Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

July 1, 2020

v1.0

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Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of __Montana____ requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is HCBS SDMI Case Management Waiver to run concurrently with the Behavioral Health Severe Disabling Mental Illness Home and Community Based Services (SDMI) Waiver.
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
_ _ an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
_x_ a renewal request

Section A is:
___ replaced in full
___ carried over with no changes
_x_ changes noted in BOLD.

Section B is:
___ replaced in full
_x_ changes noted in BOLD.

Effective Dates: This waiver/renewal/amendment is requested for a period of __**5**__ years beginning **07/01/2020** and ending **06/30/2025**.

State Contact: The State contact person for this waiver is Jennifer Fox and can be reached by telephone at (406) 444-4927, or fax at (406) 444-7391, or e-mail at JenFox@mt.gov. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The State notifies in writing all federally-recognized Tribal Governments of the State's intent to submit a Medicaid waiver request to CMS at least 30 days before the submission date. The notification provides a summary of the waiver request and an opportunity to comment on the proposal. Tribal notifications were mailed **February 3, 2020**.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

The 1915(b)(4) Waiver is limited to the provision of case management services in the 1915(c) **Behavioral Health Home and Community-Based Services (HCBS), Severe and Disabling Mental Illness (**SDMI**)** Waiver. Montana has historically contracted with case management entities through Medicaid enrollment. The State sought to continue case management services though a limited number of providers through a procurement process effective . The selected provider(s) entered into the standard Medicaid provider agreement but are required to meet additional quality standards and perform enhanced quality monitoring and remediation duties identified through the solicitation process. Montana is currently approved to serve 357 unduplicated members through our Behavioral Health 1915(c) HCBS SDMI waiver. **Effective July 1, 2020, Montana is requesting additional unduplicated members through our Behavioral Health 1915(c) HCBS SDMI waiver renewal, for a total of 600 unduplicated members in waiver year (WY) one, 650 in WY two, and 750 in WYs three through five.**

Waiver Services:
Please list all existing State Plan services the State will provide through this selective contracting waiver.

The 1915(b)(4) Waiver is limited to the provision of case management services in the Behavioral Health Severe and Disabling Mental Illness Home and Community Based Services 1915(c) HCBS SDMI waiver.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   _x_ **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a.___ **Section 1902(a) (1) - Statewideness**
   b.___ **Section 1902(a) (10) (B) - Comparability of Services**
   c._x_ **Section 1902(a) (23) - Freedom of Choice**
   d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   ___ the same as stipulated in the State Plan
   _x_ is different than stipulated in the State Plan (please describe)

Reimbursement for waiver case management services in the Behavioral Health HCBS SDMI Case Management Waiver are based on a rate defined in state regulations as a fee-for-service. The rate was established historically as a negotiated rate and has been adjusted across the years by Montana state's legislature.

2. **Procurement**. The State will select the contractor in the following manner:

   _x_ **Competitive** procurement
   ___ **Open** cooperative procurement
   ___ **Sole source** procurement
   ___ **Other** (please describe)

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

   _x_ Beneficiaries will be limited to a single provider in their service area.
   ___ Beneficiaries will be given a choice of providers in their service area.

   (NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

Members are served statewide by one provider per service area. Services areas are defined by a specific grouping of counties. There are ten defined service areas:

- Area 1 will include:
  - Flathead County;
  - Lake County;
  - Lincoln County; and
  - Sanders County.
- Area 2 will include:

    - Mineral County;
    - Missoula County; and
    - Ravalli County.
- Area 3 will include:
    - Granite County;
    - Powell County;
    - Silver Bow County;
    - Deer Lodge County; and
    - Beaverhead County.
- Area 4 will include:
    - Broadwater County;
    - Jefferson County;
    - Meagher County; and
    - Lewis and Clark County.
- Area 5 will include:
    - Gallatin County;
    - Madison County;
    - Park County; and
    - Sweet Grass County.
- Area 6 will include:
    - Big Horn County;
    - Carbon County;
    - Stillwater County;
    - Yellowstone County;
    - Musselshell County;
    - Wheatland County; and
    - Golden Valley County.
- Area 7 will include:
    - Carter County;
    - Custer County;
    - Fallon County;
    - Powder River County;
    - Rosebud County; and
    - Treasure County.
- Area 8 will include:
    - Daniels County;
    - Dawson County;
    - McCone County;
    - Richland County;
    - Roosevelt County;
    - Sheridan County;
    - Valley County;
    - Prairie County;
    - Wibaux County; and
    - Garfield County.
- Area 9 will include:

- Glacier County;
- Toole County;
- Liberty County;
- Hill County;
- Blaine County;
- Phillips County; and
- Pondera County.

- Area 10 will include:
  - Teton County;
  - Choteau County;
  - Cascade County;
  - Judith Basin County;
  - Fergus County; and
  - Petroleum County.

2. **State Standards.**

   Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

   The selected provider(s) entered into the standard Medicaid provider agreement but must meet additional quality standards and perform enhanced quality monitoring and remediation duties identified through the solicitation process.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

   ___ Section 1931 Children and Related Populations
   _x_ Section 1931 Adults and Related Populations
   _x_ Blind/Disabled Adults and Related Populations
   ___ Blind/Disabled Children and Related Populations
   _x_ Aged and Related Populations
   ___ Foster Care Children
   ___ Title XXI CHIP Children

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

   ___ Dual Eligibles
   ___ Poverty Level Pregnant Women
   ___ Individuals with other insurance
   _x_ Individuals residing in a nursing facility or ICF/MR
   ___ Individuals enrolled in a managed care program
   ____ Individuals participating in a HCBS Waiver program

___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
_x__ Other (Please define):

The population covered in this waiver is limited to enrollees of the 1915(c) Behavioral Health HCBS SDMI waiver. Excluded populations would include any individual not eligible for the 1915(c) Behavioral Health HCBS SDMI waiver.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.,* what constitutes timely access to the service?

In 2018, Montana issued a Request for Proposal to add the provision of case management services through the 1915(b)(4) waiver. The State selection of case management agencies require commitments to standards regarding staffing ratios, timeliness for completing Person-Centered Recovery Planning (PCRP), and the understanding and ability to meet all quality standards.

Timely access is detailed in program policy and monitored as part of the ongoing quality assurance review work that is detailed in the 1915(c) Behavioral Health HCBS SDMI waiver. Access is dependent on referral to the 1915(c) Behavioral Health HCBS SDMI waiver and subsequent enrollment. Timely access is defined in the 1915(c) Behavioral Health HCBS SDMI waiver as phone contact with the member within five days of referral being received. Case management teams are required to contact members placed on a waitlist every 90 days to determine if they need referral to services outside of the waiver as described below.

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

   Montana is in the process of updating the referral and admission process to the case management teams. Effective July 1, 2020, case management teams will be expected to contact a member within five business days of referral.
   (1) If the case management team has a waitlist, the case management team will inform the member regarding their status on the waitlist and refer the member to other availale services within their service area. Case magement teams are required to continue contact with the member every 90 days while a member is on the waitlist.

(2) If there is not a waitlist, the case management team must immediately begin the admission process.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

   If a deficiency is identified, a Quality Assurance Performance sheet is issued for the identified deficiency. This Quality Assurance Performance sheet informs the case management team of the deficiency and requires the case management team to provide a corrective action plan.

   A Community Program Officer must review and sign off on all corrective action plans. The Program Manager monitors all corrective action plans to ensure they are being completed within the required time frame. If the case management team fails to complete the corrective action plan within the designated time frame, the Program Manager contacts the appropriate case management team's supervisor to address the issue. If the corrective action plan is still not completed, the Program Manager refers the case to the appropriate supervisor with the Addictive and Mental Disorders Division, who contacts the supervisor of the case management team to discuss possible remedies.

   If the deficiency is still not addressed then per contract, the supervisor with the Addictive and Mental Disorder Division initiates the next level of corrective actions which may include the following: The supervisor initiates the next level of corrective actions which may include the following:
   1) Discuss alternative solutions with the case management supervisor;
   2) Provide training, if appropriate;
   3) Withhold payment for failure to perform; and/or
   4) Terminate the contract, if appropriate.

   Deficiencies may be identified through a complaint received by a member or their legal representative, or through the annual quality review process.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

The selection of providers through this process has not reduced capacity from current levels. The request for proposals for case management services required commitment to standards of staffing ratios and timeframes regarding referral and assessment for waiver services. **The 10 defined service areas provide statewide access to case management services.** Access to case management services is assured up to the capacity and funding approved by the Montana Legislature.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

   The ratio of members to case management teams is 50:1. Currently only two services areas are serving at that capacity. In the event that a case management team exceeds capacity, their contract may be renegotiated, the member may be referred to another service area, or the member may be placed on a waitlist until such time the case management team has capacity to provide the service. If a member is placed on a waitlist, they are contacted every 90 days by the case management team to make additional referrals as needed. The initial determination of the number of case management teams in an area was derived from a historical needs analysis.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

   Through the procurement process, Montana selected two providers to deliver case management statewide in a service area defined by a specific grouping of counties. Timely access is detailed in the program policy and monitored as a part of the ongoing quality assurance review work that is detailed in the 1915(c) Behavioral Health HCBS SDMI waiver.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?
   The Quality Assurance Progam Manager pulls monthly utilization reports submitted to the state and monitors for trends and potential issues. In addition, the Community Program Officers complete an annual review.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

   If a deficiency is identified, a Quality Assurance Performance sheet is issued for the identified deficiency. This Quality Assurance Performance sheet informs the case management team of the deficiency and requires the case management team to provide a corrective action plan. The Community Program Officer must review and sign off on all corrective action plans.

   The Program Manager monitors all corrective action plans to ensure they are being completed within the required time frame. If the case management team fails to complete the corrective action plan within the designated time frame, the Program Manager contacts the appropriate case management team's supervisor to address the issue. If the corrective action plan is still not completed, the Program Manager refers the case to the appropriate supervisor with the Addictive and Mental Disorders Division, who contacts the supervisor of the case management team to discuss possible remedies.

   If the deficiency is still not addressed then per contract, the supervisor with the Addictive and Mental Disorder Division initiates the next level of corrective actions which may include the following:
   1) Discuss alternative solutions with the case management supervisor;
   2) Provide training, if appropriate;
   3) Withhold payment for failure to perform; and/or
   4) Terminate the contract, if appropriate.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

   a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

      i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

      Using the Care Management System, Community Program Officers complete an annual desk review for each case management team that administers the waiver. The Community Program Officers use a standardized tool, the Standards Review Form, to review the case management functions including: process regarding evaluation of need, service planning, member monitoring (contact), case reviews, complaint procedures, provision of member choice, waiver expenditures, etc. The

information is also reviewed and analyzed in aggregate to track, illustrate state trends, and use for the basis for future remediation.

Case management teams send the Participant Experience Surveys (PES) to members annually and the results are compiled by the Addictive and Mental Disorders Division and analyzed for trends. In addition, The Mental Health Statistics Improvement Program (MHSIP) survey is sent out to members annually.

ii. Take(s) corrective action if there is a failure to comply.
Following completion of the annual program reviews, case management teams are notified of individual deficiencies. They are allowed 30 days to remediate deficiencies identified during the review process. The remediation must include a plan of correction with specific time frames describing the remedies for the issue and the steps the agency plans to take to reverse the trend. Addictive and Mental Disorders Division monitors progress of each case management team's corrective actions plans.

2. Describe the State's contract monitoring process specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

Consumer Self-Report Data:
The contractors will develop and implement a consumer satisfaction survey that will allow the consumer to report information about their case management services to be utilized for quality monitorying.

Case management teams send the Participant Experience Surveys (PES) to members annually and the results are compiled by the Addictive and Mental Disorders Division and analyzed for trends.

Provider Self-Report Data:
Case management teams are required to review 10% of their cases annually and submit this information to the Addictive and Mental Disorders Division.

Data Analysis: The Quality Assurance Management System (QAMS) database collect information on serious incidents. This data will be ustilized by the State to monitor the consumers experience with the program and case management services. In addition, the State monitors case management utilization on a quarterly basis to determine services are being provided based on assessed needs as specified in the service plan.

Quality Desk Reviews: The Community Program Officers perform annual quality assurance reviews and utilization reviews. The quality reviews focus multiple areas of contractual requirements including services provided, care/service plans, assessments, recovery markers, and health and safety.

Community Program Officers have bi-weekly contact with case management providers regarding upcoming policy changes, issues, and current trends. In addition, the Program Manager provides for a monthly quality assurance meeting with the **case management team's** administrator for each waiver contractor. These monthly meetings are the vehicle for continuous statewide oversight of the waiver contractors. During these monthly meetings the program manager will identify trainings as necessary.

ii. Take(s) corrective action if there is a failure to comply.

If a deficiency is identified, a Quality Assurance Performance sheet is issued for the identified deficiency. This Quality Assurance Performance sheet informs the case management team of the deficiency and requires the case management team to provide a corrective action plan. The Community Program Officer must review and sign off on all corrective action plans.

The Program Manager monitors all corrective action plans to ensure they are being completed within the required time frame. If the case management team fails to complete the corrective action plan within the designated time frame, the Program Manager contacts the appropriate case management team's supervisor to address the issue. If the corrective action plan is still not completed, the Program Manager refers the case to the appropriate supervisor with the Addictive and Mental Disorders Division, who contacts the supervisor of the case management team to discuss possible remedies.

If the deficiency is still not addressed then per contract, the supervisor with the Addictive and Mental Disorder Division initiates the next level of corrective actions which may include the following:

1) Discuss alternative solutions with the case management supervisor;
2) Provide training, if appropriate;
3) Withhold payment for failure to perform; and/or
4) Terminate the contract, if appropriate.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

The case management contractor(s) provide both transitional and ongoing case management to the applicants and members in their coverage areas. Waiver enrollees benefit from the continuity of one provider providing all aspects of case management from application through enrollment. This ensures continuity of high quality services for the member which will be seamless from application through enrollment. The provision of a contractor ensures applicants and members in rural areas have access to a case management provider to assist with coordination of care.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

The State provided information and outreach to providers through our website and selective procurement process. Changes and amendments to our waiver programs are distributed through mailings to providers, postings on our website, provider trainings and notifications to our tribal entities. The State provides information and outreach to members and potential members through the Department's website, informational program booklets, and presentations at local outreach activities.

B. Individuals with Special Needs.

__X_ The State has special processes in place for persons with special needs (Please provide detail).

The State will make reasonable accommodations upon request. Accommodations for foreign translators are arranged through a telephone based interpreter service. Accommodations for members who are deaf or hard of hearing are made through Montana Deaf and Hard of Hearing Services. Individuals are notified of the opportunity for reasonable accommodations during the screening determination process.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

Reimbursement for waiver case management services is based on a rate defined in state regulations as a fee-for-service. The rate was established historically as a negotiated rate and has been adjusted across the years by legislative provider rate increases. Montana used a competitive solicitation process to select providers of case management services that will bill for providing case management as a waiver service.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: **07/01/2020 to 06/30/2021**

Trend rate from current expenditures (or historical figures): **.91%**

Projected pre-waiver cost **N/A**
Projected Waiver cost **$ 2,098,152.00**
Difference: 0

Year 2 from**: 07/01/2021 to 06/30/2022**

Trend rate from current expenditures (or historical figures): **1.5 %**

Projected pre-waiver cost **N/A**
Projected Waiver cost **$2,307,084.00**
Difference: 0

Year 3 (if applicable) from: **07/01/2022 to 06/30/2023**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost **N/A**
Projected Waiver cost **$ 2,703,420.00**
Difference: **0**

Year 4 (if applicable) from: **07/01/2023 to 06/30/2024**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost **N/A**
Projected Waiver cost **$ 2,742,750.00**
Difference: **0**

Year 5 (if applicable) from: **07/01/2024 to 06/30/2025**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost **N/A**
Projected Waiver cost **$ 2,784,150.00**
Difference: **0**