

APPENDIX K: Emergency Preparedness and

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.ⁱ This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: Montana

B. Waiver Title(s):

Montana Behavioral Health Severe and Disabling Mental Illness (SDMI) Waiver

C. Control Number(s):

MT.0455.R03.09

D. Type of Emergency (The state may check more than one box):

<input checked="" type="checkbox"/>	Pandemic or Epidemic
<input type="checkbox"/>	Natural Disaster
<input type="checkbox"/>	National Security Emergency
<input type="checkbox"/>	Environmental
<input type="checkbox"/>	Other (specify):

E. **Brief Description of Emergency.** *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state’s mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

On March 13, 2020, as authorized under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (the “Stafford Act”), President Donald J. Trump declared a state of emergency resulting from the ongoing Coronavirus Disease 2019 (COVID-19) pandemic. On January 31, 2020, pursuant to the Public Health Services Act, Secretary of Health and Human Services (HHS) Alex Azar declared a public health emergency. On March 12, 2020, Governor Steve Bullock issued an [executive order](#) declaring a state of emergency related to the continued spread of COVID-19 to allow the governor to direct a coordinated response to the outbreak of communicable disease. This includes mobilizing all available state resources, such as emergency funds or personnel from the National Guard. It also allows the governor to take additional steps to ease regulatory requirements, continue federal and multi-state coordination, and ensure continued access to critical services for the State’s most vulnerable.

The novel COVID-19 pandemic has already begun to place unprecedented burdens on Montana’s health care programs and systems. Per the [Centers for Disease Control and Prevention \(CDC\)](#), as of March 31, 2020, there are 177 reported COVID-19 cases; this number is expected to grow as more people become tested and the virus spreads to other communities in Montana, increasing the risk of exposure for the State’s residents. Montana has three approved 1915(c) waivers with 5400 participants, many of which are among the most vulnerable and susceptible to COVID-19. Health care workers caring for patients with COVID-19, individuals who have had close contact with persons with COVID-19, and travelers returning from affected international locations where community spread is occurring are all at elevated risk of exposure. Montana’s knowledge of COVID-19 is still rapidly evolving.

Montana has received approval to waive certain Medicaid and the Children's Health Insurance Program (CHIP) requirements to ensure sufficient health care items and services are available to meet the needs of individuals under 1135 of the Social Security Act. A number of requirements Montana has committed to in its Medicaid state plan and waiver applications are dependent on staff and provider ability to perform tasks. Due to the evolving nature of this crisis, we may reach a point where we must adjust service delivery methods, suspend home visits, and shift workload priorities due to staff shortages to in order to meet immediate health and safety needs.

Effective February 1, 2022: This amendment will apply to the SDMI Waiver (0455). This Appendix K makes the following changes:

- Add two services to the wavier
 - Fiscal Management Services (FMS)
 - Individual Directed Goods and Services
- Expand self-directed services to include:
 - FMS
 - Individual Directed Goods and Services

F. Proposed Effective Date: Start Date: January 27, 2020 Anticipated End Date: End of the PHE

G. Description of Transition Plan.

SDMI Waiver (0455)

The Department intends to formally submit a waiver amendment to continue FMS self-directed services and Individual directed goods and services past the public health emergency.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus.

I. Description of State Disaster Plan (if available) *Reference to external documents is acceptable:*

N/A-no change

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state’s response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. ___ Access and Eligibility:

i. ___ Temporarily increase the cost limits for entry into the waiver.

[Provide explanation of changes and specify the temporary cost limit.]

N/A-no change

ii. ___ Temporarily modify additional targeting criteria.

[Explanation of changes]

N/A-no change

b. ___ Services

i. X Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___ Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

[Explanation of changes]

N/A-no change

iii. X Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

Adding Fiscal Management Service and Individual Directed Goods and Services increases the resources available to members during the COVID-19 PHE, particularly to members in our rural and frontier areas. This provides additional options for members to receive necessary services during a time when, due to COVID-19, providers are experiencing shortages in resources. The additional service options will expand the number of providers, increase access to the community and the frequency of services provided to members throughout the state during the COVID-19 PHE.

Add the following proposed services for self-direction:

- FMS
- Individual Directed Goods and Services

iv. ___ Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

N/A-no change

v. ___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

N/A-no change

c. ___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

N/A-no change

d. ___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i. ___ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

N/A-no change

ii. ___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

iii. ___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

N/A-no change

e. ___ Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

N/A-no change

f. ___ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

N/A-no change

g. ___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

N/A-no change

h. ___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

N/A-no change

i. ___ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

N/A-no change

j. ___ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

N/A-no change

k. X Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

Effective February 1, 2022: Adding Fiscal Management Service and Individual Directed Goods and Services increases the resources available to members during the COVID-19 PHE, particularly to members in our rural and frontier areas. This provides additional options for members to receive necessary services during a time when, due to COVID-19, providers are experiencing shortages in resources. The additional service options will expand the number of providers, increase access to the community and the frequency of services provided to members throughout the state during the COVID-19 PHE.

Add the following proposed services for self-direction:

- FMS
- Individual Directed Goods and Services

l. ___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

N/A-no change

m. ___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

N/A-no change

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

- a. Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

- a. Add an electronic method of service delivery (e.g., telephonic) allowing services to continue to be provided remotely in the home setting for:
- i. Case management
 - ii. Personal care services that only require verbal cueing
 - iii. In-home habilitation
 - iv. Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
 - v. Other [Describe]:

N/A-no change

- b. Add home-delivered meals
- c. Add medical supplies, equipment and appliances (over and above that which is in the state plan)
- d. Add Assistive Technology

3. Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.

- a. Current safeguards authorized in the approved waiver will apply to these entities.
- b. Additional safeguards listed below will apply to these entities.

N/A-no change

4. Provider Qualifications

- a. Allow spouses and parents of minor children to provide personal care services
- b. Allow a family member to be paid to render services to an individual.
- c. Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*
- d. Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

- a. Allow an extension for reassessments and reevaluations for up to one year past the due date.
- b. Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- c. Adjust prior approval/authorization elements approved in waiver.
- d. Adjust assessment requirements
- e. Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

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

First Name: Mary Eve
Last Name Kulawik
Title: Medicaid Analyst
Agency: MT Public Health and Human Services
Address 1: PO Box 4210
Address 2: 111 North Sanders
City Helena
State MT
Zip Code 59620
Telephone: 406-444-2584
E-mail mkulawik@mt.gov

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

Same as above

8. Authorizing Signature

Signature:

Date: 7/5/2022 Revised 7/7/2022

/s/
State Medicaid Director or Designee

First Name: Mike
Last Name Randol
Title: Medicaid & Health Services Executive Director/State Medicaid Director
Agency: MT Public Health and Human Services
Address 1: PO Box 4210
Address 2: 111 North Sanders
City Helena
State MT
Zip Code 59620
Telephone: 406-444-1286
E-mail Michael.Randol@mt.gov

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Title:	Financial Management Services – effective February 1, 2022		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
Service Definition (Scope):			
<p>Financial Management Services (FMS) are provided to assure that participant directed funds outlined in the Person-Centered Recovery Plan (PCRP) are managed and distributed as intended. The FMS provider receives and disburses funds for the payment of participant-directed services under an agreement with the Department, the State Medicaid agency. The FMS provider files claims through the Medicaid Management Information System for participant directed goods and services. The FMS provider is responsible for maintaining separate accounts on each member’s participant-directed service funds and producing expenditure reports as required by the Department. The FMS provider executes and holds Medicaid provider agreements through being deemed by the state to function as an Organized Health Care Delivery System or as authorized under a written agreement with the Department. The FMS provider must not provide any other SDMI Medicaid waiver service to the member receiving FMS. FMS must be authorized prior to service delivery by the case management team at least annually in conjunction with the PCRP development and with any PCRP revisions. FMS is intended for those goods and services that are not covered by the State Medicaid Plan or those instances in which a participant’s need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
New Enrollment (one-time fee) \$150.00			
Monthly Check Transaction \$75.00 per member per month			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Fiscal Employer Agent
Specify whether the service may be provided by <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>

Fiscal Employer Agent	Applicable business license as required by the local, city, or county government in which the services are provided.		<p>Must understand the laws and rules that regulate the expenditure of public resources</p> <p>Must have a surety bond issued by a company authorized to do business in the State of Montana in an amount not less than \$250,000.</p> <p>Must not be enrolled to provide any other SDMI Waiver Medicaid services to the member</p> <p>FMS provider executes and holds Medicaid provider agreements through being deemed by the state to function as an Organized Health Care Delivery System or as authorized under a written agreement with the Department.</p> <p>FMS Agent must provide monthly budget reports to the Department.</p>

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Fiscal Employer Agent	State Medicaid Agency (SMA)	Annually

Service Delivery Method <i>(check each that applies):</i>		Participant-directed as specified in Appendix E		Provider managed
	X			



Service Title:	Individual Directed Goods and Services – effective February 1, 2022
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Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope):

Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid state plan are services, equipment, or supplies that are provided through this waiver through a non-Medicaid provider, that or address an identified need in the service plan (including improving and maintaining the participant’s opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; or promote inclusion in the community; or increase the participant’s safety in the home environment; and, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. Individual Directed Goods and Services are purchased from the participant-directed budget. Experimental or prohibited treatments are excluded. Individual Directed Goods and Services must be documented in the person-centered recovery plan.

The cost plan is based on the person-centered recovery plan and approved by the community program officers. For newly enrolled members, the cost plan will estimate the cost based on the member’s assessed needs, using standard operating policies and processes currently in place. The value the cost plan for existing members is largely based on the historical amount awarded to the member with adjustments made based on changing needs.

The methodology used to authorize payments for services, and to review and approve reimbursements to direct workers based on the delivery of agreed upon services will vary depending on the category of service. The delivery of services is based on the cost plan and the person-centered recovery plan. All services outlined in the cost plan will correspond to a need outlined in the person-centered recovery plan.

Cost plans will be evaluated for accuracy quarterly along with the person-centered recovery plan.

The specific goods and services that are purchased under this coverage must be documented in the service plan.

Currently, all members and persons acting on their behalf are informed of the details of the member’s cost plan. The cost plan details are based on the outcome of the planning process, which, in turn, is based on assessments and the expressed desires of the member. The cost plan functions as the contractual basis between the member, the provider, and the department in the delivery of services. If the quantity and type of services outlined in the cost plan are not considered adequate in meeting the needs of the member, additional funds may be requested on behalf of the member. Requests for additional funding go through the case manager and the community program officer. Members and team members are able to request budget adjustments by contacting their case manager.

The cost plan is included with the person-centered recovery plan and is provided to and signed by the member or the member’s representative to confirm agreement.

The goods and services that are purchased under this coverage must be clearly linked to an assessed participant need established in the service plan.

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

<p>The following represents a non-inclusive list of non-permissible Goods and Services:</p> <ul style="list-style-type: none"> • Goods, services or supports benefiting persons other than the individual • Room and board • Personal items and services not related to the disability • Gifts, gift certificates, or gift cards for any purpose • Items used solely for entertainment or recreational purposes • Personal hygiene items • Discretionary cash • General clothing, food, or beverages (not specialized diet or clothing) 			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:	
		Fiscal Employer Agent	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian	
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Fiscal Employer Agent	Applicable business license as required by the local, city, or county government in which the services are provided.		<p>Must understand the laws and rules that regulate the expenditure of public resources.</p> <p>Must have a surety bond issued by a company authorized to do business in the State of Montana in an amount not less than \$250,000.</p> <p>Must not be enrolled to provide any other SDMI Waiver Medicaid services to the member.</p> <p>FMS provider executes and holds Medicaid provider agreements through being deemed by the state to function as an Organized Health Care Delivery System or as authorized under a written agreement with the Department.</p> <p>FMS Agent must provide monthly budget reports to the Department.</p>
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	

Fiscal Employer Agent	State Medicaid Agency (SMA)	Annually		
Service Delivery Method <i>(check each that applies):</i>		Participant-directed as specified in Appendix E		Provider managed
	X			

ⁱ Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.