Olmstead Plan for the State of Montana

JUNE 29, 2026

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

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EXECUTIVE SUMMARY

This document outlines Montana's Olmstead Plan for implementation and monitoring by the Department of Public Health and Human Services (DPHHS). As summarized in House Bill 922 from the 2023 Legislative Session, Montana's Olmstead Plan must provide data on current services for people with disabilities, along with measurable goals and objectives that DPHHS is committed to implementing to improve access to and delivery of home and community-based services. The format of this document follows the requirements as outlined in House Bill 922.

The overarching goal of Montana's Olmstead Plan is to ensure that people with disabilities across the lifespan can live, work, learn, and fully engage in the communities of their choice and in the most integrated setting possible, while reducing and preventing unnecessary institutionalizations. While DPHHS has done significant work to advance independence, inclusion, and integration, this plan will strategically guide future efforts and help shape policy and practices. To achieve this purpose, the Montana Olmstead Plan focuses on six goals:

1. Promote the rights, choice, and autonomy of people with disabilities
2. Increase collaborations and enhance state programs to expand choice in housing and transportation for people with disabilities
3. Increase access to and choice of health care and mental health services in community settings
4. Improve creation and delivery of accessible information and resources
5. Support Competitive Integrated Employment while working towards becoming an Employment First state
6. Improve benefits education and transition-planning services

DPHHS acknowledges that Montana's Olmstead Plan is intended to be a living document. Objectives, activities, and recommendations are subject to change based on various situations, including meeting plan indicators earlier than expected, failing to meet plan indicators, the amount of funding received for implementation, or unforeseen circumstances. Any substantive changes will be justified and publicly communicated via the processes outlined in the quality assurance plan. The creation and development of Montana's Olmstead Plan was a collaborative effort between people with disabilities, their family members and caregivers, statewide advocacy groups, disability service

providers, state agencies and employees, tribal councils, the Statewide Independent Living Council (SILC), and many others.

OVERVIEW OF THE OLMSTEAD DECISION

Lois Curtis and Elaine Wilson were two women with disabilities receiving services in institutional settings in Georgia. They filed a lawsuit asserting that, under the Americans with Disabilities Act (ADA), they have the right to live more independently in their communities with appropriate supports. The case went to the Supreme Court, and in 1999, it was decided that segregation and isolation of a person with a disability are forms of discrimination under Title II of the ADA[1]. The Supreme Court ruled that people with disabilities have the right to receive state-funded services in the community, as opposed to in an institution, as long as:

- That is the person's choice
- The person's treatment team agrees that community services will meet their needs
- It is a reasonable accommodation and fair when compared to other people receiving services

This case, the Olmstead Decision, resulted in a ruling that requires states to provide community-based services to people with disabilities. It acknowledges that institutional care diminishes participation in life activities, including socialization, employment opportunities, educational pursuits, time with family, economic independence, and cultural engagement.

The Olmstead Decision means that states must actively work to prevent and correct inappropriate institutionalizations, while ensuring that all people with disabilities receive services in the most integrated settings. A state can meet this obligation by demonstrating a current, comprehensive, working Olmstead Plan that provides people with disabilities with access to and choice in home- and community-based services.

[1] Olmstead Rights. (n.d.). *About Olmstead*. Retrieved March 10, 2026 from https://www.olmsteadrights.org/about-olmstead/

MONTANA'S OLMSTEAD PLAN

Montana developed an initial Olmstead Plan in 2000 and reviewed it in 2006. In 2022, Montana's SILC advocated for an updated Olmstead Plan and helped get House Bill 922[2] passed in the 2023 Montana Legislature. House Bill 922 required DPHHS to develop a new Olmstead Plan for Montana, which will be reviewed again in 2029. DPHHS contracted with the Rural Institute for Inclusive Communities, Montana's University Center for Excellence in Disability, to complete this work.

This plan is structured to mirror the requirements of House Bill 922, including four distinct sections: 1) an overview of the Olmstead Decision, 2) an analysis of the Department's current efforts to integrate people with disabilities into the community and the Department-funded services and supports available to people with disabilities, 3) an assessment of the strengths and weaknesses of the system, 4) recommendations for increasing the availability of and access to community-based services and supports, and the incorporation of quality assurance activities to ensure compliance. Where applicable, limitations in data are acknowledged, and recommendations are made so that future analysis can more effectively illustrate service provision.

View Appendix A for an accessible language flyer explaining the Olmstead Decision and what it means in Montana.

DEFINITIONS

Accessible Language: This concept describes communication that is clear, direct, and easy to understand so that all readers and users have equal access to the content. This may also be called "plain language."

Client: A client is a person receiving services. A client may also be called a "member" or "recipient."

Community First Choice Services/Personal Care Services (CFCS/PCS): The CFCS/PCS Program is an entitlement program, not a waiver. There is no waiting list. The CFCS/PCS Program offers personalized, long-term support for Medicaid-eligible members who are disabled and/or elderly, enabling them to remain in the communities of their choice. Services are customized based on individual needs and living situations. They encompass assistance with basic and more complex activities of daily living (e.g.,

[2] Montana State Legislature. (2023). *House Bill 922 (HB 922): Text*. Retrieved March 10, 2026, from https://legiscan.com/MT/text/HB922/id/2792801

bathing, dressing, housekeeping, laundry, community integration, etc.). Not all CFCS/PCS members are on a Medicaid waiver, but many are.

Competitive Integrated Employment: This means work is paid at or above minimum wage, with wages and benefits equal to those received by coworkers without disabilities for similar work. Employment occurs in community settings where employees with and without disabilities interact as peers and have opportunities for advancement. It may also include self-employment and/or entrepreneurship, leading to self-sufficiency, independence, and dignity.

Developmental Disability Region: This is the way we have chosen to view geographic trends in the state of Montana, according to the five regions that the Developmental Disabilities Program (DDP) serves. Because some Montana counties have such low populations, separating the state this way still highlights geographic trends while protecting the privacy of people with disabilities in individual counties.

Employment First: This philosophy is a commitment to the framework that recognizes employment in the general workforce is the first and preferred outcome of publicly funded services for all working-age Montanans with disabilities. It also recognizes that employment exists within a broader life of community connection and engagement. Employment First does not mean Employment Only. It means that people have the right to work and to participate in civic, educational, recreational, and social life with or without accommodation.

Home and Community-Based Services (HCBS): This category of care provides services and supports that enable people with disabilities and older adults to live, work, learn, and meaningfully engage in their homes and communities rather than in an institutional setting. Examples of these services include assistance with activities of daily living, job coaches, residential supports, and private nursing care.

HCBS Settings Rule: A federal regulation that mandates specific community-integrated standards for where HCBS are provided. It ensures that people who receive services and supports through Medicaid's HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting. It emphasizes autonomy, choice, and control over decisions, including a person-centered process for planning services.

1915(c) Medicaid Waivers: Waivers provide extra supports that regular Medicaid does not cover. These 1915(c) waivers help people stay in their homes, participate in their

communities, and avoid unnecessary institutional care. Some waiver services add to services already covered by Medicaid (e.g., physical or occupational therapy) and/or cover services not usually covered by Medicaid (e.g., in-home caregiving services, specialized medical equipment, or respite care).

- **Big Sky Waiver (BSW) Program:** The BSW program allows people who would otherwise be in an institution or nursing facility to live in their own home or community. Members must be financially eligible for Medicaid and meet nursing facility level of care, but prefer to stay in their community. BSW provides these individuals a choice of services that maximize their independence, provide quality care, and ensure financial accountability.

- **Home and Community-Based 0208 Comprehensive Waiver for Individuals with Developmental Disabilities (DD Waiver):** The DD Waiver supports choices and opportunities for people with developmental disabilities (DD) to live, learn, work, and participate in their community instead of an institution. Services are individualized based on need and may include community living services, skill development, employment supports, behavioral services, and other supports. To receive waiver services, individuals must first be determined to be eligible through the Montana DDP.

- **Severe Disabling Mental Illness HCBS Waiver (SDMI Waiver):** The SDMI Waiver provides community-based services to Medicaid-eligible members 18 years or older experiencing a severe mental illness. These services support recovery, stability, and independent living for those who would otherwise receive care typically provided in a nursing facility.

- **Universal Design:** This concept supports the design of an environment (and the buildings, products, and/or services in that environment) so that it can be accessed and used by all people, regardless of their age, size, or ability.

Residential Service Settings:

- **Community-Based Living:** Housing located within the broader community where individuals live in their own homes, apartments, or other community residences with services and supports as needed. These settings provide individuals with opportunities for inclusive community participation, access to community resources, and the ability to make choices about their daily lives consistent with the requirements of the HCBS Settings Rule.

- **Congregate Setting:** Housing arrangements where unrelated individuals live in the same residence or building and may share common spaces, services, or supports. Examples may include group homes, assisted living facilities, or other shared residential settings. These settings also provide HCBS and are expected to support individuals' rights, autonomy, and access to the broader community consistent with HCBS Settings Rule requirements.

- **Institutional Setting:** Residential facilities designed to provide structured care, supervision, or treatment services, often including medical or behavioral health services. Examples include skilled nursing facilities, the Montana State Hospital (MSH), and the Intensive Behavior Center (IBC). These settings are generally not considered home and community-based settings under the HCBS Settings Rule.

Note that the 1999 Olmstead Decision involved only psychiatric hospitals, but courts later clarified that an Olmstead Plan should apply to any state- and/or Medicaid-funded institutions, including nursing facilities.

ANALYSIS OF CURRENT EFFORTS TO INTEGRATE PEOPLE WITH DISABILITIES INTO THE COMMUNITY

This section of Montana's Olmstead Plan explains disability rates and types in Montana, including a regional representation of disability. It provides information on who receives Medicaid services and where they receive those services. It also shows how many people receive services in the community versus within institutional settings and discusses costs associated with receiving services in those settings. Finally, this section describes two large-scale related initiatives underway in Montana that are also working toward improved integration of people with disabilities into the community. As a whole, this section provides a data-driven foundation to show current services and how they relate to the recommendations of Montana's Olmstead Plan.

The data used in this report were pulled from a variety of sources (as indicated). The most widely used source was de-identified Medicaid claims data from DPHHS. Where applicable, limitations are noted in the available data and offered suggestions to simplify future Olmstead analyses. Many of the charts and maps in this section serve as a starting place for measuring system-level impacts of Montana's Olmstead Plan as the goals, objectives, and activities of the plan are implemented and evaluated (see the Quality Assurance Plan beginning on page 54 for more information about how this data will be used to measure trends).

POPULATIONS CURRENTLY SERVED, BY DISABILITY AND GEOGRAPHIC LOCATION

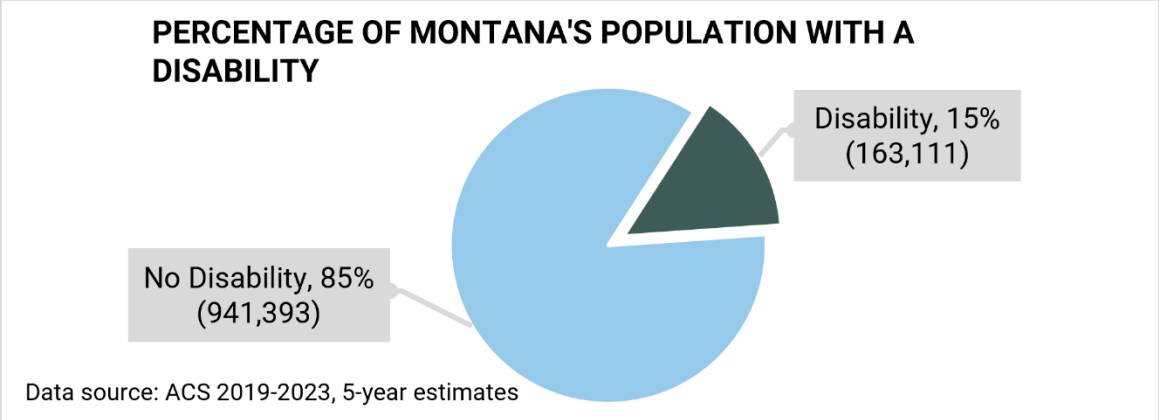
DISABILITY IN MONTANA

FIGURE 1A. PERCENTAGE OF MONTANA'S POPULATION WITH A DISABILITY

People with disabilities make up approximately 15% of Montana's population, according to data from the American Community Survey (ACS)[3]. In other words, there are over 163,000 people living with disabilities across the state. The ACS is the largest and most reliable publicly available dataset measuring disability in the United States. Because of its large sample size, data is available at a more local level, such as counties and census tracts, making it the most useful dataset for understanding disability, especially in rural areas.

Disability exists along a broad spectrum. Some individuals require little to no support to manage daily activities, while others have more significant support needs and benefit from comprehensive services. While approximately 15% of Montana residents live with a disability, the Medicaid and DPHHS services described in this Olmstead Plan tend to focus on individuals who meet specific eligibility criteria based on functional needs and other factors.

This initial overview is intended to provide a high-level picture of disability across the state, including the diversity of disability types and where people live, while the analysis that follows focuses more specifically on the delivery of Medicaid-funded services.



[3] Learn more about how the ACS defines disability here: Disability Counts - An RTC: Rural Product.

FIGURE 1B. DISABILITY BY TYPE IN MONTANA, ALL AGES

People in Montana have a range of disabilities and often report having more than one disability. This chart shows disability by type as a proportion of the total population of Montanans living in the community. These estimates do not include people with disabilities living in group quarters, which are residential settings where individuals live in groups of unrelated individuals (see Figures 1C and 1D for more information). For example, 6.2% (approximately 67,000) of Montana's community-dwelling population are estimated to have an ambulatory (or walking) disability. Because these numbers do not include people living in nursing facilities, group homes, and other communal living settings, the number of Montanans with disabilities is likely higher than represented in Figure 1B.

To measure disability, the ACS asks a set of questions about a person's experiences of functional limitations. These questions are grouped as a set of six functional limitations that individuals may experience in their daily lives, including limitations around vision, hearing, cognition, mobility, self-care, and independent living. If an individual indicates that they regularly experience one or more of these limitations, they are classified as having a disability. Individuals may report more than one limitation.

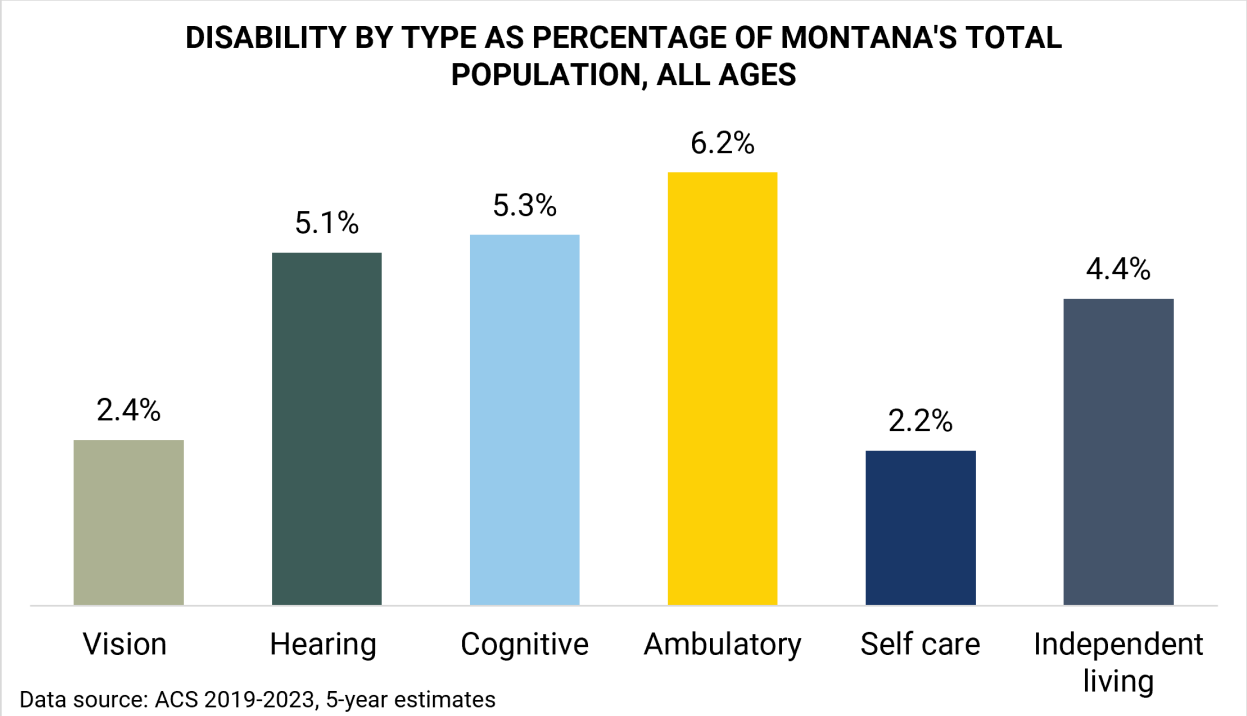
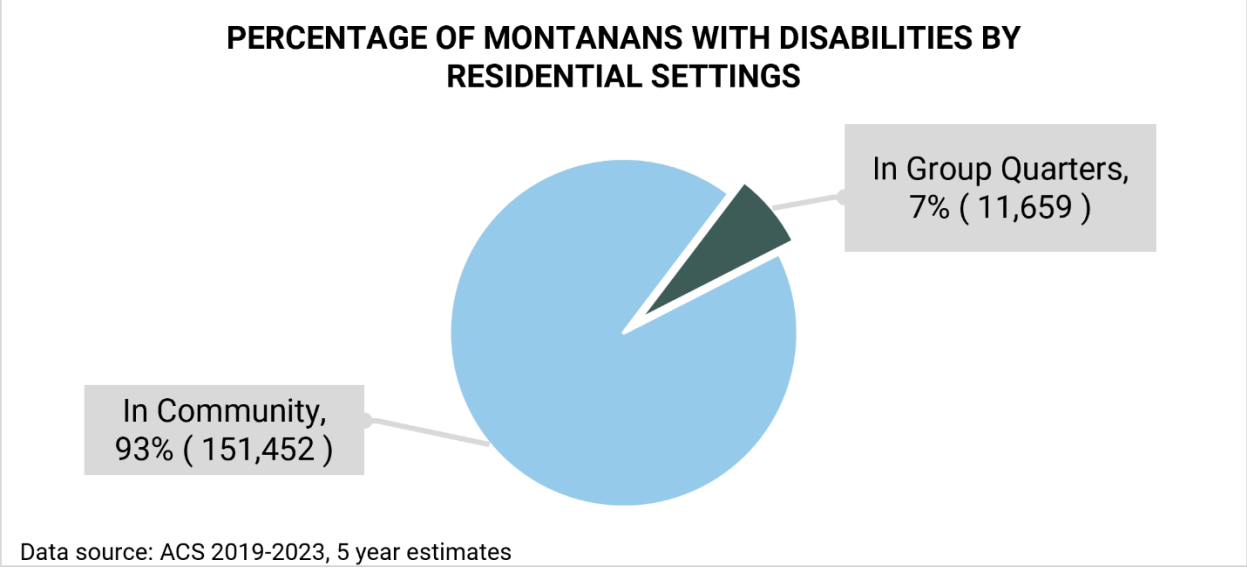


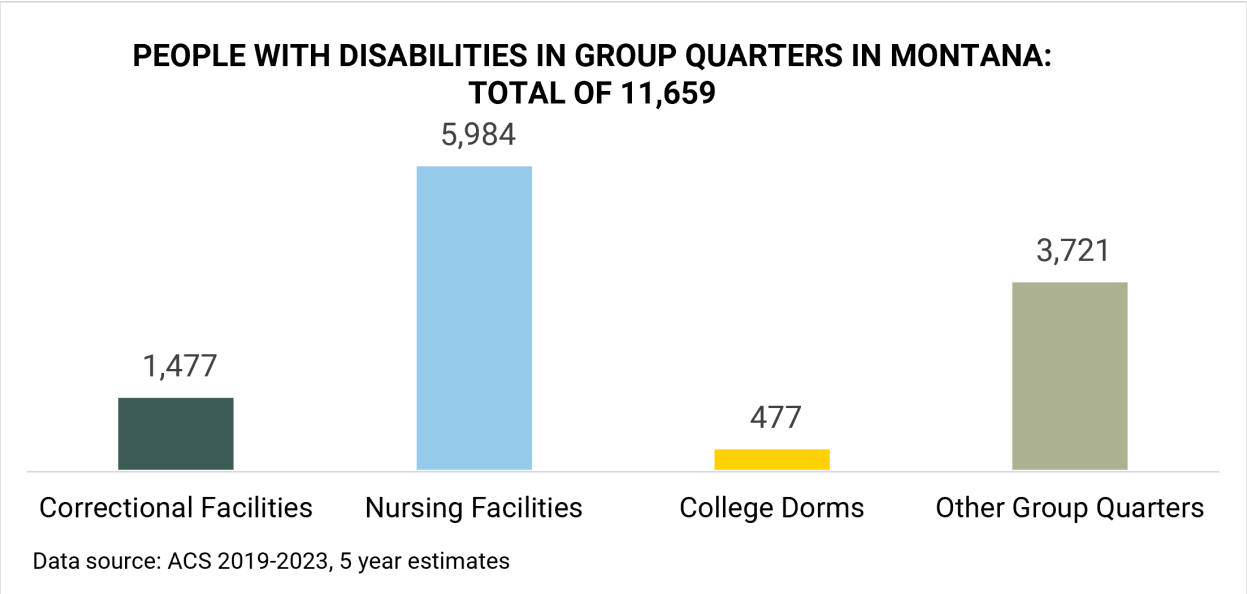
FIGURE 1C. PERCENTAGE OF MONTANANS WITH A DISABILITY LIVING IN EITHER COMMUNITY OR GROUP QUARTERS

The ACS collects data on individuals living in the community as well as in what they define as “group quarters”. Group quarters are residential settings where individuals live in groups of unrelated individuals and include places like prisons/correctional facilities, nursing homes/long-term care facilities, college dorms, military barracks, and group homes. This would encompass both “congregate” and “institutional” settings as defined on pages 7-8.



Data source: ACS 2019-2023, 5 year estimates

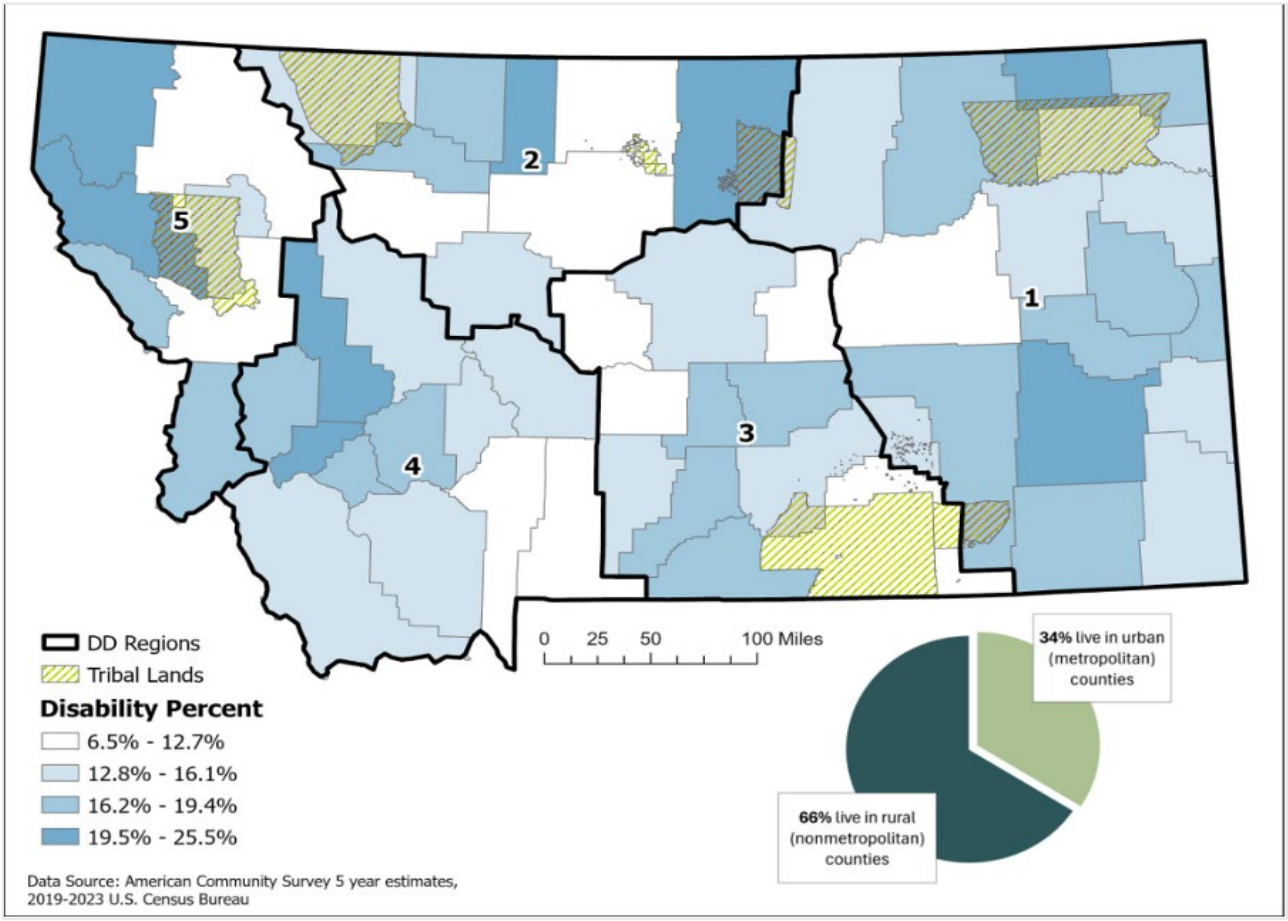
FIGURE 1D. PEOPLE WITH DISABILITIES IN GROUP QUARTERS



Data source: ACS 2019-2023, 5 year estimates

FIGURE 1E. PERCENTAGE OF PEOPLE WITH DISABILITIES IN NON-GROUP QUARTERS IN MONTANA BY COUNTY

People with disabilities live across the state, and some places have a higher proportion of people with disabilities than others. For example, while approximately 15% of the state's population is estimated to have a disability, we see that some counties have much higher or much lower disability rates. Counties with the highest proportions of people with disabilities include Lincoln, Sanders, Powell, Deer Lodge, Liberty, Blaine, Daniels, and Custer Counties. This map shows the percentage of people with disabilities by county in Montana and illustrates which counties are in each DD Region.



Montanans with disabilities live in both urban (metropolitan) and rural (non-metropolitan) communities. The largest portion (66%) of Montanans with disabilities live in rural areas and represents nearly 100,000 people. Due to data limitations, these

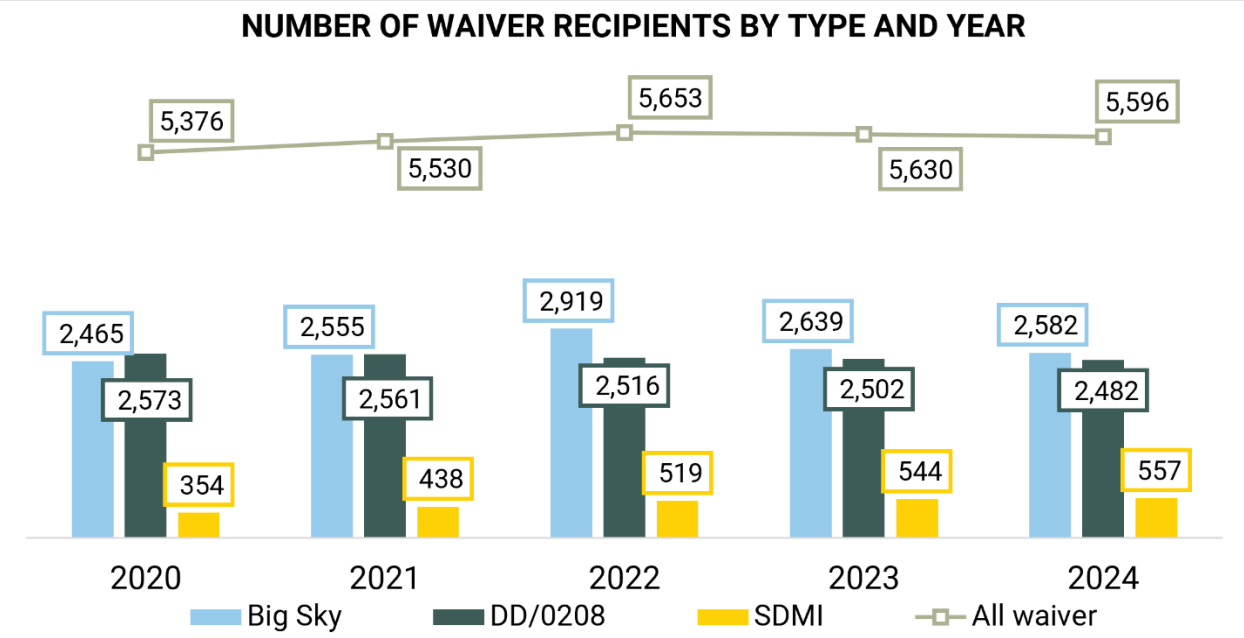
estimates do not include individuals living in group quarters (Office of Management and Budget's County Classification System[4]

WAIVERS AND CFCS/PCS BY YEAR AND REGION

HCBS and Montana Medicaid Waivers are explained in the Definitions section of this document.

FIGURE 2A. NUMBER OF WAIVER RECIPIENTS BY TYPE AND YEAR

The number of DD Waiver clients has stayed relatively consistent from 2020-2024, while BSW and SDMI Waivers have seen moderate increases and decreases. Some variation in counts, including that the total number does not directly equal the sum of the three waiver counts each year, is likely due to movement from one waiver to another, across all waivers. These numbers look larger than the DPHHS Data Dashboard numbers[5] because they capture a year's worth of data rather than monthly numbers.



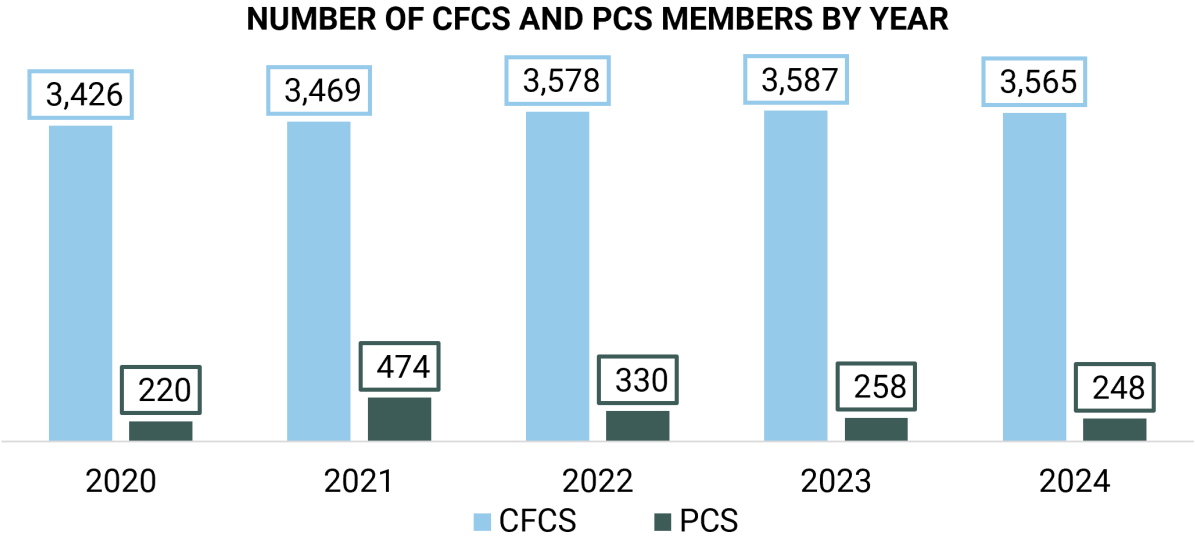
Data source: MT Medicaid waiver claims

[4] There are many ways to define rural. Here we used the 2020 OMB's county classification system, based on residential population and commuting patterns. Metropolitan counties are counties with an urban core of at least 50,000 people. All remaining counties are non-metropolitan and considered rural.

[5] https://dphhs.mt.gov/interactivedashboards/Medicaid/montanamedicaidwaiversdashboard

FIGURE 2B. NUMBER OF CFCS/PCS MEMBERS PER YEAR

CFCS/PCS programs have remained relatively consistent in the number of people served from 2020 to 2024.

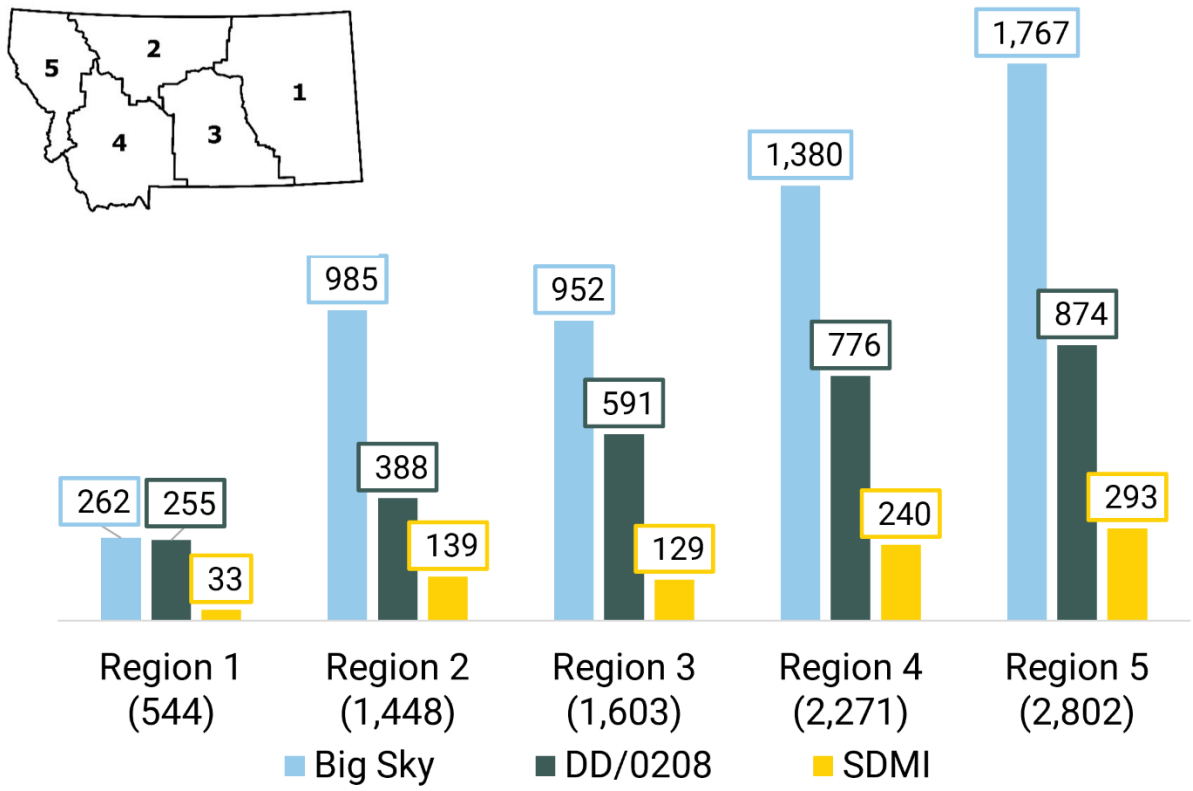


Data source: MT Medicaid waiver claims

Olmstead-related Recommendation: Since the CFCS/PCS program is an entitlement program, not a Medicaid Waiver, DPHHS should share CFCS/PCS information with people on waiver waitlists. This directly aligns with Olmstead Goal 3, Objective 2, Activity 6 (Ensure developed resources include information for stop-gap services for those eligible for services but on a waitlist).

FIGURE 2C. UNIQUE COUNT OF WAIVER MEMBERS BY DEVELOPMENTAL DISABILITY REGION IN MONTANA

Figure 2C breaks down waiver members by region and waiver type for fiscal years 2020 – 2024. Again, because of movement across waivers within a year, the total count (in parentheses at the bottom) may not equal the sum of the three waiver counts each year.



Data source: MT Medicaid waiver claims

SETTINGS IN WHICH SERVICES ARE PROVIDED

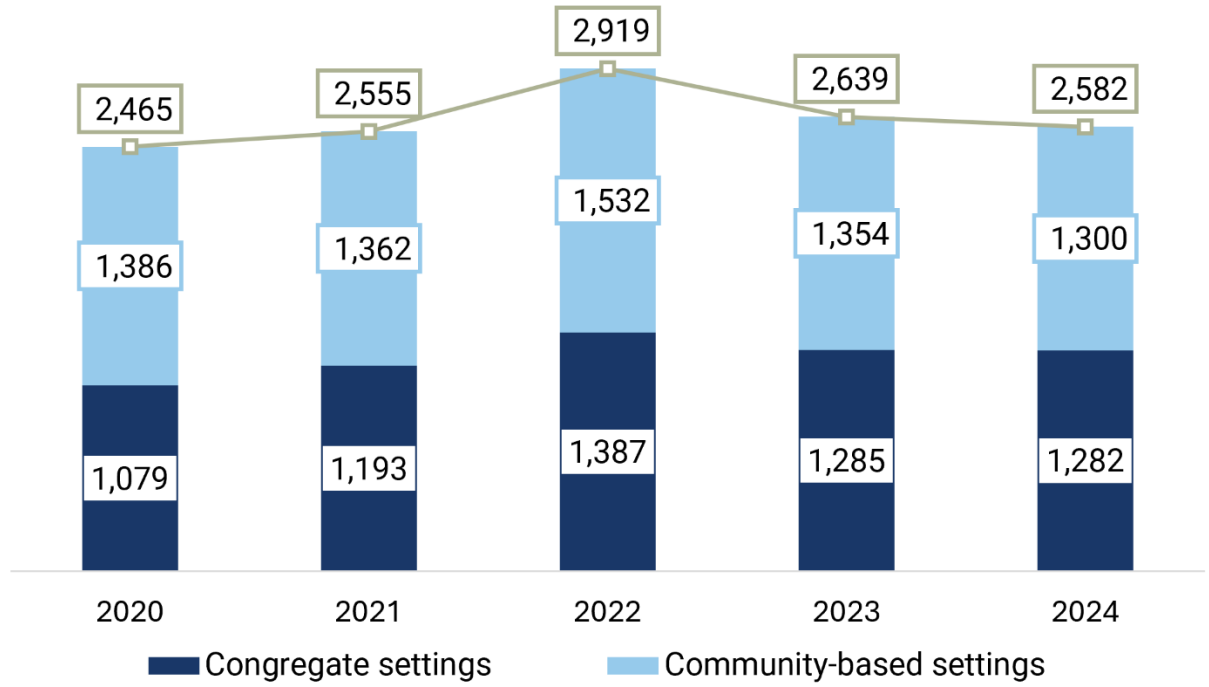
COMMUNITY SETTINGS

FIGURES 3A-3C. STATEWIDE NUMBER OF MEMBERS BY WAIVER AND RESIDENTIAL SETTING

The following three charts show where waiver members live, whether in a community-based setting or in a congregate setting, such as a group home or assisted living facility. Due to limitations in the data, it was not feasible to reliably separate types of residential congregate settings (e.g., assisted living facilities and group homes). Currently, some waiver programs use the same procedure codes to indicate multiple types of residential settings. For example, the code T2016 is used by BSW to indicate Level 3 Assisted Living Facilities, Adult Family Homes, and Group Homes. While some

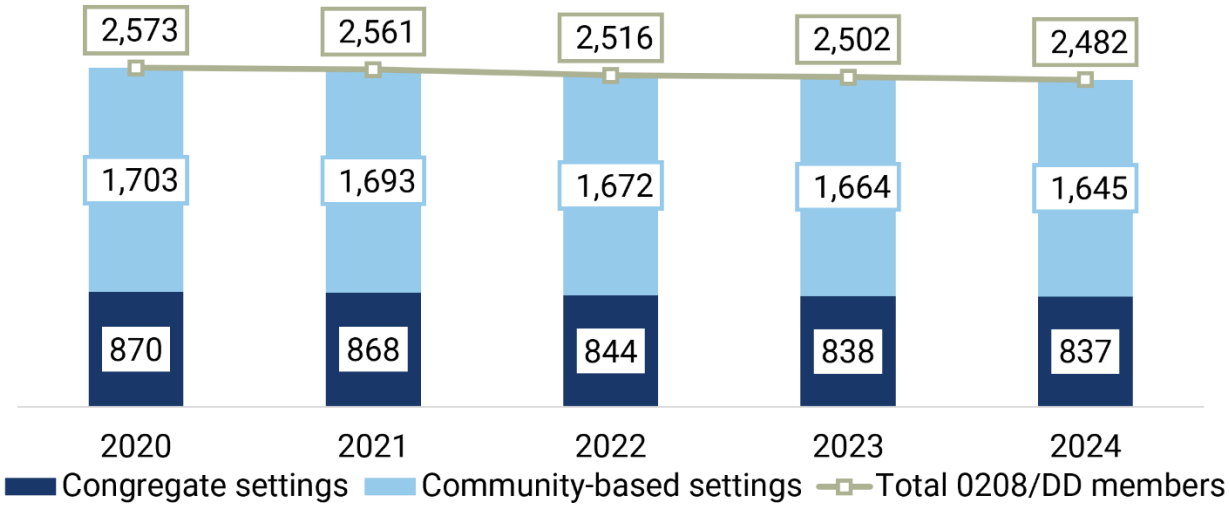
differentiation is possible using the per-unit fee rate, using fee rates to break services apart is not exact.

FIG. 3A: BIG SKY WAIVER MEMBER: RESIDENTIAL SETTINGS



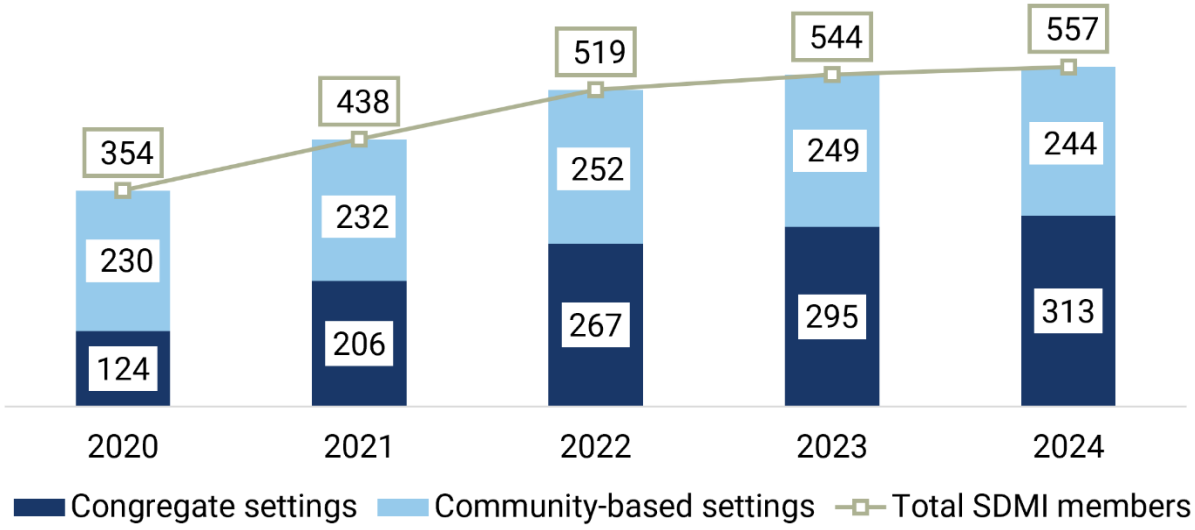
Data source: MT Medicaid waiver claims

FIG. 3B: 0208/DD WAIVER MEMBERS: RESIDENTIAL SETTINGS



Data source: MT Medicaid waiver claims

FIG. 3C: SDMI WAIVER MEMBERS: RESIDENTIAL SETTINGS



Data source: MT Medicaid waiver claims

It must be noted that identifying the settings in which members receive services presents some challenges. Ultimately, settings in which members receive services were identified using procedure codes. Members are identified and counted as receiving a service in a setting if they are associated with at least one claim with the corresponding procedure code. However, definitions of settings are not consistent across services, waivers, and procedure code titles. The above charts do not include members served in institutions.

Olmstead-related Recommendations: DPHHS could modify data reporting processes to ensure consistency both within and across waiver programs to better allow for comparisons across setting types. Developing a data dictionary to more clearly define settings as they relate to Olmstead priorities/HCBS services and developing a corresponding variable to track service settings over time that is consistent across waiver types would also facilitate improved future analysis. Directly aligns with Goal 1, Objective 1, Activity 4 (Improve data collection by establishing interdepartmental standards for defining service and employment settings and tracking institutionalization, congregate living, independent living, segregated employment, enclave employment, and competitive integrated employment).

FIGURE 3D. COMMUNITY-BASED CONGREGATE FACILITIES ACROSS MONTANA

This map indicates the location of congregate facilities (assisted living facilities and group homes) across the state. As mentioned in the interviews with disability providers serving tribal communities on page 41, there are several reservations without access to these community-based congregate facilities.

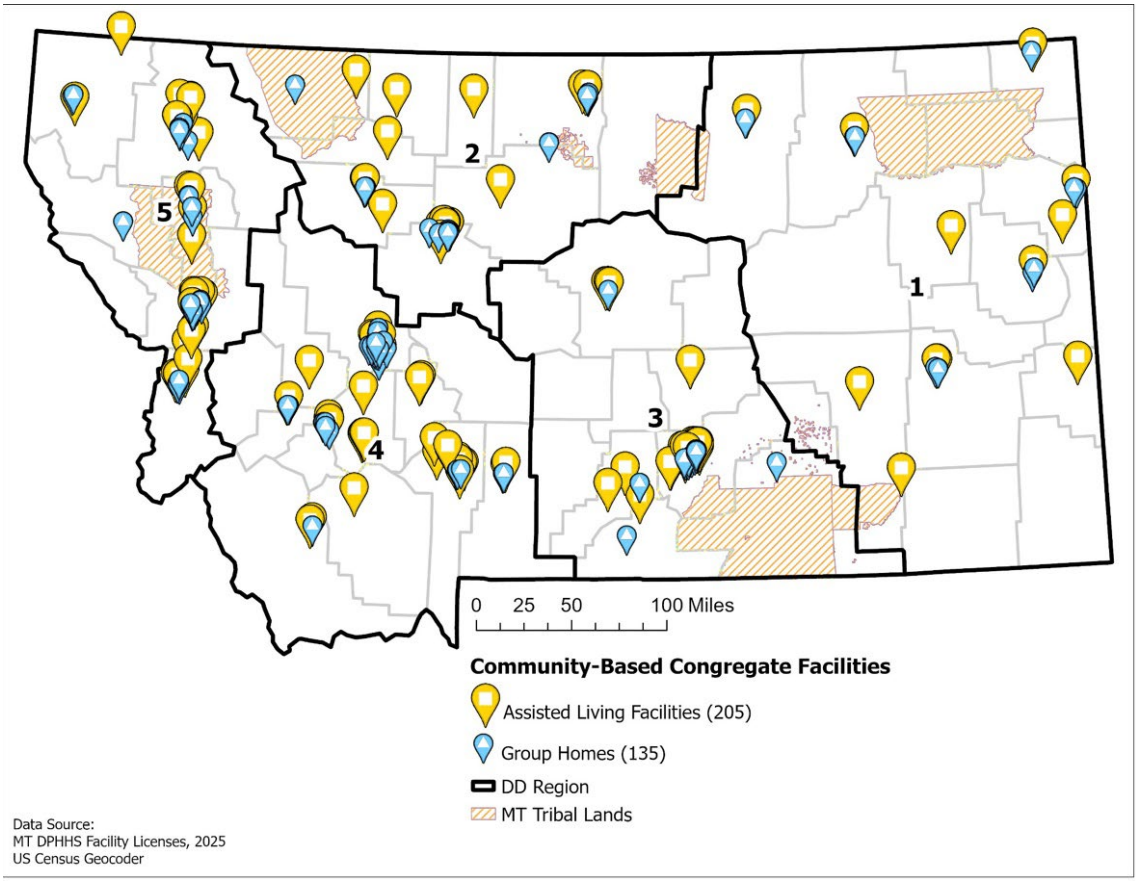


TABLE 3E. COMMUNITY-BASED CONGREGATE FACILITIES BY DD REGION

This table provides the number of community-based congregate facilities by DD region, as well as the percentage of each facility type within the total number of facilities.

Region	Community/Group Home	Assisted Living	Total Facilities (340)
1	13 (10%)	13 (6%)	26 (8%)
2	17 (13%)	36 (18%)	53 (15%)

3	26 (19%)	52 (25%)	78 (23%)
4	44 (33%)	51 (25%)	95 (28%)
5	35 (26%)	53 (26%)	88 (26%)

INSTITUTIONAL SETTINGS AND POPULATIONS

The previous information focused on Montana Medicaid members who receive HCBS through Montana's Medicaid waiver programs or CFCS/PCS. These numbers do not include individuals living in institutional settings such as MSH, IBC, contracted Veterans' Homes, or any nursing facilities across the state. HCBS services are no longer billed under waiver fee schedules when a person transitions to an institutional setting. Once institutionalized, members are immediately at risk of losing their HCBS services. Each waiver handles this transition differently and has different processes in place for tracking and monitoring these transitions, as well as for reinstating HCBS services upon transition back to community or congregate settings.

Tracking movement of Medicaid members to/from MSH is further complicated by the federal Institution for Mental Diseases exclusion, which blocks Medicaid from being used to pay for treatment of adults aged 21–64. This exclusion creates a situation in which Medicaid eligibility and reimbursement depend not just on a person's needs but also on exactly where they are and whether that setting qualifies for federal funding.

Olmstead-related Recommendation: Improving consistency in how these transitions are tracked would strengthen future data and tell a more complete story about Montana's efforts to reduce and/or divert institutionalization. This would align with Goal 1, Objective 1 (Prevent and reduce institutionalization through data-informed strategies that enhance access to community supports).

FIGURE 4A. INSTITUTIONAL CONGREGATE FACILITIES

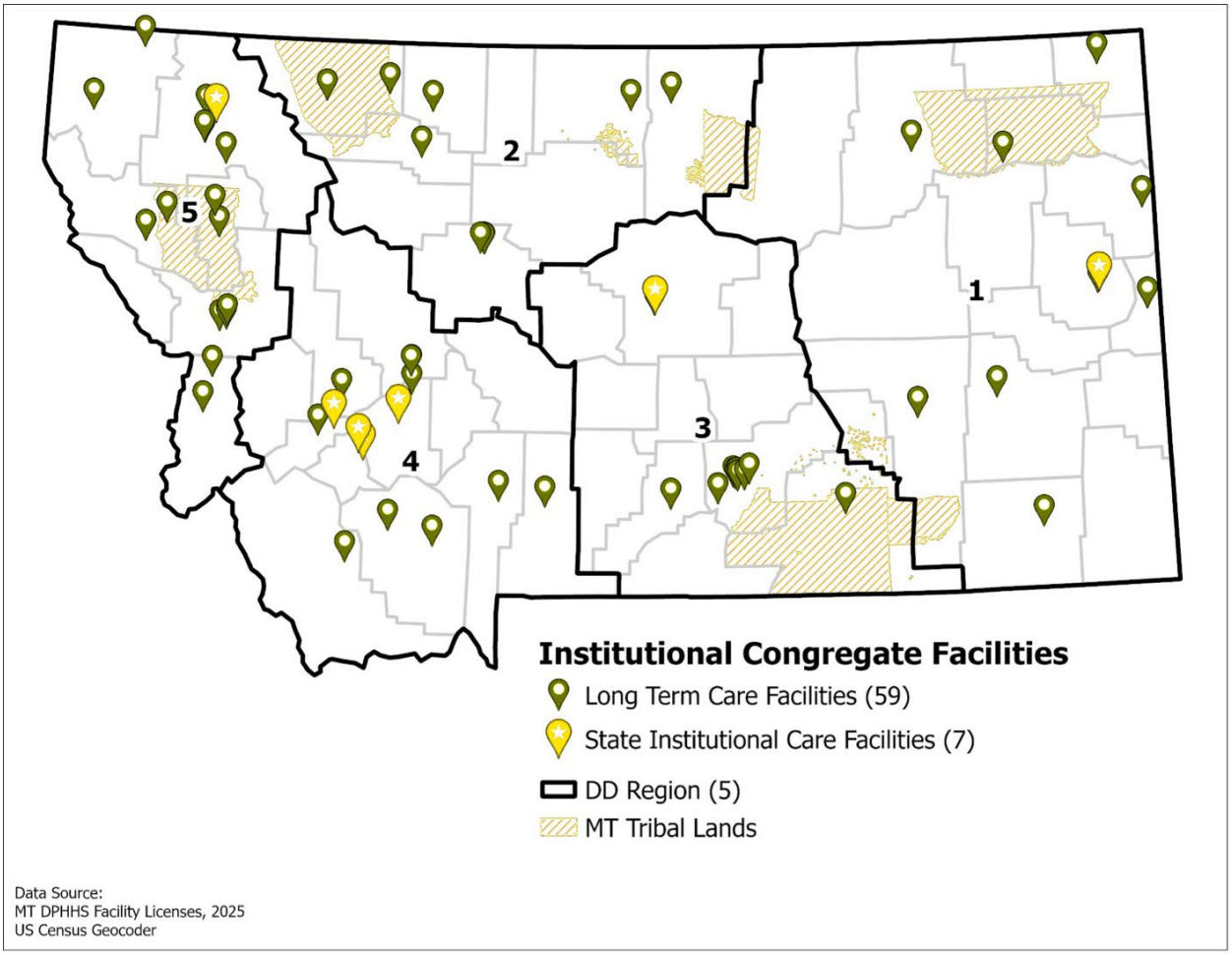


TABLE 4B. PEOPLE RECEIVING SERVICES IN STATE-RUN INSTITUTIONS 2022 AND 2023

This table provides a high-level overview of state-run institutions, comparing the average facility census for October 2022 and October 2023[6]. These data were gathered from publicly available DPHHS Facility Status Reports. With the data provided, it is not possible to determine how many people were served by Medicaid in institutions during this time. With an increase in home and community-based services as outlined by the Montana Olmstead Plan, we would expect a decrease in census numbers and/or length of stay for certain populations over time.

[6] Montana Department of Public Health and Human Services. (n.d.). *Healthcare facilities*. Retrieved February 2, 2026, from https://dphhs.mt.gov/healthcarefacilities/

State-Run Institutions	October 2022	October 2023
MSH (Warm Springs)	Main - 146 Forensic - 46 Group home - 35	Main - 139 Forensic - 47 Group home – 32
Montana Mental Health Nursing Care Center (Lewistown)	67	65
IBC (Boulder)	10	9
Montana Chemical Dependency Center (Butte)	23	21
Montana Veterans Home (Columbia Falls)	61	63
Southwest MT Veterans Home (Butte)	43	55
Eastern MT Veterans Home (Glendive)	56	43

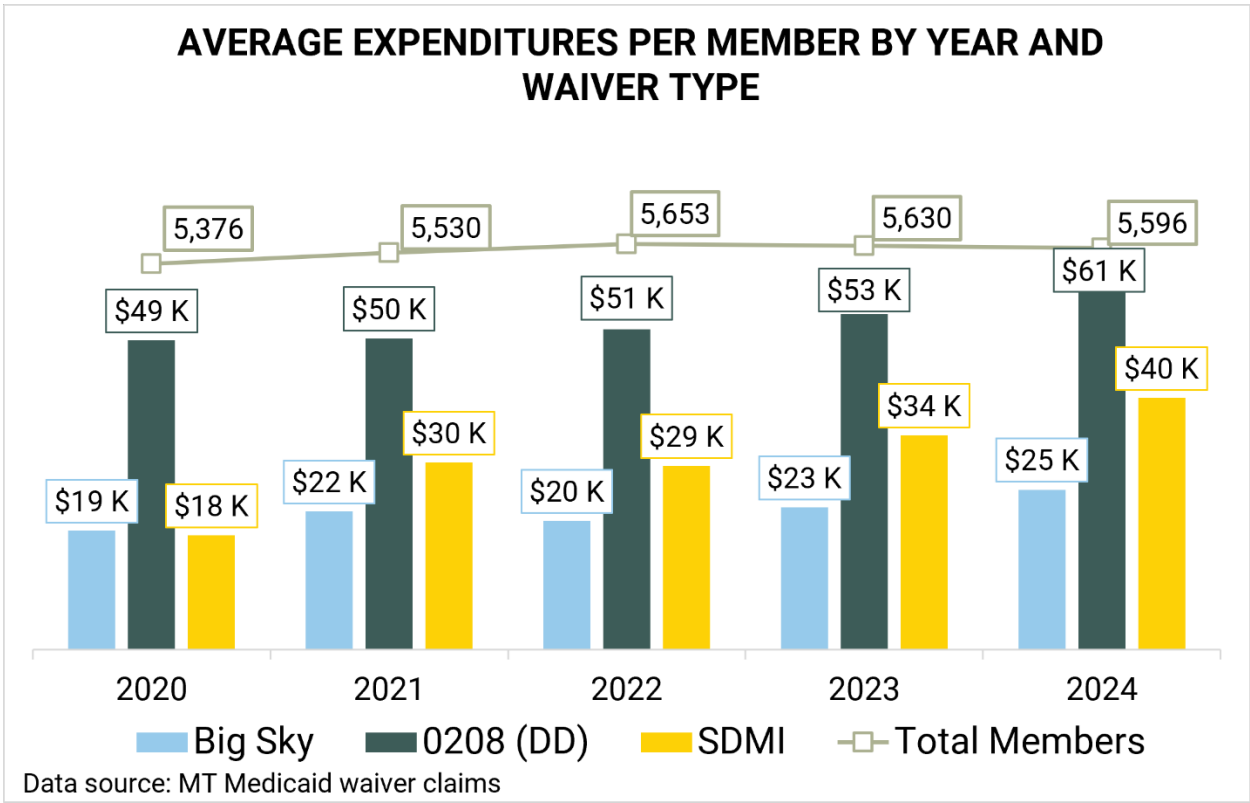
EXPENDITURES MADE FOR SERVICES AND SUPPORTS

This section reviews information on how the costs of Medicaid services have changed over time. Disability service providers invoice Medicaid for a variety of services. Each waiver outlines the different services available and provides reimbursement to the providers based on the services provided. This information was analyzed using Montana Medicaid waiver claims data.

WAIVERS

FIGURE 5A. AVERAGE EXPENDITURES PER MEMBER BY YEAR AND WAIVER TYPE

This chart includes a line showing the total members across all three HCBS waivers. The bars show average spending by waiver type, per person, per year. As personnel and equipment costs have increased, so have expenditures. The increase in expenditures likely corresponds to legislation that increased Medicaid provider rates, a strong effort to retain members of the workforce. This chart shows the average expenditures per member. Comprehensive expenditures for each waiver by year can be viewed at https://dphhs.mt.gov/interactivedashboards/.



Data source: MT Medicaid waiver claims

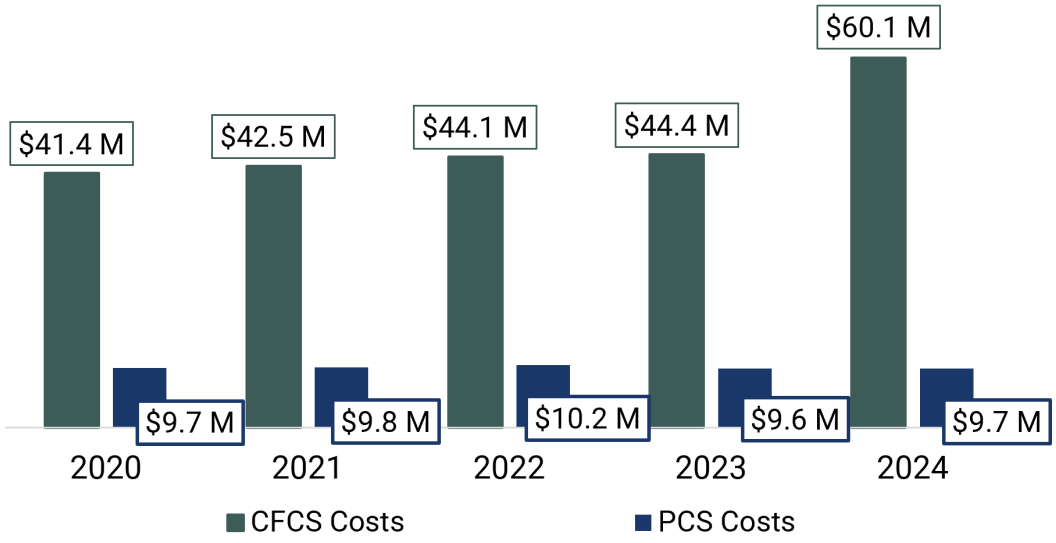
Olmstead-related Recommendation: Even with the most recent provider rate increase, workforce recruitment and retention continue to be a high priority at DPHHS and within the disability community, evidenced by inclusion in the related initiatives mentioned in the next section and in Goal 3, Objective 1 of Montana's Olmstead Plan (Improve workforce education and sustainability).

CFCS/PCS

FIGURE 5B-5C. AVERAGE EXPENDITURES FOR CFCS/PCS

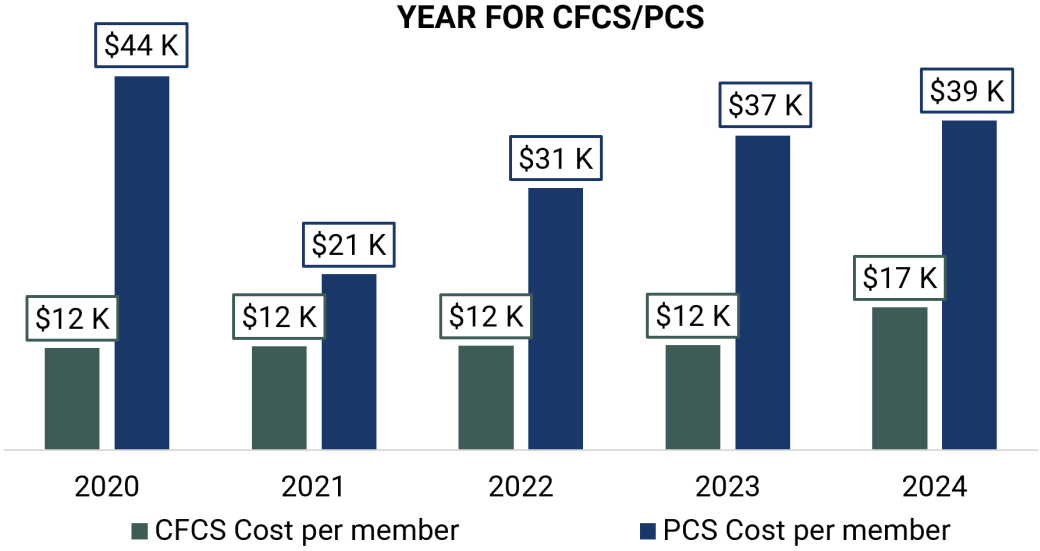
The first chart illustrates the total expenditures for fiscal years 2020-2024 for CFCS/PCS members. Again, expenditures increased, likely in response to the provider rate increase and efforts to retain direct support professionals and other Medicaid service providers. The second chart shows average expenditures per member, per year, for each program.

FIGURE 5B: AVERAGE EXPENDITURES BY YEAR FOR CFCS/PCS



Data source: MT Medicaid waiver claims

FIGURE 5C: TOTAL AVERAGE EXPENDITURES PER MEMBER BY YEAR FOR CFCS/PCS

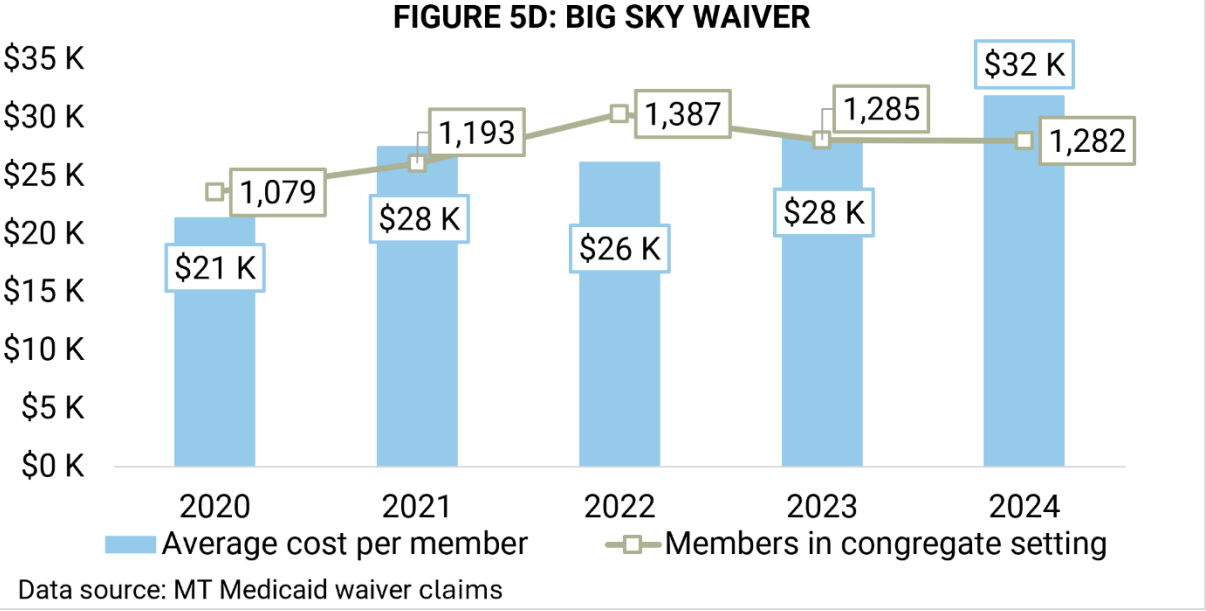


Data source: MT Medicaid waiver claims

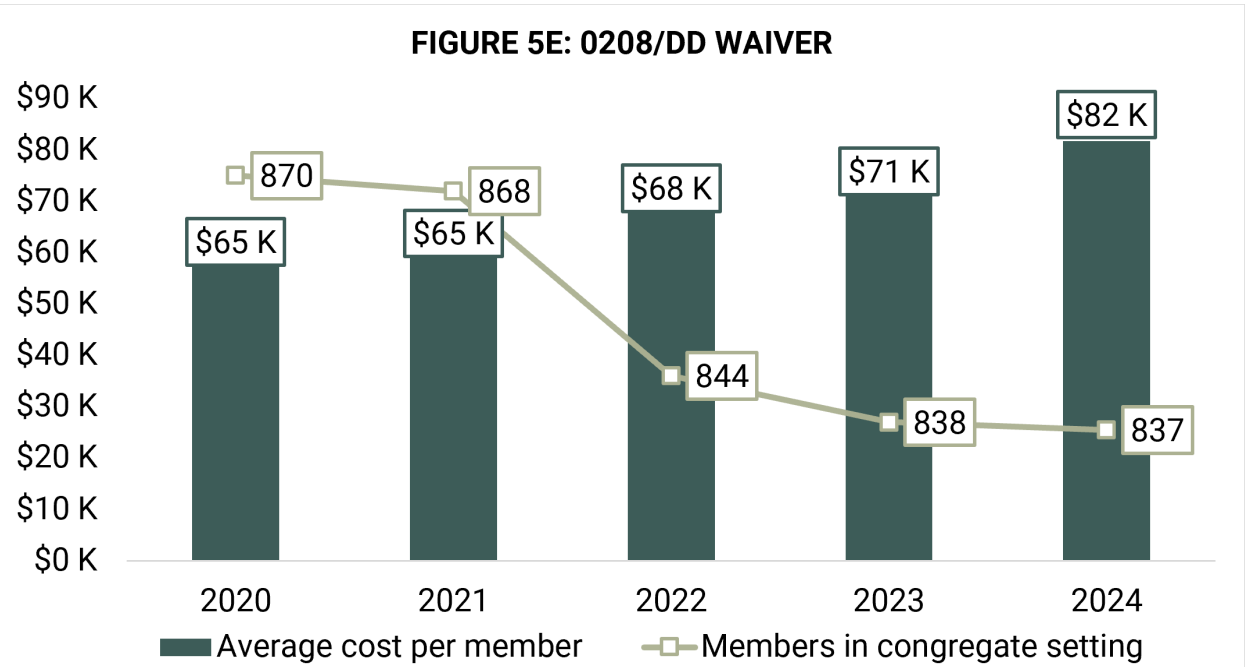
SETTING-SPECIFIC

FIGURE 5D-5F. AVERAGE EXPENDITURES BY SETTING

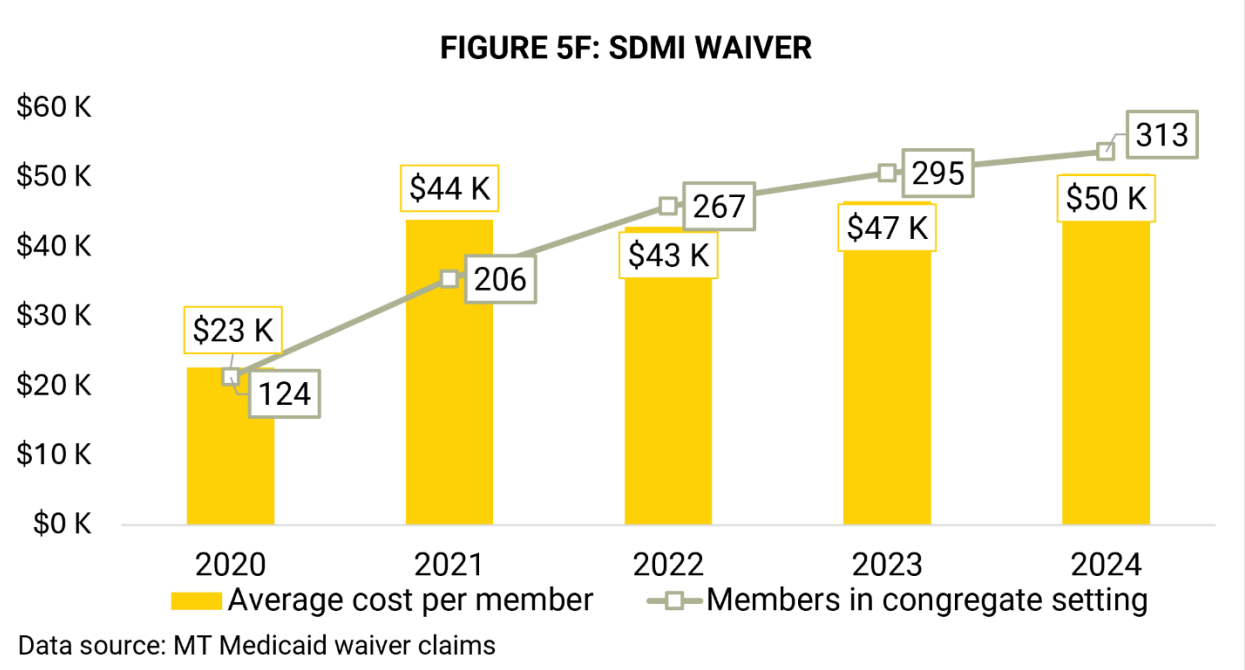
The next three charts show average expenditures across fiscal years 2020-2024 for members of each waiver living in congregate settings (assisted living facilities and/or group homes).



Data source: MT Medicaid waiver claims



Data source: MT Medicaid waiver claims

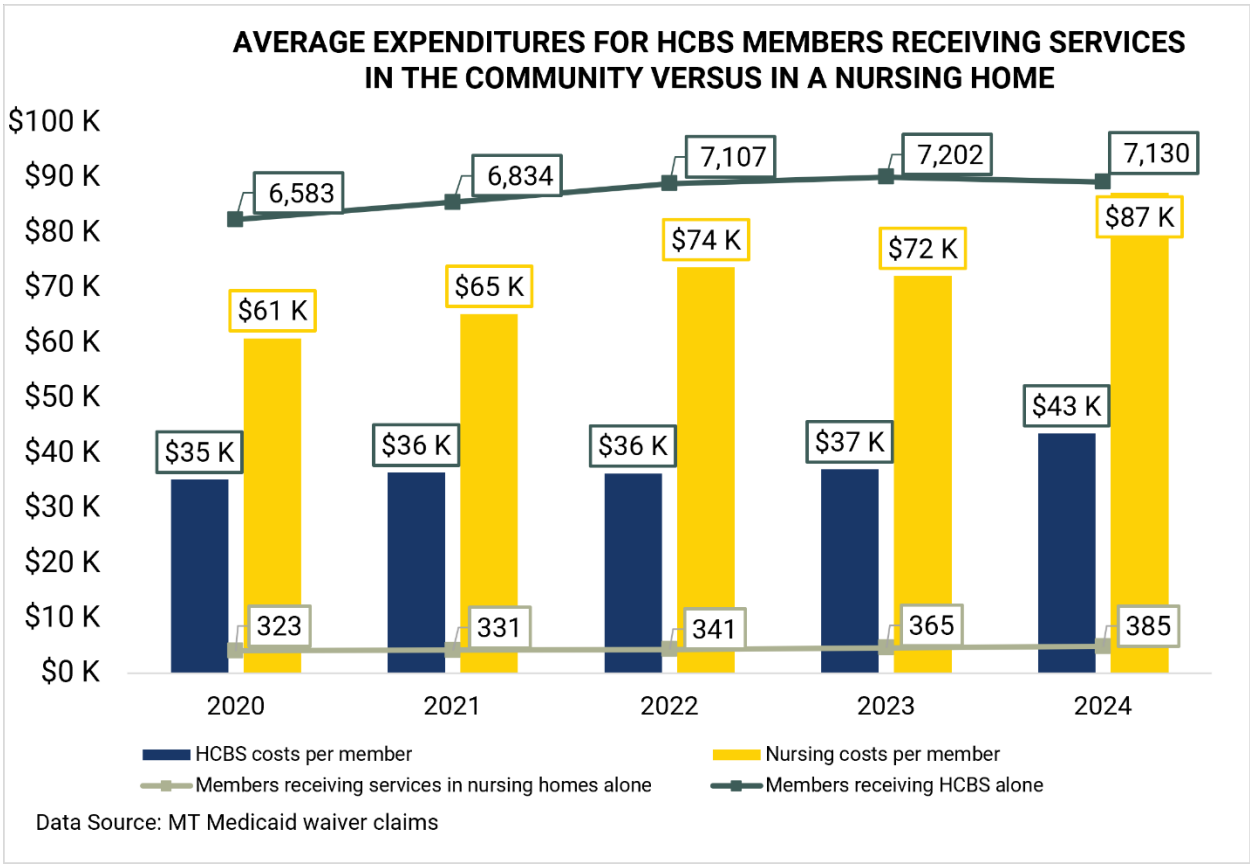


Based on the data sets provided, it is not possible at this time to show when members move to and from community congregate settings and institutional settings, or how far from their home community they must move when those residential changes take place. This would be valuable information to track to better understand geographic and service trends. It was also not possible at this time to compare congregate-setting costs with those for members living in community-based settings. This would be an important analysis to focus on during the next review and update of Montana's Olmstead Plan.

COMMUNITY-BASED VS. NURSING HOME SERVICES

FIGURE 5G. COMPARISON OF AVERAGE EXPENDITURES FOR SOLELY COMMUNITY-BASED SERVICES VERSUS SOLELY NURSING HOME SERVICES PER MEMBER BY YEAR

While the intent of HCBS is to ensure that individuals receive care in the community, there are times when members transition in and out of nursing facilities. Medicaid covers the costs for both settings (HCBS and nursing home). This chart compares average costs for members who receive care solely in HCBS settings (community-based and congregate settings) during the year versus members who receive care solely in a nursing facility during the year. This chart illustrates that the cost of nursing home care is significantly higher than providing care in the community.



Note that all individuals reported here received HCBS services at some point. Each year, there are additional members who receive services in both the community and in a nursing facility during a fiscal year. These individuals are not included in the cost comparison, as it is not currently possible to adequately demonstrate movement from one setting to the other. However, it is important to note that people do move between categories across years. This means that some individuals may have received care only in the nursing home one year, and the next have transitioned to the community, or vice versa. Because of the complexities of the federal Institution for Mental Diseases exclusion, it is also not possible to analyze costs for stays at or movement to/from the MSH using this data.

RECOMMENDATIONS FOR FURTHER ANALYSIS

Further future analysis would be valuable for understanding the experiences of waiver members who receive services over time in both community (HCBS) and institutional settings (including both nursing homes and state facilities). Understanding when and how individuals transition into or out of an institution can inform the state's Olmstead strategy. For example, incorporating indicators that note when a waiver member shifts

from receiving services in the community to receiving services in an institution (and vice versa) would help track where individuals receive services over time. Additional indicators for whether a member passes away or moves out of state would also be valuable. Such an indicator could also serve as a signal that a waiver member may be eligible for future transition services if, for example, community-based housing access was an obstacle to returning to the community after hospitalization or rehabilitation.

Additionally, it is important to gain a better understanding of where within the state people are receiving services. Current data is limited in this regard. While the data include county-level variables indicating a member's county of residence, county indicators for service providers are less clear. Many providers are based in more urban areas and serve catchment areas across several counties. Others are categorized as out-of-state despite coordinating local services.

Including additional indicators or variables to accurately reflect the location of services, such as an indicator when an individual receives a service in a county different from their "home" county, would be useful in demonstrating whether members are actually receiving local services. Given the intent of Montana's Olmstead Plan to keep people in their communities rather than in institutions, tracking both the number of individuals served in nursing homes and other institutions and the locations where those services are provided relative to a member's "home community" is critical.

RELATED INITIATIVES WITHIN DPHHS

During the development of Montana's Olmstead Plan, DPHHS also led separate but related initiatives that intersect with Olmstead priorities. Detailed information on these two large initiatives and their alignment with Montana's Olmstead Plan is below. Similar to the activities below, additional recommendations from stakeholder engagement and the public feedback process are outside the scope of this Olmstead Plan. However, those recommendations have been collected and will be provided to the future Olmstead Coordinator.

BEHAVIORAL HEALTH SYSTEM FOR FUTURE GENERATIONS

House Bill 872, signed into law in May 2023, established the Behavioral Health System for Future Generations (BHSFG) Commission.[7] With a $300 million investment, BHSFG

[7] Montana Department of Public Health and Human Services. *Behavioral Health System for Future Generations Commission final report*. September 2024, from https://dphhs.mt.gov/assets/FutureGenerations/BHSFGCommissionFinalReport.pdf

aims to enhance Montana's behavioral health and developmental disabilities services and systems. A final report was provided in September 2024, outlining 22 Recommendations and 11 Near-Term Initiatives (NTIs).

During the development of Montana's Olmstead Plan, several priority issues identified through public engagement overlapped with initiatives already underway or planned for later implementation by the BHSFG Commission. While the activities below were reviewed for potential inclusion in Montana's Olmstead Plan, they were deemed to be sufficiently addressed at this time through existing BHSFG work:

- Increase caregiver and health care workforce recruitment and retention through tuition reimbursement *(integrated into Recommendation 19 and NTI 5)*
- Increase waiver slots to reduce waitlists (*integrated into Recommendations 1, 2, 4, and 5)*
- Support local crisis intervention option enhancement *(integrated into NTIs 3 and 4)*
- Continue ongoing reimbursement reform to expand access to specialized services *(integrated into Recommendations 3 and 6)*

There are several additional objectives and activities in this Olmstead Plan that align with or support other BHSFG initiatives and recommendations. These are expressly noted in the goals section. The BHSFG Commission initially convened in 2023, and the work is ongoing.

RURAL HEALTH TRANSFORMATION PROGRAM

The Rural Health Transformation Program (RHTP) is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $233,509,358.76, with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Montana received this funding in late 2025 to modernize rural health care delivery. The five core initiatives of the funding are:[8]

- Develop workforce through recruitment, training, and retention
- Ensure rural facility financial sustainability and access through partnerships and restructuring
- Launch innovative care delivery and payment models
- Invest in community health and preventative infrastructure
- Upgrade health care technology to coordinate and improve care

The ongoing work of the RHTP will directly support many of the Olmstead objectives. Again, the objectives and activities in Montana's Olmstead Plan that align most closely with these initiatives are highlighted in the goals section to indicate areas for future collaboration as programs and activities develop. The RHTP began in early 2026 and will run through 2030.

ASSESSMENT OF THE STRENGTHS AND WEAKNESSES OF THE SYSTEM

DPHHS is Montana's largest executive branch agency with a mission of "serving Montanans in their communities to improve health, safety, well-being, and empower independence."[9]*Across 12 divisions, DPHHS operates and oversees hundreds of programs, initiatives, projects, and councils. Many of these programs include direct services to people with disabilities. Per House Bill 922, this section of Montana's Olmstead Plan, which outlines the strengths and challenges of this system, includes analysis of waitlist data for HCBS, current workforce needs to support people with disabilities in their communities of choice, and suggestions from individuals receiving services.*

While this section of Montana's Olmstead Plan focuses primarily on identifying areas for improvement within DPHHS programs and systems, it is important to acknowledge

[8] Montana Department of Public Health and Human Services. *Rural Health Transformation Plan*. February 17, 2026, from https://dphhs.mt.gov/assets/RuralHealthTransformation/RHTP-Plan.pdf

[9] Montana Department of Public Health and Human Services. (n.d.). *About us*. Retrieved March 23, 2026, from https://dphhs.mt.gov/aboutus/

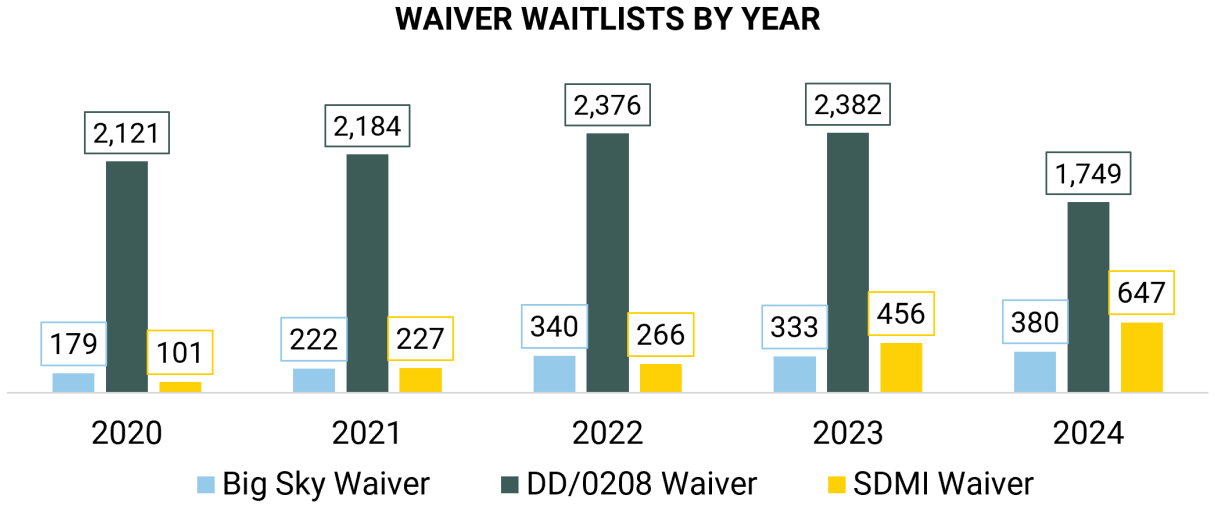
the Department's strong and ongoing commitment to meaningful program enhancement. DPHHS has demonstrated this commitment through historic investments in initiatives such as BHSFG and RHTP, which reflect a willingness to engage in innovation, self-assessment, and reform. Across disability-serving units, DPHHS consistently emphasizes improving both the quality of and access to services for people with disabilities through intentional stakeholder feedback and strategic planning. Participants in focus groups and interviews noted that many DPHHS programs already align well with Olmstead priorities and embody best practices for community-based services. A recurring challenge identified was not the absence of effective programs, but rather ensuring that clear, accessible information about these services reaches the individuals and families who would most benefit from them.

NUMBER AND LOCATION OF PEOPLE WAITING FOR SERVICES

WAIVER WAITLISTS

FIGURE 6A. WAIVER WAITLISTS BY YEAR

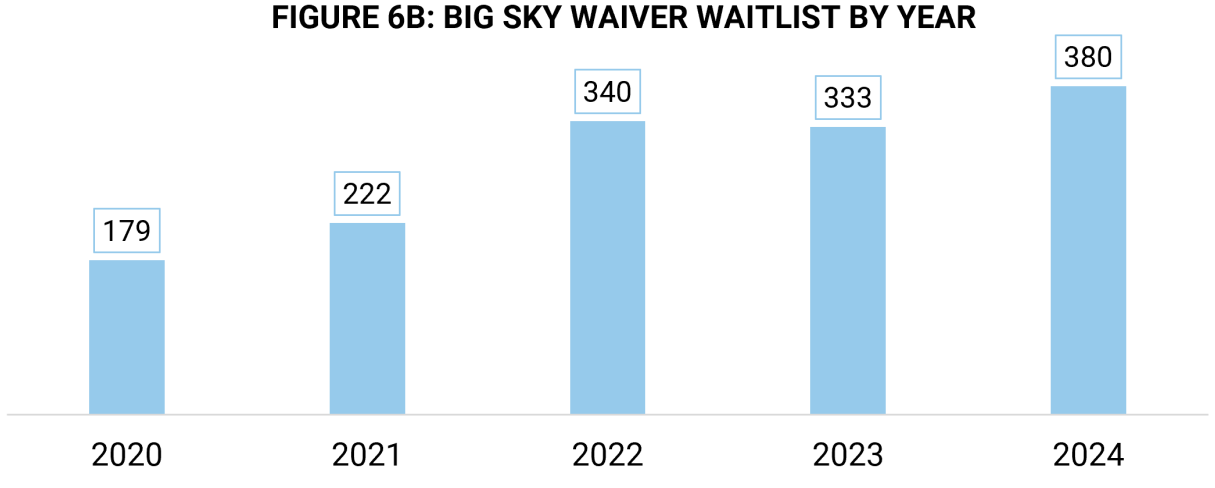
DPHHS has made progress in reducing the DD Waiver waitlist in the last three years, in part by allowing eligible members to join the BSW while on the waitlist. It should also be noted that DD Waiver waitlist numbers are inflated because people can be added to the waitlist before fully establishing waiver eligibility. However, most people still wait years before they receive services under the DD Waiver, and many stakeholders in the Olmstead development process described a continued need to reduce all waiver waitlists to increase access to services. Montana's Olmstead Plan does not directly address this issue because it is already being supported by BHSFG Recommendation #2 (*Expand Access to Waiver Services through a 1915 Supports Waiver)* and Recommendation #5 (*Conduct an In-Depth Study of the Current DDP Waitlist Management Process)*.



Data source: Kaiser Family Foundation

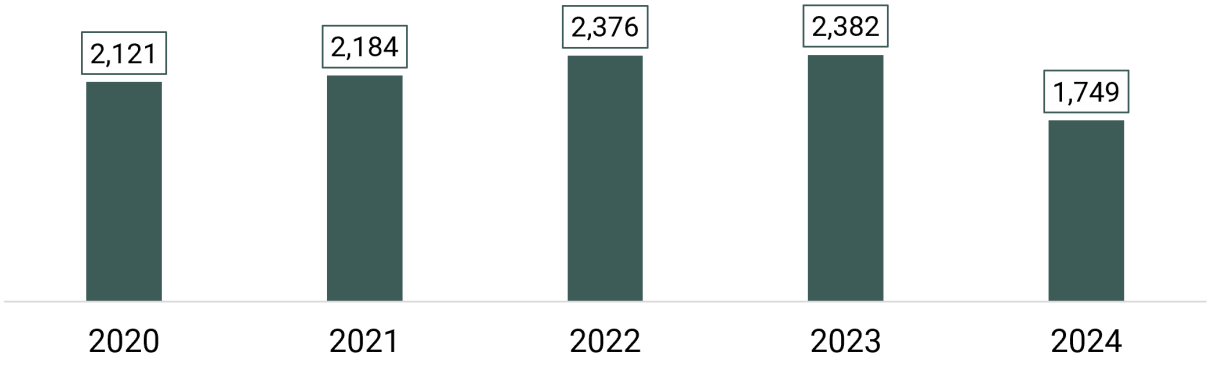
FIGURE 6B-6D. TOTAL PEOPLE BY WAITLIST BY YEAR FOR EACH SEPARATE WAIVER

The BSW waitlist increase between 2021 and 2022 may have been due to changes that allowed people on the DD Waiver waitlist to also be added to the BSW, in conjunction with an aging population requiring more services. People can still be on the DD Waiver waitlist while receiving BSW services. The SDMI Waiver waitlist has shown a significant increase yearly, especially in 2023 and 2024. This data should be closely monitored to determine if the increase continues in later years or is reduced by current BHSFG, RHTP, and Olmstead initiatives.



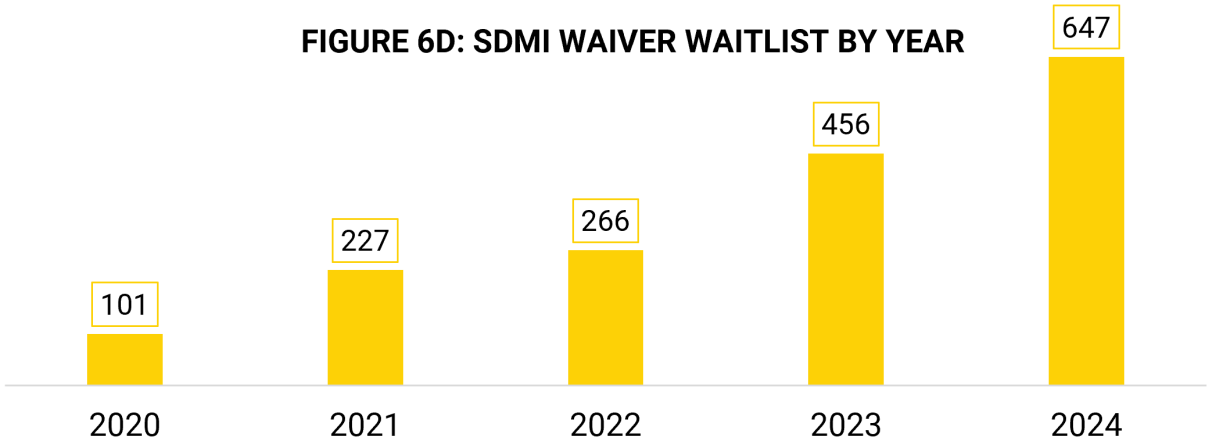
Data source: Kaiser Family Foundation

FIGURE 6C: O208/DD WAIVER WAITLIST BY YEAR



Data source: Kaiser Family Foundation

FIGURE 6D: SDMI WAIVER WAITLIST BY YEAR



Data source: Kaiser Family Foundation

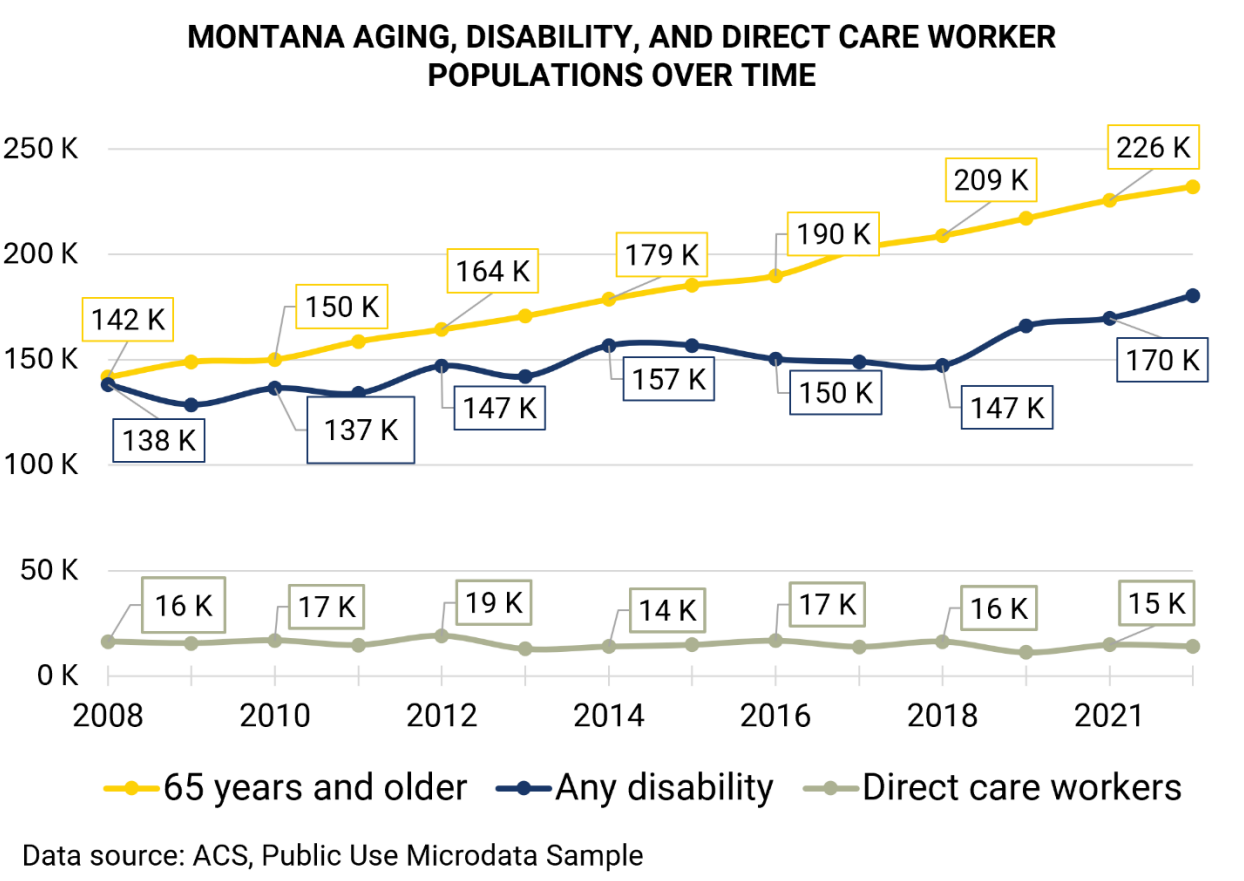
Olmstead-related Recommendation: Currently, there is no unified tracking or coordination between waivers and waitlists. Stakeholders during the Olmstead process noted that information from DPHHS can often be siloed, and that this can make the waitlist process more challenging. Working towards Goal 3, Objective 2, Activity 6 (Ensure developed resources include information for stop-gap services for those eligible for services but on a waitlist), Goal 4, Objective 1 (Expand interdepartmental coordination to reduce information silos and improve service accessibility and communication), and Goal 4, Objective 2 (Improve accessibility and transparency of public-facing information) will improve these processes.

WORKFORCE NEEDS

DIRECT CARE WORKER DATA

FIGURE 7A. MONTANA AGING, DISABILITY, AND DIRECT CARE WORKER POPULATIONS OVER TIME

The chart below illustrates a steadily increasing population of aging adults (those over 65) and people with disabilities, while the direct care workforce stays relatively stable.



Data source: ACS, Public Use Microdata Sample

In 2023, Montana had approximately 15,000 direct service workers, including personal care aides, home health aides, and nursing assistants. Between 2022 and 2032, Montana will need to fill 20,000 direct care jobs due to both the growth of need and people leaving this type of employment.[10]

[10] "PHI. (n.d.). *Montana*. Retrieved April 11, 2024. https://www.phinational.org/state/montana/

The BHSFG report identified "workforce" as one of three primary gaps in Montana, noting that the scarcity of specialized professionals in the state limits care capacity, creates competition, and exacerbates deficiencies, particularly in rural areas. Several BHSFG Recommendations and NTIs focus on growing, retaining, and strengthening the workforce. Where applicable, Olmstead activities that align with BHSFG initiatives are highlighted in the goals section beginning on page 44.

The first initiative of Montana's RHTP is also heavily focused on workforce development. The RHTP application for funding noted that significant investments will help strengthen recruitment, training, and workforce retention across rural Montana.[11] This work will be conducted in partnership with the Montana Department of Labor and Industry over the next five years.

In addition to BHSFG and RHTP, DPHHS's Senior and Long-Term Care (SLTC) Division is concurrently evaluating an initiative to recruit and retain personal care attendants and direct care employees of organizations that receive most of their revenue from providing Medicaid-funded long-term care services. This evaluation will analyze the effectiveness of current hiring and retention efforts, research how other states improve their Medicaid programs, and recommend ways to simplify administrative processes. The project will also provide recommendations for improvement and/or strategies for alternative, and more effective, methods of recruitment and retention. This evaluation report can provide additional support and evidence for future workforce efforts that will affect Olmstead priorities and goals. The expected completion date is August 2026.

Past work contracted through the Behavioral Health and Disabilities Division (BHDD) at DPHHS on identified strategies, creative solutions, and resources for behavioral health workforce recruitment and retention should be reviewed and integrated alongside these efforts.

Olmstead-related Recommendation: While other state projects are also working to support Montana's personal care workforce, Montana's Olmstead Plan will assist in these efforts towards workforce retention and expansion by increasing provider education experiences, partnering with 406 JOBS, exploring the expansion of the Montana State Loan Repayment Program, and provision of change management support under Goal 3,

[11] Montana Department of Public Health and Human Services. (n.d.). *Rural Health Transformation Project: Project summary* [PDF]. Retrieved March 19, 2026. https://dphhs.mt.gov/assets/RuralHealthTransformation/RHTP-Project-Summary.pdf

Objective 1 (Improve workforce education and sustainability). Coordination across projects, divisions, and activities is imperative to operational success.

SUGGESTIONS FROM INDIVIDUALS RECEIVING DEPARTMENT-FUNDED SERVICES AND SUPPORTS

To support a comprehensive evaluation of the system's current strengths and challenges, feedback was gathered and analyzed from multiple sources using a variety of methods, including:

- April 2024: Statewide kick-off meeting with DPHHS employees and community partners
- May 2024: Consensus-building workshop with the SILC to identify stakeholder engagement priorities
- Summer – Fall 2024: 26 focus groups with people with disabilities, family members and caregivers of people with disabilities, and members of statewide advocacy groups
- Winter 2024-2025: 6 interviews with individuals who had transitioned from institutional to community-based living
- Spring 2025: 3 targeted focus groups with providers from the housing, transportation, and health care sectors
- Summer 2025: 5 interviews with disability service providers on 4 of Montana's Tribal Reservations
- Summer 2025: Facilitated workshop with DPHHS employees in disability-serving programs
- Winter 2025: Public feedback period to collect comments on proposed goals, objectives, and activities

FOCUS GROUPS

The first round of engagement sessions, or focus groups, collected information about current needs and barriers to community living. The focus groups included people with disabilities (living in community or congregate settings), family members or caregivers of people with disabilities (living in community or congregate settings), and statewide advocacy groups. Focus groups were scheduled across Montana. To meet the needs of

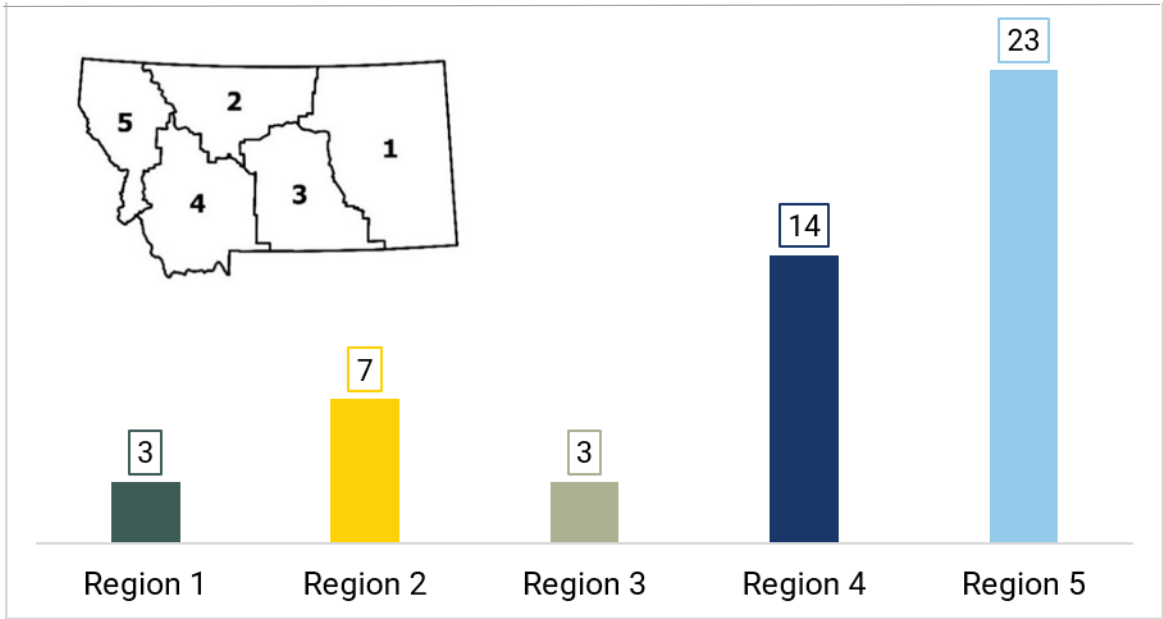
the various groups and accommodate requests for multiple types of engagement, some groups were in person, some were hybrid, and some were completely virtual. Twenty-six focus groups were planned and advertised widely.

REGIONAL DATA

FIGURE 8A. PEOPLE WITH DISABILITIES, FAMILY MEMBERS, AND CAREGIVER PARTICIPATION IN FOCUS GROUPS BY THE DD REGION

Despite significant outreach, participation by people with disabilities and family members/caregivers in Regions One and Three was limited. Partners working at the time reported similar recruitment challenges, with stakeholders reporting feeling over-engaged by current research and program development work. In the first round of focus groups, participants included 31 people with disabilities, 19 family members/caregivers, and 31 representatives of statewide organizations.

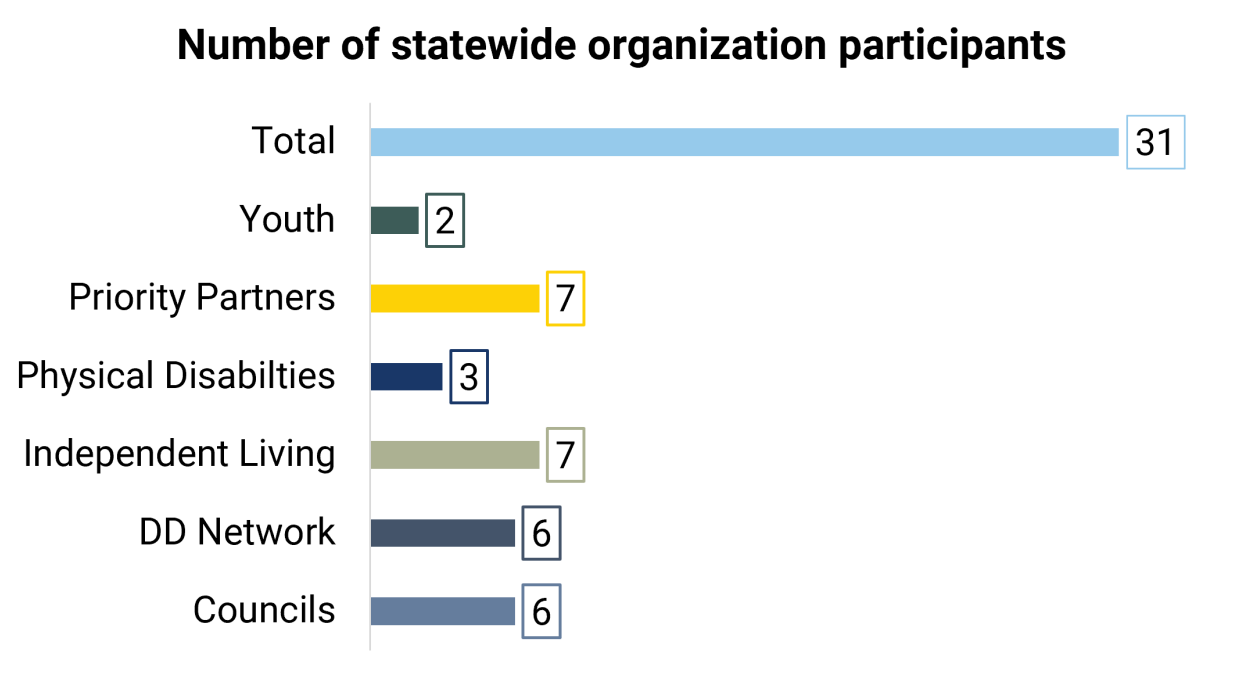
NUMBER OF PEOPLE WITH DISABILITIES, FAMILY MEMBERS, AND CAREGIVERS IN FOCUS GROUPS, BY DD REGION



ORGANIZATION PARTICIPATION

FIGURE 8B. STATEWIDE ORGANIZATION PARTICIPATION IN FOCUS GROUPS

Efforts were made to engage with multiple stakeholder groups. Participants in the "priority partners" focus group included people from veteran-serving organizations and organizations working with American Indians.



The focus group questions were designed to align with the objectives set forth in House Bill 922, specifically to examine the strengths and weaknesses of the current system and to gather suggestions for improvement from people who receive services. After analyzing the data from the focus groups, participants reported primarily on five themes. The findings presented below summarize perspectives shared by focus group participants. These findings are intended to reflect participant feedback accurately and do not necessarily represent the views or commitments of DPHHS.

1) Housing and Transportation: Current available housing and transportation options do not offer true choice, are limited in both accessibility and availability, and do not meet the needs of rural citizens with disabilities. The State needs to offer more options, expand infrastructure, and extend or expand current systems.

2) Home-Based Supports for Disability and Mental Health Services: The current system of home-based supports is hindered by numerous challenges, including long waitlists, low reimbursement rates, bureaucratic processes, limited provider choice and access to specialists, and insufficient telehealth. Expanding options will expand choice.

3) Education and Employment: There is a need for more school-based services, increased teacher training, and improved transition services to support children into adulthood. The State also needs to hire more people with disabilities and incentivize private businesses to hire people with disabilities at competitive wages.

4) Choice, Autonomy, and Reducing Bureaucratic Barriers: People with disabilities deserve easy access to legal protections, increased education on tools like special needs trusts and Achieving a Better Life Experience (ABLE) tax-advantaged savings accounts, and training on alternatives to guardianship. The State needs to reduce paperwork and reporting burdens and expand Medicaid eligibility.

5) Accessibility, Representation, Training, and Public Awareness: Inaccessible physical environments limit participation in public spaces, and there is not enough funding for universally designed infrastructure. The State should require disability representation in State planning processes and fund paid advisory groups for people with disabilities.

See Appendix B for a three-page document detailing these Focus Group Findings in more detail.

Through an iterative process, the analysis of this data led to the planning of three additional focus groups, with targeted participation by service providers of transportation, health care, and housing. These groups included providers specifically focused on people with disabilities, as well as providers who serve the wider public. Providers were asked to share gaps in the previously identified challenges and solutions from the first round of focus groups, while also helping problem-solve solutions to the barriers in the focus group report.

In the health care group, participants highlighted the importance of developing sustainable career pathways for personal care attendants, expanding respite and emotional support for caregivers, ensuring continuous HCBS waiver eligibility, and supporting Employment First initiatives. Additional needs included more benefits

coordinators and expanded access to specialized services through reimbursement changes, paired with stronger navigation and advocacy support.

Across the housing sector, providers stressed persistent affordability barriers and recommended greater state investment in rental assistance, homeownership programs, and shared equity models such as cooperatives and community land trusts. They also emphasized shifting from adapting housing after the fact to fully accessible development from the outset, as well as stronger coordination between housing and service systems. Providers noted that current systems do not reflect the realities of housing markets, and case managers need deeper market knowledge and more community-based engagement to effectively support clients.

Transportation needs centered on both infrastructure and coordination challenges. Providers noted that public transit can be physically taxing for people with disabilities and that rural transportation funds often go unused due to a lack of administrative capacity. They recommended expanding transportation through aging services agencies, improving inter-provider coordination, and better utilizing regional transportation coordinator roles. Additional recommendations included offering more training for transportation providers, increasing transportation vouchers, enhancing client education on transit options, and offering incentives for volunteer drivers. Beyond specific sectors, providers also called for increased education of policymakers on Olmstead obligations, expanded provider training, clearer state processes, and stronger crisis services to make it easier to serve clients effectively.

The focus group information was shared with disability-serving DPHHS employees during a facilitated full-day workshop. They used this information to develop the six Olmstead goals and the foundation of the objectives now found in the current Montana Olmstead Plan.

INTERVIEWS

Outside of the focus groups, it was important to gain more detailed information from two additional populations in Montana: people who have transitioned from institutional settings back to community living and American Indians familiar with disability services.

TRANSITION INTERVIEWS

Key themes emerged across the six interviews with individuals who had transitioned from institutional to community-based living. Of note, three interviewees were served on the DD Waiver and three on BSW. Despite significant outreach, attempts to interview

individuals who had experienced transition and were served on the SDMI Waiver were unsuccessful.

Overall, interviewees were very pleased with their transition experience and noted several key supports that helped them succeed. Access to their waiver services enabled crucial supports upon return to community living, including in-home care and home modifications that were essential for continued safety and independence. They spoke highly of the support they received from social workers and case managers. These professionals helped coordinate housing, secure services, and provide continuity of care during the transition process. Once back in the community, access to activities, employment, and transportation options supported community integration and well-being. Interviewees noted that, beyond Medicaid services, having family and friends to help with moving and providing emotional support aided in a successful transition.

Despite these facilitators, participants still faced challenges. Similar to focus group participants, interviewees noted housing inaccessibility (e.g., lack of accessible bathrooms), limited choice in housing options, and long waitlists for modifications as barriers to a smooth transition. Participants also faced complex administrative challenges, including delays in caregiver availability and difficulty navigating systems. A topic brought up in the transition interviews that was not highlighted in the focus group data was that negative or traumatic experiences in institutions were a driving force behind transitions and also impacted trust and adjustment once back in community settings. Also, transitions were more difficult when behavioral or mental health challenges were present.

Interviewees involved in transitions led by the Money Follows the Person (MFP) initiative positively highlighted the program's infrastructure and access to helpful services. Currently, MFP primarily serves BSW members. Strengthening coordination between MFP and other waiver services could enhance successful transitions from institutional settings to the community.

Olmstead-related Recommendations: Based on these interviews, it is important to ensure more choice in housing options, especially related to accessibility, captured in Goal 2, Objective 2 (Develop more inclusive, accessible housing and infrastructure for individuals with disabilities and aging populations). It is also vital that people with disabilities have more localized support for navigating systems and dealing with the trauma of institutionalization. This theme is supported by Goal 3, Objective 2, Activity 4 (Seek funding to employ or contract with community-level disability services navigators or community health workers).

DISABILITY PROVIDERS SERVING TRIBAL COMMUNITIES INTERVIEWS

In close partnership with DPHHS's Office of American Indian Health (OAIH) director, the Rural Institute for Inclusive Communities presented to tribal councils about Montana's Olmstead Plan and sought permission via the council or the tribe's Institutional Review Board to conduct interviews with disability service providers on each of Montana's tribal reservations. The following themes emerged from interviews with five disability service providers across four Montana tribal communities. Resource availability varies significantly by location; these findings illustrate common patterns but may not be representative of every tribal community in Montana.

During outreach conversations, it was apparent that access to state or tribal disability-specific services was very limited or nonexistent within several tribal communities. Available services tend to be distributed across two main systems: education and tribal health. The braiding of systems creates multiple access points but also introduces variation and inconsistency depending on an individual's age and the system they enter first. The available services most frequently mentioned in the education system were special education services and related services (speech-language pathology, occupational therapy, physical therapy, and mental health supports). In the tribal health system, it was mental health services, rotating specialty care, and transportation. Tribal health and Indian Health Services (IHS) act as the financial backbone of disability support. They reduce out-of-pocket costs for clients. This support reduces financial strain but requires navigation, documentation, and provider advocacy to fully access benefits.

Participants described their clients struggling to access sufficient services, such as school-based therapy and personal care attendants (PCAs). Some services are missing entirely; the most frequently mentioned was group homes. High provider turnover means that a single departure can deprive an entire community of access to that service. Even when programs exist, vacant positions, inadequate leadership capacity, and low salaries often keep them from operating reliably.

Additionally, system navigation and information gatekeeping shift the work onto families. Individuals and families repeatedly encounter invisible pathways to care and bureaucratic hurdles. People are required to "know where to start," and benefits and financial supports are poorly communicated. Technical language on application forms prevents individuals from applying.

Similar to the Olmstead focus groups, American Indian interviewees shared that people with disabilities often face limited access due to unreliable transportation and

technology infrastructure. Transportation and connectivity determine whether a service is reachable. There are multiple transit options, but hours of availability and jurisdictional limitations restrict use. Limited phone/internet access in some areas undermines telehealth, care communication, and coordination with providers.

Interviewees stressed that accessibility exists on paper but breaks down in practice. Participants described physical spaces that are technically accessible but not reliably usable depending on the weather or community events. Inaccessible housing is another prevalent barrier; a home without a ramp restricts an individual's ability to access their community.

To increase access to more independent living, there needs to be available housing, transportation, and in-home supports. Communities need accessible and affordable housing, continuous sidewalks, and wheelchair-accessible transportation staffed by people trained in safe transfers. A strong PCA workforce and a funded continuum of housing options (from group home to assisted living) would provide more flexibility.

Beyond the physical pieces, individuals need coordinated transitions from care facilities to home and wraparound support from tribal health. Clear, centralized information, through tribal administration/council outreach and community meetings, helps everyone know what services exist and who to call.

A consistently mentioned barrier to services was very limited to zero choice among PCAs, transport, housing, and providers. Many communities have only one provider, so individuals and families lack options that would ensure the best fit between provider and client. Additionally, individuals advised that information is hard to find or withheld.

Participants recommended several state actions to expand choice: invest in local housing/program infrastructure (group homes, assisted living) to keep people in their communities, support programs that give an early autism diagnosis and early intervention, expand mental health services in schools and clinics, increase telehealth access, and implement community transportation plans. Raising rural salaries and Medicaid reimbursement would support the workforce. Finally, outreach/site visits, along with responsive state communication, would make options visible and navigable. Many of these suggestions are directly tied to the current goals, objectives, and activities in Montana's Olmstead Plan.

Participants expressed a desire for the state to support universal design and to codesign spaces and services with disabled people, so inclusion is built into streets, buildings, and services from the beginning. To feel welcome in day-to-day life, people

need human help and clear information. An example of social infrastructure provided was social workers and case managers who support the coordination of services, including transportation. Additionally, funding inclusion-focused events and outreach helps shift norms, so participation is expected and celebrated.

When discussing how people learn about services, it is mostly through word of mouth and familiar institutions such as schools, tribal programs, tribal colleges, and tribal health centers. In general, trusted community hubs are the primary sources of information. Outside of relationships, people rely on Facebook, Google, on-site digital signage at the tribal health center, and radio. Participants emphasized that digital channels help, but they don't replace the trust and guidance offered by trusted community members. In disseminating Montana's Olmstead Plan, this information will be key to increasing awareness and expanding outreach.

There is no one theme to draw on from these interviews. Rather, they stretch across all the proposed Olmstead goals and objectives. Continued partnership with tribal councils and American Indian partners to ensure thoughtful and culturally appropriate implementation of Olmstead-related priorities will be key to statewide success.

RELATED INITIATIVE: LONG-TERM SERVICES AND SUPPORTS STRATEGIC PLANNING – STRENGTHENING TRIBAL RELATIONSHIPS

This concurrent project is a contract between DPHHS's SLTC Division and Montana's Office of Rural Health/Area Health Education Center. Through respectful consultation and collaboration with Tribal Governments and Urban Indian Organizations across Montana, this project seeks to understand the needs and identify opportunities for improvement when it comes to SLTC services. Montana's Olmstead Plan development and the Strengthening Tribal Relationships project had overlapping timelines and were seeking similar information. In an effort not to over-engage possible participants, both teams worked closely with DPHHS's OAIH director to collaboratively collect meaningful feedback from American Indians across Montana. The final report from the Strengthening Tribal Relationships project that will be given to DPHHS can be used to augment the information within Montana's Olmstead Plan that addresses disability service gaps and possible solutions to ensure all Montanans with disabilities, including American Indians, have access to HCBS. The expected completion date for this report is Summer 2026.

RECOMMENDATIONS FOR INCREASING THE AVAILABILITY OF AND ACCESS TO COMMUNITY-BASED SERVICES AND SUPPORTS

To fully develop Montana's Olmstead Plan, we created a set of goals, objectives, and activities that encompass the full array of information collected from the focus groups, interviews, and the state employee workshop. We sought additional feedback through state employee reviews and a public feedback process. This section of Montana's Olmstead Plan outlines the measurable goals, objectives, and activities, including the steps needed to correct unnecessary institutionalizations and prevent future institutionalizations. Timelines and responsibilities are covered in the Quality Assurance and Monitoring Plan (beginning on page 54).

CROSS-GOAL OBJECTIVES

Montana's Olmstead Plan will require coordinated staff oversight and active engagement from people with lived experience of disability. These cross-goal objectives are integral for raising awareness and ensuring progress across the six other Olmstead goals.

Objective 1: Secure funding for a full-time Olmstead Coordinator to oversee the advisory group, monitor timeline and quality assurance, and drive progress towards goals and objectives.

Objective 2: Secure funding to develop an Olmstead advisory group to ensure goals and objectives are being met on the expected timeline.

Objective 3: Partner with disability serving providers, organizations, and other state departments to create a public service campaign raising awareness about disability issues and addressing disability stigma (*Supports BHSFG Recommendation 14).*

- **Activity 1:** A different disability-serving entity leads this initiative each year.
- **Activity 2:** Include a public service announcement series on radio/television to reach communities without broadband internet, matched with streaming videos (e.g., YouTube) for those with more consistent internet access.

Objective 4: Host a yearly solutions-focused Olmstead Disability Summit between DPHHS waiver and state plan staff, Vocational Rehabilitation, Centers for Independent Living/SILC, disability service providers, Department of Commerce, MDT, and people with disabilities and their families.

GOAL #1: PROMOTE RIGHTS, CHOICE, AND AUTONOMY OF PEOPLE WITH DISABILITIES

This goal reflects the fundamental principles of the Olmstead Decision and was voiced by people in communities across Montana. There needs to be more options for home and community-based services to reduce institutionalization, and people with disabilities should have access to increased options for informed choice.

Objective 1: Prevent and reduce institutionalization through data-informed strategies that enhance access to community supports.

- **Activity 1:** Ensure each 1915c waiver has an up-to-date diversion plan for institutionalization.
- **Activity 2:** Identify data collection needs to gather the primary reasons individuals are institutionalized, using insights from analysis to inform and shape Olmstead Plan priorities.
- **Activity 3:** Build out existing citizen complaint and assistance process to ensure timely feedback.
- **Activity 4:** Improve data collection by establishing interdepartmental standards for defining service and employment settings and tracking institutionalization, congregate living, independent living, segregated employment, enclave employment, and competitive integrated employment (*Supports multiple BHSFG recommendations that require performance measures and baseline data).*

Objective 2: Expand access to choice in decision-making for people with disabilities.

- **Activity 1:** Develop an implementation and reporting plan to ensure all team members (e.g., case managers, community rehabilitation program staff, designated provider agency team members) supporting Montanans with disabilities will have ready access to training in the person-centered planning (PCP) process, including how to transfer PCP goals into a plan of care and how to provide informed choice in employment and independent living. In subsequent years, a modified training will be developed for use with the client, parent/guardian, and/or designated support person (*Aligns with/builds on BHSFG NTI 5, and Recommendations 3, 7, and 20).*
- **Activity 2:** Expand timely education on supported decision making and less restrictive options to guardianship that is accessible to all ages (e.g., students

leaving school, older adults with cognitive challenges, people with mental health diagnoses).

- **Activity 3:** Explore the state's option to formally eliminate Medicaid claw back of ABLE account funds to increase utilization; expand public promotion of ABLE accounts.

GOAL #2: INCREASE COLLABORATIONS AND ENHANCE STATE PROGRAMS TO EXPAND CHOICE IN HOUSING AND TRANSPORTATION FOR PEOPLE WITH DISABILITIES

Achieving this goal is contingent upon legislative action in 2027 to fund, build, and implement a unified, statewide approach to address the top priorities of Montanans with disabilities: transportation and housing. DPHHS's efforts will be amplified through collaboration across state departments to implement the changes needed to address these identified challenges.

Objective 1: Improve interagency collaboration and system alignment within DPHHS and across other state entities.

- **Activity 1:** Commit to two interagency meetings with the Department of Commerce yearly to set and evaluate progress toward measurable goals to improve access to housing for people with disabilities.
    - Set the groundwork with "What is Olmstead", goal setting for an integrated plan, and disability-specific trainings.
    - Begin with review of existing housing policies for consistent alignment with Olmstead priorities and in consideration of feedback gathered from stakeholders.
- **Activity 2:** Commit to two interagency meetings with the MDT yearly to set and evaluate progress toward measurable goals to improve access to transportation for people with disabilities.
    - Set the groundwork with "What is Olmstead", goal setting for an integrated plan, and disability-specific trainings.
    - Topics for later meetings could include how best to work with transit providers on exploration of extension of accessible transportation options beyond 8-5 and including weekends, piloting rural transportation options,

strengthening on-demand transit options, expanding access to assistive technology options for driving, and supporting services for driving training and assessments.

- **Activity 3:** Establish interagency training for state staff on universal design principles for increased accessibility, highlighting housing, transportation, and public spaces.

Objective 2: Develop more inclusive, accessible housing and infrastructure for individuals with disabilities and aging populations alongside and in collaboration with the Montana Department of Commerce's current services.

- **Activity 1:** Expand the role description of the existing transportation coordinator to include housing coordinator duties during Year 1. Seek to secure funding for a full-time position in each role in later years of the plan.
- **Activity 2:** Explore partnerships with non-profit housing organizations and/or local/county housing councils or authorities across Montana, including areas with acute housing needs, to discuss the feasibility of incentivizing the creation of more universally accessible units.
- **Activity 3:** Develop and implement training on accessibility standards/options, including universal design, for housing developments, and provide this training to at least five rural housing providers yearly.
- **Activity 4:** In partnership with the Department of Commerce housing division and existing housing providers/partners, improve access to homebuyer education relevant to people with disabilities (include options for accessible housing and use of ABLE accounts).
- **Activity 5:** Explore incentive options, seek new potential funding sources, and/or deploy existing resources more strategically to facilitate universally designed infrastructure (e.g., public bathroom modifications, playgrounds, ramp installations, etc.). *Aligns with the MDT updates to its ADA Transition Plan, occurring in 2026.*
- **Activity 6:** Examine co-housing options that allow people with disabilities living with family members to have more independent housing on the property, including the use of low-interest loans, grants, or subsidies to build accessory dwelling units or home additions.

Objective 3: Strengthen and expand accessible transportation systems for individuals with disabilities and aging populations alongside and in collaboration with the MDT's current services.

- **Activity 1:** Realign the transportation and housing coordinator position for most effective collaboration and ensure ongoing meetings with the MDT.
- **Activity 2:** Meet with interested legislators before the 2027 legislative session to discuss funding to incentivize private accessible ride services to strengthen transportation options for people with disabilities and those aging in place.
- **Activity 3:** Utilize community-level transportation advisory councils to greater effect, ensuring transportation coordinator attends these meetings and reports up to Olmstead coordinator for increased collaboration, resource sharing, and information dissemination.
- **Activity 4:** Serve as a sponsoring agency for an expanded transportation voucher system using Medicaid transportation funding, aiming to increase voucher distribution by 10% annually.
- **Activity 5:** Co-plan with MDT to pilot a volunteer transportation program and/or accessible ride-share co-op in at least two rural communities. If successful, expand to two additional communities yearly.
- **Activity 6:** Conduct analysis on existing transportation data and interview clients to better understand barriers to use; based on analysis, revise how transportation options are organized on the website and presented to the public for easier access to the right service in the right community *(Supports BHSFG Recommendation 15)*.
- **Activity 7:** Create a Disability Transportation Service Line directly connected to the DPHHS transportation coordinator for coordination assistance and data tracking.
- **Activity 8:** Create new and/or promote existing training opportunities for transportation providers serving the general public on working with people with disabilities.

GOAL #3: INCREASE ACCESS TO AND CHOICE OF HEALTH CARE AND MENTAL HEALTH SERVICES IN COMMUNITY SETTINGS

Montana's Olmstead Plan will work with other DPHHS initiatives, such as BHSFG and the Rural Health Transformation Program (RHTP), to improve health care and mental health services for people with disabilities in the communities of their choice.

Objective 1: Improve workforce education and sustainability.

- **Activity 1:** Expand provider education and access to specialized evidence-based telehealth services *(Aligns with and builds on BHSFG NTI 5 and Recommendations 3 and 6)*:
    - Train an additional 500 health care workers using "Curriculum in IDD (intellectual or developmental disability) Healthcare" to help providers better understand and support individuals with IDD when they need medical and behavioral care.
    - Scale "Station MD" beyond pilot project to an additional five providers each year, contingent on positive feedback from pilot study (Aligns with Montana's RHTP application).
- **Activity 2:** Engage with local sector partnerships under 406 JOBS to address workforce needs for direct service professionals (DSPs), including recruitment, retention, and professionalizing the occupation.
- **Activity 3:** Explore expansion of Montana State Loan Repayment Program to include more levels of education involving residential care employees *(Aligns with and builds on BHSFG Recommendation 19).*
- **Activity 4:** Provide change management support: ongoing communication/training from the state to those implementing changes and those receiving services to review new technologies and processes and to support implementation *(Aligns with and builds on BHSFG Recommendation 3).*

Objective 2: Expand service delivery to improve access to care across rural and urban settings.

- **Activity 1:** Initiate and develop a partnership with at least one large provider in the state to explore setting up rural and tribal hubs to increase access to specialists (*Aligns with RHTP application*).

- **Activity 2:** Maintain and increase access to telehealth and local specialty care to reduce the need to travel for services (*Aligns with Montana's RHTP application and aligns/builds on BHSFG Recommendation 3*).
- **Activity 3:** Explore options for statewide initiatives to promote assistive technology, home modifications that support independence, and monitoring/communication technologies to decrease the need for direct support staff (*Aligns with Montana's RHTP application*).
- **Activity 4:** Seek funding to employ or contract with community-level disability services navigators or community health workers (*Aligns with and builds on BHSFG Recommendation 6*).
- **Activity 5:** Coordinate monthly meetings between the Developmental Disabilities Program (DDP) and the SDMI Waiver staff to improve services for people with co-occurring I/DD and mental health conditions.
- **Activity 6:** Ensure developed resources include information for stop-gap services for those eligible for services but on a waitlist.

Objective 3: Increase support to caregivers.

- **Activity 1:** Enhance promotion of respite services and eligibility criteria for caregivers through targeted messaging to providers across populations who can benefit, i.e., aging services, child care resource agencies, regional waiver case managers, and medical providers serving adults with I/DD and older adults with memory impairment (*Supports BHSFG Recommendation 16*).

GOAL #4: IMPROVE CREATION AND DELIVERY OF ACCESSIBLE INFORMATION AND RESOURCES

People with and without disabilities benefit from information that is easy to understand, readily available, and accessible. This goal will improve internal processes and external delivery so that Montanans have clear access to necessary services.

Objective 1: Expand inter-departmental coordination to reduce information silos and improve service accessibility and communication.

- **Activity 1:** Integrate cross-DPHHS session at yearly Olmstead Summit with focus on identifying projects for collaboration and cross-promotion.

- **Activity 2:** Create a repository to share strategic plans across all disability-serving DPHHS units. Administrators will be responsible for identifying common goals for collaborative action and developing information-sharing processes.
- **Activity 3:** Develop consistent case management requirements and expectations across divisions, including the use of accessible or plain language in all internal and external trainings.

Objective #2: Improve accessibility and transparency of public-facing information.

- **Activity 1:** Consider funding to establish a dedicated full-time position for knowledge translation, housed in DPHHS's Communications Office.
- **Activity 2:** Review current brochures, rack cards, and websites for accessibility and revise with accessible or plain language as needed.
- **Activity 3:** Expand outreach and public information activities to promote different programs or resources monthly. Create a calendar to include DPHHS staff tabling at one conference per month.
- **Activity 4:** Create a publicly accessible system to flag outdated or inaccessible content and links on the website.

Objective #3: Build internal capacity to create and maintain accessible materials.

- **Activity 1:** Use an external accessibility expert to develop consistent plain language policies for information dissemination, online content, and transparency of services.
- **Activity 2:** Ensure web developer, information technology (IT) team members, and staff responsible for website updates have ongoing accessible media training.
- **Activity 3:** Include training on the development of accessible or plain language resources, accessible digital content creation, resources for Braille creation, use of translation services, etc., in new hire orientation and ongoing training for all staff across units.
- **Activity 4:** Model accessibility (e.g., CART, ASL, plain language, etc.) in all trainings, with a post-training evaluation component to help improve accessibility.

GOAL #5: SUPPORT COMPETITIVE INTEGRATED EMPLOYMENT WHILE WORKING TOWARDS BECOMING AN EMPLOYMENT FIRST STATE

Montana recognizes that all individuals, including those with significant disabilities, are capable of participation in employment and community life. This goal will align policies and practices to more fully commit to competitive integrated employment for all Montanans.

Objective #1: Establish DPHHS as a model employer for people with disabilities.

- **Activity 1:** Develop a skills-based, disability-led hiring guide for use across divisions and statewide education materials on disability employment in state government, piloting the materials with DPHHS and the Department of Administration, with future expansion to all state departments.
- **Activity 2:** Require Windmill (or similar) training provided by Disability Employment and Transitions Division (DETD) staff for all DPHHS management, contracted case managers, and Community Rehabilitation Program staff, and ensure Human Resources and hiring managers have training on accommodations and the process for requesting accommodations.
- **Activity 3:** Track hiring and retention of people with disabilities, gather feedback about the process, and make changes accordingly.
- **Activity 4:** Host at least one yearly interagency meeting focused on the value of disability employment.

Objective #2: Montana will become an Employment First state.

- **Activity 1:** Establish Employment First policy through legislation or executive order; review and amend policies to identify and change those that hinder Competitive Integrated Employment. *(Aligns with the 406 JOBS Year One Workplan).*
- **Activity 2:** Develop Memorandums of Understanding (MOUs) with industry representatives on the State Workforce Innovation Board and at least four partner agencies (e.g., Office of Public Instruction, Department of Labor and Industry) to foster collaboration around inclusive workforce practices and the advancement of employment opportunities for individuals with disabilities. Each

MOU will outline shared values, clearly defined roles, and a focus on strengthening systems.

Objective #3: Increase the number of disability-inclusive employers by engaging private businesses and supporting sustainable relationships.

- **Activity 1:** Educate private businesses on the value of disability employment. Conduct formal trainings with 12 private businesses yearly.
- **Activity 2:** Host an annual Value of Disability Employment showcase for a public audience.
- **Activity 3:** Identify 50 new businesses yearly that are committed to disability employment initiatives such as the annual Disability Employment Summit, Recovery Friendly Workplace training, Relay Friendly Workplace training, and Disability Mentoring Week. Provide ongoing support and technical assistance.

GOAL #6: IMPROVE BENEFITS EDUCATION AND TRANSITION-PLANNING SERVICES

At key transition points, people with disabilities, families, and support networks should have timely access to current and understandable information about available services, benefits, and planning supports. This access can help everyone make informed decisions about employment, education, and community participation.

Objective #1: Improve infrastructure to enable accessible, widespread information dissemination.

- **Activity 1:** Create an online, comprehensive, centralized benefits portal, including frequently asked questions, resources, benefit planning fee structure, and benefits education/trainings.
- **Activity 2:** Establish person-centered benefit planning services within each 1915c waiver, including the consideration of funding for three more qualified benefit analysis coordinators.
- **Activity 3:** Create a strengthened transition system to provide consistent information, education, resources, and an updated list of providers for people with disabilities at all stages of life (below). Require existing disability-serving governmental councils within DPHHS to review, update, and disseminate transition information. Examples of transitions include: early intervention to

school age, primary school to junior high to high school, high school to out-of-school and/or post-secondary education, pediatric to adult health care, discharge planning from institutional or congregate settings to community settings, transition to retirement age for caregivers, transition to retirement age for people with disabilities, and discharge planning from community settings to long-term care.

Objective 2: Expand benefits education and transition planning.

- **Activity 1:** Partner with Aging and Disability Resource Centers and Centers for Independent Living for expanded benefits education and Independent Living Skills instruction, jointly hosting five trainings/year.
- **Activity 2:** Expand membership of the Montana Secondary Transition Partnership (MTSTP) to include active participation from the Behavioral Health and Developmental Disabilities Division. MTSTP will ensure school personnel have access to best practices and information/resources that support successful transitions to adulthood for youth with disabilities, including information on alternatives to guardianship and competitive, integrated employment opportunities.
- **Activity 3:** Create and provide access to trainings on comprehensive public assistance benefits planning and financial education training on tools like special needs trusts, ABLE accounts, Plan to Achieve Self-Support (PASS) plans, and financial literacy programs. Trainings should be available for both staff and clients.

A note about funding: Initiation and/or completion of objectives and activities with an associated fiscal impact may be contingent upon legislative appropriation and executive branch approval.

INCORPORATION OF QUALITY ASSURANCE ACTIVITIES TO ENSURE COMPLIANCE

PURPOSE AND SCOPE

Montana's Olmstead Plan was developed pursuant to House Bill 922, which required DPHHS to develop a comprehensive plan to ensure that people with disabilities have

access to services in the most integrated setting appropriate to their needs, consistent with the Olmstead Decision and Title II of the ADA.

The planning process included analysis of Medicaid claims and administrative data, review of institutional and community-based service utilization, examination of waiver and waitlist trends, and extensive stakeholder engagement across the state, including focus groups, interviews, public comment, and consultation with disability-serving organizations and state partners. The resulting Olmstead Plan includes:

- A data-driven narrative describing current services, gaps, and system trends
- A structured set of goals, objectives, and activities designed to improve access to community-based services and reduce unnecessary institutionalization

This Quality Assurance and Monitoring (QA) Plan accompanies those documents and establishes a structured framework for overseeing implementation.

The purpose of this QA Plan is to:

- Track progress toward the goals, objectives, and activities identified in the Montana Olmstead Plan
- Document ongoing efforts toward compliance with Olmstead principles
- Promote internal accountability and coordinated management within DPHHS
- Identify implementation barriers and support timely course correction
- Provide structured reporting to leadership and advisory bodies

This QA Plan focuses primarily on implementation monitoring and systems oversight. It will draw on existing administrative data, structured implementation updates from responsible divisions, and advisory board feedback. The approach is designed to be feasible, presuming the hiring of a dedicated Olmstead coordinator, and sustainable over time.

While most monitoring will occur through biannual implementation reporting, a limited number of system-level indicators drawn from the baseline data presented in the Olmstead Plan narrative will be reassessed at longer intervals (e.g., five years) to examine broader systems change.

Together, the Olmstead Plan narrative, the goals/objectives/activities framework, and this QA Plan provide a coordinated structure for advancing integration, choice, and community living for people with disabilities in Montana.

QUALITY ASSURANCE FRAMEWORK

Implementation monitoring under this Plan is grounded in the legal obligations established by the Olmstead Decision, Title II of the ADA, and the federal HCBS Settings Rule. These authorities require states to provide services to individuals with disabilities in the most integrated setting appropriate to their needs and to ensure meaningful access, informed choice, and community participation. This quality assurance framework applies specifically to implementation monitoring under the Olmstead Plan.

Within that context, the quality assurance framework described in this section defines how implementation progress will be documented, monitored, and interpreted. The framework establishes the standards that will guide biannual reporting and oversight activities.

1. CONTINUOUS IMPROVEMENT AND ADAPTIVE IMPLEMENTATION

Monitoring activities are designed to support learning and course correction. Biannual reports will document progress, identify barriers or delays, and describe adjustments made in response to implementation challenges. When objectives or activities are modified or stalled, reporting will include contributing factors and planned next steps. The purpose of monitoring is to strengthen implementation over time and support sustained progress towards the goals in Montana's 2026 Olmstead Plan.

2. STRUCTURED DOCUMENTATION AND TRANSPARENCY

The QA process emphasizes clear, consistent documentation of implementation status, funding availability, interagency dependencies, and emerging constraints. Reporting will distinguish between completed, ongoing, modified, and stalled activities. This structured documentation supports internal management and demonstrates ongoing, good-faith compliance efforts.

3. INCLUSION OF LIVED EXPERIENCE IN OVERSIGHT

Implementation monitoring will incorporate input from people with disabilities, family members, and stakeholders through advisory board review and structured feedback mechanisms. Advisory board input will inform the identification of implementation gaps and areas requiring adjustment. The advisory function is consultative and intended to

strengthen alignment with community input and priorities. Advisory Board governance is described in more detail below.

4. FEASIBLE AND SUSTAINABLE MONITORING PROCESSES

The QA approach relies primarily on existing administrative data and structured implementation updates from responsible divisions. Monitoring processes are designed to be sustainable within available staffing and resource capacity and do not require extensive new data collection.

GOVERNANCE AND OVERSIGHT STRUCTURE

Implementation of the Montana Olmstead Plan will be overseen through a defined governance structure with clear roles, responsibilities, and lines of review for activity leads, interagency partners, and an established Advisory Board. This structure is intended to support coordinated implementation, structured monitoring, and transparency.

1. LEAD AGENCY: DPHHS

DPHHS serves as the lead agency responsible for implementing the current Montana Olmstead Plan and overseeing the quality assurance and monitoring process.

DPHHS responsibilities include:

- Designating and supporting the Olmstead coordinator
- Ensuring biannual implementation reporting across relevant divisions
- Reviewing progress toward established goals, objectives, and activities
- Documenting barriers, funding limitations, and implementation dependencies
- Facilitating collaboration with other state agencies where activities require cross-agency coordination

Where activities identified in the Olmstead Plan require participation from other state agencies, implementation is contingent upon 2027 legislative action and funding, as well as executive branch approval. Until additional legislative direction and/or appropriations are secured, DPHHS is only responsible for activities within its authority.

2. OLMSTEAD COORDINATOR

The Olmstead coordinator, housed centrally within DPHHS, will serve as the central point of coordination for implementation monitoring and reporting.

The coordinator's responsibilities in regard to the QA plan will include:

- Compiling biannual reports organized by goal
- Tracking implementation timelines and activity status
- Coordinating structured updates from responsible divisions
- Identifying cross-division issues, barriers, and dependencies
- Preparing annual summary materials for advisory review

The Olmstead coordinator will facilitate communication, information sharing, and collaborative efforts across divisions and agencies.

3. OLMSTEAD ADVISORY BOARD

The Olmstead Advisory Board will be appointed by the director of DPHHS. The Advisory Board will include individuals with lived experience of disability and other stakeholders. It will serve as the primary structured mechanism for incorporating stakeholder input into implementation oversight. It will operate under written bylaws or a charter approved by the director, outlining membership criteria, terms, meeting frequency, and procedures for issuing recommendations.

The Advisory Board will serve a transparency-based accountability function within the governance structure. Its role will include:

- Reviewing annual implementation summaries
- Providing formal recommendations regarding progress toward goals
- Identifying implementation gaps or emerging concerns
- Offering feedback to strengthen alignment with lived experience
- Advising on problem-solving and/or steps to advance activities and objectives

Advisory Board recommendations will be made publicly available.

DPHHS will provide a formal response to Advisory Board recommendations within 60 days. Agency responses will document any planned implementation adjustments or provide an explanation where recommendations cannot be adopted. Subsequent reporting cycles will reflect follow-up actions as appropriate.

The Advisory Board serves in an advisory capacity and does not exercise operational control over DPHHS or other state agencies.

4. INTERAGENCY PARTNERS

Certain objectives and activities within the Olmstead Plan identify collaboration with other state agencies or external partners, dependent on future legislative action. Interagency partners will contribute to implementation where activities fall within their authority. The Olmstead Coordinator will be tasked with developing formal mechanisms for collaboration between DPHHS and interagency partners.

STRUCTURE OF QUALITY ASSURANCE MONITORING

Quality assurance and monitoring will occur through three interconnected components: 1) implementation monitoring, 2) advisory review, and 3) system-level indicators. Together, these components establish how implementation progress is tracked, interpreted, and reviewed over time. The structure is designed to provide disciplined oversight while remaining feasible within existing administrative capacity. Implementation monitoring will provide structured tracking of activities. Advisory review provides interpretive oversight and transparency. System-level indicators will provide a long-term assessment of change in Montana's service system for people with disabilities. Each component operates on a defined schedule and serves a distinct purpose, summarized in Table 1 below.

1. IMPLEMENTATION MONITORING

The primary function of the QA process is to monitor the implementation of the specific objectives and activities identified in the 2026 Montana Olmstead Plan. Implementation monitoring will focus on whether planned actions occur within anticipated timeframes, whether they are supported by adequate resources, and whether structural barriers are affecting progress.

For each objective and activity, responsible divisions will provide a structured update that identifies the current status, funding conditions, work completed during the reporting period, and anticipated next steps. When activities are delayed, modified, or stalled, reports are expected to describe contributing factors, including legislative

constraints, funding limitations, staffing challenges, or interagency dependencies. The required reporting template is in Appendix D: Biannual Reporting Template.

Implementation monitoring is not intended to function as program evaluation. It does not assess service quality, individual outcomes, or causal impact. Rather, it provides a rigorous mechanism for tracking whether commitments articulated in the Olmstead Plan are being pursued and whether obstacles are clearly documented. The Olmstead coordinator is responsible for ensuring consistency and clarity in reporting across goals and divisions and for identifying recurring themes or structural challenges that may require attention.

2. ADVISORY REVIEW OF ALIGNMENT WITH OLMSTEAD INTENT

Advisory review provides a structured mechanism for transparency and accountability within the implementation-oversight framework. While implementation monitoring tracks the status of activities and objectives, advisory review focuses on interpreting annual progress in relation to the stated goals of the 2026 Montana Olmstead Plan.

Each year, the Olmstead Advisory Board will review the two biannual reports as the basis for its annual recommendations. To support efficient discussion, the Olmstead coordinator will also provide a brief annual synthesis (e.g., 2-4 pages or 15-minute presentation) highlighting cross-cutting progress, recurring challenges, and items that would benefit from Advisory Board guidance. This synthesis is intended to support discussion and does not replace the biannual reports. The Advisory Board will not evaluate individual program data or conduct independent investigations. Instead, it will assess whether reported activities reflect meaningful progress toward increased community integration and expanded access to community-based services.

In conducting this review, the Advisory Board will use a structured rubric to guide discussion and recommendations. The structured rubric is provided in Appendix E: Advisory Board Review Rubric. The rubric directs the Advisory Board to assess:

- Completeness of required reporting
- Substantive movement toward stated goals and objectives
- Identification of barriers and implementation conditions
- Alignment of reported activities with the intent of the Olmstead Decision, including advancement of services in the most integrated setting appropriate and expansion of informed choice

- Cross-cutting themes such as transparency, responsiveness to stakeholder input, and system coordination

In addition to identifying implementation gaps or emerging concerns, the rubric supports the Advisory Board in making recommendations regarding priority focus areas for upcoming implementation cycles. The rubric is intended to promote structured, goal-aligned review and thoughtful written recommendations.

Prior to documenting final written recommendations, the Advisory Board will convene a meeting with the Olmstead coordinator (and other relevant implementation staff, as appropriate) to ask clarifying questions, discuss points of concern, and confirm shared understanding of reported progress, constraints, and next steps. Advisory Board findings will be documented in written recommendations. DPHHS will provide a written response to these recommendations, documenting any planned implementation adjustments or explaining constraints that affect feasibility. Follow-up actions will be reflected in subsequent reporting cycles, creating a visible feedback loop between advisory review and agency implementation.

3. SYSTEM-LEVEL INDICATORS

In addition to implementation monitoring and advisory review, this QA Plan includes a defined set of long-term system-level indicators intended to assess broader structural trends in Montana's disability service system over time. These indicators are drawn directly from baseline data presented in the 2026 Montana Olmstead Plan narrative and are intended to evaluate whether the overall system is moving toward greater community integration and reduced reliance on segregated and institutional settings.

The following indicators will be reassessed at the end of the current plan cycle (i.e., 2029), using the most recent available administrative data:

- Institutional Census
    - Number of individuals receiving services in institutional settings, including state-operated facilities and nursing facilities.
- Residential Setting Distribution for Waiver Participants
    - Distribution of waiver members across community-based residential settings and congregate or group settings.
- Waiver Waitlist Size

    - Number of individuals on waitlists for relevant Medicaid waiver programs.

- Long-Term Services and Supports (LTSS) Expenditures
    - Proportion of Medicaid LTSS expenditures allocated to home- and community-based services relative to institutional care.
- Competitive Integrated Employment Participation
    - Number or proportion of individuals participating in competitive integrated employment relative to sheltered or congregate employment settings.

These indicators are selected because they reflect core structural dimensions of Olmstead compliance: access to community-based services, reduction in institutional reliance, and meaningful participation in community life.

System-level indicators will not be used to evaluate individual divisions, assign performance ratings, or attribute outcomes to specific activities within the Plan. Instead, they provide a high-level directional assessment of system change over time. Where trends do not reflect anticipated improvement in integration, DPHHS and other interagency partners may use this information to inform future planning, policy development, and legislative strategy.

Reassessment will occur at the conclusion of the plan cycle, or earlier if substantial policy changes or legislative actions warrant interim review. This approach preserves the ability to examine structural change without imposing additional data-collection and annual-reporting burdens.

TABLE 1. COMPONENTS OF QUALITY ASSURANCE PLAN: IMPLEMENTATION MONITORING, ADVISORY BOARD REVIEW, AND SYSTEM-LEVEL INDICATORS

Component	Purpose	Primary Mechanism	Frequency	Lead
Implementation Monitoring	Track status of goals, objectives, and activities, and document barriers or constraints	Structured reporting by responsible divisions	Biannual	DPHHS and interagency partners; compiled by Olmstead Coordinator
Advisory Review of Alignment with Olmstead Intent	Review annual implementation summary; identify implementation gaps; provide written recommendations and priority guidance	Review of implementation report; written recommendations	Annual	Olmstead Advisory Board; DPHHS provides written response
System-Level Indicators	Examine trends in institutionalization, community integration, and service access	Reassessment of selected baseline indicators	End of Plan Cycle (e.g., 2029)	DPHHS, using available administrative data

DATA SOURCES AND DOCUMENTATION

Quality assurance activities under this plan rely on existing administrative information, structured implementation reporting, and advisory review. The QA process does not require new primary data collection beyond what is necessary to document progress toward Plan activities.

DIVISION-LEVEL DOCUMENTATION

DPHHS and other interagency partners are accountable for providing accurate and complete information in their biannual implementation reports. Divisions should use existing administrative and program data, internal tracking systems, policy

documentation, and operational records to support reported activity status and narrative descriptions. Examples of documentation that may inform reporting include:

- Program enrollment or participation counts
- Internal implementation tracking documents
- Legislative or rulemaking updates
- Meeting records or implementation timelines
- Funding allocations or budget status

Divisions are responsible for ensuring the accuracy and integrity of submitted information. The Olmstead coordinator compiles and synthesizes these submissions.

ADMINISTRATIVE DATA FOR SYSTEM-LEVEL INDICATORS

Reassessment of long-term system-level indicators will rely on existing statewide administrative data sources, including Medicaid claims and enrollment data, institutional census records, waiver participation data, waitlist records, and expenditure reports.

This data will be used to assess directional system trends and will be drawn from the most recent available validated sources at the time of reassessment.

POLICY AND LEGISLATIVE DOCUMENTATION

Implementation progress under the Olmstead Plan may be influenced by statutory authority, rulemaking, budget allocations, or formal interagency agreements. Where relevant, divisions should reference applicable legislative actions, administrative rules, executive directives, or formal policy changes that enable, constrain, or modify plan activities. Documentation of these conditions will provide context for implementation status and support transparent reporting of dependencies beyond division-level control. Such documentation will be used to clarify structural barriers or enabling factors, not to conduct a legal review.

USE AND LIMITATIONS OF DATA

Information collected through this QA process is used for implementation oversight, transparency, and strategic planning. It is not used to conduct formal program evaluation, assign compliance ratings, or evaluate individual staff performance.

Where data limitations exist, divisions should acknowledge those limitations in reporting. Transparency regarding constraints and data gaps is considered a component of responsible implementation monitoring.

REVIEW CYCLES AND DELIVERABLES

Quality assurance activities under this plan occur on a defined cycle that aligns biannual implementation monitoring with annual advisory review. This sequencing is intended to support internal management and transparent advisory oversight, while remaining feasible within existing administrative capacity.

Timeframe	What Happens	Key Output(s)
Months 1–6	Implement Montana Olmstead Plan activities (Implementation Period #1).	Implementation work completed (no QA reporting deliverable due in this period).
Months 7–8	Complete **Biannual Report #1** documenting activities completed in Months 1–6; Olmstead coordinator compiles submissions and implementation partners use the compiled packet to review progress on priority activities and identify barriers/course corrections.	Biannual Report #1 (Appendix D); Internal action planning to assess progress and priorities.
Months 7–12	Continue implementation (Implementation Period #2), incorporating any adjustments identified during the biannual review.	Implementation work completed (no reporting deliverable due in this period).
Months 13–14	Complete **Biannual Report #2** documenting activities completed in Months 9–12 and prepare the **brief annual synthesis.**	Biannual Report #2 (Appendix D) Brief Annual Synthesis
Month 14	Share compiled reporting packet with the Advisory Board for annual review. Optional clarification meeting with Olmstead Coordinator (and relevant implementation staff) before final recommendations.	Compiled reporting packet for Advisory Board: • Biannual Report #1 • Biannual Report #2 • Brief Annual Synthesis Advisory Board meets to review progress and draft recommendations.

No later than the last day of Month 15	Advisory Board submits final written recommendations to the Olmstead Coordinator.	Final written recommendations submitted to Olmstead coordinator.

QA PLAN REVIEW AND UPDATES

This QA Plan is intended to function as a living administrative document that may be refined as implementation progresses and conditions evolve. To ensure continued relevance and feasibility, the QA Plan will be reviewed annually.

The annual review will consider whether modifications to the QA Plan are warranted based on:

- Changes in implementation context or organizational structure
- Availability of new or improved administrative data sources
- Legislative, regulatory, or policy developments affecting Olmstead Plan activities
- Feedback from the Olmstead Advisory Board regarding oversight processes

Where updates are identified, revisions will be documented and incorporated into subsequent QA plan versions. Minor administrative updates (e.g., role clarifications, template refinements, schedule adjustments) may be made as needed to maintain operational clarity.

Substantive changes affecting governance structure, reporting expectations, or oversight components will be reviewed by DPHHS leadership prior to adoption.

ABBREVIATIONS USED IN THIS DOCUMENT

ABLE: Achieving a Better Life Experience

ACS: American Community Survey

ADA: Americans with Disabilities Act

ASL: American Sign Language

BHSFG: Behavioral Health Systems for Future Generations

BSW: Big Sky Waiver

CART: Communication Access Realtime Translation

CFCS/PCS: Community First Choice Services/Personal Care Services

CMS: Centers for Medicare and Medicaid Services

DD: Developmental Disabilities

DDP: Developmental Disabilities Program

DETD: Disability Employment and Transitions Division

DPHHS: Department of Public Health and Human Services

DSP: Direct Support Professional

HCBS: Home and Community-Based Services

HHS: U.S. Department of Health and Human Services

IDD: Intellectual and Developmental Disabilities

IT: Information Technology

LTSS: Long-Term Services and Supports

MFP: Money Follows the Person

MTSTP: Montana Secondary Transition Partnership

MOU: Memorandum of Understanding

NTI: Near-term Initiatives

OMB: Office of Management and Budget

PASS: Plan to Achieve Self-Support

PCA: Personal Care Attendant

QA: Quality Assurance

RHTP: Rural Health Transformation Program

SDMI: Severe and Disabling Mental Illness

SILC: Statewide Independent Living Council

SLTC: Senior and Long-Term Care Division

ACKNOWLEDGEMENTS

The development of Montana's Olmstead Plan would not have been possible without the contributions of many. The SILC played an important role in supporting the update of the Montana Olmstead Plan, including early efforts related to House Bill 922 and active participation throughout the development process. The staff at DPHHS provided extensive expertise, operational input, and cross-divisional coordination in support of this work, recognizing the importance of this plan for all Montanans. The SLTC Division has housed the contract and been essential to this process by creating buy-in, building collaborative partnerships, and determining overall direction for this plan.

The contributions of people with disabilities, their families and caregivers, disability advocates, and disability service providers shaped all the content of this plan with intention, thoughtfulness, and a focus on solutions that will work across all parts of Montana.

This physical report was developed through the hard work and dedication of a multi-disciplinary team at the Rural Institute for Inclusive Communities, including people with disabilities, family members of people with disabilities, direct service staff, researchers, and evaluators. Their collective work ensured that this plan was representative of the wide swath of data collected and could be accessed by individuals most impacted by Olmstead priorities.

Going forward, the continued involvement and commitment of these groups and individuals, as well as those who will join us over time, will be essential to helping Montana uphold the work first led by Lois Curtis and Elaine Wilson, to ensure all people with disabilities can remain in the communities of their choice.

APPENDIX A: THE OLMSTEAD DECISION IN ACCESSIBLE LANGUAGE

This flyer was presented at the Olmstead kick-off meeting in April of 2024 to provide background information on the Olmstead Decision and the intention to develop an Olmstead Plan in Montana. It was created using accessible language and was widely disseminated during the plan development process.

The Olmstead Decision and What it Means in Montana

APPENDIX B: OLMSTEAD FOCUS GROUP FINDINGS

This document was created to share the information collected and analyzed during the first round of focus group engagement. It was shared with the focus group participants and used to inform provider focus groups and the state employee goal-building workshop. The challenges, solutions, and recommendations for change are intended to accurately reflect participant feedback and do not necessarily represent the views or commitments of DPHHS.

Olmstead Focus Group Findings

APPENDIX C: OLMSTEAD GOALS, OBJECTIVES, AND ACTIVITIES IN ACCESSIBLE LANGUAGE

CROSS-GOAL OBJECTIVES

The Olmstead Plan needs staff who work together as a team. It also needs people with disabilities to be involved and share their experiences. People with disabilities and staff in state departments will need to work together. These cross-goal objectives will help everyone learn more about the Olmstead Plan. Cross-goal objectives are important for reaching the other six Olmstead goals.

Objective 1: Hire a full-time Olmstead coordinator to assist the advisory group. This coordinator will monitor the plan to make sure the state is meeting goals. They will also manage all the activities listed in this plan.

Objective 2: Start an Olmstead advisory group (a group of people with knowledge or experience related to Olmstead). This advisory group will check that the plan is working and on time.

Objective 3: Work with groups and organizations that support people with disabilities. Together, create a public service campaign about disability awareness. A public service campaign means using ads, billboards, and commercials to educate the public about a topic.

Objective 4: Every year, host a summit (group meeting) focused on working together to find solutions to help Montanans with disabilities. Groups that should be invited include:

- People with disabilities and their families
- DPHHS waiver and state plan staff
- Vocational Rehabilitation
- Centers for Independent Living
- SILC
- Disability service providers
- Department of Commerce
- MDT

GOAL #1: SUPPORT THE RIGHTS AND CHOICES OF PEOPLE WITH DISABILITIES TO MAKE THEIR OWN DECISIONS.

The Olmstead Decision is about people with disabilities making their own choices about where they live and what supports they receive. It is also about helping people live in a community, rather than in an institution. There needs to be more options for community-based services so people with disabilities can live independently.

Objectives (smaller steps taken to get to the bigger goal)

Objective 1: Collect information about strategies that make it easier to find support in a person's own community, so we can keep people out of institutions whenever possible.

Activities (How to make this objective happen)

- **Activity 1:** Waivers are how people receive services in their homes and communities. Waivers use Medicaid money to help keep people out of institutions. Each specific Home and Community-Based Waiver (called 1915(c) waivers) should include a plan that helps people stay in their community and avoid living in an institution.
- **Activity 2:** Collect information about the reasons why people end up in institutions. Use this information to improve the next Olmstead Plan.
- **Activity 3:** Build a system that can respond more quickly to complaints and requests for help.
- **Activity 4:** Make sure all state programs are using the same definitions of service, employment, and living settings. Track how many people are living in institutions, living independently, or living in group homes, and how many people have regular jobs that pay at least minimum wage.

Objective 2: Make it easier for people with disabilities to have real choices and make decisions.

- **Activity 1:** Create a plan to make sure all members of a person's team are trained in person-centered planning and understand how to present choices about where to live and work. Listen to what the person says and include their personal goals in their plan.
- **Activity 2:** Provide more education for people with disabilities or guardians about how to make their own choices and live safely and independently.

- **Activity 3:** Make sure more people know about opening and using an ABLE account. Look at ways to change the rules about where money in a person's ABLE account goes when that person dies.

GOAL #2: GIVE PEOPLE WITH DISABILITIES MORE CHOICES IN HOUSING AND TRANSPORTATION. HELP GROUPS WORK TOGETHER TO IMPROVE HOUSING AND TRANSPORTATION PROGRAMS.

Reaching this goal will require money from Montana's legislature in 2027. DPHHS will work with other state departments to build a plan to help improve transportation and housing for Montanans with disabilities.

Objective 1: DPHHS and state agencies should cooperate more. All the state systems should work together to provide services for people with disabilities.

- **Activity 1:** Schedule two meetings every year between DPHHS and the Department of Commerce. Use the meetings to talk about how housing for people with disabilities can be improved.
    - Start with a conversation about what the Olmstead Plan is, so everyone can understand. Then develop goals and trainings on disability.
    - Look at current housing policies first to make sure they fit the Olmstead Plan.
- **Activity 2:** Schedule two meetings every year between DPHHS and the MDT. Use the meetings to talk about how transportation options for people with disabilities can be improved.
    - Start with a conversation about what the Olmstead Plan is, so everyone can understand. Then develop goals and trainings on disability.
    - More topics for meetings on transportation for people with disabilities could include:
        - Working with public transportation providers to extend their hours.
        - Trying out new rural transportation programs.

    - Improving on-demand transportation, so people can call for a ride when they need one.
    - Training for drivers on how to support people with disabilities.

- **Activity 3:** Create training for state workers and leaders on increasing accessibility for all people through universal design. Universal design is when buildings, websites, programs, and tools are made so **all people** can use them easily – people with and without disabilities.

Objective 2: Provide more accessible housing for people with disabilities and older adults.

- **Activity 1:** Have the transportation coordinator also work as the housing coordinator for the first year. Then hire a full-time housing coordinator.
- **Activity 2:** Work with other organizations that are already working on the housing problem to build more accessible homes. Talk about financial breaks for those who build accessible housing.
- **Activity 3:** Develop training on accessible housing for builders. Give that training to at least five rural housing providers every year.
- **Activity 4:** Work with the Department of Commerce and other housing organizations to teach people with disabilities how to buy a house. Include information on accessible housing and using ABLE accounts.
- **Activity 5:** Find funding to encourage builders to create fully accessible public bathrooms, playgrounds, entrances to buildings, etc.
- **Activity 6:** Look for ways for people with disabilities to live independently on family property. Promote loans or grants to pay for new buildings or home additions.

Objective 3: Create more ways for people with disabilities and people who are aging to get where they need to go.

- **Activity 1:** Change the duties of the Transportation & Housing Coordinator to better work with other people doing similar work.
- **Activity 2:** Meet with legislators before 2027 to talk about how to encourage accessible ride-sharing services to increase service in rural Montana.

- **Activity 3:** Make sure the work of local Transportation Advisory Councils is effective. Require the Transportation and Housing Coordinator to attend meetings and make them responsible for sharing information with others.
- **Activity 4:** Increase the number of transportation vouchers given by 10% each year.
- **Activity 5:** Work with people providing transportation to try a volunteer-driver or ride-share program in at least two rural communities.
- **Activity 6:** Collect information from Montanans to better understand why they don't use existing transportation options. Use that information to improve how the state explains those options to the public.
- **Activity 7:** Create a Disability Transportation Service Phone Line connected to the Transportation Coordinator that people can call for help.
- **Activity 8:** Share training opportunities with transportation workers on how to work with people with disabilities.

GOAL #3: MAKE IT EASIER FOR PEOPLE WITH DISABILITIES TO GET MEDICAL AND MENTAL HEALTH SERVICES IN THEIR COMMUNITIES. PROVIDE MORE CHOICES FOR HEALTH CARE.

The Olmstead Plan will work with other DPHHS programs to improve health care and mental health services for people with disabilities in their communities.

Objective 1: Help more medical providers better understand the needs of people with disabilities so they can keep providing high-quality care.

- **Activity 1:** Expand access to telehealth services. Telehealth services are when a person can see a doctor online instead of in person. Train providers on high-quality telehealth services.
    - Train 500 more health care workers in providing care to patients with intellectual and developmental disabilities (IDD) through online learning.
    - Increase the use of Station MD by five providers each year. (Station MD allows direct online contact with a doctor already trained in helping patients with disabilities and behavioral needs).

- **Activity 2:** Reach out to those working on the 406 JOBS project to talk about how to better recruit and keep more direct support professionals (DSPs), including creating a clear path for training and qualifications
- **Activity 3:** Expand the Montana State Loan Repayment Program to include more people who provide direct care work.
- **Activity 4:** Keep everyone informed when things change and provide information and training on those changes.

Objective 2: Offer health care services in more places so people with disabilities can get quality care, whether they live in a rural area or in a city.

- **Activity 1:** Work together with at least one large provider to set up places on reservations and in rural areas where people can see specialists without having to travel to a city center.
- **Activity 2:** Increase telehealth and local specialty care.
- **Activity 3:** Explore how the state can help support the use of assistive technology and home renovations. Make it easier for people to live independently with fewer direct support workers.
- **Activity 4:** Find money to contract with case managers and health care workers who know their community resources well and can guide people to them.
- **Activity 5:** Hold monthly meetings between Montana's DD Program and SDMI Waiver staff. Work together to improve services for people who have both developmental disabilities and mental health conditions.
- **Activity 6:** Make sure people on a waitlist know what services they can still get while they wait.

Objective 3: Support caregivers and direct care workers.

- **Activity 1:** Improve how we share information about respite services with caregivers. Respite is when caregivers get a break from providing care. Make sure people know who can use respite, so caregivers can get help. This would include people caring for:
    - Children

- Older people
- People with memory loss
- People with intellectual and developmental disabilities

GOAL #4: MAKE INFORMATION AND RESOURCES ACCESSIBLE. MAKE SURE PEOPLE HAVE THE INFORMATION AND RESOURCES THEY NEED.

People need information they can understand. Not just people with disabilities, but all people. If someone needs services, they need to know where to find them. Information about services should be accessible and easy to read.

Objective 1: Government departments should work together. They should be able to easily share information, so staff across all programs know which services are available. They should focus on clear communication to help people find the services they need.

- **Activity 1:** Talk about projects at the Olmstead Summit each year. Look for ways for departments to work together and promote each other's programs.
- **Activity 2:** Make a library for all the plans for all the departments serving people with disabilities. Look for ways for departments to work together on common goals and share what is going on.
- **Activity 3:** Have staff use plain or accessible language when communicating with the public so people understand. Make sure all departments and case managers understand and use plain language also.

Objective 2: People should be able to find and understand information about public services and programs. This information should be clear and accessible.

- **Activity 1:** Consider hiring a "knowledge translator" in the communications office. This person will make sure information is easy to understand.
- **Activity 2:** Look at all the information on public services and make sure it is accessible or plain language. This should include items that are printed out and things that are online only.

- **Activity 3:** Promote different programs or resources each month. Have DPPHS workers attend and share at one conference in Montana each month.
- **Activity 4:** Let people tell you when they cannot understand or access information. Have a way for people to tell you when something is out of date or wrong.

Objective 3: People need information they can understand and use. More staff should be able to write and share accessible materials for everyone.

- **Activity 1:** Hire an expert to make sure information on services is clear and accessible, including information on websites. This expert should create rules so this continues to happen across all departments, all the time.
- **Activity 2:** Make sure people in charge of websites have regular accessibility training.
- **Activity 3:** Train new staff on what people may need to access information. Train them in plain language, digital accessibility, and other supports that help people read and understand.
- **Activity 4:** Make all meetings accessible and show people how to make their meetings accessible. Include evaluations after meetings. This way, people can say what worked for them or suggest ways to make it easier to participate in meetings.

GOAL #5: PAY PEOPLE WITH DISABILITIES THE SAME WAGE AS OTHER EMPLOYEES. EMPLOYEES WITH DISABILITIES SHOULD WORK IN THE SAME ENVIRONMENT AS EMPLOYEES WITHOUT DISABILITIES.

People with disabilities should have jobs that they want to do, where they are treated as equal employees. Having a satisfying and rewarding job is important for living independently. Montana should work to provide more job opportunities for all people.

Objective 1: DPHHS will work on hiring more people with disabilities. They can show other departments and businesses how they did it. DPHHS will be a model employer for people with disabilities.

- **Activity 1:** Develop a guide on employing people with disabilities in state government. Use the guide to educate employers on hiring people with disabilities. Start with DPHHS and expand across state departments.
- **Activity 2:** Make sure managers and other staff have training on tools that can help a person do their job. Make sure managers know how to respond if someone asks for accommodation. Accommodations are changes or tools that help you do your job the best you can.
- **Activity 3:** Keep track of how many people with disabilities are hired by the state and how long they stay at their jobs. Let them give feedback on what changes would make it easier to do their jobs and get promotions.
- **Activity 4:** Have one meeting each year about hiring people with disabilities. Invite all departments to talk about why disability employment is beneficial. This meeting should include real-world facts and success stories from employers about why hiring people with disabilities is good business.

Objective 2: Montana will support employment with equal wages for people with disabilities. This is called being an Employment First state.

- **Activity 1:** Make an Employment First policy for Montana. This will make sure people with disabilities are paid the same as other employees, receive benefits, and work in the same place with people without disabilities.
- **Activity 2:** Partner with the State Workforce Innovation Board and at least four other agencies that are committed to hiring people with disabilities and making them feel welcome. Have all the agencies sign a document that explains what they will do together and how.

Objective 3: Get more businesses to hire people with disabilities.

- **Activity 1:** Educate businesses on why hiring people with disabilities helps their business. Train 12 businesses each year.
- **Activity 2:** Host an event each year on why employing people with disabilities is important and a good thing for businesses.
- **Activity 3:** Identify and support 50 new businesses each year to help promote disability employment.

GOAL #6: HELP PEOPLE LEARN WHAT BENEFITS AND TRANSITION SERVICES THEY CAN RECEIVE.

When people with disabilities go through big life changes, they should be able to get information about the help and services available. This helps them make choices about jobs, school, and being part of their community.

Objective 1: Make it easier for people to find information. Improve the communications system and make sure the information is easy to read and understand.

- **Activity 1:** Create an online resource with all the information on benefits and supports for when life changes. Put information where people can see and use it.
- **Activity 2:** Set up help for people receiving the 1915(c) waivers in planning their benefits. Work on hiring three more workers to help manage the workload.
- **Activity 3:** Improve supports for people going through times of transition. Make sure people can find the information and care they need. Require that all groups that serve people with disabilities provide information on transition. Examples of transitions include:
    - From preschool to school age
    - Primary school to junior high
    - Junior high to high schools
    - High school to out of school or college
    - Child to adult health care
    - Moving from an institution to a community setting
    - Caregivers retiring
    - People with disabilities who are retiring
    - Moving from a community setting to long-term care

Objective 2: Give people more education on available benefits and transition. Help them learn about money and plan for changes in life.

- **Activity 1:** Work with other groups to provide education on benefits. Partner with organizations that serve people with disabilities and older adults. Host 5 trainings every year.
- **Activity 2:** Expand the groups working with people with disabilities transitioning to adulthood. Make sure the groups have the best information and resources, and that school teams are also receiving this information. Teach people with disabilities about the transition to adulthood.
- **Activity 3:** Train people with disabilities on financial education. Make sure people know about:
    - Benefits planning
    - Special needs trusts
    - ABLE accounts
    - Programs to teach people how to manage, use, and save their money

Whether some activities can be completed depends on available funding and approval from state government leaders.

APPENDIX D: BIANNUAL REPORTING EXAMPLE

This report is an example of what should be completed biannually for each Goal of the 2026 Montana Olmstead Plan, as well as for the “Cross-Goal Objectives.”

SECTION 1. REPORTING INFORMATION

Reporting Period:

Goal Number and Title:

Responsible Division(s):

Primary Contact:

Name

Title

Email

Date Submitted:

SECTION 2. GOAL-LEVEL SUMMARY (REQUIRED)

Provide a brief (3–5 sentence) summary of overall progress toward this Goal during the reporting period. Highlight major accomplishments, significant implementation barriers, funding constraints, or structural conditions affecting progress.

SECTION 3. OBJECTIVE-LEVEL REPORTING

Complete the following for *each* Objective under this Goal.

GOAL X, OBJECTIVE X. [TITLE]

Objective Status (select one):

☐ On Track ☐ Delayed ☐ Not Yet Started

☐ In Progress ☐ Modified ☐ Complete

Legislative Action Required:

☐ Yes ☐ No

If yes, briefly describe the relevant legislative action needed:

Funding Status (select one):

☐ N/A - No Funding Needed ☐ Partially Funded ☐ Funding Pending Legislative Action

☐ Fully Funded ☐ Unfunded

Interagency Coordination Required:

☐ Yes ☐ No

If yes, identify relevant agency partners and describe coordination status:

NARRATIVE PROGRESS UPDATE (REQUIRED)

Describe implementation activities in progress or completed during this reporting period. Include tangible outputs where applicable (e.g., training delivered, program launched, guidance issued). Provide a list of any activities not started or delayed in this reporting period.

BARRIERS OR CONSTRAINTS (REQUIRED IF OBJECTIVE IS DELAYED OR MODIFIED)

Identify fiscal, legislative, staffing, policy, or coordination constraints affecting progress.

NEXT STEPS (REQUIRED)

Describe anticipated actions for the next reporting period.

(Repeat this section for each Objective.)

SECTION 4. CROSS-OBJECTIVE OBSERVATIONS (OPTIONAL)

Identify recurring barriers, funding constraints, staffing limitations, or structural conditions affecting multiple objectives under this Goal.

SECTION 5. SUPPORTING DOCUMENTATION (OPTIONAL)

List or attach relevant supporting materials (e.g., policy documents, legislative updates, implementation timelines, guidance memos).

APPENDIX E: ADVISORY BOARD REVIEW RUBRIC

This rubric helps the Olmstead Advisory Board review the annual progress summary for the Montana Olmstead Plan. It is meant to make reviews clear, consistent, and focused on the plan's goals.

The rubric helps the Advisory Board:

- Review updates for each goal and objective
- Write recommendations about progress
- Spot gaps, delays, or new concerns
- Check whether the work reflects what people with disabilities and families need
- Suggest what should be a priority in the next cycle

This rubric is not a scoring tool. It does not give grades, ratings, or enforcement decisions. It is a guide for a thoughtful review.

PART I: GOAL-BY-GOAL REVIEW

For each goal and its objectives, use the questions below.

A. CLEAR AND COMPLETE REPORTING

- Is the status of each objective easy to understand?
- Is there enough detail to know what happened during this time?
- Is it clear whether the work is funded, partly funded, or not funded?
- If work changed or stopped, is the reason explained?

B. PROGRESS TOWARD THE GOAL

- Do the activities move the goal forward in a real way?
- Does the report describe action (like a policy change, program start, or service expansion), not just planning?
- If progress is limited, does the report explain why?
- Do the same barriers show up across more than one objective?

- Is there evidence that partners tried to solve problems or adjust plans?

C. FIT WITH OLMSTEAD PRINCIPLES

Note: The Montana Olmstead Plan is meant to improve access to community-based services and reduce unnecessary institutionalization. Some activities may support this directly. Others may build the systems (such as staffing, training, or data improvements) that enable the work to happen.

Use these questions to look at the overall fit:

- Does this work help people get services in the most integrated setting that fits their needs?
- Does this work increase choice and control for people with disabilities in Montana?

D. PRIORITY QUESTIONS

- Based on current progress and barriers, should any objectives move up in priority?
- Do any objectives need to change because of laws, funding, staffing, or other limits?
- Are there new issues that need attention sooner rather than later?

PART II. CROSS-CUTTING REVIEW THEMES

After reviewing each goal, step back and look at the full picture.

A. CONNECTION TO LIVED EXPERIENCE

- Does the report show meaningful involvement of people with disabilities and families?
- Are any groups missing or underrepresented in the work?

B. COORDINATION ACROSS AGENCIES (WHEN RELEVANT)

- When work involves more than one agency, is it clear who is doing what?
- Are limits (like legal authority or legislative needs) explained in a clear and honest way?

PART III. ADVISORY OUTPUTS

At the end of the review, the Advisory Board will complete an Advisory Board Review and include:

- Where there is strong progress or strong alignment
- Gaps, delays, or concerns
- Objectives or activities that need attention
- Barriers that may need leadership or legislative action
- Recommendations, including:
    - What action should happen (or what priority should change)
    - Which division/agency should lead (when appropriate)
    - When it should happen (soon, next cycle, next legislative session)
- Questions for follow-up
- Clarifying questions to be answered in the next reporting cycle

ADVISORY BOARD REVIEW EXAMPLE

Review period covered:

Date(s) reviewed / meeting date:

Completed by:

PART 1. GOAL-BY-GOAL REVIEW

Complete this section for each Goal in the Montana Olmstead Plan.

Goal #: Goal title:

A. Progress and strengths (what moved forward?)
Notes:

B. Gaps, delays, or concerns (what did not move forward, and why?)
Notes:

C. Key barriers for this Goal (what got in the way?)
(Examples: funding, staffing, legal authority, coordination, data, other)
Notes:

D. Questions for follow-up (what do we need clarified?)
Notes:

E. Priority actions for the next cycle (what should happen next?)
Notes:

(Repeat this section for each Goal.)

PART 2. BIG-PICTURE SUMMARY

1. Overall progress (what is the story across all Goals?)

Notes:

2. Areas of strong progress (what stands out as working well?)

Notes:

3. Areas needing attention (what stands out as most concerning or stuck?)

Notes:

4. Cross-cutting barriers (issues that show up across multiple Goals)

Notes:

5. Lived experience and community priorities (how well does the work match what people need?)

Notes:

PART 3. RECOMMENDATIONS AND FOLLOW-UP

A. Recommendations

List clear recommendations for DPHHS and/or partners. Keep each one specific.

Recommendation (what should happen)	Who should lead (division/agency)	Suggested timing

B. Questions for follow-up

What should be addressed in the next reporting cycle or in a clarification meeting?

C. Final summary (2–4 sentences)

In plain language, summarize the Advisory Board's main message.

Notes: