequency specified in the PCRP. This task will be monitored by AMDD Staff that matches services reimbursed by Medicaid for waiver members with PCRP goals. CPOs will review records of services by member to compare with PCRPs. Discrepancies will be referred to the CMT for further review.
- b) The CPO will authorize the initial PCRP for members enrolling into the waiver. CPOs will be available to problem-solve difficult situations as requested by the CMTs.
- c) Through annual reviews of the CMTs records, CPOs will determine that PCRP for members were updated annually or more frequently as needed.
- d) The annual reviews will provide documentation that the member was afforded the choice between waiver services and institutional care; offered free choice of waiver providers; and was directly involved in the development of their PCRP.
- e) Discrepancies will be summarized at annual review and reported to the Program manager and CMTs.

3. Qualified Providers:

- a) The Department will verify that providers meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
- b) The Department will verify on an annual basis that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards.
- c) All SDMI Waiver service providers must be licensed in their field of expertise. The Fiscal Intermediary Contractor will verify licenses of service providers on a regular basis. If a provider does not have an active license, Fiscal Intermediary Contractor will inactivate the provider number and notify the provider and the Department.
- d) The Department will identify and remediate situations where providers do not meet requirements.
- e) The Department will implement policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver.

4. Health and Welfare:

- a) There will be continuous monitoring of the health and welfare of members and remediation actions will be initiated when appropriate.
- b) The Department, on an on-going basis, will identify, address and seek to prevent the occurrence of abuse, neglect and exploitation.
- c) All suspected occurrences of abuse, neglect and exploitation will be reported to the appropriate agency (please refer to Appendix G-1-c).
- d) Annual reviews completed by the CPOs will provide baseline data regarding quality services, adequacy of services, comprehensive review of all SORs, and assurance records are in order and follow the principles of charting. Paid claims data will be reviewed quarterly. Once data is pulled, there will be an in-depth review to determine if a common pattern is occurring. If there is a common pattern, the Department will develop a corrective action plan to address any and all issues.
- e) Any corrective action plans identified to remedy a situation will be documented and results provided to the appropriate State agency. CMTs and waiver providers will cooperate to prevent any further occurrences of abuse, neglect, or exploitation.
- f) The MHSB will ensure training of CPOs and CMTs in the areas of health and welfare of members.
- g) The CMTs will do home visits at least quarterly. The teams will review the self-administration of medication with the member. The teams will contact providers on a monthly basis to ensure medication is administered appropriately. Any inappropriate medication management such as missed doses, missing medication or taking medication more frequently than prescribed will warrant a SOR. The CPO will investigate and contact Agency for resolution. The resolution would be training on medication administering, equipment that controls dosage, written reprimand, or dismissal to name examples.
- h) Montana does not allow the use of restraints. Should the Teams, CPOs or others suspect any use of restraints an immediate report will be given to APS and the Ombudsman Office for an investigation.

i) Alcohol and drug abuse, at times, poses additional health and safety issues. The CMTs meet with the providers monthly to review their waiver members. Alcohol and drug abuse by a member may warrant a SOR. At the very least, the CMT must address their concerns with the member and will be closely monitored by more home visits and more frequent contact with the providers going into the home through a risk negotiation process. Training on alcohol and drugs, stages of change, and motivational interviewing will be provided to CMTs, CPOs, and providers.

5. Administrative Authority:

- a) The Department, AMDD will retain ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions of contracted entities. The LOC contracted entity contract oversight will be shared responsibility between the SLTC Division and AMDD.
- b) The CPOs will conduct annual reviews of the CMTs records to ensure services were provided to members in accordance with their identified needs. These annual reviews will encompass interviews with CMT staff; other waiver providers and the members of the waiver.
- c) The Division may request an audit from the Audit and Compliance Bureau if determined necessary by the AMDD through activities completed by the CPOs.
- d) The MMIS Contract Manager directly oversees the Fiscal Intermediary Contractor contract. Fiscal Intermediary Contractor will provide a report card monthly to the Divisions which include the contract requirements. In addition, Fiscal Intermediary Contractor and the Department have a monthly status meeting.

6. Financial Accountability:

- a) Claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to members, authorized in the PCRPP and properly billed by qualified waiver providers in accordance with the approved waiver.
- b) The CPOs will complete a comparison of up-to-date documentation of paid claims data with the members' PCRPP to ensure accurate billing of services occurred in accordance with those services outlined in the PCRPP. The Division will have a data base that compiles the paid claims history from Fiscal Intermediary Contractor for the member and allows the CPO to match the information with the PCRPP. This review process will occur annually for each member.
- c) The Division will provide ongoing training to each CMT to ensure accuracy of coding and payments. If there is a CMT experiencing issues with billing deficiencies, AMDD central office will meet with the CMT as warranted.

7) CPO QA Roles and Responsibilities:

- a) CPOs will be charged with the role of regular review and monitoring of planning, documentation, quality, and delivery of services to HCBS Waiver service members. The CPO will approve the initial PCRPP for members enrolling into the SDMI Waiver. Annually a member survey will be sent to 100% of HCBS Waiver members to ensure the participants are in charge of their plans of care development; they agreed to all of the services outlined in their plans of care; they had freedom of choice of service providers; and they signed their plans of care and retained copies for their files.
 - b) Chart reviews will include an evaluation of the need for and inclusion of a written evaluation for LOC for all applicants for whom there is reasonable indication that services may be needed in the future. Also included in charts will be annual reevaluations of LOC. The CMTs will will reevaluate LOC at annually for waiver member is.
 - c) Annually, CPOs will verify through a review of waiver member's files, the documentation of selection of waiver services or institutional care by members; and selection of waiver services and providers, as indicated by the member's signature. A new PCRPP will be written annually by the CMT. The CPOs will conduct annual comprehensive reviews to ensure full compliance by the CMTs. The CPOs will follow the established quality assurance review process.
 - d) At least every 90 days (or when warranted by changes in the waiver participant's needs), a PCRPP will be reviewed with the member by the CMT to ensure the PCRPP addresses all of the members assessed needs (including health and safety risk factors) and personal goals. The CMT will do the recovery markers review during the 90 day review. The recovery markers measure the level of symptom interference; housing situation; employment/volunteer; substance use: level of use; and substance use: stage of change.
- 4) AMDD will survey waiver members annually.

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

02/21/2020

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*):

Participant Experience Surveys (PES) are sent to members annually. Results are compiled by Central Office and analyzed for trends.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department provides financial oversight to assure that claim coding and payment are in line with the waiver reimbursement methodology. The Department does not require waiver providers to secure an independent audit of their financial statements. Paid claims reports will be run by the AMDD of the Department on at least a monthly basis (or as needed). These reports will depict the services utilized, the number of members using each service, the number of units utilized, and the total dollar amount paid for each service. As a part of the quality assurance reviews, financial accountability will be assessed. Charts will be reviewed by AMDD staff to ensure that no payments were made for waiver services when a member was permanently or temporarily discharged from waiver services. The Audit and Compliance Bureau of the Department will conduct financial audits upon request of the AMDD. The Audit and Compliance Bureau is further mandated to perform reviews for any and all areas of suspected overpayments and as such, may be completing financial audits relative to the SDMI Waiver providers without being directly referred by the AMDD. Audits will be conducted in compliance with the single state audit act. State staff make up the Quality Assurance Committee including CPOs, Program Manager, Program Supervisor, and Program Specialist. Providers and CMTs will keep state staff informed of effectiveness of design changes at state-wide meetings quarterly or during the monthly individual case management team calls with the CPO.

The Department conducts an annual onsite review of each case management team as part of the quality review process.

*Member feedback through surveys/advocates such as mental health ombudsman.
Service Area Authorities and Mental Health Local Advisory Councils.*

The CPOs does desk audits on a minimum of 100% of members during each fiscal year. The desk audits have waiver paid claims by member and by service. The State Plan expenditures are reviewed to ensure State Plan funds have been used prior to waiver funds. The claims are compared with the cost sheet and PCRPP to ensure the member is receiving the services identified on the cost sheet. Any discrepancies are discussed with the CMTs and a summary of trends is sent to central office AMDD.

Surveillance Utilization Review (SURS) identifies overpayments. When an overpayment is identified, SURS does a provider audit by reviewing records provided by the provider, discusses with provider and requests the overpayment by letter. They are notified of their fair hearing rights.

CPOs do desk audits of the waiver programs. They review 100% of state plan and waiver services utilized. These are compared with the member cost sheets and PCRPP. If an error is identified this is discussed with CMT and provider. CPOs review 100% of member utilization.

When an overpayment is identified through the SURS process a letter is sent to the provider with a copy of the findings requesting recoupment of funds. (The letter informs the provider of their fair hearing rights.) Appropriate follow-up is taken by SURS to ensure recovery.

If fraud is identified they can be sanctioned and be discontinued as a Medicaid and Medicare provider. The findings are sent to Office of Inspector General (OIG) and the licensing board of the provider.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the

reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

Number and percent of claims that are paid within the member's PCRP authorizations.

Numerator is number of claims paid correctly according to PCRP. Denominator is the total number of paid claims.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

	Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
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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: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

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

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

Performance Measure:

Providers are paid in accordance with the rate methodology specified in the approved waiver application. Numerator is the number of paid claims based on the rate methodology in the approved waiver. Denominator is the number of paid claims.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	

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: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	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: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

The AMDD and CPOs will conduct at least annual audits of member records to ensure the waiver services are aligned to address the identified needs and the cost sheet matches services provided and paid claims support services authorized and provided.

b. Methods for Remediation/Fixing Individual Problems

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

AMDD will provide ongoing training to all waiver providers identified as having issues with billing to ensure accuracy of coding and proper billing. If there is a waiver provider experiencing issues with billing deficiency, AMDD will meet with the provider until resolution has occurred. The Department's fiscal agent holds two provider trainings annually where waiver providers have the opportunity to learn proper billing procedures and to discuss any billing issues.

Discovery AMDD will run a paid claims report monthly (or as needed). These reports will include the services utilized, the number of members using each service, the number of units utilized, and the total dollar amount paid for each service. As part of the onsite quality assurance reviews, financial accountability will be assessed. Member files will be reviewed by AMDD to ensure that no payments were made for waiver services when a member was permanently or temporarily discharged from waiver services. AMDD will also ensure that no payments were made for waiver services that were not included in the plan.

CMTs are required to conduct internal audits of their records to ensure member files include the necessary documentation to support the members identified needs. The PCRPs must be accurate and complete; services must be aligned to address the identified needs; the cost sheet must match the services provided; and all required information must be included in the file. Information from the internal audits, which are completed annually, are made available to AMDD during the annual reviews of the CMTs. Areas of concern that may fall into suspected overpayments will be referred to the Audit and Compliance Bureau.

CPOs will complete a comparison of up-to-date documentation of paid claims data (desk audit) with the members PCRPs to ensure accurate billing of services occurred in accordance with those services outlined in the PCRPs. The CPOs will review a minimum of 100% of the members plan of care to ensure accurate billing annually. The CPOs will review a selection of PCRPs quarterly with 1000% being completed annually.

Remediation The Program Manager will review the monthly paid claims reports. If there is a discrepancy the CPO and CMT will be notified, requesting more information. If an error is identified training will be provided. When reviewing the internal audit, areas of concern that may fall into suspected overpayments will be referred to the Audit and Compliance Bureau. The Audit and Compliance Bureau will investigate and send recommendations to the CMT agency and AMDD.

The CPO shares the results of the desk audits with the CMT with any corrections made at that time. The CPO will send a summary of the desk audits to the Program Manager within 30 days. The summary will be due to AMDD thirty days following the completion of the desk audits. The desk audits will be done quarterly, with a minimum of 100% members reviewed each fiscal year. If the desk audits are not completed with the time frame the CPO supervisor will conduct a coaching session with the CPO staff. If there continues to be difficulty in timely submission of reports the supervisor will begin the State of Montana personnel disciplinary process.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

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Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

** Payments for waiver services will be consistent with efficiency, economy and quality of care and will be enough to enlist enough providers. Services will be reimbursed via fee for service; there will be no interim rates, no prospective payments, and no cost settlements.*

**The Department's Senior and Long Term Care (SLTC) Division has operated a home and community based waiver program for elderly and physically disabled consumers since the early 1980s. SDMI HCBS waiver service descriptions that are the same or similar as the SLTC HCBS waiver, will use the established fee schedule. Many of the same service providers provide waiver services to both waivers participants and having the same fee schedule will ensure uniformity of rates. The Senior and Long Term Services Division and the Addictive and Mental Disorders Division waiver programs share the majority of the providers and services. Following is the list of services the two Divisions share: Adult Day Care; Community Transition Services; Consultative Clinic and Therapeutic Services; Environmental Accessibility Modifications; Health and Wellness; Homemaker; Homemaker Chore; Nutrition (Meals); Pain and Symptom Management; Personal Assistance Attendant – Agency Based; Personal Attendant – Self-Direction; Personal Emergency Response System, Rental and Installation; Prevocational Services; Private Duty Nursing; Residential Habilitation; Respite Care; Specialized Medical Equipment and Supplies; Specially Trained Attendant; Supported Employment; and Non-Medical Transportation. These rates were originally determined by surveying current providers.*

**Private Duty Nursing rate calculation included the following steps: 1) determine the number of PDN providers across the state and how the number of providers impacts access, 2) review entry level nursing salaries in a cross cutting sample of hospitals across the state, 3) estimate the employment and provider agency costs in addition to salaries, and 4) calculate a rate that would reasonably cover employing nurses at a minimally competitive entry salary level.*

**There are three (3) PDN provider agencies enrolled in Montana Medicaid. Analysis of the three PDN provider agencies determined the RN and LPN staffing shortage for PDN services estimates 275 to 670 direct care nursing hours unfilled on a biweekly basis. If the state were to lose one of the three remaining PDN agencies, a total of 3,631 direct care nursing hours offered through SDMI HCBS waiver and Big Sky Waiver would be unfilled monthly. A review of hourly wages for LPNs and RNs gathered from hospitals across the state range from \$24.30 to \$27.39 per hour.*

**The department analyzed data from multiple hospitals across the state ensuring the sample represented large, medium, and small hospitals to ensure payments for PDN services are consistent with the 1902(a)30(A) of the social security act and determine the prevailing wage rate for LPNs and RNs.*

**Montana analyzed the following data elements to determine the provider agency costs: current staff salaries, benefits, taxes, number of hours approved for current members requiring PDN services, number of members receiving PDN, overhead administrative costs, and total charge for PDN related procedures to determine RVU (relative value unit) and the cost per RVU. Using this information, the state developed an hourly salary calculation based on a weighted hourly rate less 38% to account for benefits and overhead.*

**The department estimated the percentage in the response above for employer taxes, benefits and organizational overhead. We determined the desired average starting salary and applied the overhead percentage to the calculation.*

**The new rate was calculated by utilizing the estimated taxes and benefits for state government employees' salaries at \$60,000 plus the current state of Montana standard overhead of 10% and determined a 28% increase was required to align with the average starting wage for RNs and LPNs.*

**The department used the following data sources in the rate setting process:*

- Wage Study*
- Provider discussions regarding overhead and benefits*
- Projected units of service*
- Additional budget authority of \$400,000*

**The proposed hour values are a result of the basic wage study completed by the department. Wage data was collected from five hospitals of different sizes and locals on RN starting wages. The average was calculated for setting the rates*

**Currently 80% of private duty nursing is completed by LPNs due to the inability to recruit RNs. This can leave a gap in care due to the licensure/educational differences of the two levels of nursing. This differential adjustment is to attract RNs for in private duty nursing and begin to close the gaps in services. In addition, this split addresses the wage needs to the 3 providers, who are critical to waiver operations and services to children under 19 in both rural and urban areas within the state. Montana believes that access to waiver PDN services is now comparable to access for the general population in the geographic area and comparable to the Medicaid rates in similar state Medicaid programs because of the PDN rate increase.*

**As per question a, \$37.52 is the average wage paid plus employer costs base on survey and discussion with providers. The actual calculated rate, \$37.67, is the result of current spend, plus an additional \$400,000 and trended units.*

**The providers of private duty nursing are not governmental agencies. Montana does not have a standard overhead rate for non-governmental agencies. The 38% represents taxes, employer benefits and overhead. Our consultation with providers in this instance indicated this overhead is necessary to maintain services in a rural and frontier state*

**Although the loss of the first PDN provider agency did not significantly impact SDMI HCBS waiver members, the loss of*

the second PDN provider agency would have placed a hardship on members being served in the community. Even though Montana Medicaid authorized the direct care worker hours for members, PDN services were either denied or reduced because providers were not able to cover the approved hours due to the growing impact of staffing shortages. If the second PDN provider were to voluntarily terminate their enrollment with Medicaid, the effectiveness of the state's three HCBS waivers would be severely impacted. This precarious situation prompted the state to seriously consider PDN reimbursement rate increases to avoid deterioration of health and safety of enrolled HCBS members and proactively take steps to keep members in their communities to avoid institutionalization.

**Montana solicited feedback from all PDN provider providers using multiple methods including: interested party notification, public notice through Montana Administrative rules process, newspaper, *posted on the department's website, public hearing, waiver public notice, tribal consultation, Montana Health Coalition notice, and meetings the department held with PDN provider agencies.*

**All feedback received from PDN providers was positive. The provider who contemplated exiting the program has committed to providing home and community based services. The department raising the rate demonstrates the commitment to providers and HCBS.*

**The department did not receive additional feedback during the rules or waiver comment period for the new LPN and RN rates.*

**Montana was not required to seek legislative approval for rate increase as the increase is within legislative appropriations.*

**The PDN provider that withdrew as a Medicaid provider did not provide the department with feedback as to why they opted out of the program.*

The PDN provider agency who reached out to the department to discuss PDN rate concerns has committed to serving the HCBS waiver population as a Medicaid provider if the reimbursement rates are increased.

**The department did not request feedback from all PDN providers between SFY2016 and SFY2017.*

**The department did not request provider feedback from the PDN providers. There was not a great impact to SDMI HCBS waiver members when the first PDN provider withdrew.*

**The department reviewed feedback by multiple sources identified indicating the struggles PDN agencies have had with staffing.*

**AMDD does not have a geographical (rural) differential currently. The Self-direction program may assist waiver participants that live in rural areas to access providers in their areas.*

**The Case Management Team and the waiver participant develop the person centered recovery plan. The cost sheet is made available to the waiver participant as the services are identified. The waiver participant is aware of the reimbursement rate for each of their services identified in the person centered recovery plan.*

**The SLTC and AMDD review the rates annually to ensure shared services remain consistent and are within our Montana Legislative appropriation. Proposed fee schedules are posted as part of the Administrative Rule of Montana process for public comment when fees are changed, added or deleted. Services are reimbursed according to fee schedule. The fee schedule identifies the maximum allowable rate.*

**AMDD and SLTC meet annually to review information received through multiple sources including: number of providers, feedback received from providers and members, member complaints, legislative appropriation, and the state of Montana's Access Plan.*

**In addition, AMDD and SLTC will review claim history of all providers for trends in the amount of services utilized and monitor the number of provider enrollments and compare previous state fiscal year to current year to determine whether there has been a significant reduction of providers. Montana will research trend if the overall provider network decreases by 10 percent.*

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

SDMI Waiver service providers bill Montana Medicaid through the MMIS. Payments are issued directly to the providers; no funds are retained by the Department or by the State. All services are prior authorized by provider and by units. All claims are paid through MMIS.

Edits are in place with MMIS to ensure all services are allowable and reimbursed at the appropriate rate. The providers are enrolled as SDMI Waiver providers in the MMIS. Each provider has a charge file of the services (procedure codes) that they are approved to provide. These files are updated annually with the appropriate fiscal year reimbursement rate and the services. Department staff provides the information to the fiscal intermediary for updating.

Medicaid eligibles are initially entered into the Medicaid eligibility system (CHIMES) as Medicaid and SDMI Waiver eligible. The eligibility file is transferred nightly to the MMIS.

MMIS has edits to ensure the person receiving the service is eligible for the service, and the prior authorization and provider charge file are reviewed. If all is appropriate, the claim is paid. If there is an error anywhere in this process, the claim is denied.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's

approved service plan; and, (c) the services were provided:

The state's MMIS has a member eligibility system that verifies eligibility for Medicaid and the SDMI Waiver. Case managers will prior authorize all waiver services in the member's PCRP. These prior authorizations will be submitted to the state's fiscal intermediary contractor. The quality assurance plan includes a process to verify that payments for services were made in accordance with the PCRP and no SDMI Waiver services were paid for a member who was discharged from the waiver.

SURS do post payment validation. In addition, the desk audits by the CPOs review all services utilized by a minimum of 100% of members. The CMT checks in with each member on a monthly basis to determine services are being provided appropriately. The CMT meets monthly with providers to discuss the delivery of services. SURS identify outliers and then conduct an audit of services for that provider. The recoupment process was described above.

CPOs conduct desk audits and review all services utilized by 100% of members. The CMT checks in with each member on a monthly basis to determine services are being provided appropriately. The CMT meets monthly with providers to discuss the delivery of services.

- e. Billing and Claims Record Maintenance Requirement.** *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability**I-3: Payment (4 of 7)**

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Nursing facilities that receive county tax dollars may provide Respite Services to members who are on the SDMI Waiver. Local city-county health departments that receive city or county tax dollars may provide case management services or direct nursing services to members who are on the SDMI Waiver. Community Mental Health Centers that receive county tax dollars may provide professional mental health services to members who are on the SDMI Waiver.

Appendix I: Financial Accountability**I-3: Payment (5 of 7)**

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability**I-3: Payment (6 of 7)**

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the

geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability**I-5: Exclusion of Medicaid Payment for Room and Board****a. Services Furnished in Residential Settings. Select one:**

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

The Department sets reimbursement for room and board in residential settings. Upon admission, providers are notified that the SDMI Waiver may not cover the cost of room and board for the member. The cost calculation sheet utilized by the case managers to determine reimbursement for services has a line item for room and board, which is identified as the responsibility of the member.

Appendix I: Financial Accountability**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	21198.27	1326.00	22524.27	60571.75	2508.00	63079.75	40555.48
2	15640.75	1352.52	16993.27	61783.18	2558.00	64341.18	47347.91
3	15291.76	1352.52	16644.28	61833.18	2508.00	64341.18	47696.90
4	15455.59	1352.52	16808.11	61833.18	2508.00	64341.18	47533.07
5	15455.62	1352.52	16808.14	61833.18	2508.00	64341.18	47533.04

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	275		275
Year 2	330		330
Year 3	357		357
Year 4	357		357
Year 5	357		357

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The FY 2016 has the average length of stay of 281. An average over the last four years of 372 reports with an average length of stay of 272 days. The assumption was made that the ALOS may not be impacted by the increase in enrollment. It would be more impacted by the acuity of the waiver members and the state does not believe the ALOS will change. This will be used in each waiver year appendix J.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

State FY 2014 data was used as the base line to determine utilization of services and estimate number of users per services. The FY 2014 average annual cost per waiver participant was used as the base to determine Waiver Year 1 with a 2% provider rate increase. A 2% provider rate increase was factored into waiver years 2.

A 2.99% provider rate decrease was included for six months in waiver year 3. In waiver year 4 a 2.99% decrease was used for the entire year. State FY 2016 data was used as the base line to determine utilization of services and estimate number of users per services.

Appropriation for waiver year 5 will be addressed in the 2019 Montana Legislative session. It is estimated the waiver will increase unduplicated enrollment participant numbers because of the estimated reserve capacity in the waiver; Money Follows the Persons grant; and the estimated increased number of persons with SDMI who are aging, will meet nursing home level of care and will qualify for the waiver

Changes to factor D for WY4 and WY5 due to Private Duty Nursing increased rates.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The FY 2012 372 report was used for baseline with an 2% annual provider rate increase factored in for waiver years 1 and 2.

A 2.99% provider rate decrease was included for six months in waiver year 3. In waiver year 4 a 2.99% decrease was used for the entire year. State FY 2016 data was used as the base line to determine utilization of services and estimate number of users per services.

The legislature meets every two years and the next biennium will determine percentage of provider rate increase for waiver year 5.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

FY 2014 was used as the baseline and a 2% annual provider rate increase was factored in for waiver years 1 and 2. FY 2016 was used as the baseline and a 2.99% annual provider rate decrease (six monthths only in year 3) was factored in for waiver years 3 and 4.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Determined from FY 2014 paid claims. A 2% provider rate increase was factored in for waiver years 1 and 2. A 2.99% provider rate decrease was included for six months in waiver year 3. In waiver year 4 a 2.99% decrease was used for the entire year. State FY 2016 data was used as the base line to determine utilization of services and estimate number of users per services.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Health	
Case Management	
Homemaker	
Prevocational Services	
Residential Habilitation	
Respite	
Supported Employment	
Community Transition	
Consultative Clinical and Therapeutic Services	
Environmental Accessibility Adaptations	
Habilitation Aide	
Health and Wellness	
Homemaker Chore	
Life Coach	
Meals	
Non-Medical Transportation	
Pain and Symptom Management	
Peer Support	
Personal Assistance Attendant	
Personal Emergency Response System	
Private Duty Nursing/ Registered Nurse Supervision	
Specialized Medical Equipment and Supplies	
Specially Trained Attendant	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							82183.68
Adult Day Health		15 min	8	4756.00	2.16	82183.68	
Case Management Total:							925980.00
Case Management, Daily		day	275	276.00	12.20	925980.00	
Homemaker Total:							140356.80
Homemaker		15 minute	190	171.00	4.32	140356.80	
Prevocational Services Total:							1227.20
Prevocational Services		hour	4	40.00	7.67	1227.20	
Residential Habilitation Total:							1355430.72
Specialized Residential Habilitation		day	4	158.00	151.71	95880.72	
Residential Habilitation		day	75	225.00	74.64	1259550.00	
Respite Total:							30636.80
Respite		15 minute	4	250.00	4.24	4240.00	
Respite Care, Per Diem		day	4	40.00	164.98	26396.80	
Supported Employment Total:							2268.00
Supported Employment		15 minute	4	45.00	12.60	2268.00	
Community Transition Total:							11250.00
Community Transition		service	5	4.50	500.00	11250.00	
Consultative Clinical and Therapeutic Services Total:							188328.60
Consultative Clinical and Therapeutic Services		service	45	11.50	363.92	188328.60	
Environmental Accessibility Adaptations Total:							420000.00
GRAND TOTAL:							5829523.39
Total: Services included in capitation:							
Total: Services not included in capitation:							5829523.39
Total Estimated Unduplicated Participants:							275
Factor D (Divide total by number of participants):							21198.27
Services included in capitation:							
Services not included in capitation:							21198.27
Average Length of Stay on the Waiver:							276

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations		service	28	10.00	1500.00	420000.00	
Habilitation Aide Total:							173430.00
Habilitation Aide		hour	100	94.00	18.45	173430.00	
Health and Wellness Total:							407000.00
Health and Wellness		service	185	22.00	100.00	407000.00	
Homemaker Chore Total:							22500.00
Homemaker Chore		per job	30	3.00	250.00	22500.00	
Life Coach Total:							0.00
Life Coach		15 minute	0	0.00	0.01	0.00	
Meals Total:							108900.00
Meals		meal	60	300.00	6.05	108900.00	
Non-Medical Transportation Total:							49599.40
Non-Medical Transportation		trip	115	16.00	12.16	22374.40	
Non-Medical Transportation, per mile		mile	150	550.00	0.33	27225.00	
Pain and Symptom Management Total:							245250.00
Pain and Symptom Management		service	109	30.00	75.00	245250.00	
Peer Support Total:							58500.00
Peer Support		15 minute	130	36.00	12.50	58500.00	
Personal Assistance Attendant Total:							1206975.00
Personal Assistance Attendant		15 min	275	825.00	5.32	1206975.00	
Personal Emergency Response System Total:							53855.28
GRAND TOTAL:							5829523.39
Total: Services included in capitation:							
Total: Services not included in capitation:							5829523.39
Total Estimated Unduplicated Participants:							275
Factor D (Divide total by number of participants):							21198.27
Services included in capitation:							
Services not included in capitation:							21198.27
Average Length of Stay on the Waiver:							276

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS, Installation and Testing		visit	38	1.00	100.00	3800.00	
Personal Emergency Response System		item	10	5.00	500.00	25000.00	
PERS, Monthly Rental		monthly	178	2.00	70.38	25055.28	
Private Duty Nursing/ Registered Nurse Supervision Total:							67920.91
RN Supervision		15 min	58	4.00	8.63	2002.16	
Private Duty Nursing/ Registered Nurse Supervision		15 min	125	75.00	7.01	65718.75	
PAS Nurse Supervision		hour	2	2.00	50.00	200.00	
Specialized Medical Equipment and Supplies Total:							252440.00
Specialized Medical Equipment		item	268	4.15	200.00	222440.00	
Specialized Medical Supply		item	80	15.00	25.00	30000.00	
Specially Trained Attendant Total:							25491.00
Specially Trained Attendant		15 min	30	145.00	5.86	25491.00	
GRAND TOTAL:							5829523.39
Total: Services included in capitation:							
Total: Services not included in capitation:							5829523.39
Total Estimated Unduplicated Participants:							275
Factor D (Divide total by number of participants):							21198.27
Services included in capitation:							
Services not included in capitation:							21198.27
Average Length of Stay on the Waiver:							276

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							62562.50
Adult Day Health		15 min	13	2187.50	2.20	62562.50	
Case Management Total:							1133035.20
Case Management, Daily		day	330	276.00	12.44	1133035.20	
Homemaker Total:							134284.50
Homemaker		15 minute	210	145.00	4.41	134284.50	
Prevocational Services Total:							1157.36
Prevocational Services		hour	4	37.00	7.82	1157.36	
Residential Habilitation Total:							1354640.88
Specialized Residential Habilitation		day	4	153.00	154.74	94700.88	
Residential Habilitation		day	75	220.00	76.36	1259940.00	
Respite Total:							94737.92
Respite		15 minute	4	29.00	4.32	501.12	
Respite Care, Per Diem		day	28	20.00	168.28	94236.80	
Supported Employment Total:							1336.40
Supported Employment		15 minute	4	26.00	12.85	1336.40	
Community Transition Total:							13770.00
Community Transition		service	6	4.50	510.00	13770.00	
Consultative Clinical and Therapeutic Services Total:							244992.00
Consultative Clinical and Therapeutic Services		hour	60	11.00	371.20	244992.00	
Environmental Accessibility Adaptations Total:							385560.00
GRAND TOTAL:							5161448.20
Total: Services included in capitation:							
Total: Services not included in capitation:							5161448.20
Total Estimated Unduplicated Participants:							330
Factor D (Divide total by number of participants):							15640.75
Services included in capitation:							
Services not included in capitation:							15640.75
Average Length of Stay on the Waiver:							276

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations		service	28	9.00	1530.00	385560.00	
Habilitation Aide Total:							237047.31
Habilitation Aide		hour	162	77.75	18.82	237047.31	
Health and Wellness Total:							377400.00
Health and Wellness		service	185	20.00	102.00	377400.00	
Homemaker Chore Total:							64515.00
Homemaker Chore		per job	110	2.30	255.00	64515.00	
Life Coach Total:							15312.00
Life Coach		15 minute	25	96.00	6.38	15312.00	
Meals Total:							101518.56
Meals		meal	52	319.00	6.12	101518.56	
Non-Medical Transportation Total:							23465.70
Non-Medical Transportation		trip	115	15.00	12.40	21390.00	
Non-Medical Transportation, per mile		mile	185	33.00	0.34	2075.70	
Pain and Symptom Management Total:							237532.50
Pain and Symptom Management		service	115	27.00	76.50	237532.50	
Peer Support Total:							137572.50
Peer Support		15 minute	130	83.00	12.75	137572.50	
Personal Assistance Attendant Total:							216521.25
Personal Assistance Attendant		15 min	275	145.00	5.43	216521.25	
Personal Emergency Response System Total:							19612.62
GRAND TOTAL:							5161448.20
Total: Services included in capitation:							
Total: Services not included in capitation:							5161448.20
Total Estimated Unduplicated Participants:							330
Factor D (Divide total by number of participants):							15640.75
Services included in capitation:							
Services not included in capitation:							15640.75
Average Length of Stay on the Waiver:							276

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS, Installation and Testing		visit	38	1.50	102.00	5814.00	
Personal Emergency Response System		item	2	1.00	510.00	1020.00	
PERS, Monthly Rental		monthly	178	1.00	71.79	12778.62	
Private Duty Nursing/ Registered Nurse Supervision Total:							9020.00
RN Supervision		15 min	58	4.00	8.80	2041.60	
Private Duty Nursing/ Registered Nurse Supervision		15 min	244	4.00	7.15	6978.40	
PAS Nurse Supervision		15 min	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies Total:							269841.00
Specialized Medical Equipment		item	268	4.25	204.00	232356.00	
Specialized Medical Supply		item	98	15.00	25.50	37485.00	
Specially Trained Attendant Total:							26013.00
Specially Trained Attendant		15 min	30	145.00	5.98	26013.00	
GRAND TOTAL:							5161448.20
Total: Services included in capitation:							
Total: Services not included in capitation:							5161448.20
Total Estimated Unduplicated Participants:							330
Factor D (Divide total by number of participants):							15640.75
Services included in capitation:							
Services not included in capitation:							15640.75
Average Length of Stay on the Waiver:							276

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							23590.09
Adult Day Health		15 min	9	1207.89	2.17	23590.09	
Case Management Total:							1209840.58
Case Management, Daily		day	357	276.42	12.26	1209840.58	
Homemaker Total:							199983.39
Homemaker		15 minute	61	757.14	4.33	199983.39	
Prevocational Services Total:							8009.90
Prevocational Services		hour	2	520.80	7.69	8009.90	
Residential Habilitation Total:							1737185.70
Specialized Residential Habilitation		day	7	223.67	155.13	242885.49	
Residential Habilitation		day	93	213.61	75.22	1494300.21	
Respite Total:							61378.94
Respite		15 minute	1	684.36	4.33	2963.28	
Respite Care, Per Diem		day	17	20.37	168.69	58415.66	
Supported Employment Total:							18344.66
Supported Employment		15 minute	21	67.77	12.89	18344.66	
Community Transition Total:							0.00
Community Transition		service	0	0.00	0.01	0.00	
Consultative Clinical and Therapeutic Services Total:							0.00
Consultative Clinical and Therapeutic Services		15 minute	0	164.63	365.00	0.00	
Environmental Accessibility Adaptations Total:							58157.35
GRAND TOTAL:							5459156.77
Total: Services included in capitation:							
Total: Services not included in capitation:							5459156.77
Total Estimated Unduplicated Participants:							357
Factor D (Divide total by number of participants):							15291.76
Services included in capitation:							
Services not included in capitation:							15291.76
Average Length of Stay on the Waiver:							276

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations		service	3	4.92	3940.20	58157.35	
Habilitation Aide Total:							168859.25
Habilitation Aide		hour	63	139.02	19.28	168859.25	
Health and Wellness Total:							17387.97
Health and Wellness		service	11	9.17	172.38	17387.97	
Homemaker Chore Total:							82600.53
Homemaker Chore		per job	62	5.41	246.26	82600.53	
Life Coach Total:							407097.36
Life Coach		15 minute	174	201.00	11.64	407097.36	
Meals Total:							122652.87
Meals		meal	94	233.42	5.59	122652.87	
Non-Medical Transportation Total:							91089.55
Non-Medical Transportation		trip	22	143.90	12.21	38654.42	
Non-Medical Transportation, per mile		mile	233	681.95	0.33	52435.14	
Pain and Symptom Management Total:							60775.38
Pain and Symptom Management		service	7	13.56	640.28	60775.38	
Peer Support Total:							1632.84
Peer Support		15 minute	3	44.00	12.37	1632.84	
Personal Assistance Attendant Total:							702138.46
Personal Assistance Attendant		15 minute	95	1405.12	5.26	702138.46	
Personal Emergency Response System Total:							19107.83
GRAND TOTAL:							5459156.77
Total: Services included in capitation:							
Total: Services not included in capitation:							5459156.77
Total Estimated Unduplicated Participants:							357
Factor D (Divide total by number of participants):							15291.76
Services included in capitation:							
Services not included in capitation:							15291.76
Average Length of Stay on the Waiver:							276

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS, Installation and Testing		visit	6	0.59	98.51	348.73	
Personal Emergency Response System		item	6	0.25	788.04	1182.06	
PERS, Monthly Rental		monthly	30	8.62	67.97	17577.04	
Private Duty Nursing/ Registered Nurse Supervision Total:							152839.55
RN Supervision		15 min	60	47.53	8.83	25181.39	
Private Duty Nursing/ Registered Nurse Supervision		15 min	126	134.04	7.50	126667.80	
PAS Nurse Supervision		15 min	3	28.00	11.79	990.36	
Specialized Medical Equipment and Supplies Total:							290471.54
Specialized Medical Equipment		item	142	0.92	1970.10	257373.86	
Specialized Medical Supply		item	70	0.24	1970.10	33097.68	
Specially Trained Attendant Total:							26013.00
Specially Trained Attendant		15 min	30	145.00	5.98	26013.00	
GRAND TOTAL:						5459156.77	
Total: Services included in capitation:							
Total: Services not included in capitation:						5459156.77	
Total Estimated Unduplicated Participants:						357	
Factor D (Divide total by number of participants):						15291.76	
Services included in capitation:							
Services not included in capitation:						15291.76	
Average Length of Stay on the Waiver:							276

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							23512.01
Adult Day Health		15 min	9	1226.50	2.13	23512.00	
Case Management Total:							1210449.34
Case Management, Daily		day	357	280.68	12.08	1210449.34	
Homemaker Total:							200251.94
Homemaker		15 minute	61	768.81	4.27	200251.94	
Prevocational Services Total:							23162.32
Prevocational Services		hour	2	528.82	21.90	23162.32	
Residential Habilitation Total:							1737188.70
Specialized Residential Habilitation		day	7	227.11	152.77	242869.16	
Residential Habilitation		day	93	216.90	74.08	1494319.54	
Respite Total:							61400.17
Respite		15 minute	1	694.91	4.27	2967.27	
Respite Care, Per Diem		day	17	20.69	166.13	58432.90	
Supported Employment Total:							18351.63
Supported Employment		15 minute	21	68.81	12.70	18351.63	
Community Transition Total:							8207.05
Community Transition		service	3	1.41	1940.20	8207.05	
Consultative Clinical and Therapeutic Services Total:							0.00
Consultative Clinical and Therapeutic Services		hour	0	167.17	359.46	0.00	
Environmental Accessibility Adaptations Total:							58089.59
GRAND TOTAL:							5517646.36
Total: Services included in capitation:							
Total: Services not included in capitation:							5517646.36
Total Estimated Unduplicated Participants:							357
Factor D (Divide total by number of participants):							15455.59
Services included in capitation:							
Services not included in capitation:							15455.59
Average Length of Stay on the Waiver:							281

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations		service	3	4.99	3880.40	58089.59	
Habilitation Aide Total:							168790.66
Habilitation Aide		hour	63	141.16	18.98	168790.66	
Health and Wellness Total:							17386.15
Health and Wellness		service	11	9.31	169.77	17386.15	
Homemaker Chore Total:							82702.73
Homemaker Chore		job	62	5.50	242.53	82702.73	
Life Coach Total:							407097.36
Life Coach		15 minute	174	201.00	11.64	407097.36	
Meals Total:							122534.17
Meals		meal	94	237.01	5.50	122534.17	
Non-Medical Transportation Total:							90301.94
Non-Medical Transportation		trip	22	146.12	12.03	38672.12	
Non-Medical Transportation, per mile		mile	233	692.46	0.32	51629.82	
Pain and Symptom Management Total:							60780.64
Pain and Symptom Management		service	7	13.77	630.57	60780.64	
Peer Support Total:							1632.84
Peer Support		15 minute	3	44.00	12.37	1632.84	
Personal Assistance Attendant Total:							702138.12
Personal Assistance Attendant		15 min	95	1426.82	5.18	702138.12	
Personal Emergency Response System Total:							19125.56
GRAND TOTAL:							5517646.36
Total: Services included in capitation:							
Total: Services not included in capitation:							5517646.36
Total Estimated Unduplicated Participants:							357
Factor D (Divide total by number of participants):							15455.59
Services included in capitation:							
Services not included in capitation:							15455.59
Average Length of Stay on the Waiver:							281

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS, Installation and Testing		item	6	0.60	94.01	338.44	
Personal Emergency Response System		item	6	0.26	776.08	1210.68	
PERS, Monthly Rental		monthly	31	8.47	66.94	17576.44	
Private Duty Nursing/ Registered Nurse Supervision Total:							187442.26
RN Supervision		15 min	59	49.08	11.28	32663.72	
Private Duty Nursing/ Registered Nurse Supervision		15 min	125	137.20	8.95	153492.50	
PAS Nurse Supervision		15 min	3	28.00	15.31	1286.04	
Specialized Medical Equipment and Supplies Total:							291088.21
Specialized Medical Equipment		item	143	0.93	1940.20	258027.20	
Specialized Medical Supply		item	71	0.24	1940.20	33061.01	
Specially Trained Attendant Total:							26013.00
Specially Trained Attendant		15 min	30	145.00	5.98	26013.00	
GRAND TOTAL:							5517646.36
Total: Services included in capitation:							
Total: Services not included in capitation:							5517646.36
Total Estimated Unduplicated Participants:							357
Factor D (Divide total by number of participants):							15455.59
Services included in capitation:							
Services not included in capitation:							15455.59
Average Length of Stay on the Waiver:							281

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							23512.01
Adult Day Health		15 min	9	1226.50	2.13	23512.00	
Case Management Total:							1210449.34
Case Management, Daily		day	357	280.68	12.08	1210449.34	
Homemaker Total:							200251.94
Homemaker		15 minute	61	768.81	4.27	200251.94	
Prevocational Services Total:							23162.32
Prevocational Services		hour	2	528.82	21.90	23162.32	
Residential Habilitation Total:							1737188.70
Specialized Residential Habilitation		day	7	227.11	152.77	242869.16	
Residential Habilitation		day	93	216.90	74.08	1494319.54	
Respite Total:							61400.17
Respite		15 minute	1	694.91	4.27	2967.27	
Respite Care, Per Diem		day	17	20.69	166.13	58432.90	
Supported Employment Total:							18351.63
Supported Employment		15 minute	21	68.81	12.70	18351.63	
Community Transition Total:							8207.05
Community Transition		service	3	1.41	1940.20	8207.05	
Consultative Clinical and Therapeutic Services Total:							0.00
Consultative Clinical and Therapeutic Services		hour	0	167.17	359.46	0.00	
Environmental Accessibility Adaptations Total:							58089.59
GRAND TOTAL:							5517657.16
Total: Services included in capitation:							
Total: Services not included in capitation:							5517657.16
Total Estimated Unduplicated Participants:							357
Factor D (Divide total by number of participants):							15455.62
Services included in capitation:							
Services not included in capitation:							15455.62
Average Length of Stay on the Waiver:							281

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations		service	3	4.99	3880.40	58089.59	
Habilitation Aide Total:							168790.66
Habilitation Aide		hour	63	141.16	18.98	168790.66	
Health and Wellness Total:							17386.15
Health and Wellness		service	11	9.31	169.77	17386.15	
Homemaker Chore Total:							82702.73
Homemaker Chore		per job	62	5.50	242.53	82702.73	
Life Coach Total:							407097.36
Life Coach		15 minute	174	201.00	11.64	407097.36	
Meals Total:							122534.17
Meals		meal	94	237.01	5.50	122534.17	
Non-Medical Transportation Total:							90301.94
Non-Medical Transportation		trip	22	146.12	12.03	38672.12	
Non-Medical Transportation, per mile		mile	233	692.46	0.32	51629.82	
Pain and Symptom Management Total:							60780.64
Pain and Symptom Management		service	7	13.77	630.57	60780.64	
Peer Support Total:							1632.84
Peer Support		15 minute	3	44.00	12.37	1632.84	
Personal Assistance Attendant Total:							702138.12
Personal Assistance Attendant		15 min	95	1426.82	5.18	702138.12	
Personal Emergency Response System Total:							19136.36
GRAND TOTAL:							5517657.16
Total: Services included in capitation:							
Total: Services not included in capitation:							5517657.16
Total Estimated Unduplicated Participants:							357
Factor D (Divide total by number of participants):							15455.62
Services included in capitation:							
Services not included in capitation:							15455.62
Average Length of Stay on the Waiver:							281

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS, Installation and Testing		visit	6	0.60	97.01	349.24	
Personal Emergency Response System		item	6	0.26	776.08	1210.68	
PERS, Monthly Rental		monthly	31	8.47	66.94	17576.44	
Private Duty Nursing/ Registered Nurse Supervision Total:							187442.26
RN Supervision		15 min	59	49.08	11.28	32663.72	
Private Duty Nursing/ Registered Nurse Supervision		15 min	125	137.20	8.95	153492.50	
PAS Nurse Supervision		15 min	3	28.00	15.31	1286.04	
Specialized Medical Equipment and Supplies Total:							291088.21
Specialized Medical Equipment		item	143	0.93	1940.20	258027.20	
Specialized Medical Supply		item	71	0.24	1940.20	33061.01	
Specially Trained Attendant Total:							26013.00
Specially Trained Attendant		15 min	30	145.00	5.98	26013.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							5517657.16 5517657.16 357 15455.62 15455.62 281