

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Major Changes

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

1. Update language to clarify, remove outdated information, and correct grammar;
2. Update Performance Measures/Quality Assurance standards; and
3. Add a definition of 'Extraordinary Care'.

## Appendix A:

1. Update program title from Montana Big Sky to Big Sky Waiver (BSW) for consistency of existing documents and program references; and
2. Add Attachment #1: Supported Living and Community Supports transition plan.

## Appendix B:

1. Update Reserve Waiver Capacity to reflect At-Risk;
4. Update policy for selecting entrants to the waiver to reflect an admit visit deadline from 60 to 30 days and update wait list criteria to clearly define when an applicant may remain on the waitlist; and
5. Update Medicaid Eligibility Groups Served to include the Adult Medicaid Expansion and 217 groups and clarify Post-Eligibility Treatment of Income.

## Appendix C:

1. Remove PDN as Specially Trained Attendant and Establish Specially Trained Attendant as a separate service;
2. Remove BSW Community Supports service and transition members to existing stand alone BSW services;
3. Limit Personal Assistance Services and Non-Medical Transportation service utilization as authorized within the current Service plan;
4. Expand the scope and definition of the Personal Assistance Services.
5. Establish Money Management as a new service;
6. Revise the Prevocational service to remove the compensation requirement that members be paid at less than 50 percent of the minimum wage;
7. Revise Homemaker to include laundry and shopping tasks;
8. Update Consumer Goods and Services service title to Member Directed Goods and Services, revise definition, and update prior authorization limit;
9. Update Dietetic service title to Dietetic-Nutrition Services and revise provider qualifications;
10. Revise Environmental Accessibility Adaptions service definition;
11. Revise the Homemaker Chore service definition to remove costs associated with moving from one residence to another and expand the definition to include extermination services;
12. Revise Pain and Symptom Management service to require written documentation from the member's health care professional indicating the treatment will not harm the member;
13. Revise the Senior Companion service definition to ensure it is not duplicative of State Plan services and to limit the service to non-medical companionship services provided in the home;
14. Revise the Specialized Medical Equipment service definition.
15. Establish Service Animals as a separate service, directing limited supplies to specialized equipment and supplies.
16. Remove requirement to exhaust volunteer resources from Non-Medical Transportation service.
17. Revise Big Sky Bonanza Financial Management service definition.
18. Revise Big Sky Bonanza Independence Advisor service definition.
19. Development of the participant direction option of Employer with Budget Authority to replace Big Sky Bonanza option.
20. Remove Supported Living service and transition members to existing stand alone BSW services.
21. Completed C-5 HCB Settings
22. Revise Specialized Child Care for Children Who Are Medically Fragile removing the ability to pay Legally responsible individuals
23. Establish Nurse Supervision for Personal Care Assistance as a separate service.

## Appendix I Rates, Billing and Claims - Rate Determination

1. Update to services as a result of comprehensive rate review.
2. Update factor G to 07/01/2024 NH rate.

## Appendix J Rates

1. Updated rates to reflect rates effective 07/01/2024 and utilized a 1.5% trend rate in years 2 through 5.

## Appendix K flexibilities: As a continuation of a flexibility of the Appendix K unwinding:

-Telehealth may substitute face-to-face visits when there are extenuating circumstances. Agencies should reach out to their

Regional Program Officer when this occurs. Electronic method of service delivery (e.g., telephonic) may be provided remotely in the home setting for:

- Case Management
- Personal care services that only require verbal cuing.
- Monthly monitoring (i.e. in order to meet the reasonable indication of need for services requirement in 1915(c) waivers.
- Medication assistance for those members who can respond to verbal prompting.

The Department contracted with Guidehouse to conduct a comprehensive provider rate study of services delivered to these four populations to address legislative requirements issued in 2021 through HB 632 Section 20 Subsection 2B. Guidehouse' work also included a detailed cost reporting plan to support future rate updates for these services, as required by HB 155 Section 1. Guidehouse conducted a comprehensive cost and wage survey to gather data from providers across programs as the basis for the rate studies. Guidehouse also reviewed the State's Medicaid claims data, and other extensive state, regional, and national benchmark metrics, basing assumptions on industry data when provider-reported data was unavailable or insufficient for rate setting. The approach used to establish the Department's benchmark rates is an "independent rate build-up" methodology commonly applied by states for setting rates for similar populations. Many of the service rate benchmarks proposed follow a series of general assumptions for the components of each rate, adjusted according to the specific context and goals for providing each service. This rate build-up approach is based on a core set of wage assumptions for direct care staff, supplemented by estimates of the cost of other supporting staff, activities and materials needed to support direct care provision. Various components were calculated in the rate models including Staff Wages, Employment Related Expenditures (ERE), Productivity of Direct Care Staff, Occupancy and Absences, Supervision, Staffing Ratios, Staff Mileage, Administrative Expenses, Program Support Expenses and Self-Directed Service Adjustments. July 1, 2023 rate increases will be reflective of the Legislative approval of HB 649 and HB 2. In the Guidehouse study, community residential services follow a similar structure as the non-residential models (indicated above) with wages for direct care staff, supervision cost, administrative add-on, applicable program support and additional adjustments for extra staff and occupancy adjustments. The rate study Guidehouse conducted beginning in 2021 included the rebasing of rates and has been temporarily approved through an Appendix K (July 1, 2023 through November 11, 2023) and a formal waiver amendment with public notice submitted to CMS.

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

### 1. Request Information (1 of 3)

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

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

Big Sky Waiver (BSW)

**C. Type of Request:** renewal

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

3 years    5 years

**Original Base Waiver Number:** MT.0148

**Waiver Number:** MT.0148.R07.00

**Draft ID:** MT.010.07.00

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

Regular Waiver

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

07/01/24

**Approved Effective Date:** 07/01/24

### PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the

Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**1. Request Information (2 of 3)**

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

**Hospital**

Select applicable level of care

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

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

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

**Nursing Facility**

Select applicable level of care

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

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

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

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

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

**1. Request Information (3 of 3)**

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

The 1915(b) waiver was approved on July 1, 2011. The renewal was approved by CMS on November 6, 2017 with an effective date of January 1, 2018. The waiver limits the number of providers of case management.

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

**§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

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

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

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

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

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

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

**A program authorized under §1115 of the Act.**

*Specify the program:*

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

**2. Brief Waiver Description**

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

Big Sky Waiver (BSW) provides individuals with chronic disabilities of all ages a choice of long term care services that maximize their independence, provide quality care, and assure financial accountability. BSW is designed to provide an individual with physical disabilities or 65 years of age or older, a choice of receiving long term care services in a community setting as an alternative to an institutional setting. The individual must meet nursing home level of care. Extensive stakeholder involvement has been obtained to develop, refine, and maintain these services over the years. Stakeholders include current members of the BSW program, families, self-advocacy organizations, member advisory committees, representatives of Native American organizations, service providers and State staff. The BSW is statewide and includes Montana's seven Indian Reservations.

The waiver provides a vast array of traditional and self-directed services. Services are assessed and developed through the completion of a service plan. Each member works with their Case Management Team (CMT) or Big Sky Bonanza Independence Advisor to individually develop this plan and corresponding budget to successfully meet the identified needs. Representatives are permitted to serve on behalf of a member, if necessary. Legally responsible family members meeting specific criteria may be paid workers.

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

1. Conducting quality assurance reviews;
2. Including a robust Financial Accountability component to the quality assurance review;
3. Conducting satisfaction surveys with waiver participants; and
4. Providing training/education to all waiver providers;

The Community Services Bureau (CSB), of the Senior and Long Term Care Division (SLTC), Department of Public Health and Human Services, oversees the waiver. SLTC contracts with the Mountain Pacific Quality Health (MPQH), the Quality Improvement Organization (QIO), to conduct level of care assessments and disseminate information to members and potential service providers. Applicants receive level of care screenings to ensure they receive services from the most appropriate waiver. SLTC contracts with local CMTs that work in conjunction with members to develop a service plan that delineates the services and the cost of those services for each enrollee. BSW Regional Program Officers (RPOs) are available at the local level to assist providers and members with the delivery of services and offer training. CSB staff conduct quality assurance reviews to ensure that members are satisfied with the services they receive and that providers function within the rules governing the service providers. The Medicaid agency, as a whole, contracts with Conduent EDI Solutions, Inc. for Montana's Medicaid Management Information System. In those instances, in which members utilize a Big Sky Bonanza Financial Manager, the latter submits claims to Conduent for payment.

### 3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

**Yes. This waiver provides participant direction opportunities.** Appendix E is required.

**No. This waiver does not provide participant direction opportunities.** Appendix E is not required.

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

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

**H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.

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

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

#### 4. Waiver(s) Requested

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

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

**Not Applicable**

**No**

**Yes**

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

**No**

**Yes**

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

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

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

#### 5. Assurances

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

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

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

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

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

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*



- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

Public notice to inform interested parties of the pending waiver renewal was posted in three major Montana newspapers on August 19, 2022 and on the Department of Public Health and Human Services, Community Services for Seniors and People with Disabilities website on August 19, 2022. The notice contained information regarding the purpose of the renewal and proposed major changes/additions to the 1915c waiver. In addition, a clause to request a paper copy of the draft waiver was included within the notice. The public was invited to submit questions or comments through September 17, 2022 via phone or email to identified Department staff. Tribal notice of similar content was provided on August 19, 2022. A review of public comments is outlined within the B. Optional information section.

<https://dphhs.mt.gov/SLTC/csb/index>

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

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

## 7. Contact Person(s)

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

**Last Name:**

Brunett

**First Name:**

Denise

**Title:**

Community Services Bureau Chief

**Agency:**

Department of Public Health and Human Services

**Address:**

P.O. Box 4210

**Address 2:**

1100 North Last Chance Gulch

**City:**

Helena

**State:**

Montana

**Zip:**

59604

**Phone:**

(406) 444-4544

Ext:

TTY

**Fax:**

(406) 444-7743

**E-mail:**

Denise.Brunett2@mt.gov

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

**Last Name:**

Kulawik

**First Name:**

Mary Eve

Title:

Medicaid State Plan Amendment and Waiver Coordinator

Agency:

Department of Public Health and Human Services

Address:

P.O. Box 4210

Address 2:

111 N. Sanders

City:

Helena

State:

Montana

Zip:

59604

Phone:

(406) 444-2584

Ext:

TTY

Fax:

(406) 444-1970

E-mail:

mkulawik@mt.gov

## 8. Authorizing Signature

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

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

Signature:

Mary Eve Kulawik

State Medicaid Director or Designee

Submission Date:

Jun 14, 2024

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

Last Name:

Kulawik

First Name:

Mary Eve

Title:

Medicaid Analyst

Agency:

MT DPHHS

Address:

PO Box 4210

Address 2:

City:

Helena

State:

Montana

Zip:

59601

Phone:

(406) 444-2584

Ext:

TTY

Fax:

(406) 444-1970

E-mail:

**Attachments**

mkulawik@mt.gov

**Attachment #1: Transition Plan**

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

**Replacing an approved waiver with this waiver.**

**Combining waivers.**

**Splitting one waiver into two waivers.**

**Eliminating a service.**

**Adding or decreasing an individual cost limit pertaining to eligibility.**

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

**Reducing the unduplicated count of participants (Factor C).**

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

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

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

Specify the transition plan for the waiver:

In response to CMS' clarification of 42 CFR 441.3019(b)(4), BSW will implement the following transition plans. The plans will facilitate efforts to minimize potential adverse impacts on members receiving the Supported Living (SL) and Community Supports (CS) services. The Department will ensure waiver members can exercise choice of providers for each service and access the full range of waiver services.

The transition plan to remove the bundled service of SL due to its non-compliance with 42 CFR 441.301(b)(4) will not impact the MOE. Case Management teams (CMTs) will support members in a seamless transition from the SL services to identical services under the BSW program. The State attests that this transition will not create an MOE violation because the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021.

Member transition of SL service to BSW stand-alone services will reflect the following:

a. Independent Living (IL) Evaluation; see Mod 1 IAT; This service has never been utilized or billed through BSW. CMTs ensure members receive information and education about the IL Evaluation services available through Montana's Centers for IL network and service support to transition from BSW to community resources. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021.

b. Homemaking to BSW Homemaker; This service is identical to the BSW stand-alone service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

c. Habilitation Aids to BSW Personal Assistance Services: This service is identical to the BSW service and there is no reduction of the member's services due to this transition. The State attest that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

d. Behavioral Programming to BSW Consultative Clinical and Therapeutic Services: This service was a part of the SL bundle but has never been utilized or billed. Members in need of behavioral programming will be transitioned to Consultative Clinical and Therapeutic Services which provides access to clinical evaluations, development of supplemental home/community treatment plans which is incorporated into the individual's service plan; training and technical assistance to implement treatment; monitoring of treatment; and one-to-one consultation and support for paid and non-paid care givers. These services are provided by professionals in the psychiatric, psychology, neuro-psychology, and psychiatry fields, among others. CMTs will continue to ensure members receive information and education about Behavioral Programming services available through Mental Health Centers, Substance Abuse Treatment Providers, and National Alliance on Mental Illness resources, as well as service support to transition from BSW to community resources. The State attests that the transition of this service to BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

e. Non-Medical Transportation to BSW Non-Medical Transportation: This service is identical to the BSW service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

f. Specially Trained Attendants to BSW Specially Trained Attendants: This service is identical to the BSW service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

g. Day Habilitation to BSW Day Habilitation: This service is identical to the BSW stand-alone service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

h. Residential Habilitation to BSW Residential Habilitation: This service is identical to the BSW service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

i. Prevocational Training to BSW Prevocational Training; This service is identical to the BSW service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

j. Supported Employment to BSW Supported Employment: This BSB service is identical to the BSW service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

k. 24-hour availability of staff for supervision and safety to Residential Habilitation and/or Personal Assistance Services. This service is identical to the BSW services and there is no reduction of the member's services due to this transition. The State attest

that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

The transition plan to remove the bundled service of Community Support (CS) as CMS requires due to its non-compliance with 42 CFR 441.301(b)(4) will not impact the MOE. CMTs will support members in a seamless transition from the participant directed CS service to identical existing participant directed services under the BSW. The State attests that this transition will not create an MOE violation because the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021.

a. CS Personal Assistance Services to BSW Personal Assistance Services (PAS). This service is identical to the BSW PAS service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

b. CS Personal Assistance to BSW Personal Assistance. This service is identical to the BSW Personal Assistance service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

c. CS/Homemaking service to BSW Homemaker service; This service is identical to the BSW and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

d. CS/Non-Medical Transportation service to BSW Non-Medical Transportation service: This service is identical to the BSW service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

e. CS/Respite service to BSW Respite service: This service is identical to the BSW service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

f. CS/Specialized Childcare for Medically Fragile Children to Specialized Child Care for Medically Fragile Children. This service is identical to the BSW service and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

g. CS/Physical/Occupational Therapy Services to BSW Physical/Occupational Therapy Services. These services are identical to the BSW services and there is no reduction of the member's services due to this transition. The State attests that the transition of this service to existing BSW services will not create a MOE violation since the change will not restrict or reduce eligibility, rates or covered benefits that are not fully implemented as of April 1, 2021;

CM ensures the health and welfare of persons who receive services through the approved waiver, as indicated in the CM service definition.

The transition plan has been updated to reflect a time frame of 7/1/24 through 6/30/25, instead of the original January 1 through June 30 of 2023. This is intended to coincide with the approval of the waiver extension through June 30, 2024.

CMT will ensure that members will be transitioned to BSW identical services without interruption to service deliver to meet the member's needs as reflected on the member service plans.

#### Actions:

- April 1, 2023 – June 30, 2024

Identify members currently receiving Supported Living (SL) and Community Support (CS) services;

Evaluate members' service plans; and

Provide member referrals to community resources and State Plan services.

- July 1, 2024 – June 30, 2025

Evaluate and finalize member transition from SL and CS services to existing BSW stand-alone services.

Provide member referrals to community resources and State Plan services as needed.

Evaluate and finalize member transition from SL and CS services to existing BSW services.

CMT will notify all members who are receiving SL and CS services of the transition from bundled services to stand-alone BSW services beginning July 1, 2024. CMT will utilize person centered planning processes to smoothly transition members.

Transitions are expected to begin July 1, 2024

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

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

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

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

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

### **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

## Public Comment

BSW1 Other Stakeholder BSW Proposed Annual Cost

Comment: Please provide an explanation of the determination of the Big Sky Waiver proposed annual cost of \$43,000,000 when the past two years (at least) exceeded \$50,000,000. What reductions in costs are anticipated to reduce the proposed amount?

Response: There are two separate issues to address. The \$43M is not directly tied to the waiver budget. This amount is calculated by estimating slots based on average costs of the last fully completed fiscal year. This number does not include any direct care wages or health care for health care workers or the credit for cash option payments.

Second, the waiver did exceed \$50M in FY 22 and will in FY 23. Demand remains high for in home services. The turnaround budget increase through the budget amendment process. The table below illustrates the status of the budget for FY 2023.

Big Sky Waiver

FY 22 FY 23

Turnaround Budget \$48,142,310 \$45,429,165

Amended Budget \$52,165,337\* \$57,277,808

August 2022 Projection \$56,158,161 \$57,049,082

\*Budget Change Document in process.

BSW2 Other Stakeholder Appendix B: Participant Access and Eligibility

Comment: Appendix B-3, Page 30: I recommend the ability for children to be eligible for waiver of deeming from their parents be removed and the Department instead implement the state plan option known as the Katie Beckett State Plan Option found at Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), (P.L. 97-248). This will eliminate the misuse of Medicaid funds where waiver services are fabricated for the disabled child for the purpose of obtaining full access to Medicaid benefits for the child regardless of the parents' income and resources. The majority of children receiving Big Sky Waiver services fall in this category. Implementation of the Katie Beckett State Plan Option can be capped at a certain income and resource limit to end this abuse by closing the loophole currently being used.

Response: The Department notes the stated concerns regarding children on the Big Sky Waiver.

BSW3 Provider Appendix B: Participant Access and Eligibility

Comment: Appendix B, B-6: the minimum number of waiver services that an individual must require in order to be determined to need waiver services is (2) (page 41). In lieu of the possible expansion of CFC services in the near future, where members might have their traditional waiver services provided through expanded services under the state plan CFC program instead of the Waiver, but still be in need of case management services, we recommend that the minimum number of waiver services that an individual must require in order to be determined to need waiver services remain at 1. Case management services, which can help members to coordinate their services, link them to other programs, help ensure their health and safety, help in addressing problems with respect to services and providers, respond to crises, and help in gaining access to not only BSW services but also to state plan, medical, social, and other services regardless of the funding source, are critical for many individuals with significant disabilities. The loss of such a service could be the determining factor as to whether some members can remain living in the community or be placed on the brink of being, or actually be institutionalized.

Response: Thank you for your comment. The Case Management service, as defined by the waiver application, assists members in gaining access to BSW services, State Plan services as well as needed medical, social and other services regardless of funding source.

BSW4 Provider Appendix B: Participant Access and Eligibility

Comment: Also, NCILS recommends that DPHHS outlines through policy manuals and directives that Medicaid members seeking to become HCBS Big Sky waiver eligible need one core service rather than two core services to become HCBS big sky waiver eligible. In the process of eligibility determination, HCBS BSW applicants will naturally outline their critical need for services if the MPQH interview and eligibility reviews are done well and are comprehensive. (Pg41)

Response: Thank you for your comment. The Case Management service, as defined by the waiver application, assists members in gaining access to BSW services, State Plan services as well as needed medical, social and other services regardless of funding source.

BSW5 Provider Appendix B: Participant Access and Eligibility

Comment: Our agency opposes the change to the BSW Application that requires two BSW services for BSW eligibility. We recommend continuing as stated in the 2018 Big Sky Waiver Application to require only one service (case management) for waiver eligibility due to the current labor market impact on both availability of PAS/CFC services as well as impacts on skilled



nursing and assisted living facility placement.

It would be appropriate then to add an additional requirement to establish need of monthly case management intervention through documented in person/virtual connection with members receiving case management as a single service. The service plan documentation would (a) show documented monthly case manager evaluation of the member's needs for intermittent (less often than monthly) services and (b) show evidence of reevaluation of the need for continuing case management services.

This intervention would not be a requirement for members receiving a second monthly service, for example nutrition.

Response: Thank you for your comment. The Case Management service, as defined by the waiver application, assists members in gaining access to BSW services, State Plan services as well as needed medical, social and other services regardless of funding source.

BSW Member Appendix B: Participant Access and Eligibility

Comment: As someone who has gone without an STA for over a year, the idea that I could lose my services because I am reduced to case management services at the moment (currently exploring other opportunities) is terrifying! I have always utilized these services and used them to maximize my life. This new mandate would not only affect me, but any other participants who have gone without their caregivers due to the caregiver shortage. While I think that case management should not be a member's ONLY service, the inability to obtain STA services is currently out of members' hands and should not be reflected in the new policy changes at this time.

Response: Thank you for your comment. The Case Management service, as a core element defined by the waiver application, , assists members in gaining access to BSW services, State Plan services as well as needed medical, social and other services regardless of funding source.

BSW6 Provider Appendix B: Participant Access and Eligibility

Comment: NCILS also hopes that the State of Montana will strengthen its Olmstead planning and HCBS institutional transition policies, practices, procedures and funding opportunities. NCILS hopes that DPHHS will adopt both MAR 37-1008 and MAR37-990 which will authorize changes to both the medically needy program and community settings. But the State must adopt the 2016 HCBS Community Settings rule

Response: Thank you for your comment. The following DPHHS website provides information for Montana's work to comply with the HCBS Settings Rule. <https://dphhs.mt.gov/hcbs>.

BSW7 Provider

Comment: NCILS understands that HCBS waivers are based on some universal foundations and principles. The Big Sky Waiver and all HCBS waivers provide essential services for Montanans with disabilities to stay active and independent in our communities. Many of these services are optional under CMS operational protocols. Many Montana Medicaid members use a myriad of services to maximize independence and NCILS believes that HCBS waiver services should be mandatory just as nursing home services are in the United States.

Response: Thank you for your comment. This is a Centers for Medicare & Medicaid Services (CMS) decision.

BSW8 Provider Appendix C: Case Management service

Comment: This agency recommends that the language in the application regarding the Case Management Team qualifications be consistent with the BSW policy 802 allowing for the Social Work Case manager have a bachelor's degree in social work or a related behavioral science degree.

Response: The waiver application provides for exception opportunities regarding Case Management Team qualifications.

BSW9 Other Stakeholder (Provider?) Appendix C: Health and Wellness

Comment: I am contacting you about removing the Hippotherapy Service line item. The justification being:

HIPPOTHERAPY (HPOT): The term hippotherapy refers to how occupational therapy, physical therapy and speech-language pathology professionals use evidence-based practice and clinical reasoning in the purposeful manipulation of equine movement as a therapy tool to engage sensory, neuromotor and cognitive systems to promote functional outcomes. Best practice dictates that occupational therapy, physical therapy and speech-language pathology professionals integrate hippotherapy into the patient's plan of care, along with other therapy tools and/or strategies.<sup>12</sup> Hippotherapy exists within a medical model of treatment, in which the equine movement is a treatment tool applied by the therapist.

IDENTIFICATION OF HIPPOOTHERAPY IN REIMBURSEMENT: The American Medical Association CPT Coding Manual (Current Procedural Terminology, 2018) guides the medical billing process. All tools/strategies, such as Hippotherapy, that are used by therapists are part of their clinical protocols and fall under the designation of Therapeutic Procedures within the HCPCS

Level I CPT coding system. 13 Elements of equine interaction, equine movement, or the equine environment can be considered treatment tools and/or treatment strategies and may be utilized within an overall treatment plan. Tools/strategies do not have their own CPT billing codes.

**TREATMENT TOOL** - An object or element that can be manipulated to achieve specific goals. It is important to note that the horse themselves is not a tool but their movement or the interaction can be a tool when skillfully provided by a therapist.

Hippotherapy is best described as a treatment tool..

**TREATMENT STRATEGY** - A plan of action or technique, selected by a therapist based on specific principles. Strategies and/or treatment techniques may be learned in professional education programs or may be sought out by the healthcare professional as continuing education or by mentorship as advanced practice. Hippotherapy is best articulated as a treatment tool, not a strategy.

**THERAPEUTIC PROCEDURE** - A manner of effecting change through the application of clinical skills and/or services by a physician or other qualified healthcare professional (i.e. licensed therapist).<sup>14</sup> Therapeutic procedures are used to diagnose, treat, or restore function and include physical rehabilitation procedures. Such procedures are billed for using existing Current Procedural Terminology (CPT) codes such as Therapeutic Exercise (97110), Therapeutic Activities (97530), or Treatment of speech, language, voice, communication and/or auditory processing disorder (92507). The Therapeutic Procedure a therapist provides typically consists of the application of many possible techniques, approaches, tools or strategies. Hippotherapy is NOT a therapeutic procedure. **MODALITY** - Any physical agent applied to produce therapeutic changes to biologic tissue: includes but not limited to thermal, acoustic, light, mechanical or electric energy.<sup>14</sup> Hippotherapy does NOT meet the definition of a modality and should not be referred to as such.

It appears that maybe the original intent in including Hippotherapy in the waiver was actually to include Therapeutic Riding. Facilities have realized that the term Therapeutic Riding is misleading and confusing so are now using the term Adaptive Riding instead. **ADAPTIVE RIDING (AR)**: Horseback riding lessons for individuals with special needs. Taught by experienced instructors who have received specialized training and are often certified to work with students with disabilities. These instructors adapt their teaching style, the environment and/or equipment to facilitate acquisition of riding skills and participation in an enjoyable activity. Opportunities are available to participate in competitive equestrian events, recreation and leisure, education, socialization, and/or fitness. Certification in teaching riding lessons for individuals with special needs may be obtained through organizations such as PATH Intl., Certified Horsemanship Association (CHA), the Canadian Therapeutic Riding Association (CANTRA) or Riding for the Disabled (RDA). 'Adaptive Riding' is synonymous with 'Therapeutic Riding'. AHA, Inc. recommends use of the term 'Adaptive Riding' to replace 'Therapeutic Riding' because it is more accurate and is consistent with other activities and sports for individuals with disabilities. 'Therapeutic Riding' is often confused with 'Therapy', whereas 'Adaptive Riding' is easier to distinguish.

The term Hippotherapy may have also been included in the waiver initially as an attempt to include other "therapeutic" services that included horses, such as life coaching, and/or other type of personal development and education. In this case, an umbrella term that is often used to cover these services that are "therapeutic" but not necessarily "therapy" are Equine-Assisted Education.

Incorporating horses in a therapy service that has a CPS code does not need to be included in the waiver program as a Licensed therapist (Physical, Occupational, Speech Language, LPC, LSW, LMFT, etc.) is able to provide the therapy service and bill the appropriate CPS code.

Response: Thank you for your comment. New service categories are to be evidence-based and vetted.

BSW10 Other Stakeholder Appendix C: Personal Care Service

Comment: Appendix C-1/C-3, Page 58: I recommend Personal Assistance services be eliminated as originally was included in the application proposal (with the expansion of the Community First Choice program). This service is available through the Community First Choice program; therefore, is a duplication of services. A second option is to only allow this service when the beneficiary is not eligible for the Community First Choice program. I recommend a 'soft' limit in this service where Department staff must prior authorize any services beyond the limit. A soft limit will allow oversight and reduce fraud, waste and abuse. Any use of a Legally Responsible Person or Legal Guardian should only be allowed in certain circumstances, such as no other caregiver availability.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW11 Provider Appendix C: Personal Care Services

Comment: Personal assistance services (page 59): Language under nurse supervision section is taken from old policy manual, not newer policy worked on by waiver review team. Suggest using updated policy language (BSW 722) agreed upon by waiver review team.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW12 Other Stakeholder Appendix C: Homemaker

Comment: Appendix C-1/C-3, Page 64: I recommend Homemaker services be eliminated as originally was included in the application proposal (with the expansion of Community First Choice program). This service is available through the Community First Choice program; therefore, is a duplication of services. Removal of this service will eliminate fraud, waste and abuse of Medicaid funds. Any use of a Legally Responsible Person or Legal Guardian should only be allowed in certain circumstances, such as no other caregiver availability.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW13 Provider Appendix C: Homemaker

Comment: Homemaker (page 65): Current administrative rules for homemaking include "household management services consisting of assistance with those activities necessary for maintaining and operating a home and may include assisting the recipient in finding and relocating into other housing..." If assistance with moving to an alternate community-based location is not allowed under the service by CMS, suggest adding an alternate service that could assist a member with such a move, unless the boxing, unpacking, and organizing household items would cover packing up an existing household and unpacking into a new household. If those items are covered, suggest an alternative Waiver service that could assist a member with the moving costs associated with moving from one community-based location to another community-based location in order for that member to avoid institutionalization because they cannot afford to move to an alternate community-based location.

Due to an option checked on Montana's approved BSW waiver, homemaker services in the past have not been allowed to be self-directed. This was also discussed during the waiver review team meetings and there was a consensus that individuals under either the agency-based or self-directed programs would have the homemaker service available to them. However, it does not appear that a change was made in this waiver application that would allow the homemaker service to be provided through a self-direct agency. We suggest amending the BSW waiver application to indicate that homemaker services may be provided through an agency-based or self-direct agency to ensure that both agency-based and self-direct members have access to this service.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW14 Appendix C: Homemaker Service

Comment: NCILS believes that homemaker and respite services must have the option of being self directed by consumers that need those services. Self direction in both CFC and BSW have been both a needed and foundational service option and in policy since 1995. NCILS strongly recommends that a self direction option and opportunity be allowed for Homemaker/ Respite services in our BSW waiver. ( Pg 65,71)

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW15 Provider Appendix C: Prevocational Services

Comment: Prevocational services (page 69): We fully support removing the requirement that when compensated, members are paid at less than 50% of the minimum wage.

Response: Thank you for your comment.

Waiver renewal change: The BSW application renewal will be updated to remove the existing compensation requirement that members be paid at less than 50 percent of the minimum wage with the intent of reflecting current federal and state wage laws.

BSW Provider Appendix C: Prevocational Services

Comment: NCILS strongly supports the language outlined in the section on pre-vocational services which removes the requirement that when compensated members are paid at less than 50% of the minimum wage. We hope that this change in BSW policy will help advance statewide conversations on pre- vocational services needs which can be offered by BSW and all of our waiver v systems when searching, obtaining, and keeping a job and competitive integrated employment in Montana.

(pg.69)

Response: Thank you for your comment.

Waiver renewal change; The BSW application renewal will be updated to remove the existing compensation requirement that members be paid at less than 50 percent of the minimum wage with the intent of reflecting current federal and state wage laws..

BSW16 Other Stakeholder Appendix C: Respite

Comment: Appendix C-1/C-3, Page 70: I recommend eliminating the ability of a legally responsible person or legal guardian to provide Respite services. By allowing a legally responsible person or legal guardian, such as a parent, to provide this service contradicts the reason for the service. I also recommend limited use of relatives allowed to provide this service for the same reason.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW17 Provider Appendix C: Respite

Comment: Respite (page 71): As with the homemaker service, respite has not been allowed to be provided through self-direct. This also was discussed during the waiver review team meetings and the consensus was that individuals under self-direct programs should also have access to the respite service and that the service be able to be self-directed. However, it does not appear that a change was made in this waiver application that would allow the respite service to be provided through a self-direct agency. We suggest amending the BSW waiver application to indicate that respite services may be provided through an agency-based or self-direct agency to ensure that both agency-based and self-direct members have access to the service.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW17 Provider Appendix C: Respite

Comment: NCILS believes that homemaker and respite services must have the option of being self directed by consumers that need those services. Self direction in both CFC and BSW have been both a needed and foundational service option and in policy since 1995.NCILS strongly recommends that a self direction option and opportunity be allowed for Homemaker/ Respite services in our BSW waiver. ( Pg 65,71)

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW18 Other Stakeholder Appendix C: Specially Trained Attendant Service

Comment: Appendix C-1/C-3, Page 77: Regarding ADLs and IADLs, I recommend a 'soft' limit in this service where Department staff must prior authorize any services beyond the limit. A soft limit will allow oversight and reduce fraud, waste and abuse. I recommend much tighter constraints and limits of Life Coach services. If the service is to gain a skill it should be temporary. This service should also contain 'soft' limits to avoid fraud, waste and abuse. Any use of a Legally Responsible Person or Legal Guardian should only be allowed in certain circumstances, such as no other caregiver availability.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW19 Provider Appendix C: Specially Trained Attendant Service

Comment: Specially trained attendants (page 78): uses language from old policy instead of new, agreed upon language from waiver review team policy; only references PAS and omits references to CFC in (1). Fails to switch out language of STA qualifications with language in waiver review team policy. We suggest utilizing language from waiver review team policy.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW21 Provider Appendix C: Consultative Clinical and Therapeutic Service

Comment: Other health (consultative clinical) and therapeutic services (page 110): Does not include updated language from waiver review team policy (BSW 707). We suggest utilizing language from the waiver review team policy

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW22 Provider Appendix C: Dietetic-Nutritionist Service

Comment: Dietetic-nutritionist services (page 112): Does not contain language from waiver review team policy (BSW 710). We suggest utilizing language from the waiver review team policy

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW 23 Provider Appendix C: Environmental Accessibility Adaptions

Comment: Environmental accessibility adaptations (page 114): partial usage of waiver review team policy but goes into far greater detail. Unclear language: "such adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the member." Waiver review team policy states "adaptations may include the installation of specialized electrical and plumbing systems to accommodate the medical equipment and supplies needed for the welfare of the member." We suggest using the language from the waiver review team policy, which is more precise and understandable.

Additionally, the waiver review team policy agreed-upon language raises the prior authorization threshold from \$5000 to \$25,000, however, this waiver renewal application maintains the prior authorization threshold of \$5000 (BSW 711). We suggest utilizing the suggested prior authorization of \$25,000, which we believe is consistent with prior authorization limits for procurement and other areas in the Department.

Response: Thank you for your comment. The wording "such adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the member." is taken verbatim from CMS' waiver technical guide with the exception of a change from participant to member.

Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW24 Provider Appendix C: Environmental Accessibility Adaptions

Comment On environmental accessibility adaptations BSW waiver policy NCILS recommends, as this is one of our biggest requests, from our Medicaid members for temporary admission for a BSW waiver slot that all home modifications be discussed and considered which will enhance the members safety and independence needs in a home. NCILS staff strongly agrees with the language that states "adaptations may include installation of specialized electrical and plumbing systems to accommodate the medical equipment and supplies needed for the welfare of the member". NCILS also asks that the RPO prior authorization amount for this service be raised to \$25 000.

NCILS also recommends that DPHHS and SLTC staff consider that many Medicaid and BSW potential members live in modular homes or trailers. The standard rule is that home modifications are considered if a trailer is on a permanent foundation. NCILS hope that DPHHS will also outline home modifications policies for those who need home modifications that are not on a permanent foundation or are on a partial foundation. NCILS hopes that this can be one of our Medicaid innovation policies in future because not all Medicaid members can afford newly constructed universally designed homes. ( Pg 114)

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW25 Provider Appendix C: Family Training and Support

Comment: Family training and support (page 116/117): waiver review team updates title of service to training and counseling for unpaid caregivers, waiver application does not. Fails to include language from updated policy by waiver review team (BSW 712). We suggest using the updated language from the waiver review team policy.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with

minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW26 Other Stakeholder Appendix C: Non-Medical Transportation Service

Comment: Appendix C-1/C-3, Page 137: I recommend a 'soft' limit in this service where Department staff must prior authorize any services beyond the limit. A soft limit will allow oversight and reduce fraud, waste and abuse. Any use of a Legally Responsible Person or Legal Guardian should only be allowed in certain circumstances, such as no other caregiver availability.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW27 Provider Appendix C: Non-Medical Transportation Service

Comment: Non-medical transportation (138): We suggest eliminating "volunteer" from list of transportation options that must be exhausted or determined inappropriate. Just as members cannot be told/forced to go look for third-party grants, they should not be forced to seek out volunteers to provide a service that has a real cost. Individuals providing the service deserve to be paid for doing so.

Response: Thank you for your comment.

Waiver renewal change: The Department welcomes the suggestion that "volunteers" be eliminated from Appendix C: Non-Medical Transportation Service section of the waiver renewal. The BSW application renewal will be updated to reflect the elimination of the references to volunteers.

BSW28 Provider Appendix C: Non-Medical Transportation Service

Comment: On non medical transportation, NCILS supports eliminating the language of finding a volunteer to provide service as members should not be searching for a volunteer driver without compensation. NCILS understands that many public transportation systems can have volunteer drivers but it should not be incumbent upon consumers and/or members to utilize volunteers' drivers without compensation for services rendered.

NCILS recommends that for those that do not have access to public transportation systems in both small urban communities and rural areas of Montana that both medical and non medical transportation can be compensated and part of a member's service package as a standalone service when determining eligibility for BSW, HCBS, Passport to Health, as well as Medicaid services. (Pg .138)

Response: Thank you for your comment.

Waiver renewal change: The BSW application renewal will be updated to eliminate reference to 'volunteer' in the Non-Medical Transportation service. The Department welcomes the suggestion that "volunteers" be eliminated from Appendix C: Non-Medical Transportation Service section of the waiver renewal. The BSW application renewal will be updated to reflect the elimination of the reference to "volunteers".

BSW29 Member Appendix C: Non-Medical Transportation Service

Comment: Limiting transportation services to medical appointments is going to significantly affect the services and quality of care members receive. As someone who is not able to drive and does not live near public transportation. I rely on my caregivers to get to and from places. Implementing this policy change would mean having to find another route to getting places. When I do have an STA again, we would only be able to go to and from doctors appointments without prior authorization. I would not have access to run to the grocery store (which would affect our meal planning and cooking goals) as well as other errands I need to remain independent.

Response: Thank you for your comment. The waiver application renewal indicates "Medical transportation is available under the State Plan Medicaid program."

BSW30 Provider Appendix C: Pain and Symptom Management Ser

Comment: Pain and symptom management (page 145): Treatments included in waiver application language is missing pain mitigation, counseling/coaching, and nursing services by a nurse specializing in pain and symptom management. Also, this waiver application language states that all treatments require written documentation by a health care professional indicating that the treatment will not harm the member prior to initial authorization. However, the waiver review team policy language that was agreed upon by the work group states that only nontraditional treatments require written documentation by a health care professional indicating that the treatment will not harm the member. We suggest sticking with the language in the waiver review team policy and adhering to person-centered service delivery practices and member's being in charge and knowledgeable about

what will and won't work for them and not base this service on the old medical model that health care professionals know best. (BSW 721)

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW31 Provider Appendix C: Homemaker Chore

Comment: Homemaker chore (page 123): This section does not include language from waiver review team policy, does not include minor home repairs. New language missing is "when an individual requires one-time only unique or specialized services in order to maintain a healthy and safe environment or to improve or enable the continuance of community living, they may receive highly skilled chore services, which include but are not limited to moving, extensive cleaning, or extermination services."

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW32 Provider Appendix C: Post-Acute Rehabilitation Service

Comment: Post-acute rehabilitation (page 154): This section contains language that was stricken in the waiver review team policy. Waiver application language states "the goal of this program is to facilitate integration into the community and in addition to reducing the level of disability of the member," whereas the waiver review team policy states "the goal of this program is to facilitate integration into the community and support the member's functional abilities" (BSW 725). We suggest using the updated language from the waiver review team policy that was agreed upon.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW33 Provider Appendix C: Senior Companion service

Comment: Senior companion services (page 159): This waiver application uses older language such as "senior companion services are directed at providing..." instead of the updated waiver review team policy language that states "senior companion services are intended to provide..." Waiver application also states that this service will not be provided simultaneously with other BSW services, however, the waiver review team policy only states that the service will not be provided simultaneously with respite or homemaking. We suggest using the updated language from the waiver review team policy that was agreed upon.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW34 Provider Appendix C: Money Management Service

Comment: Money management (page 135/136): We recommend adding to the description that this service also provides hands-on assistance for individuals to be able to manage their own funds. Agree with the language that a provider should never have full or partial ownership or direct access to a member's financial accounts. List language could also add in that a caregiver should never have full or partial ownership or direct access to a member's financial accounts.

While money management may not be able to be used for the cost of a payee service, members who require payee services receive a very limited income via Social Security and, therefore, we encourage the Department to explore adding an additional waiver service that could assist members to pay the cost of payee services.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW35 Other Stakeholder Appendix C: Vehicle Modification Service

Comment: Appendix C-1/C-3, Page 172: I recommend including the original language that a vehicle modification cannot be used to "partially purchase" a vehicle that has already been modified. CMS has provided guidance for the past two application renewals indicating that Medicaid cannot be used to purchase an already modified vehicle, but the service is only allowed to provide an actual current modification.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with

minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW36 Provider Appendix C: Vehicle Modification Service

Comment: On vehicle modification services authorized through BSW, NCILS supports removing the partial vehicle purchase language which will hopefully allow for the purchase of modifications that are already installed on vehicles. As DPHHS/ SLTC staff knows, the BSW waiver application does not contain any language specifically stating that modifications can already be installed in a vehicle or the method of how BSW will determine the value of such modifications. The Waiver application supports prior authorization of \$5000 for vehicle modifications, but NCILS recommends that prior authorization baselines and limits for vehicle modifications be substantially higher than \$5000. The BSW policy working groups when studying potential BSW policy and service changes recommended \$25,000 for prior authorization for this service. (Pg,172-173)

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW37 Provider Appendix C: Vehicle Modification Service

Comment: Vehicle modifications (page 172/173): This section does not follow waiver review team policy word for word but does eliminate “partial vehicle purchase” language, hopefully allowing for the purchase of modifications that may already be installed in a vehicle, such as a lowered floor/ramp. Will it be the practice of the department to follow the policy drafted and agreed upon by the waiver review team that the BSW waiver may provide assistance for vehicle modifications that may already be installed in a vehicle?

Also, the waiver review team policy suggested raising prior authorization level to \$25,000 for this service, however, this waiver application maintains a prior authorization amount at \$5000. We suggest utilizing the suggested prior authorization of \$25,000, which we believe is consistent with prior authorization limits for procurement and other areas in the Department.

Response: Thank you for your comment. Under the direction of new leadership, the BSW waiver renewal is proceeding with minimal changes. As part of DPHHS' ongoing effort to identify areas of improvement, waiver services, policies, rules, stakeholder feedback, and reimbursement rates will be reviewed to determine opportunities for future program enhancements.

BSW38 Other Stakeholder Appendix C: Residential Habilitation Service

Comment: Residential Habilitation (page 57): This section lists Personal Emergency Response Systems as an item that may not be received by residents residing in adult group homes, however, the draft waiver policy worked on by the waiver review team, and existing policy, states that a Personal Emergency Response System could be provided if a case management team feels that a member's circumstances warrants the authorization of one and specific reasons are documented prior to initiation. We suggest not flatly eliminating the availability of PERS to members in these settings as there may be certain cases, determined individually, where such a system could be needed.

Response: Thank you for your comment. The Department agrees with the commenter. The waiver renewal will be updated to reflect that the case management team will determine when circumstances warrant the authorization of a PERS system and will document specific reasons for the addition of the service prior to authorization.

## Appendix A: Waiver Administration and Operation

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

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

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

**The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)



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

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

Senior and Long Term Care Division

(Complete item A-2-a).

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

Specify the division/unit name:

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

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

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

(a) The Senior and Long Term Care Division (SLTC) is responsible for the design, implementation and monitoring of all activities associated with this waiver.

(b) There is no single document serving to outline the roles of all staff related to waiver operation. Multiple documents serve to outline the responsibilities of assigned staff regarding specific aspects of the waiver, including SLTC rules and policies relating directly to the operation of the waiver. SLTC maintains organizational charts, individual position descriptions and web based information serving to assist persons who need assistance in accessing information. The waiver application is the authoritative document serving to outline the person/positions responsible for ensuring all the requirements of the waiver are met (more detail regarding implementation detail is available in various SLTC and provider forms, policies, administrative directives, and rules).

(c) The Medicaid Director and his/her designee are ultimately responsible for ensuring the administration of the waiver. The Medicaid Director and his/her designee are not directly involved in the day to day operational decisions of the SLTC staff. The Big Sky Waiver Program Managers, CSB Bureau Chief and the SLTC Administrator provide the State Medicaid Director and/or his/her designee with information on the submittal of waiver renewals, or new waiver application to CMS.

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

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

**Appendix A: Waiver Administration and Operation**

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

**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Mountain Pacific Quality Health (Montana's QIO) conducts the initial level of care assessments and disseminates information on the waiver to potential enrollees.

The Department of Public Health and Human Services' fiscal intermediary contractor, Conduent EDI Solutions, Inc. (Conduent) adjudicates claims for waiver providers through the Medicaid Management Information System (MMIS). Conduent enrolls and verifies that providers meet licensure requirements to provide waiver services.

Big Sky Waiver Case Management Teams (CMTs) enroll individuals in the Big Sky Waiver, provide case management services and conduct annual level of care re-evaluations and when there are significant changes in the member's needs. However, anytime the CMT believes the member no longer meets Level of Care criteria, the CMT will consult with the CSB Regional Program Officer. Case management teams will work within the communities to identify potential providers of waiver services appropriate to meet the needs of enrollees in the waiver.

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

**Appendix A: Waiver Administration and Operation**

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

**Not applicable**

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

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

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

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

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

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## Appendix A: Waiver Administration and Operation

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

The Senior and Long Term Care Division (SLTC) is responsible for contract administration and for assessing the performance of Mountain Pacific Quality Health and the Big Sky Waiver Case Management Teams. Contracts for these entities spell out duties and performance requirements.

The MMIS Contract Manager in the Director's Office directly oversees the Conduent contract. Conduent provides a report on a monthly basis to the Department which reports on contract requirements. Status meetings are held monthly.

## Appendix A: Waiver Administration and Operation

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

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

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

**Appendix A: Waiver Administration and Operation**

**Quality Improvement: Administrative Authority of the Single State Medicaid Agency**

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

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

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

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

*Where possible, include numerator/denominator.*

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

**Performance Measure:**

**Number of complete LOC screens submitted to the case management team by Mountain Pacific quality health (MPQH) within five (5) business days from referral. The denominator is the number of LOC screens and the numerator is the number of screens recieved within 5 days.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:  <input type="text" value="Mountain Pacific Quality Health"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

Number of LOC screens completed before the 15th day of 12th month of member services. Numerator is the number of completed re-evaluations by the 15th of the month and the denominator is the number of re-evaluations due on the 15th of the month.

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

	Specify: <input style="width: 100%; height: 30px;" type="text"/>	
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**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input style="width: 100%; height: 30px;" type="text"/>
<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input style="width: 100%; height: 30px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>
	<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>	

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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



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

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

The BSW Program Manager oversees the statewide operation of the waiver. Bi-weekly staff meetings are the vehicle for continuous statewide oversight of the waiver contractors. Contractors are responsible to have adequate resources and training to meet contracted obligations. LOC recommendations are reviewed as part of the BSW quality assurance process. If referral information is not completed within a timely manner, services may be delayed. Training will be used to alleviate knowledge gaps, contractual adjustments may be necessary if resources are not available (i.e. qualified individuals)

**b. Methods for Remediation/Fixing Individual Problems**

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

MPQH and Conduent performance measures: If reports are not submitted as required, the contractor will be called upon that month for an explanation and if necessary, action items will be imposed. Any missing report must be submitted within 30 days of the date of discovery.

Case Management Team (CMT) performance measure: If a level of care re-evaluation has not been completed at all, the CMT must immediately schedule a meeting with the member to complete the assessment. In the event that the member no longer meets level of care, discharge will be initiated as outlined in the approved waiver. If the level of care was not completed within the required time frame, the CMT must submit an explanation to the Program Managers within 30 days of discovery. If, as a result of long term discovery, trends emerge, the Program Managers will demand more extensive pertinent remediation - such as mandated training or corrective action items to be completed within a specified time frame.

ii. **Remediation Data Aggregation**

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

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

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

**c. Timelines**

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

**No**

**Yes**

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

**Appendix B: Participant Access and Eligibility**

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<b>Aged or Disabled, or Both - General</b>					
		Aged	65		
		Disabled (Physical)	0	64	
		Disabled (Other)	0	0	
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
		Brain Injury	□	□	
		HIV/AIDS	□	□	
		Medically Fragile	□	□	
		Technology Dependent	□	□	
<b>Intellectual Disability or Developmental Disability, or Both</b>					
		Autism	□	□	
		Developmental Disability	□	□	
		Intellectual Disability	□	□	
<b>Mental Illness</b>					
		Mental Illness	□	□	
		Serious Emotional Disturbance	□	□	

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

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

**Not applicable. There is no maximum age limit**

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

*Specify:*

Individuals younger than 65 years who meet the waiver criteria remain on the waiver moving into the aged category when they reach 65 years of age.

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Specify the percentage:

**Other**

*Specify:*

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

**Other safeguard(s)**

Specify:

**Appendix B: Participant Access and Eligibility**

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2783
Year 2	2783
Year 3	2783
Year 4	2783
Year 5	2783

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

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

**The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

**Appendix B: Participant Access and Eligibility**

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

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

**Not applicable. The state does not reserve capacity.**

**The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Assisted Living At Risk Slots	
Money Follows the Person Demonstration Grant	

**Appendix B: Participant Access and Eligibility**

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

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

Assisted Living At Risk Slots

**Purpose** (*describe*):

Slots are reserved as a resource for residents of assisted living facilities (ALFs) who have depleted their financial resources, as a result of their stay in the ALF, and are at risk of nursing home placement (or eviction from the ALF) due to inability to pay their costs to remain in the facility. At Risk slots require prior authorization by Community Services Bureau staff.

**Describe how the amount of reserved capacity was determined:**

The Community Services Bureau (CSB) has built capacity to 28 slots over the past several years which has been adequate to meet needs statewide. In general, CSB maintains between one to three open slots to ensure applicants are not hindered from receiving services. At Risk slots require prior authorization by CSB staff.

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

Waiver Year	Capacity Reserved
Year 1	28
Year 2	28
Year 3	28
Year 4	28
Year 5	28

**Appendix B: Participant Access and Eligibility**

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

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

Money Follows the Person Demonstration Grant

**Purpose** (describe):

Create a sustainable system that supports community options as a first choice for individuals needing long term care services.

Goals include:

1. increase the use of home and community based services (HCBS);
2. strengthen ability of Medicaid programs to provide HCBS to people who transition out of institutions such as nursing homes;
3. develop community infrastructures that support and promote community placement; and,
4. use procedures to provide quality assurance and improvement of HCBS.

Between 2014 and 04/06/2022, Montana transitioned a total of 198 individuals using the Money Follows the Person Grant BSW continues to utilize the MFP grant and transition members that meet established MFP guidelines.

**Describe how the amount of reserved capacity was determined:**

Members must meet the following MFP criteria:

1. 60 consecutive days in a qualifying facility;
2. must be Medicaid eligible for at least one day prior to transition; and,
3. must qualify for HCBS waiver services.

Reserved capacity is based directly on the benchmarks established in the MFP grant for this population.

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

Waiver Year	Capacity Reserved
Year 1	11
Year 2	15
Year 3	18
Year 4	20
Year 5	21

## Appendix B: Participant Access and Eligibility

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

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

**The waiver is not subject to a phase-in or a phase-out schedule.**

**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

Select one:

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

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

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

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

Entry to the Big Sky Waiver is based on a need-based prioritization process. Case Managers offer slot openings as they become available to individuals determined to be most in need of and most likely to benefit from, waiver services.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

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

§1634 State

SSI Criteria State

209(b) State

**2. Miller Trust State.**

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

No

Yes

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

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

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

**SSI recipients**

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

**Optional state supplement recipients**

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

Select one:

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



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

Specify percentage:

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

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

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

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

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

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

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

*Specify:*

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

Disabled Adult Child (DAC) Citation: 42 U.S.C. 1383c(c), or, alternatively, section 1634(c) of the Social Security Act.

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

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

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

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

*Select one and complete Appendix B-5.*

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

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

*Check each that applies:*

**A special income level equal to:**

*Select one:*

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

*Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

*Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).*

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

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

**Use spousal post-eligibility rules under §1924 of the Act.**

*(Complete Item B-5-b (SSI State) and Item B-5-d)*

**Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

**Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a**

community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

**Appendix B: Participant Access and Eligibility**

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

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

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

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

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

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

Select one:

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

(select one):

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

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

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

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the state Plan**

Specify:

**The following dollar amount**

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

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

Specify:

**Other**

*Specify:*

---

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

---

**Not Applicable (see instructions)**

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

The Community Spouse Income Maintenance Allowance is the lesser of:

(Calculation 1)

a) The Maximum Spousal Standard\* minus the community spouse’s total gross monthly income; or

(Calculation 2)

A combination of:

a) The community spouse’s shelter expenses (principal residence) that exceed the Basic Shelter Allowance\*; plus

b) The Basic Needs Standard\*; less

c) The community spouse’s total gross income.

\*As established by the Montana Department of Public Health and Human Services’ Office of Public Assistance.

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

---

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

**Other**

Specify:

Family Maintenance Allowance:

The Basic Needs Standard\* minus the gross income of the dependent family member; the difference of that calculation is then divided by 3 and the remaining amount is the family allowance.

\*As established by the Montana Department of Public Health and Human Services' Office of Public Assistance.

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

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

Select one:

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

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

**The state establishes the following reasonable limits**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

**Appendix B: Participant Access and Eligibility**

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

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

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

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

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

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

*Select one:*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

*(select one):*

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

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

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

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the state Plan**

*Specify:*

**The following dollar amount**

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

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

*Specify:*

**Other**

*Specify:*

[Empty text box]

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

**Not Applicable**

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

*Specify:*

[Empty text box]

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

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

[Empty text box]

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

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

Family Maintenance Allowance:  
  
The Basic Needs Standard\* minus the gross income of the dependent family member; the difference of that calculation is then divided by 3 and the remaining amount is the family allowance.  
  
\*As established by the Montana Department of Public Health and Human Services' Office of Public Assistance.

**Other**

Specify:



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

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

Select one:

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

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

**The state establishes the following reasonable limits**

Specify:



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## Appendix B: Participant Access and Eligibility

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

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

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

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

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## Appendix B: Participant Access and Eligibility

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

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

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

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

**i. Allowance for the personal needs of the waiver participant**

(select one):

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**



**A percentage of the Federal poverty level**

Specify percentage:

**The following dollar amount:**

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

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

*Specify formula:*

The Community Spouse Income Maintenance Allowance is the lesser of:

(Calculation 1)

a. The Maximum Spousal Standard\* minus the community spouse’s total gross monthly income; or

(Calculation 2)

A combination of:

a. The community spouse’s shelter expenses (principal residence) that exceed the Basic Shelter Allowance\*; plus

b. The Basic Needs Standard\*; less

c. The community spouse’s total gross income

\*As established by the Montana Department of Public Health and Human Services’ Office of Public Assistance.

**Other**

*Specify:*

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

Select one:

**Allowance is the same**

**Allowance is different.**

*Explanation of difference:*

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

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

Select one:

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

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

**The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

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

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

**i. Minimum number of services.**

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

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

**The provision of waiver services at least monthly**

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

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

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

**Directly by the Medicaid agency**

**By the operating agency specified in Appendix A**

**By a government agency under contract with the Medicaid agency.**

*Specify the entity:*

**Other**

*Specify:*

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

Registered Nurses or Licensed Practical Nurses (LPN) in the State of Montana and individuals with a bachelor's degree in Social Work; exceptions must be prior authorized by the Community Services Bureau.

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

The LOC screening tool used by the QIO for initial and reevaluations is a standardized form reviewed and approved by the SMA. This is the form to assess for level of care for the waiver program.

The medical and functional assessment involves a systemic analysis of the individual's medical, functional, and environmental resources and limitations. The State attest that the Level of Care process meets all federal requirements.

The State of Montana attest that no non-governmental entity evaluates/determines an individual's required level-of-care, and the LOC process involves no discretion by the non-governmental entity. The development of the requirements, rules, and policies operationalized by the tool are overseen by the State of Montana.

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

**The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

An applicant may be referred to the QIO from any source (self, family member, treatment provider, etc.) Once the member is in contact with the QIO, the QIO outreaches to the member to initiate the telephonic LOC evaluation. A screening determination form which includes the information gathered during the level of care evaluation, is used by the QIO to document the LOC evaluation for the waiver. This evaluation is based on functional capabilities, medical condition(s) and the ability to access the community. The QIO is responsible for documenting and validating this information. If a determination cannot be made based upon this interview, the QIO must obtain missing information from other individuals who can assist with the evaluation. This can include the applicant's physician, family members, etc.

Individual(s) seeking waiver placement are screened by Mountain Pacific Quality Health (MPQH) the state's contracted Quality Improvement Organization (QIO) using the approved Level of Care (LOC) tool which is approved by the SMA. The State of Montana attest that no non-governmental entity evaluates/determines an individual's required level-of-care, and the LOC process involves no discretion by the non-governmental entity. The development of the requirements, rules, and policies operationalized by the tool are overseen by the State of Montana.

Placement decisions for individuals applying for nursing home/Home and Community Based Services (HCBS) involves a systemic analysis of the individual's medical, functional, cognitive and environmental resources and limitations. Primarily these decisions are anchored by objective boundaries from which clinical judgment, or subjective expertise, is used to interpret the boundaries. This is particularly true in assessing medical and functional issues, as decisions for long-term care should assure that the proposed restrictive preadmission screen is consistent with the individual's needs. Obtained data should be compared against specific criteria to determine the individual's functional/medical care needs. In determining medical eligibility for nursing facility services, the individual typically should require or meet a minimum of one of the criteria listed on the LOC tool.

Once an individual has been verified to meet the level of care requirement, Case Management teams (CMTs) verify that the individuals medical and functional needs can be appropriately met by a HCBS service(s). Utilizing the level of care data collection worksheet's includes identification of specific functional/medical barriers or problems; assessment of the status of these issues (particularly as they interface with the individuals current living environment and resources) identification of services, equipment, and/or resources, if any, which currently accommodate these needs, and; specification of the types of services, equipment, or resources needed to improve that interface. Obtained data is then compared against specific anchors, which reflect services typically required of persons needing institutional care.

The CMTs must review the members' status within 12 months of the initialer previous assessment. A review may be completed sooner if there is a significant change in the member's condition or if required by program criteria. The CMTs must review the members' status within 12 months of the initial or previous assessment. A review may be completed sooner if there is a significant change in the member's condition or if required by program criteria.

During the level of care redetermination, Case Management Teams (CMTS) screen the individuals using the approved Level of Care (LOC) tool based on the systematic analysis of the individual's medical, functional, cognitive and environmental resources and limitations. These decisions are not only made using clinical judgment, subjective expertise, but are also supported by documentation supported by the individual's primary healthcare professional, as well as documented evidence within the member service plan. Once it is confirmed that the individual meets level of care requirement, the individualized service plan is developed to provide member chosen services, equipment, and/or resources needed to help overcome these specific functional/medical barriers.

Case Managers must be either a licensed nurse or a person with a bachelor's degree in social work (exceptions must be prior authorized by the Community Services Bureau). If a Case Management Team suspects during an annual visit, or at any other time, that a participant's level of care has changed significantly, they will make a referral to MPQH for a full level of care re-assessment. Members are referred to the Quality Improvement Organization (QIO) to complete the initial level of care evaluations via the telephone.

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

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule**

*Specify the other schedule:*

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

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

**The qualifications are different.**

*Specify the qualifications:*

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

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

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

QIO maintains records of evaluations for at least 3 years.

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

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

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

**Performance Measure:**

**Number/percent of Level of Care (LOC) reviews started within three business days by MPQH as required in the contractual agreement. The numerator is the number of LOC reviews started within three business days by MPQH. The denominator is the number of LOC referrals received.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="Mountain Pacific Quality Health"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number/percent of mandated reports submitted to SMA by Conduent to demonstrate compliance with contractual mandates. The numerator is the number of reports submitted by Conduent to SMA. The denominator is the total number of Conduent reports mandated by the SMA.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  <input type="text"/>
Other	Annually	Stratified

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

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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



	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	
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**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input style="width: 100%; height: 20px;" type="text"/>
<b>Other</b> Specify:  <input style="width: 100%; height: 20px; border: 1px solid black;" type="text" value="Conduent"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input style="width: 100%; height: 20px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>
	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number/percent of Level of Care reevaluations completed by the case management team (CMT) within 12 months of waiver enrollment or previous assessment. The numerator is number of reviewed LOC reevaluation completed by the CMT within 12 months of waiver enrollment or previous assessment. The denominator is the total number of reviewed LOC reevaluations completed by the CMTs.

**Data Source** (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

<div style="border: 1px solid black; padding: 2px; width: fit-content; margin: auto;">Case Management Team</div>		<div style="border: 1px solid black; width: 100%; height: 20px; margin: auto;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px; margin: auto;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px; margin: auto;"></div>	

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; width: 100%; height: 20px; margin: auto;"></div>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: auto;">Case Management Team</div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100%; height: 20px; margin: auto;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px; margin: auto;"></div>

	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	
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**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input style="width: 100%; height: 20px;" type="text"/>
<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/> Case Management	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input style="width: 100%; height: 20px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>
	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**#/% of new applicants that received an LOC assessment when there is a reasonable indication that services are needed in the future. Num is the # of new applicants who received a LOC Screen indicating need for appropriate institutional LOC when there was a reasonable indication that services were needed in the future. The denom is total # of new applicants.**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

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

<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     95% confidence level with +/- 5% margin of error                 </div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     Case Management Team                 </div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; width: 100px; height: 30px; margin-top: 10px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-top: 10px;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-top: 10px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; width: 150px; height: 30px; margin-top: 10px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

**Performance Measures**

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

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

**Performance Measure:**

**#/% of new waiver participants whose eligibility was determined using the approved processes and instruments. N: Number of new waiver participants whose eligibility was determined using the approved processes and instruments D: Total number of new waiver participants reviewed.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<b>Other</b>	<b>Annually</b>	<b>Stratified</b>

Specify:  MPQH		Describe Group:  
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  	

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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



	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	
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**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input style="width: 100%; height: 20px;" type="text"/>
<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input style="width: 100%; height: 20px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>
	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	

**Data Aggregation and Analysis:**

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

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

**b. Methods for Remediation/Fixing Individual Problems**

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

Number/percent of new applicants that received an evaluation for level of care assessment when there is a reasonable indication that services are needed in the future. The numerator is the number of new applicants who received a level of care eligibility determination (LOC Screen) indicating need for appropriate institutional level of care when there was a reasonable indication that services were needed in the future. The denominator is that total number of new applicants.

**ii. Remediation Data Aggregation**

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

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
Case Management Team	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  

**c. Timelines**

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

**No**

**Yes**

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

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

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

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

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

During the preadmission screening determination Mountain Pacific Quality Health (MPQH) informs eligible members of the feasible alternatives available under the waiver and allows members to choose either institutional or waiver services. Freedom of choice is documented on the Screening Determination form that is sent to the member from MPQH. During the development of the service plan, members are again informed of their right to choose service settings, service options and service providers and this is documented on the service plan signature page.

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

Mountain Pacific Quality Health maintains the Screening Determination forms, which includes documentation of freedom of choice, for a minimum of three years. Case Management Teams keep copies of service plans which indicate freedom of choice for a minimum of three years.

**Appendix B: Participant Access and Eligibility**

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

**Access to Services by Limited English Proficient Persons.** Specify the methods that the state uses to provide meaningful access  
06/26/2024

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

The State will make reasonable accommodations upon request. Accommodations for foreign translators are arranged through the local college and university system. Accommodations for members who are deaf or hard of hearing are made through Montana Deaf and Hard of Hearing Services. Members are notified of the opportunity for reasonable accommodations in the Medicaid application, during the screening determination process and in the Medicaid Screening determination letter.

## Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Big Sky Waiver Personal Assistance		
Statutory Service	Case Management		
Statutory Service	Community Adult Group Homes		
Statutory Service	Day Habilitation		
Statutory Service	Homemaker		
Statutory Service	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Extended State Plan Service	Audiology		
Extended State Plan Service	Respiratory Therapy		
Extended State Plan Service	Speech Therapy		
Supports for Participant Direction	Financial Management Services - Self Direction		
Supports for Participant Direction	Independence Advisor - Self Direction		
Other Service	Adult Foster Care		
Other Service	Community Transition		
Other Service	Consultative Clinical and Therapeutic Services		
Other Service	Dietetic-Nutritionist Services		
Other Service	Environmental Accessibility Adaptations		
Other Service	Family Training and Support		
Other Service	Health and Wellness		
Other Service	Homemaker Chore		
Other Service	Level 1 Assisted Living		
Other Service	Level 2 Assisted Living Behavioral Health Modification		
Other Service	Level 3 Assisted Living Specialized Care		
Other Service	Member Directed Goods and Services		
Other Service	Money Management		
Other Service	Non-medical Transportation		
Other Service	Nurse Supervision for Personal Care Attendants		
Other Service	Nutrition		
Other Service	Occupational Therapy		
Other Service	Pain and Symptom Management		
Other Service	Personal Emergency Response Systems		
Other Service	Physical Therapy		

Service Type	Service		
Other Service	Post Acute Rehabilitation Services		
Other Service	Senior Companion		
Other Service	Service Animals		
Other Service	Skilled Nursing		
Other Service	Specialized Child Care for Children Who Are Medically Fragile		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Specially Trained Attendant		
Other Service	Vehicle Modifications		

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04060 adult day services (social model)

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Adult Day Health provides a broad range of health, nutritional, recreational, and social services in settings outside the members place of residence. Adult Day Health services do not include residential overnight services. Adult Day Health services are furnished in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the member. The scope of Adult Day Health service will not duplicate State Plan services or habilitation aid services. Adult Day Health services shall be authorized and delivered using person-centered practices.

Meals provided as part of these services shall not constitute a full nutritional regiment (3 meals per day).

Transportation between the member's place of residence and the Adult Day Health center will be provided as a component part of Adult Day Health services. The cost of this transportation is included in the rate paid to providers of Adult Day Health services.

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

This service is not duplicative of the Non-Medical Transportation or Nutrition service.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult Day Provider

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Adult Day Health**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Provider

**Provider Qualifications**

**License** (specify):

Adult Day License

**Certificate** (specify):

**Other Standard** (specify):

ARM 37.40.1445  
ARM 37.106.310

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and license renewal.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Personal Care

**Alternate Service Title (if any):**

Big Sky Waiver Personal Assistance

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08030 personal care

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

BSW Personal Assistance services are an extension of State Plan Community First Choice personal assistance services. This service is available under the waiver only if the scope, amount, or duration of the available Medicaid State Plan Personal Care is insufficient in meeting the needs of the person. Frequency or intensity of services provided are in the plan of care. BSW provides member accessible on-line policy manuals which outline all policies and procedures relating to State Plan services.

Personal Assistance Services (PAS) under the Big Sky Waiver (BSW) may include:

1. Supervision for health and safety reasons;
2. Socialization;
3. Community Integration; and
4. Escort and transportation for non-medical reasons.

Relatives/legal guardians, including biological or adopted parent, guardian, or spouse, may be reimbursed for personal care or similar services when qualified to provide the services. The state makes payment to legally responsible individuals for the provision of extraordinary care when the care is in the best interest of the member.

Extraordinary care is defined as care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. Care can include line of sight supervision, night supervision or when not required by a person without a disability of the same age. Authorization of services are based on recommendations of the plan of care professional, as well as comparison to the developmental stage of an equivalent person without a disability of the same age.

Montana ensures that the provision of personal care or similar services by a legally responsible individual is in the best interest of the participant by ensuring that appropriate informed consent was given during the person centered planning process.

For authorized waiver services the difference between self-direct and agency-based service delivery by a legally responsible person is that services delivered through agency-based require that the person delivering the services received the required training by the Provider agency's training which is at least 16 hours and contains mandatory subjects.

The services legally responsible individuals may provide include: Personal Assistance Services (BSW/PAS), Specially Trained Attendant, Homemaker, and Homemaker Chore, and Nurse Supervision for Personal Care Attendants (if the legally responsible individual is employed by an agency and appropriately licensed to deliver this service).

For a legally responsible individual to be paid for the provision of services, all the following authorization criteria and monitoring provisions must be met.

The service(s) must:

1. Meet the definition of a service/support as outlined in the federally approved waiver plan;
2. Be necessary to avoid institutionalization.
3. Be a service/support that is specified in the member service plan;
4. Be provided by a parent or spouse who meets the provider qualifications and training standards specified in the waiver for that service;
5. Be paid at a rate that does not exceed what is allowed by the department for the payment of similar services;
6. Utilize EVV system; and
7. Not be an activity that the family would ordinarily perform or is responsible to perform.

A relative, spouse or legal guardian who is a member's authorized representative may not be paid to provide services.

The State has administrative rules for waiver services that list criteria of care, requirements of documentation and invoicing of waiver services. Claims billed and paid for services are screened to ensure that waiver members received services within the scope, type, amount, and frequency of services authorized within the service plan. Controls to ensure that payments are made only for services delivered are the same of all providers of waiver services. Quality assurance personnel monitor billed services during the annual Performance Measure Review, in terms of type, scope, amount, duration, and frequency. In addition, BSW contracted provider claims are subject to SURS and PERM audits.

Providers that meet provider requirements are welcome to enroll as a Medicaid provider. All requests for enrollment in the Medicaid Program must be made to Conduent EDI Solutions, Inc. The provider enrollment process is managed online by Conduent via Montana's MPATH provider services system. Conduent assists providers to navigate the online system and provide status reports on the enrollment process. The enrollment forms must be completed in their entirety before Conduent can approve and process the enrollment application. Conduent will forward completed enrollment forms to the Senior and Long Term Care Division for approval, procedure codes and



rates.

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

A relative, spouse or guardian who is a member's authorized representative may not be paid to provide BSW services.

BSW Personal Care Assistance Services are services beyond what is required to be provided by the facility are not allowed for a member residing in adult residential settings.

BSW Personal Care Assistance services are an extension of State Plan Community First Choice personal assistance services. This service is available under the waiver only if the scope, amount, or duration of the available Medicaid State Plan Personal Care is insufficient in meeting the needs of the person. This service may be authorized when the member's need for BSW Personal Assistance Services ADLs exceeds the allowable time limits, the scope of service, or the service locations available through Community First Choice (CFC) as outlined below.

The member's total service need for PAS must:

1. Exceed the allowable 42-hour limit provided through CFC as defined in the Montana State Plan;
2. Require supervision for health and safety, which does not function as prompting, cueing, or hands-on assistance as these are available through CFC; or
3. ADLs required outside of the member's home.

**Retainer Days**

Providers of this service may be eligible for a retainer payment if authorized by the case management team. Retainers are days on which the member is either in the hospital, nursing facility or on vacation and the CMT has authorized the provider to be reimbursed for services. Retainer days may not be used for any other BSW services when they are utilized for CFC/PAS. If a provider rate includes vacancy savings, retainer days are a duplication of services and may not be paid in addition. Retainer days are limited to no more than 24 days per resident in each rate year (July 1 through June 30).

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Personal Assistant, Specially Trained Personal Assistant
Agency	Personal Assistance Agencies, Home Care Agency, Supported Living Provider

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Big Sky Waiver Personal Assistance**

**Provider Category:**

Individual

**Provider Type:**

Personal Assistant, Specially Trained Personal Assistant

**Provider Qualifications**

**License** (*specify*):

If a nurse, must be licensed by the state.

**Certificate** (*specify*):

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

The individual must:  
Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);  
Possess a valid Social Security Number;  
Be a US citizen or possess a valid work permit;  
Sign an affidavit regarding confidentiality and HIPAA;  
Possess the ability to communicate effectively with the consumer/personal representative;  
Possess the ability to complete documentation requirements of the program;  
Demonstrate to the member specific competencies necessary to perform paid tasks;  
Complete a self-declaration regarding infections and contagious diseases;  
At the discretion of the member, agree to a state criminal background check;  
Possess a valid drivers license and proof of automobile liability insurance if transporting the consumer;  
Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect and exploitation; and  
Advocate for the member to assure that the member's rights are protected and the member's needs and preferences are honored.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Member and Independence Advisor/FM

**Frequency of Verification:**

Upon enrollment and as necessary.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Big Sky Waiver Personal Assistance**

**Provider Category:**

Agency

**Provider Type:**

Personal Assistance Agencies, Home Care Agency, Supported Living Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Agency-based provider agencies are responsible for certifying that every personal care attendant (PCA) providing BSW PAS has successfully completed mandatory training or has had the training waived according to policy. The requirement for completion of a basic training program may be waived if the individual providing Personal Assistance services can demonstrate competency in the required areas of content included in the basic training.

A provider agency must ensure a PCA has the following to meet competency requirements:

- a. Documented successful training through another Medicaid enrolled CFC/PAS agency or related training program such as Certified Nurse's Aide or Home Health Aide training programs, or
- b. Documented one year experience as a trained PCA in a community-based program such as a licensed developmental disabilities group home or licensed assisted living. Questions regarding PCA qualifications should be directed to the Regional Program Officer (RPO).

Note: Experience in a self-direct CFC/PAS option and experience as an informal caregiver or family caregiver does not qualify.

Basic training shall be a total of 16 hours in length and include content related to the following areas:

1. Orientation to the agency, community and services;
2. Body mechanics, transfer, and assisting with consumer mobility;
3. Personal assistance skills;
4. Care of the home and personal belongings;
5. Safety and accident prevention;
6. Food, nutrition, and meal preparation;
7. Health oriented record keeping, including service delivery records;
8. Member's rights (including confidentiality);
9. Communication skills; and
10. Basic human needs to provide PCAs with the knowledge to work with aging and disabled individuals.

Basic training shall be overseen by a licensed nurse and involve appropriate staff and community resources, such as public health nurses, home economists, physical therapists, and social workers. Every PCA must be given a certificate of completion for their personal records by the training agency. The nurse supervisor must sign the training document certifying the PCA's training. A PCA cannot deliver PAS services until they have successfully completed the basic training requirements. These records must be available upon request by the Department or its designated representative. Exceptions to this training requirement may be approved by the Department.

Personal Assistance Services providers are regularly monitored and supervised by the agency and/or waiver participant in accordance with state policies. Contracted CMTs monitor services being delivered.

For self-directed services, every member/Personal Representative (PR) is responsible for establishing the training requirements for their personal attendants and ensuring that the attendants are trained appropriately. The member/PR is responsible for training the personal attendant to deliver services according to the Service Plan. The member/PR must have a training plan and be able to direct and train the attendant to perform tasks that are outlined on the Service Plan. The member/PR must provide

training prior to delivering the service or on-the job. Training should also be provided by the member/PR, as needed, to instruct the personal attendant in skills and techniques that ensure the attendant can safely and properly carry out the duties and tasks outlined on the Service Plan.

The member/PR may document in notes each personal care attendant’s ability to perform the tasks competently and safely. These notes should be used by the member/PR to evaluate and assess the attendant’s abilities and provide or arrange for additional training, as necessary.

PCS providers are regularly monitored and supervised by the agency and/or waiver participant in accordance with state policies. Contracted CMTs monitor services being delivered.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Case Management

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

01 Case Management

**Sub-Category 1:**

01010 case management

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

- All BSW participants are required to receive/utilize case management services. psychosocial, environmental, and financial needs;
2. Member education regarding available service delivery options;
  3. Initiating the process to evaluate and/or re-evaluate the member's level of care;
  4. Assisting members in accessing BSW services, Medicaid State Plan services or other needed medical, social or educational services regardless of spending source;
  5. Authorization and monitoring of the expenditure of funds included in the approved service plan budget;
  6. Ongoing monitoring of the provision of services included in the member's service plan and or participant health and safety;
  7. Development and annual reevaluation of the service plan, including a functional assessment and service delivery;
  8. Providing member education and choice of the service delivery options available through BSW.
  9. Assisting the member in identifying risks and develop a plan to manage those risks;
  10. Recognition and report of member abuse, neglect, and exploitation.
  11. Annual review of the Freedom of Choice rights to ensure the member is aware of choice in the delivery of services; and
  12. Annual review of the member's Fair Hearing Rights.

In addition, Case Managers provide the following additional services in support of members who choose to direct all or part of their waiver services:

1. Assist members in the development of the support and service spending plan (SSSP) utilizing a person centered process;
2. Authorization of any needed amendments to the SSSP as needed;
3. Authorization, monitoring and review of Service and Support Spending Plan (SSSP) every 180 days or when member status requires reassessment;
4. Review budget reports and utilization summaries submitted by the Financial Manager and Independence Advisor;
5. Authorization of non-self-direct services as needed;
6. Work with the FM and IA to assure member's needs are met and health and safety are assured.

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

Case Management is provided under the authority of a concurrently run 1915(b) waiver.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Case Management Provider Agencies

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**

Case Management Provider Agencies

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1430

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State

**Frequency of Verification:**

Upon Enrollment  
 Verify New CM Training Annually  
 Verify RN/LPN License Annually

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Residential Habilitation

**Alternate Service Title (if any):**

Community Adult Group Homes

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02013 group living, other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**



Licensed adult group homes provide residential settings for persons with severe disabilities, as defined within Title VII of the federal Rehabilitation Act of 1973 (29 U.S.C. 796, et seq.), who otherwise are unable to live independently and who are determined to be capable of residing in noninstitutional settings. Community Adult Group Homes serve residents with a severe disability that substantially limits major life activity, such as walking, self-care, seeing, hearing, speaking, learning, reasoning, judgment, or memory and are identified to be at a much greater risk of institutional placement.

The purpose of a community group home is to provide a family-oriented, home-like residence and related residential services to persons with disabilities so as to enable those persons to enjoy a manner of living that is as close as possible to that considered to be normal in the community. Residents will reside in the least restrictive environment. Intervention will be the least intrusive into, and the least disruptive of, the person's life and represent the least departure from normal patterns of living that can be effective in meeting the resident's needs.

Group Home supports will include, by way of a person-centered approach, adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational and employment support, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs.

Community Adult Group Home services includes personal care and protective oversight and supervision. Resident needs will be met through domiciliary services, personal-social assistance and program plans and training. Residents will be encouraged to engage in meaningful activity, to develop techniques to become increasingly more independent, and to interact with the community in which they reside Community Adult Group Home services may include the provision of medical and health care services that are integral to meeting the daily needs of residents.

Community Adult Group Home services will include:

- Assistance with the arrangement of medical and nonmedical transportation when needed
- Protective oversight to assure the health, safety, and wellbeing of all residents at home and in the community
- Homemaker/homemaker chore services which are to consist of general household cleaning and maintenance activities
- Personal care assistance to support residents successfully complete activities of daily living (ADL) such as bathing, dressing, grooming, and personal hygiene, and meal prep/eating
- Assistance, monitoring, and management of prescribed medications as outlined in Administrative Rules of Montana (ARM)
- Services that are provided by third parties must be coordinated in partnership between the resident and the provider. Nursing and skilled therapy services are incidental rather than integral to the provision of group home services. Payment is not to be made for twenty-four hour skilled care. Coordinated short-term skilled services may be accessed via the resident's state plan, EPSDT, Medicare, or private insurance benefit package.

Community Adult Group Home services will also include within the rate:

- Social and recreational activities at least twice a week
- Transportation
- Money management
- Medical escort

Provider owned or leased settings where Big Sky Waiver Community Adult Group Homes services are furnished must be compliant with the Americans with Disabilities Act. Additionally, participating adult group home providers must meet the HCB setting requirements as defined within 42 CFR 441.301(c)(4)-(5), and associated CMS guidance assuring that the setting is homelike and absent of institutional-like qualities.

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

The services under Big Sky Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

The service must be initially prior authorized by the Department to avoid a duplication of services that are integral to the rate structure of the service.

The total number of individuals served in group homes cannot exceed eight (8) residents 18 years of age or older.

Qualified onsite on-site staff must be available twenty-four-hours to respond to the health, safety, and security needs of all residents residing within the setting.

Group Home services include the provision of medical and health care services that are integral to meeting the daily needs of the resident. Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents may not be included. The provision of such routine health services and the inclusion of the payment for such services in the payment for residential habilitation services is not considered to violate the requirement that a waiver may not cover services that are available through the state plan.

Residents residing in adult group homes may not receive the following services under the waiver to avoid duplication and may not be billed separately. These restrictions apply only when payment is being made for the adult group home service.

- Personal assistance services as provided under the state plan for ADL support within the home which is intended to compensate for the loss of or supplementation of direct care staff
- Homemaker/Homemaker Chore services
- Environmental modifications to resident units or common areas
- Provider compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes
- Medical transportation reimbursement as this service is a state plan benefit
- Nonmedical transportation provided by the adult group home is a component of the adult group home service and the costs associated with transportation is included in the rate
- Home delivered meals
- Personal Emergency Response Systems for use within the home
- Reimbursement for representative payee services is prohibited

#### Retainer Day Payments

- Retainer payments may be made to providers of group home services while the resident is hospitalized, in nursing facility, or on vacation for a period of no more than 30-days per service plan year and may not be used for any other service if used for adult group home services. Retainer payments allows for provider reimbursement during a member's absence in order to preserve the resident's placement at the facility.
- Big Sky Waiver does not account for provider vacancy savings; therefore, retainer days can be made available to providers of adult residential services
- The provider may not bill Medicaid for services on days the member is absent from the facility unless retainer day payments are prior authorized by the resident's case management team
- The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer

#### Room and Board

- Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for services is described in Appendix I-5

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

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

**Provider managed**

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

**Legally Responsible Person**

Relative

Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Homes for Persons with Physical Disabilities

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Community Adult Group Homes**

**Provider Category:**

Agency

**Provider Type:**

Community Homes for Persons with Physical Disabilities

**Provider Qualifications**

**License (specify):**

Service delivery within Group Home settings is contingent upon State licensure for these facilities as outlined within the Administrative Rule of Montana 37.100.401 through 37.100.440 and MCA 52-4-201 through 52-4-205 Community Homes for Persons With Physical Disabilities.

**Certificate (specify):**

**Other Standard (specify):**

All staff persons caring for residents shall be a minimum of 18 years of age. The provider shall employ no staff person who has impairments to his/her ability to protect the health and safety of the residents or who would endanger the physical or psychological wellbeing and progress of the residents.

The provider shall provide training for each new employee within the first 30 days of employment. The provider will be proficient in the standards associated with privacy and confidentiality, reporting and documentation, emergency planning and preparedness, and a knowledge of the legal and protective service system.

The provider shall provide an orientation for each new employee during the first week of employment. This orientation shall include familiarization with the residents and the rules of the home, clients' specific programs, medical concerns of clients and emergency procedures. Additionally, the provider shall provide training for each new employee within the first 30 days of employment on to continuing training and education annually thereafter. All training education and training efforts shall be well documented.

Group home staff must have 8 hours of documented disability specific training for staff annually. This training requirement must be verified annually by the Big Sky Waiver contracted case management team assigned to the group home's service area

37.40.1435 Home and Community-Based Services for Elderly and Physically Disabled Persons: Adult Residential Care, Requirements

37.40.1448 Home and Community-Based Services for Elderly and Physically Disabled Persons: Habilitation, Requirements

Providers must be enrolled as a Montana Medicaid provider and have a provider agreement according to Administrative Rules of Montana 37.85.401; 37.85.402

Safety Devices:

Montana Code Annotated 50-5-1201 - 50-5-1205

Administrative Rules of Montana 37.106.2901 - 37.106.2908

Montana Code Annotated 2019

Title 50. Health and Safety

Chapter 5. Hospitals and Related Facilities

Parts 1 through 13

Montana Code Annotated 2019

Title 52. Family Services

Chapter 3. Adult Services

Part 8. Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act

### **Verification of Provider Qualifications**

#### **Entity Responsible for Verification:**

- a) Department of Public Health and Human Services/Fiscal Intermediary.
- b) Department of Public Health and Human Services Office of Inspector General (OIG)/Quality Assurance Division (QAD).
- c) Applicable standards are verified by the service provider agency.
- d) Big Sky Waiver Program Management Staff and/or designee(s).

#### **Frequency of Verification:**

- a) Verification will occur upon provider enrollment and re-verified if necessary.
- b) HCBS Settings Criteria will be verified upon provider enrollment and re-verified as necessary.
- c) Montana's Office of Inspector General (OIG)/Quality Assurance Division will license and survey all facilities as outlined within Administrative Rules of Montana.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Day Habilitation

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04060 adult day services (social model)

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Day Habilitation is assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, which takes place in a non-residential setting, separate from the home or facility in which the member resides. Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the member's service plan. This service must be provided one on one.

Day Habilitation services shall focus on enabling the member to attain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, Day Habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Day Habilitation services shall be authorized and delivered using person-centered practices.

When Day Habilitation is provided in an adult day care, the provider must be a licensed provider.

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

Reimbursement for meals is limited to two a day. This service is not duplicative of the transportation service or the meals under the distinct meals service.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Living Provider

### Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Day Habilitation**

**Provider Category:**

Agency

**Provider Type:**

Supported Living Provider

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

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

Prior to hire the staff must be:

\*Be at least 17 years of age.

Within 30 days of hire receive training in:

\*abuse reporting,

\*incident reporting,

\*client confidentiality, and

\*any specialty training relating to the needs of the member served, as outlined in the plan of care.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduit

**Frequency of Verification:**

Upon enrollment and every two years.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Homemaker

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08050 homemaker

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Homemaker services consist of general household activities. Homemaker services are provided to members who are unable to manage their own home or when the member normally responsible for homemaking is absent.

Homemaker services do not include personal care services available under State Plan Medicaid. This service is limited to those members whose total need for light housekeeping, laundry, shopping for groceries and picking up medicinal products exceed the allowable time limits provided through Community First Choice or who do not qualify for CFC due to lack of ADL authorization. Case management must evaluate the Community First Choice authorized profile to prevent duplication of services.

Household management necessary for managing and operating a home. This may include general housecleaning, laundry, shopping, and meal preparation.

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

The service cannot provide assistance with IADLs unless:

The member's authorized time for IADL on the QIO service profile is not sufficient to meet the member's needs, or

The member doesn't qualify for CFC/PAS IADLs because he/she doesn't qualify for ADL, CFC/PAS supports, and/or

the IADL needs of the member are outside the scope of IADL service provided under CFC.

Homemaker services are not allowed for a member residing in an adult residential setting.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Homemaker
Agency	Personal Assistance Agency
Agency	Homemaker Agency, Home Care Agency
Agency	Home Health Agency

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Homemaker**

**Provider Category:**

Individual

**Provider Type:**

Homemaker

**Provider Qualifications**



**License** *(specify):*

**Certificate** *(specify):*

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

Be 18 years of age (exceptions that are applicable within state law may be granted by the department); Possess a valid Social Security Number; be a US citizen or possess a valid work permit; possess the ability to communicate effectively with the member/personal representative; possess the ability to complete documentation requirements of the program; demonstrate to the member the specific competencies necessary to perform tasks; at the description of the member and agree to a state criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Member and Independence Advisor  
The FM entity will verify provider qualifications are met and will enter into a Medicaid provider agreement with each provider on behalf of the Medicaid agency.

**Frequency of Verification:**

Upon enrollment and as necessary thereafter.

**Appendix C: Participant Services**

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

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**Service Type: Statutory Service**

**Service Name: Homemaker**

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**Provider Category:**

Agency

**Provider Type:**

Personal Assistance Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Be 18 years of age (exceptions that are applicable within state law may be granted by the department); Possess a valid Social Security Number; be a US citizen or possess a valid work permit; possess the ability to communicate effectively with the member/personal representative; possess the ability to complete documentation requirements of the program; demonstrate to the member the specific competencies necessary to perform tasks; at the discretion of the member and agree to a state criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduit

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Homemaker**

**Provider Category:**

Agency

**Provider Type:**

Homemaker Agency, Home Care Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Be 18 years of age (exceptions that are applicable within state law may be granted by the department); Possess a valid Social Security Number; be a US citizen or possess a valid work permit; possess the ability to communicate effectively with the member/personal representative; possess the ability to complete documentation requirements of the program; demonstrate to the member the specific competencies necessary to perform tasks; at the discretion of the member and agree to a state criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduit

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Homemaker**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

State License

**Certificate (specify):**

Medicare Certification

**Other Standard (specify):**

Be 18 years of age (exceptions that are applicable within state law may be granted by the department); Possess a valid Social Security Number; be a US citizen or possess a valid work permit; possess the ability to communicate effectively with the member/personal representative; possess the ability to complete documentation requirements of the program; demonstrate to the member the specific competencies necessary to perform tasks; at the discretion of the member and agree to a state criminal background check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduit

**Frequency of Verification:**

Upon enrollment and license renewal

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Prevocational Services

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04010 prevocational services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Prevocational Training services are habilitative activities that foster employability for a member.

Must not be provided if they are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Education of the Handicapped Act. The Case Management Team must document in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142. This documentation may be obtained by working with the Department of Public Health and Human Services Vocational Rehabilitation programs;

Are aimed at preparing an individual for paid or unpaid employment and includes teaching such concepts as compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, attention span, motor skills and safety.

A person receiving pre-vocational services may pursue employment opportunities at any time to enter the general work force. Pre-vocational services are intended to assist individuals to enter the general workforce. This service must provide opportunity and support members to obtain and maintain community employment in the most integrated settings. This service must not be delivered in facility based or sheltered work settings where individuals are supervised for the primary purpose of producing goods or performing services. This service must be delivered for the purpose of furthering habilitation goals such as attendance, task completion, problem solving, interpersonal relations and safety as outlined in the person's service.

Transportation between the participant's place of residence and the prevocation site/s is not provided as a component of this service.

Activities included in this service are generally not directed at teaching specific job skills, but underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the member's service plan.

Individuals participating in prevocational services may be compensated in accordance with applicable federal laws and regulations and the provision of prevocational services is always delivered with the intention of leading to permanent integrated employment at or above the minimum wage in the community."

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

Personal care/assistance may be a component of prevocational services but may not comprise the entirety of the service.

Individuals who receive prevocational services may also receive educational, supported employment and/or day habilitation services. A participant's person-centered service plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.

Prevocational services may include volunteer work, such as volunteer learning and training activities that prepare a person for entry into the paid workforce

Prevocational Training services shall be authorized and delivered using person-centered practices.

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

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization.

Pre-vocational services do not include services that are available under the Rehabilitation Act (or, in the case of youth, under the provisions of the IDEA).

Prevocational services are intended to be time limited allowing people to develop needed skills and then move on to paid employment.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Living Provider

### Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Prevocational Services**

**Provider Category:**

Agency

**Provider Type:**

Supported Living Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

An entity providing prevocational services must have two years' experience in providing services to persons with physical disabilities and be an enrolled BSW Supported Living provider.

The entity, inclusive of its staff, providing habilitation services, must be qualified generally to provide the services and specifically to meet each consumer's defined habilitation needs.

Prior to hire:

- a. Be at least 17 years of age.
- b. Within 30 days of hire receive training in:
  - Abuse reporting,
  - Incident reporting,
  - Client confidentiality, and
  - Any specialty training relating to the needs of the member served, as outlined in the plan of care.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09011 respite, out-of-home

**Category 2:**

09 Caregiver Support

**Sub-Category 2:**

09012 respite, in-home

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Respite care is short-term, intermittent care provided to members in need of supportive care to relieve those persons who normally provided the care. Respite care is only utilized to relieve a non-paid caregiver.

Respite care may include payment for room and board in adult residential facilities, nursing homes, hospitals, group homes or residential hospice facilities.

Respite care can be provided in the member's residence or by placing the member in another private residence, adult residential facilities, nursing homes, setting or other community setting, hospital, residential hospice, group home, therapeutic camp for children or adults with disabilities or licensed nursing facility.

Respite services shall be authorized and delivered using person-centered practices.

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

As a program funded by the Administration of Community Living (ACL), the State of Montana's Lifespan Respite program is not a third-party resource for the Big Sky Waiver program.

When respite care is provided, the provision of, or payment for other duplicative services under BSW is precluded (e.g., payment for respite when member is in Adult Day Health). Respite care is limited to no more than 30 consecutive days. If a member requires assistance with Activities of Daily Living (ADLs) during the respite hours, personal assistance should be used under State Plan.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Personal Assistant/Homemaker/Specially Trained Attendant/Caregiver
Agency	Homemaker Agency
Agency	Personal Assistance Agency/Home Care Agency
Agency	Assisted Living Facility
Agency	Nursing Facility

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Personal Assistant/Homemaker/Specially Trained Attendant/Caregiver

**Provider Qualifications**

**License** *(specify):*



[Empty box]

**Certificate** (specify):

[Empty box]

**Other Standard** (specify):

The individual must:

- (a) Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);
- (b) Possess a valid Social Security Number;
- (c) Be a US citizen or possess a valid work permit;
- (d) Sign an affidavit regarding confidentiality and HIPAA;
- (e) Possess the ability to communicate effectively with the member/personal representative;
- (f) Possess the ability to complete documentation requirements of the program;
- (g) Demonstrate to the member specific competencies necessary to perform paid tasks;
- (h) Complete a self-declaration regarding infections and contagious diseases;
- (i) At the discretion of the member agree to a state criminal background check;
- (j) Possess a valid drivers license and proof of automobile liability insurance if transporting the member;
- (k) Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and
- (l) Advocate for the member to assure that the member's rights are protected and the member's needs and preferences are honored.

In addition:

- (a) Be physically and mentally qualified to provide this service to the member;
- (b) Be aware of emergency assistance and/or response systems;
- (c) Be trained and knowledgeable of the physical and mental conditions of the member;
- (d) Be knowledgeable of common medications and related conditions of the member; and
- (e) Be capable to administer basic first aid

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

- a) Department of Public Health and Human Services/Fiscal Intermediary
- b) Department of Public Health and Human Services/Quality Assurance Division
- c) Applicable standards are verified by the service provider agency
- d) Big Sky Waiver Program Management Staff and/or designee(s)
- e) State/Conduent
- f) Member and Independence Advisor/FM

**Frequency of Verification:**

Upon enrollment and as necessary

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Homemaker Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1451  
A person providing respite care services must:  
(a) be physically and mentally qualified to provide this service to the member;  
(b) be aware of emergency assistance and/or response systems;  
(c) be trained and knowledgeable of the physical and mental conditions of the member;  
(d) be knowledge of common medications and related conditions of the member; and  
(e) be capable to administer basic first aid

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

- a) Department of Public Health and Human Services/Fiscal Intermediary
- b) Department of Public Health and Human Services Office of Inspector General (OIG)/Quality Assurance Division (QAD)
- c) Applicable standards are verified by the service provider agency
- d) Big Sky Waiver Program Management Staff and/or designee(s)
- e) State/Conduent

**Frequency of Verification:**

Verification will occur upon enrollment and every two years thereafter

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Personal Assistance Agency/Home Care Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

[Empty box]

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

ARM 37.40.1451  
A person providing respite care services must:  
(a) be physically and mentally qualified to provide this service to the member  
(b) be aware of emergency assistance and/or response systems  
(c) be trained and knowledgeable of the physical and mental conditions of the member  
(d) be knowledge of common medications and related conditions of the member  
(e) be capable to administer basic first aid

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

a) Department of Public Health and Human Services/Fiscal Intermediary  
b) Department of Public Health and Human Services Office of Inspector General (OIG)/Quality Assurance Division (QAD)  
c) Applicable standards are verified by the service provider agency  
d) Big Sky Waiver Program Management Staff and/or designee(s)  
e) State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Assisted Living Facility

**Provider Qualifications**

**License** (*specify*):

Service delivery within assisted living facility settings is contingent upon State licensure for these facilities. Assisted living facilities licensure requirements may be reviewed in ARM 37.106.2801 through 37.106.2898. In addition, Assisted Living Facility staff are required to be at least 18 years of age receive training in, abuse reporting, incident reporting, client confidentiality, and any specialty training relating to the need of the member/population served. The provider shall employ no staff person who has impairments to his/her ability to protect the health and safety of the residents or who would endanger the physical or psychological wellbeing and progress of the residents. The provider will be proficient in the standards associated with privacy and confidentiality, reporting and documentation, emergency planning and preparedness, and a knowledge of the legal and protective service system. Direct care staff shall be trained to perform the services established in each resident service plan. Direct care staff shall be trained in the use of the abdominal thrust maneuver and basic first aid. If the facility offers cardiopulmonary resuscitation (CPR), at least one person per shift shall hold a current CPR certificate. The facility shall have a sufficient number of qualified staff on duty 24 hours a day to meet the scheduled and unscheduled needs of each resident, to respond in emergency situations, and all related services. Facility staff may not perform any health care service that has not been appropriately delegated under the Montana Nurse Practice Act or in the case of licensed health care professionals that is beyond the scope of their license.

**Certificate** (*specify*):

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

Administrative Rules of Montana 37.40.1451 Home and Community-Based Services for Elderly and Physically Disabled Persons: Respite Care, Requirements

37.40.1435 Home and Community-Based Services for Elderly and Physically Disabled Persons: Adult Residential Care, Requirements

Providers must be enrolled as a Montana Medicaid provider and have a provider agreement according to Administrative Rules of Montana 37.85.401; 37.85.402

Administrative Rules of Montana 37.106.302 Minimum Standards Of Construction: General Requirements

Safety Devices:

Montana Code Annotated 50-5-1201 - 50-5-1205

Administrative Rules of Montana 37.106.2901 - 37.106.2908

Montana Code Annotated 2019

Title 50. Health and Safety

Chapter 5. Hospitals and Related Facilities

Parts 1 through 13

Montana Code Annotated 2019

Title 52. Family Services

Chapter 3. Adult Services

Part 8. Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

- a) Department of Public Health and Human Services/Fiscal Intermediary
- b) Department of Public Health and Human Services Office of Inspector General (OIG)/Quality Assurance Division(QAD)
- c) Applicable standards are verified by the service provider agency
- d) Big Sky Waiver Program Management Staff and/or designee(s)
- e) State/Conduent

**Frequency of Verification:**

- a) Verification will occur upon provider enrollment and re-verified as necessary
- b) HCBS Settings Criteria will be verified upon provider enrollment and re-verified as necessary
- c) Montana's Office of Inspector General (OIG)/Quality Assurance Division(QAD) will license and survey all facilities as outlined within Administrative Rules of Montana 37.106.310 Licensing: Procedure For Obtaining A License: Issuance And Renewal Of A License

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Nursing Facility

**Provider Qualifications**

**License (specify):**

State Nursing Facility License

A skilled nursing care facility shall comply with the Conditions of Participation for Skilled Nursing Facilities as set forth in 42 CFR 405, Subpart K. An intermediate care facility shall comply with the requirements set forth in 42 CFR 442, Subparts E and F. Facility staff are required to be at least 18 years of age receive training in, abuse reporting, incident reporting, client confidentiality, and any specialty training relating to the need of the member/population served. The provider shall employ no staff person who has impairments to his/her ability to protect the health and safety of the residents or who would endanger the physical or psychological wellbeing and progress of the residents. The provider will be proficient in the standards associated with privacy and confidentiality, reporting and documentation, emergency planning and preparedness, and a knowledge of the legal and protective service system. Direct care staff shall be trained to perform the services established in each resident service plan. The facility shall have a sufficient number of qualified staff on duty 24 hours a day to meet the scheduled and unscheduled needs of each resident, to respond in emergency situations, and all related services. Facility staff may not perform any health care service that has not been appropriately delegated under the Montana Nurse Practice Act or in the case of licensed health care professionals that is beyond the scope of their license.

**Certificate (specify):**

**Other Standard (specify):**

State of Montana ARM 37.40.1451

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

- a) Department of Public Health and Human Services/Fiscal Intermediary
- b) Department of Public Health and Human Services Office of Inspector General (OIG)/ Quality Assurance Division (QAD)
- c) Applicable standards are verified by the service provider agency
- d) Big Sky Waiver Program Management Staff and/or designee(s)
- e) State/Conduent

**Frequency of Verification:**

- a) Upon enrollment and upon renewal of license
- b) Montana's Quality Assurance Division (QAD) will license and survey all facilities as outlined within Administrative Rules of Montana 37.106.310 Licensing: Procedure For Obtaining A License: Issuance And Renewal Of A License

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Supported Employment

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

03 Supported Employment

**Sub-Category 1:**

03021 ongoing supported employment, individual

**Category 2:**

03 Supported Employment

**Sub-Category 2:**

03022 ongoing supported employment, group

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition** *(Scope):*

Supported Employment-Individual Employment Support services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the personal and career goals of the member. This service is required to be provided on a one-to-one basis.

- a. Supported Employment is not intended for people working in mobile work crews of small groups of people with disabilities in the community.
- b. Supported Employment does not include facility-based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
- c. All prevocational and supported employment service options should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals.
- e. Supported Employment does not include volunteer work. Such volunteer learning and training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational services.
- f. Supported Employment does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.
- g. Personal care/assistance may be a component part of supported employment individual employment supports but may not comprise the entirety of the service.

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

Supported Employment services rendered under BSW are not available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142. This documentation may be obtained by working with the DPHHS Vocational Rehabilitation program.

Transportation may be provided between the member's place of residence and the job site, or between job sites (in cases where the member is working in more than one place) as a component part of supported employment services.

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

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

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

**Provider managed**

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

**Legally Responsible Person**

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Supported Employment**

**Provider Category:**

Agency

**Provider Type:**

Supported Living Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

Prior to hire:

- \*Be at least 17 years of age.

Within 30 days of hire receive training in:

- \*Abuse reporting,
- \*Incident reporting,
- \*Client confidentiality, and
- \*Any specialty training relating to the needs of the member served, as outlined in the plan of care.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**



### C-1/C-3: Service Specification

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Audiology

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Services that are provided when the limits of audiology services under the approved Medicaid State Plan are exhausted or for maintenance and habilitation purposes. The scope and nature of these services do not otherwise differ from audiology services furnished under the Medicaid State Plan. Audiology services include screening and evaluation of members with respect to hearing function.  
  
Audiology services shall be authorized and delivered using person-centered practices.

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

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization.

1. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization; and,
2. These services are not available for special education and related services that are required to be provided through a child’s Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Agency or Hospital
Agency	Home Care Agency

### Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**

**Service Name: Audiology**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency or Hospital

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Audiology service providers, as a condition of participation in the Montana Medicaid program, must:

- (a) maintain a current audiology license issued by the Montana Board of Speech-Language Pathologists and Audiologists, or, if the provider is serving recipients outside the state of Montana, maintain a current license in the equivalent category under the laws of the state in which the services are provided;
- (b) enter into and maintain a current provider enrollment form under the provisions of state's Medicaid provider with the department's fiscal agent to provide audiology services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Conduent/State

**Frequency of Verification:**

Upon enrollment and renewal license/certification.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Audiology**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Audiology service providers, as a condition of participation in the Montana Medicaid program, must:  
 (a) maintain a current audiology license issued by the Montana Board of Speech-Language Pathologists and Audiologists, or, if the provider is serving recipients outside the state of Montana, maintain a current license in the equivalent category under the laws of the state in which the services are provided;  
 (b) enter into and maintain a current provider enrollment form under the provisions of state’s Medicaid provider with the department’s fiscal agent to provide audiology services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Respiratory Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11110 respiratory therapy

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Services include direct treatment, ongoing assessment, equipment monitoring and upkeep, pulmonary education and rehabilitation. This service is not available to individuals who are eligible to receive such services through Medicaid State Plan (including EPSDT benefits).

This service shall be authorized and delivered using person-centered practices.

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

1. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.; and,
2. These services are not available for special education and related services that are required to be provided through a child’s Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Respiratory Therapist
Agency	Home Health Agency or Hospital

Provider Category	Provider Type Title
Agency	Home Care Agency

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Respiratory Therapy**

**Provider Category:**

Individual

**Provider Type:**

Respiratory Therapist

**Provider Qualifications**

**License (specify):**

State License

**Certificate (specify):**

**Other Standard (specify):**

A certified respiratory therapy technician, as defined by the national board for respiratory care, may assist under the direct supervision of a registered respiratory therapist or physician who is responsible for and participates in the recipient's treatment program.  
 A member's legally responsible individual may provide respiratory services if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and renewal of license.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Respiratory Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency or Hospital

**Provider Qualifications**

License (specify):

[Empty text box]

Certificate (specify):

[Empty text box]

Other Standard (specify):

A certified respiratory therapy technician, as defined by the national board for respiratory care, may assist under the direct supervision of a registered respiratory therapist or physician who is responsible for and participates in the recipient's treatment program.

**Verification of Provider Qualifications**

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and renewal of license/certification.

**Appendix C: Participant Services**

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

Service Type: Extended State Plan Service

Service Name: Respiratory Therapy

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License (specify):

[Empty text box]

Certificate (specify):

[Empty text box]

Other Standard (specify):

A certified respiratory therapy technician, as defined by the national board for respiratory care, may assist under the direct supervision of a registered respiratory therapist or physician who is responsible for and participates in the recipient's treatment program.

**Verification of Provider Qualifications**

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter.

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Speech Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11100 speech, hearing, and language therapy

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

The scope and nature of these services do not otherwise differ from Speech therapy services furnished under the State plan except this service provides maintenance therapy not covered through State Plan. This service provides maintenance speech therapy therapy that is repetitive and required to maintain functions without a reasonable expectation of significant progress and do not involve complex and sophisticated therapy services requiring the skill of a licensed therapist.

Montana's HELP Act was implemented January 1, 2016, and includes the removal of the limitations to Speech Therapy. Maintenance therapies continue to be provided under waiver services. This service shall be authorized and delivered using person-centered practices.

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

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization.

A member’s legally responsible individual may provide speech therapy if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

These services are not available for special education and related services that are required to be provided through a child’s Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Care Agency
Individual	Speech Therapist
Agency	Home Health Agency or Hospital

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**  
**Service Name: Speech Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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



ARM 37.40.1462

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Speech Therapy**

**Provider Category:**

Individual

**Provider Type:**

Speech Therapist

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1462  
o A member's legally responsible individual may provide Speech Therapy if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and renewal of license.

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Speech Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency or Hospital

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1462

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and renewal license/certification.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**

Financial Management Services

**Alternate Service Title (if any):**

Financial Management Services - Self Direction

**HCBS Taxonomy:**

**Category 1:**

12 Services Supporting Self-Direction

**Sub-Category 1:**

12010 financial management services in support of self-direction

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

This service provides finance, employer, payroll, and related functions for the member/personal representative who have elected to self-direct their services. This service assures that the funds to provide services and supports outlined in the member service plan are implemented through a self-directed approach and are managed and paid appropriately as authorized. This is a mandatory service for all members who choose to self-direct their waiver services.

The Financial Manager (FM) acts as the common law employer (employer of record) and the member acts as the managing employer. Since the FM is the employer, this entity is responsible for all employee related expenses and liability risks that may be incurred if a worker's compensation or unemployment claim is filed.

More specifically, the FM will:

1. Member Enrollment:

- a. Accept referral from the member/personal representative to process the employment packet;
- b. Prepare and distribute an application package of information that is clear and easy for the potential employee to understand and follow; and
- c. Provide needed advice and technical assistance regarding the role of a FM to the member, their personal representatives, and others.

2. Individual Employed to Provide Services:

- a. Process employment application package and documentation for prospective individual to be employed (as agency employee);
- b. Complete criminal background checks on prospective member referred worker and maintain results on file, if requested by the member;
- c. Establish and maintain record for each individual employed and process all employment records;
- d. Withhold, file, and deposit FICA, FUTA, and SUTA taxes in accordance with
- e. Federal IRS and DOL, and state rules (if applicable);
- f. Process all judgments, garnishments, tax levies or any related holds on a member's worker as may be required by local, state, or federal laws;
- g. Generate and distribute IRS W-2's and/or 1099's, wage and tax statements and related documentation annually to all member-employed providers who meet the statutory threshold earnings amounts during the tax year by January 31st;
- h. Withhold, file and deposit federal and state income taxes (if applicable) in accordance with federal IRS and state Department of Revenue Services rules and regulation;
- i. Administer benefits for member-employed providers (if available);
- j. Assist the participant to verify worker citizenship status; and
- k. Collect and process timesheets of support workers;

3. Payroll and Accounting:

- a. Generate payroll checks in a timely and accurate manner, as approved in the member's self-direct spending plan, and in compliance with all federal and state regulations;
- b. Develop a method of payment of invoices and monitoring expenditures against the self-direct spending plan for each member;
- c. Receive, review, and process all invoices from individuals, vendors or agencies providing member-directed goods or services as approved in the member's self-direct spending plan authorized by the Division;
- d. Process and pay non-labor related invoices;
- e. Generate utilization reports along with payroll reflecting accurate balances for members/personal representatives, Big Sky Bonanza IA, Regional Program Officers (RPOs) and the Division; and
- f. Maintain a separate account for each participant-directed budget;
- g. Track and report participant funds, disbursements, and the balance of participant funds;
- h. Process and pay invoices for goods and services approved in the service plan; and
- i. Provide participant with periodic reports of expenditures and the status of the participant-directed budget.

3. Management:

- a. Execute provider agreements with any individual or entity that will be reimbursed with Medicaid waiver funding;
- b. Establish and maintain all member records with confidentiality, accuracy, and appropriate safeguards;
- c. Respond to calls from member or their personal representatives and employees regarding issues such as withholdings and net payments, lost or late checks, reports and other documentation;
- d. File claims through the MMIS for member-directed goods and services and prepare checks for individually hired workers; and

e. Generate service management and statistical information and reports.  
 This service shall be authorized and delivered using person-centered practices.

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

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Independent Living Center, Self Direct Personal Assistance Service Agency, Case Management Agency

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**  
**Service Name: Financial Management Services - Self Direction**

**Provider Category:**

Agency

**Provider Type:**

Independent Living Center, Self Direct Personal Assistance Service Agency, Case Management Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

FM services must be delivered by entities that are established as legally recognized in the United States, qualified/registered to do business in the State of Montana, approved as a Medicaid provider and approved by the CSB. Approval will include, at a minimum, ensuring the provider demonstrates the capacity to perform the required responsibilities through undergoing and passing a Readiness Review performed by the State.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**

Information and Assistance in Support of Participant Direction

**Alternate Service Title (if any):**

Independence Advisor - Self Direction

**HCBS Taxonomy:**

**Category 1:**

12 Services Supporting Self-Direction

**Sub-Category 1:**

12020 information and assistance in support of self-direction

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Independence Advisor serves as a member of the support team for individuals electing the participant direction option Independence Advisor (IA) services include an array of member-directed support activities to ensure the ability of members/personal representatives to direct their care successfully. Members/personal representatives can choose from any qualified and enrolled provider. This is a mandatory service under the self-direct option.

Information provided by the IA to the member will cover:

- Person centered planning and how it is applied;
- Member choices and options for services and their delivery;
- Processes for changing plans of care and budgets;
- Grievance processes;
- Risks and responsibilities of self-direction;
- Freedom of choice of providers;
- Member rights;
- Reassessment and review of schedules; and
- Other information pertinent to the member/personal representative in managing and directing services.

The IA may assist the member with;

- Service plan development to assure the members needs and personal preferences are understood and met;
- Implementation of the approved service plan and budget;
- Identifying risks and developing a plan to manage those risks;
- Development of an individualized emergency backup plan;
- Making allowable purchases and ensure those purchases are listed in the spending plan; and
- Negotiating payments for necessary and allowable goods and services.

The IA will also:

1. Monitor the provision of the services to ensure the member's health and welfare; and
2. Coordinate with the FM to ensure that member's or personal representative's budget appropriately to meet their needs as defined in the SP.

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Independent Living Center, Personal Assistance Agency, Supportive Living Provider

**Appendix C: Participant Services**

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

**Service Type: Supports for Participant Direction**

**Service Name: Independence Advisor - Self Direction**

**Provider Category:**

Agency

**Provider Type:**

Independent Living Center, Personal Assistance Agency, Supportive Living Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

An IA must complete the Community Services Bureau (CSB) mandatory training and receive formal training as an IA before providing services. Training includes:

- 1) the person-centered planning process;
- 2) principles of member-direction;
- 3) developing a comprehensive Support and Services Spending Plan (SSSP);
- 4) Department program policy and processes;
- 5) program reporting and documentation requirements;
- 6) community resources; and
- 7) techniques to enhance member-directing skills for members.

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

A certified IA must exhibit a professional commitment to the described duties and successfully demonstrate the ability to:

- 1) understand the principles of member-direction, IA and member roles, State and federal program policies and local regional, state and federal resources;
- 2) participate as a member of the support team;
- 3) follow written and verbal instructions;
- 4) communicate successfully with members, personal representative and Financial Managers;
- 5) establish community networks;
- 6) recognize and report abuse, neglect and exploitation;
- 7) comply with CSB Serious Occurrence Report policies;
- 8) advocate on the behalf of members and teach self-advocacy;
- 9) assist with developing an appropriate comprehensive SSSP that includes Medicaid, non-Medicaid, traditional and member-directed services;
- 10) instruct, counsel and guide members in problem solving and decision making;
- 11) comply with program reporting and documentation requirements; and
- 12) assist member in service plan development and monitoring.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State

**Frequency of Verification:**

Upon Enrollment and annually thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**



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

**Service Type:**

Other Service

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

**Service Title:**

Adult Foster Care

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02013 group living, other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Adult Foster Care Homes provide a home-like safe environment, light housekeeping, custodial care, and supervision to aged or physically disabled adults 18 years of age or older who require assistance in meeting their basic needs. Residents' needs are to be addressed in a manner that supports and enables residents to maximize their ability to function at the highest level of independence possible at home and in the community.

Adult foster care services are to include the delivery of personal care and supportive services that are provided in a licensed private home by a principal care provider who lives in the home. A qualified onsite provider, staff member, or adult member of the household, excluding a Big Sky Waiver Participant, must be available twenty-four-hours to respond to and meet the health, safety, and security needs of all residents residing within the setting as outlined in Administrative Rules of Montana (ARM).

Adult Foster Care services will include:

- Assistance with the arrangement of medical and nonmedical transportation when needed
- Protective oversight to assure the health, safety, and wellbeing of all residents at home and in the community
- Access to social and recreational activities at home and in the community
- Homemaker/homemaker chore services which are to consist of general household cleaning and maintenance activities
- Personal care assistance to support residents successfully complete activities of daily living (ADL) such as bathing, dressing, grooming, and personal hygiene, and meal prep/eating
- Assistance, monitoring, and management of prescribed medications as outlined in Administrative Rules of Montana (ARM)
- Periodic nursing evaluations are to occur as outlined in Administrative Rules of Montana (ARM)
- The adult foster care service is to include unskilled assistance with ADLS and IADLs, meal preparation, and routine health care services excluding any unskilled services that may be provided to the resident under the state plan or EPSDT.
- Nursing and skilled therapy services are incidental rather than integral to the provision of adult foster care services. Payment is not to be made for twenty-four hour skilled care. Coordinated short-term skilled services may be accessed via the resident's state plan, EPSDT, Medicare, or private insurance benefit package

Provider owned or leased settings where Big Sky Waiver services are furnished must be compliant with the Americans with Disabilities Act. Additionally, participating adult foster care home providers must meet the HCB setting requirements as defined within 42 CFR 441.301(c)(4)-(5), and associated CMS guidance assuring that the setting is homelike and absent of institutional-like qualities

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

The services under Big Sky Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The total number of individuals served in adult foster care homes cannot exceed four residents, 18 years of age or older, living in the home, and are unrelated to the principal care provider.

Payment rendered for adult foster care home services will encompass the services and supports that are furnished on an integrated basis. Additionally, payment for adult foster care services does not include payments made, directly or indirectly, to members of the resident's immediate family. The adult foster care home provider may arrange for the provision of some services to be delivered on an individual contractual basis as outlined in Administrative Rules of Montana (ARM).

Residents residing in adult foster care homes may not receive the following services under the Big Sky Waiver program to avoid duplication and may not also be billed separately. These restrictions apply only when payment is being made for the adult foster care home service.

- Personal assistance services as provided under the state plan for ADL support within the setting. However, personal assistance services and/or non-medical transportation/mileage for socialization may be utilized by the resident for the supervision of their health and safety when accessing the community unsupported by the responsible adult foster care homeowner or designated responsible individual(s)
- Homemaker/Homemaker Chore services
- Environmental modifications to resident units or common areas
- Provider compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes
- Respite may be provided in a adult foster care home for recipients of other service types but may not be provided for residents already residing in the setting
- Medical transportation reimbursement as this service is a state plan benefit
- Nonmedical transportation provided by the adult foster care home is a component of the service and the costs associated with transportation are included in the rate
- Home delivered meals
- Personal Emergency Response Systems for use within the home

#### Retainer Day Payments

- Retainer payments may be made to providers of adult foster care homes while the resident is hospitalized, in nursing facility, or on vacation for a period of no more than 30-days per service plan year and may not be used for any other service if used for adult foster care home services. Retainer payments allows for provider reimbursement during a member's absence in order to preserve the resident's placement at the facility.
- Big Sky Waiver does not account for provider vacancy savings; therefore, retainer days can be made available to providers of adult foster care services.
- The provider may not bill Medicaid for services on days the member is absent from the home unless retainer day payments are prior authorized by the resident's case management team.
- The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer.

#### Room and Board

- Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for services is described in Appendix I-5

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult Foster Care Homes

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Adult Foster Care**

**Provider Category:**

Agency

**Provider Type:**

Adult Foster Care Homes

**Provider Qualifications**

**License** (*specify*):

Service delivery within Adult Foster Care Home settings is contingent upon State Licensure for these facilities as outlined within Administrative Rules of Montana 37.100.101 through 37.100.175; Adult Foster Care Homes (AFCH).

**Certificate** (*specify*):

Adult Foster Care Home staff are required to be at least 18 years of age, and within 30 days of hire, receive training in, abuse reporting, incident reporting, client confidentiality, and any specialty training relating to the need of the member served. The provider shall employ no staff person who has impairments to his/her ability to protect the health and safety of the residents or who would endanger the physical or psychological wellbeing and progress of the residents. The provider will be proficient in the standards associated with privacy and confidentiality, reporting and documentation, emergency planning and preparedness, and a knowledge of the legal and protective service system.

37.40.1451 Home and Community-Based Services for Elderly and Physically Disabled Persons: Respite Care, Requirements

37.40.1435 Home and Community-Based Services for Elderly and Physically Disabled Persons: Adult Residential Care, Requirements

Providers must be enrolled as a Montana Medicaid provider and have a provider agreement according to Administrative Rules of Montana 37.85.401; 37.85.402

Safety Devices:

Montana Code Annotated 50-5-1201 - 50-5-1205

Administrative Rules of Montana 37.106.2901 - 37.106.2908

Montana Code Annotated 2019

Title 50. Health and Safety

Chapter 5. Hospitals and Related Facilities

Parts 1 through 13

Montana Code Annotated 2019

Title 52. Family Services

Chapter 3. Adult Services

Part 8. Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act

Other Standard (specify):

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

- a) Department of Public Health and Human Services/Fiscal Intermediary.
- b) Department of Public Health and Human Services Office of Inspector General (OIG)/Quality Assurance Division (QAD).
- c) Applicable standards are verified by the service provider agency.
- d) Big Sky Waiver Program Management Staff and/or designee(s).

Frequency of Verification:

- a) Verification will occur upon provider enrollment and re-verified as necessary
- b) HCBS Settings Criteria will be verified upon provider enrollment and re-verified as necessary
- c) Montana's Office of Inspector General(OIG)/Quality Assurance Division (QAD) will license and survey all facilities as outlined within Administrative Rules of Montana

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:

[Empty text box]

Sub-Category 2:

[Empty text box]

Category 3:

[Empty text box]

Sub-Category 3:

[Empty text box]

Category 4:

[Empty text box]

Sub-Category 4:

[Empty text box]

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

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

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

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

**Service Definition (Scope):**

Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the member is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a member to establish a basic household including: security deposits that are required to obtain a lease on an apartment or home; essential household furnishings required, including furniture, window coverings, food preparation items and bed/bath linens; moving expenses; usual and customary set up fees or deposits for utility or service access, including telephone, electricity, heating and water; activities to assess need, arrange for and procure resources.

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

Services do not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversion/recreational purposes.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Case Management Team
Agency	Independent Living Center

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Community Transition**

**Provider Category:**

Agency

**Provider Type:**

Case Management Team

**Provider Qualifications**

**License (specify):**

Dependent Upon Specific Service/Support Required

**Certificate (specify):**

[Empty text box]

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

Dependent upon specific provider ARM 37.40.1422

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment and annually thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Community Transition**

**Provider Category:**

Agency

**Provider Type:**

Independent Living Center

**Provider Qualifications**

**License** (*specify*):

[Empty text box]

**Certificate** (*specify*):

[Empty text box]

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

Recognized as a Center for Independent Living

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Xerox

**Frequency of Verification:**

Upon enrollment

**Appendix C: Participant Services**

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Consultative Clinical and Therapeutic Services

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11130 other therapies

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

These are services that assist unpaid and or paid caregivers in carrying out member service plans and are necessary to improve the members independence and inclusion in the community. This service is geared towards members with traumatic brain injuries or more complex disabilities that require a more clinical approach and specialized interventions. Consultation activities are provided by professionals in psychiatry, psychology, neuropsychology, physiatry, behavior management, or others specializing in specific intervention modalities  
The service may include:  
1) clinical evaluations by these professionals;  
2) development of a supplemental home/community treatment plan which is incorporated into the individual Service plan;  
3) training and technical assistance to implement the treatment;  
4) monitoring the treatment and interventions; and  
5) one-on-one consultation and support for paid and non-paid caregivers  
Professionals will work closely with case managers to ensure treatment plans are implemented and followed.  
An entity, inclusive of its staff, providing consultative clinical and therapeutic services must be qualified generally to provide the services and specifically to meet each members define needs.

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



1. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
2. These services are not available for special education and related services that are required to be provided through a child’s Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Psychologist, Psychiatrist, Neuropsychologist, Physiatrist, Rehabilitation Counselor, Professional Counselor

### Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Consultative Clinical and Therapeutic Services**

**Provider Category:**

Individual

**Provider Type:**

Psychologist, Psychiatrist, Neuropsychologist, Physiatrist, Rehabilitation Counselor, Professional Counselor

**Provider Qualifications**

**License** (*specify*):

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

**Certificate** (*specify*):

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

ARM 37.40.1465

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and renewal of license.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Dietetic-Nutritionist Services

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11040 nutrition consultation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Dietician Services are provided in Montana by a licensed nutritionist for member evaluation, monitoring of nutritional status; nutrition counseling; therapy; research, education and meal planning for members who have medically restricted diets or for members who do not eat appropriately to maintain health.

A registered nutritionist must provide dietetic-nutritionist services. Registered nutritionists must meet the qualifications in MCA 37-25-302.

This service shall be authorized and delivered using person-centered practices.

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

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.  
 These services are not available for special education and related services that are required to be provided through a child's Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Nutritionist

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Dietetic-Nutritionist Services**

**Provider Category:**

Agency

**Provider Type:**

Nutritionist

**Provider Qualifications**

**License** (*specify*):

A licensed nutritionist must provide dietitian services. Licensed nutritionist must meet the qualifications in MCA 24-156-1301 and 1304.

**Certificate** (*specify*):

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

ARM 37.40.1475

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and license renewal.

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Environmental Accessibility Adaptations

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14020 home and/or vehicle accessibility adaptations

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Those physical adaptations to the home, required by the member's service plan, which are necessary to ensure the health, welfare and safety of the member, or which enable the member to function with greater independent in the home without which the member would require institutionalization. Such adaptations may include the installation of ramps, grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the member, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefits to the member, such as carpeting, roof repair, central air conditioning, etc. All services shall be provided in accordance with applicable state or local building codes.

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

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

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

These services are not available for special education and related services that are required to be provided through a child’s Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Construction Company, Building Contractor

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations**

**Provider Category:**

Agency

**Provider Type:**

Construction Company, Building Contractor

**Provider Qualifications**

**License** (specify):

Montana Contractor License

**Certificate** (specify):

**Other Standard** (specify):

ARM 37.40.1485

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Family Training and Support

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08010 home-based habilitation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Services whereby an employee of the child and Family Services provider enrolled with the department is responsible for assisting families with training and support issues associated with their child aged 0 through 21 with disabilities and not eligible for Developmental Disabilities Division services. More specifically, Family Training and Support includes:

- 1) Providing training to families and others who work or play with the child. Training would include general orientation about the child's disabling condition as well as training specific to the needs of the child and his or her family and how best to meet those needs.
- 2) Serving as consultant to families in terms of developmental stages and teaching activities that families can do with their child that would help in the developmental process.
- 3) Collaborating with the case managers and families to develop strategies for environmental modifications or adaptations that would be beneficial to the child.
- 4) Periodically assessing child, including conducting developmental assessments, in order to discover unmet needs, determine progress or lack of progress and identifying areas of strength that can be emphasized.
- 5) Problem solving and suggesting resources such as peers and others within the disability community who could offer support.
- 6) Advocating for the families' needs with the case management team and others who may offer supports and services.
- 7) Assisting the family and case management team with transition and referral to special education, including Part C.

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

1. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
2. These services are not available for special education and related services that are required to be provided through a child's Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or services required to be provided through Part 303 (Part C) — Early Intervention Program For Infants And Toddlers With Disabilities.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Child and Family Training Services

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Family Training and Support**

**Provider Category:**

Individual

**Provider Type:**

Child and Family Training Services

**Provider Qualifications**

License (specify):

[Empty text box]

Certificate (specify):

[Empty text box]

Other Standard (specify):

Bachelor's degree with a specialty in child development.

**Verification of Provider Qualifications**

Entity Responsible for Verification:

State/Conduent/Case Manager/IA/FM

Frequency of Verification:

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Health and Wellness

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11130 other therapies

Category 2:

[Empty text box]

Sub-Category 2:

[Empty text box]

Category 3:

[Empty text box]

Sub-Category 3:

[Empty text box]

Category 4:

Sub-Category 4:



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

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

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

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

**Service Definition (Scope):**

Each service provides opportunities for members to integrate in an inclusion setting with non-disabled peers for healthy and wellness activities within their community.

- o These services focus on healthy habits thereby preventing or delaying higher cost institutional care.
- o Weight loss - Members who are at a healthy weight are less likely to acquire conditions that increase the risk of institutionalization. (i.e., uncontrolled diabetes) In addition the ability for members to move freely within the community could improve.
- o Smoking Cessation -Members who are able to quit smoking may not acquire severe medical conditions such as COPD, lung cancer, etc. Acquiring these conditions could lead to the use of oxygen, shortness of breath and restrictions in physical activities. Without these conditions the ability for members to move freely within the community improves.
- o Healthy Lifestyles – Members can take classes to address issues regarding living with a disability through the independent living centers. This information increases the capacity of the member to self-advocate, navigate community resources and improve overall health and socialization skills. These skills keep members in the community and out of an institution.
- o Health Club Memberships – Members can participate and utilize health club services to improve overall health and well-being. Since members go to these facilities in the community, they are increasing activities outside of their home and more likely remain in the community. In addition, using a private health club gets the member into a non-disability specific exercise program. This service is authorized for individuals with conditions that would benefit from gym activities.
- o Art Therapy – Members have access to art therapy as a means to express themselves and aid in coping with such conditions as depression, memory loss, traumatic brain injury, chronic illness, etc. Participation in this service requires members to access providers in the community. These services can increase the members ability to cope and increase confidence for community living and avoid institutionalization.
- o Cost associated with adaptations and direct support needed to participate in recreational activities such as skiing, horseback riding and swimming- By providing this service; members are outside of their homes and integrated into healthy settings. Members who participate adaptive activities are unlikely to be institutionalized. This cost does not include the fee for the recreational activity, such as ski-lift tickets, horse rentals, swimming pool entrance fees or lessons, professional guide fees and the like.
- o Hydrotherapy: a modality that involves the use of agitated water to relieve muscle spasms, improve circulation or promote the healing of wounds.
- o Hippotherapy: a physical therapy treatment strategy that uses equine movement as part of an integrated intervention program to achieve functional outcomes.

This service shall be authorized and delivered using person-centered practices.

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

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization.

1. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
2. These services are not available for special education and related services that are required to be provided through a child’s Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or services required to be provided through Part 303 (Part C) — Early Intervention Program For Infants And Toddlers With Disabilities.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Wellness Classes/Health Clubs/Fitness Centers
Agency	Dependent Upon Specific Service Provided

### Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Health and Wellness**

**Provider Category:**

Agency

**Provider Type:**

Wellness Classes/Health Clubs/Fitness Centers

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Dependent upon specific provider

- o Health lifestyle providers include Montana’s Independent Living Centers, licensed lifestyle providers and medical facilities.
- o Hippo therapy – licensed horse therapy business or individual providers.
- o Art therapy –art instructors or art therapists.
- o Health Club Memberships – health clubs, YMCAs or medical centers with associated health facilities.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Health and Wellness**

**Provider Category:**

Agency

**Provider Type:**

Dependent Upon Specific Service Provided

**Provider Qualifications**

**License (specify):**

As Required by state Law

**Certificate (specify):**

**Other Standard (specify):**

Dependent upon specific provider

- o Health lifestyle providers include Montana’s Independent Living Centers, licensed lifestyle providers and medical facilities.
- o Hippo therapy – licensed horse therapy business or individual providers.
- o Art therapy –art instructors or art therapists.
- o Health Club Memberships – health clubs, YMCAs or medical centers with associated health facilities.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Homemaker Chore

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08060 chore

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Homemaker Chore activities include cleaning a home requiring extensive clean-up beyond the scope of general household cleaning available under the Homemaker service.

Homemaker Chore activities may include:

1. Heavy cleaning (e.g., washing windows or walls);
2. Yard care;
3. Walkway maintenance;
4. Wood chopping and stacking, and
5. Extermination services.

This service is available to assist members unable to manage homemaker tasks, in the home, due to medical and functional limitations.

These activities must not include:

1. Household tasks that are provided in conjunction with an ADL or Instrumental Activities of Daily Living (IADLs);
2. Tasks to support other household members;
3. Tasks to support companion animals, pets, or other animals not designated as Service Animals;
4. Homemaker services available under State Plan Medicaid; or
5. Cost associated with moving member from one residence to another.

This service shall be authorized and delivered using person-centered practices.

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

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Homemaker
Agency	Personal Assistance Agency
Agency	Homemaker/House Cleaning Agency
Agency	Home Health Agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Homemaker Chore**

**Provider Category:**

Individual

**Provider Type:**

Homemaker

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Be 18 years of age (exceptions that are applicable within state law may be granted by the department); possess a valid Social Security Number; be a US citizen or possess a valid work permit; possess the ability to communicate effectively with the member/personal representative; possess the ability to complete documentation requirements of the program; demonstrate to the member the specific competencies necessary to perform tasks; at the discretion of the member agree to a state criminal background check; and, if transporting the member, possess a valid driver's license and proof of automobile liability insurance.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Member and IA/FM

**Frequency of Verification:**

At enrollment and as necessary thereafter.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Homemaker Chore**

**Provider Category:**

Agency

**Provider Type:**

Personal Assistance Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

ARM 37.40.1447 and 1450

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduit

**Frequency of Verification:**

Upon enrollment and every two years

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Homemaker Chore**

**Provider Category:**

Agency

**Provider Type:**

Homemaker/House Cleaning Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1450

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduit

**Frequency of Verification:**

Upon enrollment and every two years

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Homemaker Chore**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

License (specify):

Certificate (specify):

Other Standard (specify):

**Verification of Provider Qualifications**

Entity Responsible for Verification:

Frequency of Verification:

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

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

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**



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

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

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

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

**Service Definition (Scope):**

Assisted living facilities assist individuals 18 years of age or older and who are frail, elderly, or physically disabled by facilitating supportive health and service coordination to maintain the residents' independence, individuality, and dignity. Assisted living facilities serve adults who cannot or who chooses not to live independently.

Assisted living facilities shall provide safe, cost effective services to include twenty-four hour residential care support services, adequate sleeping and living areas, and adequate recreational areas for residents as outlined in Administrative Rules of Montana (ARM). Assisted living services will encompass the comprehensive array of holistic services and supports that are furnished on an integrated basis by the facility's own employees.

Assisted living facility services will include:

- Assistance with the arrangement of medical and nonmedical transportation when needed
- Protective oversight to assure the health, safety, and wellbeing of all residents at home and in the community
- Access to social and recreational activities at home and in the community
- Homemaker/homemaker chore services which are to consist of general household cleaning and maintenance activities
- Personal care assistance to support residents successfully complete activities of daily living (ADL) such as bathing, dressing, grooming, and personal hygiene, and meal prep/eating
- Assistance, monitoring, and management of prescribed medications as outlined in Administrative Rules of Montana (ARM); and
- Periodic nursing evaluations are to occur as outlined in Administrative Rules of Montana (ARM)

Services that are provided by third parties must be coordinated with the assisted living provider. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not to be made for twenty-four hour skilled care. Coordinated short-term skilled services may be accessed via the resident's state plan, EPSDT, Medicare, or private insurance benefit package

Provider owned or leased settings where Big Sky Waiver services are furnished must be compliant with the Americans with Disabilities Act. Additionally, participating assisted living facility providers must meet the HCB setting requirements as defined within 42 CFR 441.301(c)(4)-(5), and associated CMS guidance assuring that the setting is homelike and absent of institutional-like qualities

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

The services under Big Sky Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Residents residing in assisted living facilities may not receive the following services under the Big Sky Waiver program to avoid duplication and may not also be billed separately. These restrictions apply only when payment is being made for the assisted living service.

- Personal assistance services as provided under the state plan for ADL support within the facility which is intended to compensate for the loss of or supplementation of direct care staff. However, personal assistance services and/or non-medical transportation/mileage for socialization may be utilized by the resident for the supervision of their health and safety when accessing the community unsupported by the assisted living facility
- Homemaker/Homemaker Chore services;
- Environmental modifications to resident units or common areas;
- Provider compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes;
- Respite may be provided in a residential habilitation setting for recipients of other service types but may not be provided for residents already residing in the assisted living facility;
- Medical transportation reimbursement as this service is a state plan benefit;
- Nonmedical transportation provided by the assisted living facility is a component of the assisted living service and the costs associated with transportation is included in the rate;
- Home delivered meals; and
- Personal Emergency Response Systems for use within the facility

**Retainer Day Payments**

- Retainer payments may be made to providers of assisted living facility services while the resident is hospitalized, in nursing facility, or on vacation for a period of no more than 30-days per service plan year and may not be used for any other service if used for assisted living services. Retainer payments allows for provider reimbursement during a member’s absence in order to preserve the resident’s placement at the facility.
- Big Sky Waiver does not account for provider vacancy savings; therefore, retainer days can be made available to providers of adult residential services.
- The provider may not bill Medicaid for services on days the member is absent from the facility unless retainer day payments are prior authorized by the resident’s case management team.
- The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer.

**Room and Board**

- Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Assisted Living Facility

**Appendix C: Participant Services**

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

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**Service Type: Other Service**

**Service Name: Level 1 Assisted Living**

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**Provider Category:**

Agency

**Provider Type:**

Assisted Living Facility

**Provider Qualifications**

**License** *(specify):*

Service delivery within assisted living facility settings is contingent upon State licensure for these facilities as outlined within Administrative Rules of Montana ARM 37.106.2801 through 37.106.2898; Assisted Living Facilities.

**Certificate** *(specify):*

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

Assisted Living Facility staff are required to be at least 18 years of age receive training in, abuse reporting, incident reporting, client confidentiality, and any specialty training relating to the need of the member/population served. The provider shall employ no staff person who has impairments to his/her ability to protect the health and safety of the residents or who would endanger the physical or psychological wellbeing and progress of the residents. The provider will be proficient in the standards associated with privacy and confidentiality, reporting and documentation, emergency planning and preparedness, and a knowledge of the legal and protective service system. Direct care staff shall be trained to perform the services established in each resident service plan. Direct care staff shall be trained in the use of the abdominal thrust maneuver and basic first aid. If the facility offers cardiopulmonary resuscitation (CPR), at least one person per shift shall hold a current CPR certificate. The facility shall have a sufficient number of qualified staff on duty 24 hours a day to meet the scheduled and unscheduled needs of each resident, to respond in emergency situations, and all related services. Facility staff may not perform any health care service that has not been appropriately delegated under the Montana Nurse Practice Act or in the case of licensed health care professionals that is beyond the scope of their license.

37.40.1451 Home and Community-Based Services for Elderly and Physically Disabled Persons: Respite Care, Requirements

37.40.1435 Home and Community-Based Services for Elderly and Physically Disabled Persons: Adult Residential Care, Requirements

Providers must be enrolled as a Montana Medicaid provider and have a provider agreement according to Administrative Rules of Montana 37.85.401; 37.85.402

Safety Devices:

Montana Code Annotated 50-5-1201 - 50-5-1205

Administrative Rules of Montana 37.106.2901 - 37.106.2908

Montana Code Annotated 2019

Title 50. Health and Safety

Chapter 5. Hospitals and Related Facilities

Parts 1 through 13

Montana Code Annotated 2019

Title 52. Family Services

Chapter 3. Adult Services

Part 8. Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act

### **Verification of Provider Qualifications**

#### **Entity Responsible for Verification:**

- a) Department of Public Health and Human Services/Fiscal Intermediary.
- b) Department of Public Health and Human Services Office of Inspector General (OIG)/Quality Assurance Division (QAD).
- c) Applicable standards are verified by the service provider agency.
- d) Big Sky Waiver Program Management Staff and/or designee(s).

#### **Frequency of Verification:**

- a) Verification will occur upon provider enrollment and re-verified as necessary
- b) HCBS Settings Criteria will be verified upon provider enrollment and re-verified as necessary
- c) Montana's Office of Inspector General (OIG)/Quality Assurance Division (QAD) will license and survey all facilities as outlined within Administrative Rules of Montana

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Level 2 Assisted Living Behavioral Health Modification

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02013 group living, other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Level two assisted living services is solution oriented approach for residents 18 years of age or older already residing in a licensed assisted living facility, accessing Big Sky Waiver assisted living services, and whose placement is determined to be at-risk due to exhibited adverse behaviors.

Adverse behaviors have the potential to result in an unanticipated event or a series of events that can result in death, serious injury, harm, or similar risks that may result in an inappropriate institutionalization event. Residents identified for level two assisted living services must have a documented need for the service. The assisted living provider, in collaboration with the Department, will review barriers to safe and effective service delivery and determine how the service will be applied to meet the health and safety needs of the resident and his or her peers residing in the facility. The department will make a final determination of prior authorization and its longevity based on the documentation compiled by the provider to support the request.

The facility will provide safe, cost effective services to include twenty-four hour residential care support services, adequate sleeping and living areas, and adequate recreational areas for residents as outlined in Administrative Rules of Montana (ARM). Assisted living services will encompass the comprehensive array of holistic services and supports that are furnished on an integrated basis by the facility's own employees.

Level two assisted living services will include:

- Assistance with the arrangement of medical and nonmedical transportation when needed;
- Protective oversight to assure the health, safety, and wellbeing of all residents at home and in the community;
- Access to social and recreational activities at home and in the community;
- Homemaker/homemaker chore services which are to consist of general household cleaning and maintenance activities;
- Personal care assistance to support residents successfully complete activities of daily living (ADL) such as bathing, dressing, grooming, and personal hygiene, and meal prep/eating;
- Assistance, monitoring, and management of prescribed medications as outlined in Administrative Rules of Montana (ARM); and
- Periodic nursing evaluations are to occur as outlined in Administrative Rules of Montana (ARM).

Services that are provided by third parties must be coordinated with the assisted living provider. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not to be made for twenty-four hour skilled care. Coordinated short-term skilled services may be accessed via the resident's state plan, EPSDT, Medicare, or private insurance benefit package

Provider owned or leased settings where Big Sky Waiver services are furnished must be compliant with the Americans with Disabilities Act. Additionally, participating assisted living facility providers must meet the HCB setting requirements as defined within 42 CFR 441.301(c)(4)-(5), and associated CMS guidance assuring that the setting is homelike and absent of institutional-like qualities.

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

The services under Big Sky Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

- A resident must have resided in the licensed assisted living facility for over 30-days;
- The service must be prior authorized by the Department in collaboration with the requesting assisted living provider to avoid a duplication of services;
- The facility must demonstrate past success and/or failures to remedy the resident's presenting problem;
- Providers must submit to the department a resident-focused summary outlining the proposed plan of care to which the service will be applied;
- At a minimum, documentation to be submitted by the provider to the department will include the resident's assisted living facility's service plan, progress notes and charting, and any other applicable/relevant medical records all of which are to be lawfully obtained; and
- The service may be approved on a temporary or long-term basis depending on the individual resident's circumstances and/or actual outcomes.

Residents residing in assisted living facilities may not receive the following services under the Big Sky Waiver program to avoid duplication and may not also be billed separately. These restrictions apply only when payment is being made for the assisted living service.

- Personal assistance services as provided under the state plan for ADL support within the facility which is intended to compensate for the loss of or supplementation of direct care staff. However, personal assistance services and/or non-medical transportation/mileage for socialization may be utilized by the resident for the supervision of their health and safety when accessing the community unsupported by the assisted living facility;
- Homemaker/Homemaker Chore services;
- Environmental modifications to resident units or common areas;
- Provider compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes;
- Respite may be provided in a residential habilitation setting for recipients of other service types but may not be provided for residents already residing in the assisted living facility;
- Medical transportation reimbursement as this service is a state plan benefit;
- Nonmedical transportation provided by the assisted living facility is a component of the assisted living service and the costs associated with transportation is included in the rate;
- Home delivered meals; and
- Personal Emergency Response Systems for use within the facility

#### Retainer Day Payments

- Retainer payments may be made to providers of assisted living facility services while the resident is hospitalized, in nursing facility, or on vacation for a period of no more than 30-days per service plan year and may not be used for any other service if used for assisted living services. Retainer payments allows for provider reimbursement during a member's absence in order to preserve the resident's placement at the facility.
- Big Sky Waiver does not account for provider vacancy savings; therefore, retainer days can be made available to providers of adult residential services.
- The provider may not bill Medicaid for services on days the member is absent from the facility unless retainer day payments are prior authorized by the resident's case management team.
- The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer.

#### Room and Board

- Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Assisted Living Facility

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Level 2 Assisted Living Behavioral Health Modification**

**Provider Category:**

Agency

**Provider Type:**

Assisted Living Facility

**Provider Qualifications**

**License (specify):**

Service delivery within assisted living facility settings is contingent upon State licensure for these facilities as outlined within Administrative Rules of Montana 37.106.2801 through 37.106.2898; Assisted Living Facilities.

**Certificate (specify):**

**Other Standard (specify):**



Assisted Living Facility staff are required to be at least 18 years of age receive training in, abuse reporting, incident reporting, client confidentiality, and any specialty training relating to the need of the member/population served. The provider shall employ no staff person who has impairments to his/her ability to protect the health and safety of the residents or who would endanger the physical or psychological wellbeing and progress of the residents. The provider will be proficient in the standards associated with privacy and confidentiality, reporting and documentation, emergency planning and preparedness, and a knowledge of the legal and protective service system. Direct care staff shall be trained to perform the services established in each resident service plan. Direct care staff shall be trained in the use of the abdominal thrust maneuver and basic first aid. If the facility offers cardiopulmonary resuscitation (CPR), at least one person per shift shall hold a current CPR certificate. The facility shall have a sufficient number of qualified staff on duty 24 hours a day to meet the scheduled and unscheduled needs of each resident, to respond in emergency situations, and all related services. Facility staff may not perform any health care service that has not been appropriately delegated under the Montana Nurse Practice Act or in the case of licensed health care professionals that is beyond the scope of their license.

37.40.1451 Home and Community-Based Services for Elderly and Physically Disabled Persons: Respite Care, Requirements

37.40.1435 Home and Community-Based Services for Elderly and Physically Disabled Persons: Adult Residential Care, Requirements

Providers must be enrolled as a Montana Medicaid provider and have a provider agreement according to Administrative Rules of Montana 37.85.401; 37.85.402

**Safety Devices:**

Montana Code Annotated 50-5-1201 - 50-5-1205

Administrative Rules of Montana 37.106.2901 - 37.106.2908

Montana Code Annotated 2019

Title 50. Health and Safety

Chapter 5. Hospitals and Related Facilities

Parts 1 through 13

Montana Code Annotated 2019

Title 52. Family Services

Chapter 3. Adult Services

Part 8. Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

- a) Department of Public Health and Human Services/Fiscal Intermediary.
- b) Department of Public Health and Human Services Office of Inspector General (OIG)/Quality Assurance Division (QAD).
- c) Applicable standards are verified by the service provider agency.
- d) Big Sky Waiver Program Management Staff and/or designee(s).

**Frequency of Verification:**

- a) Verification will occur upon provider enrollment and re-verified as necessary
- b) HCBS Settings Criteria is expected to be verified upon provider enrollment and re-verified as necessary
- c) Montana's Quality Assurance Division (QAD) will license and survey all facilities as outlined within Administrative Rules of Montana

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Level 3 Assisted Living Specialized Care

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02013 group living, other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Assisted living facilities assist individuals 18 years of age or older and who are frail, elderly, or physically disabled by facilitating supportive health and service coordination to maintain the residents' independence, individuality, and dignity. Assisted living facilities serve adults who cannot or who chooses not to live independently.

Assisted living facilities shall provide safe, cost effective services to include twenty-four hour residential care support services, adequate sleeping and living areas, and adequate recreational areas for residents as outlined in Administrative Rules of Montana (ARM). Assisted living services will encompass the comprehensive array of holistic services and supports that are furnished on an integrated basis by the facility's own employees.

Level three assisted living facility services will include:

- Assistance with the arrangement of medical and nonmedical transportation when needed;
- Protective oversight to assure the health, safety, and wellbeing of all residents at home and in the community;
- Access to social and recreational activities at home and in the community;
- Homemaker/homemaker chore services which are to consist of general household cleaning and maintenance activities;
- Personal care assistance to support residents successfully complete activities of daily living (ADL) such as bathing, dressing, grooming, and personal hygiene, and meal prep/eating;
- Assistance, monitoring, and management of prescribed medications as outlined in Administrative Rules of Montana (ARM); and
- Periodic nursing evaluations are to occur as outlined in Administrative Rules of Montana (ARM).

Services that are provided by third parties must be coordinated with the assisted living provider. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not to be made for twenty-four hour skilled care. Coordinated short-term skilled services may be accessed via the resident's state plan, EPSDT, Medicare, or private insurance benefit package

Level Three Assisted Living includes within the rate:

- Social and recreational activities at least twice a week;
- Transportation;
- Money management; and
- Medical escort.

Provider owned or leased settings where Big Sky Waiver services are furnished must be compliant with the Americans with Disabilities Act. Additionally, participating assisted living facility providers must meet the HCB setting requirements as defined within 42 CFR 441.301(c)(4)-(5), and associated CMS guidance assuring that setting is homelike and absent of institutional-like qualities

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

The services under Big Sky Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The service must be initially prior authorized by the Department to avoid a duplication of services that are integral to the rate structure of the service.

Providers of this service must specialize in the care of individuals with severe disabilities.

Residents residing in assisted living facilities may not receive the following services under the Big Sky Waiver program to avoid duplication and may not also be billed separately. These restrictions apply only when payment is being made for the assisted living service.

- Personal assistance services as provided under the state plan for ADL support within the facility which is intended to compensate for the loss of or supplementation of direct care staff. However, personal assistance services and/or non-medical transportation/mileage for socialization may be utilized by the resident for the supervision of their health and safety when accessing the community unsupported by the assisted living facility;
- Homemaker/Homemaker Chore services;
- Environmental modifications to resident units or common areas;
- Provider compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes;
- Respite may be provided in a residential habilitation setting for recipients of other service types but may not be provided for residents already residing in the assisted living facility;
- Medical transportation reimbursement as this service is a state plan benefit;
- Nonmedical transportation provided by the assisted living facility is a component of the assisted living service and the costs associated with transportation is included in the rate;
- Home delivered meals;
- Personal Emergency Response Systems for use within the facility; and
- Reimbursement for representative payee services is prohibited.

#### Retainer Day Payments

- Retainer payments may be made to providers of assisted living facility services while the resident is hospitalized, in nursing facility, or on vacation for a period of no more than 30-days per service plan year and may not be used for any other service if used for assisted living services. Retainer payments allows for provider reimbursement during a member's absence in order to preserve the resident's placement at the facility.
- Big Sky Waiver does not account for provider vacancy savings; therefore, retainer days can be made available to providers of adult residential services.
- The provider may not bill Medicaid for services on days the member is absent from the facility unless retainer day payments are prior authorized by the resident's case management team.
- The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer

#### Room and Board

- Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Assisted Living Facility

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Level 3 Assisted Living Specialized Care**

**Provider Category:**

Agency

**Provider Type:**

Assisted Living Facility

**Provider Qualifications**

**License** (*specify*):

Service delivery within assisted living facility settings is contingent upon State licensure for these facilities as outlined within Administrative Rules of Montana ARM 37.106.2801 through 37.106.2898: Assisted Living Facilities.

**Certificate** (*specify*):

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

•Staff must have 8 hours of documented disability specific training for staff annually. This training requirement must be verified annually by the Big Sky Waiver contracted case management team assigned to the facility's service area.

•Providers of specialized assisted living services will maintain trained and qualified staff who specialize in caring for populations or groups of individuals with, for example comprehensive diagnoses, comorbidities, co-occurring disorders, and disease processes

Assisted Living Facility staff are required to be at least 18 years of age receive training in, abuse reporting, incident reporting, client confidentiality, and any specialty training relating to the need of the member/population served. The provider shall employ no staff person who has impairments to his/her ability to protect the health and safety of the residents or who would endanger the physical or psychological wellbeing and progress of the residents. The provider will be proficient in the standards associated with privacy and confidentiality, reporting and documentation, emergency planning and preparedness, and a knowledge of the legal and protective service system. Direct care staff shall be trained to perform the services established in each resident service plan. Direct care staff shall be trained in the use of the abdominal thrust maneuver and basic first aid. If the facility offers cardiopulmonary resuscitation (CPR), at least one person per shift shall hold a current CPR certificate. The facility shall have a sufficient number of qualified staff on duty 24 hours a day to meet the scheduled and unscheduled needs of each resident, to respond in emergency situations, and all related services. Facility staff may not perform any health care service that has not been appropriately delegated under the Montana Nurse Practice Act or in the case of licensed health care professionals that is beyond the scope of their license.

37.40.1451 Home and Community-Based Services for Elderly and Physically Disabled Persons: Respite Care, Requirements

37.40.1435 Home and Community-Based Services for Elderly and Physically Disabled Persons: Adult Residential Care, Requirements

Providers must be enrolled as a Montana Medicaid provider and have a provider agreement according to Administrative Rules of Montana 37.85.401; 37.85.402

Safety Devices:

Montana Code Annotated 50-5-1201 - 50-5-1205

Administrative Rules of Montana 37.106.2901 - 37.106.2908

Montana Code Annotated 2019

Title 50. Health and Safety

Chapter 5. Hospitals and Related Facilities

Parts 1 through 13

Montana Code Annotated 2019

Title 52. Family Services

Chapter 3. Adult Services

Part 8. Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

- a) Department of Public Health and Human Services/Fiscal Intermediary.
- b) Department of Public Health and Human Services Office of Inspector General (OIG)/Quality Assurance Division (QAD).
- c) Applicable standards are verified by the service provider agency.
- d) Big Sky Waiver Program Management Staff and/or designee(s).

##### **Frequency of Verification:**

- a) Verification will occur upon provider enrollment and re-verified as necessary
- b) HCBS Settings Criteria will be verified upon provider enrollment and re-verified as necessary
- c) Montana's Office of Inspector General (OIG)/Quality Assurance Division (QAD) will license and survey all facilities as outlined within Administrative Rules of Montana

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Member Directed Goods and Services

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14031 equipment and technology

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Member Directed Goods and Services are services, equipment, or supplies not otherwise provided through this waiver or through Medicaid state plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements:

- 1) the item or service would decrease the need for other Medicaid services; or
- 2) promote inclusion in the community; or
- 3) increase the participant's safety in the home environment; and
- 4) the participant does not have the funds to purchase the item or service, or the item or service is not available through another source. Member Directed Goods and Services are purchased from the participant directed budget. Goods and services that are purchased under this coverage must be clearly linked to an assessed member's need that has been established in the service plan.

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

Coverage of this service is limited to members who choose the Employer with Budget Authority option. Experimental or prohibited treatments are excluded. Member Directed Goods and Services must be documented in the service plan. Purchases in excess of \$5,000 must receive prior authorization from the CMT and meet the four criteria. This service is not duplicative of those services provided under environmental accessibility adaptations or specialized equipment and supplies.

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

These services are not available for special education and related services that are required to be provided through a child's Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supplier of Durable Medical Equipment and Supplies Retailers

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Member Directed Goods and Services**

**Provider Category:**

Agency

**Provider Type:**

Supplier of Durable Medical Equipment and Supplies Retailers

**Provider Qualifications**

**License** (specify):



[Empty text box]

**Certificate** (specify):

[Empty text box]

**Other Standard** (specify):

Complete a Montana Department of Justice criminal background check and results maintained in the file.  
Provider must have no felony convictions.  
If providers fail to meet the required qualifications, fail the background check or have had their Montana business license revoked or lapsed, they will either not be enrolled or they will be terminated as a waiver provider.  
The Department will check the Excluded Individual and Entities List, and the Medicare Exclusion list and the Licensee Lookup System prior to re-enrollment of provider.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Medicaid Financial Agent

**Frequency of Verification:**

Upon Enrollment and every 2 years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Money Management

**HCBS Taxonomy:**

**Category 1:**

[Empty text box]

**Sub-Category 1:**

[Empty text box]

**Category 2:**

[Empty text box]

**Sub-Category 2:**

[Empty text box]

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

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

**Service Definition (Scope):**

The Money Management service is designed to provide ongoing support for legally competent individuals to manage their budget or support to the acquisition of money management (financial budgeting) skills. Exceptions may be authorized by designated state staff on a case by case basis for those individuals who have a payee assigned through SSA but require support to manage non-SSA income/benefits and/or remaining funds allocated to the member. The purpose of this service is to offer opportunities for waiver participants to increase their ability to provide for their own basic needs, increase their ability to cope with day to day living, maintain more stability in their lives and maintain the greatest degree of independence possible.

The member shall maintain account ownership and control; the provider shall never have full or partial ownership or personal possession of the member's funds and must not have direct access to member's financial accounts.

This service may not be used to provide payee services or to pay payee-related fees and/or services.

This service may not be used to aid with general paperwork, such as applying for assistance programs such as Medicaid, SNAP, LIEAP, college admissions, etc.

Money Management service may not be used to supplant the following:

1. Payee services (e.g., Social Security Administration and Veteran Administration payee services);
2. CFC Skill Acquisition services; or
3. CFC Correspondence Assistance.

This service shall be authorized and delivered using person-centered practices.

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

Members residing in a Community Adult Group Home or Level 3 Facility shall not receive this service.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Consumer Credit Counseling Agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Money Management**

**Provider Category:**

Agency

**Provider Type:**

Consumer Credit Counseling Agency

**Provider Qualifications**

**License (specify):**

Current business license.

**Certificate (specify):**

**Other Standard (specify):**

Complete a Montana Department of Justice criminal background check and results maintained in the file.  
 Provider must have no felony convictions.  
 If providers fail to meet the required qualifications, fail the background check or have had their Montana business license revoked or lapsed, they will either not be enrolled or they will be terminated as a waiver provider.  
 The Department will check the Excluded Individual and Entities List, and the Medicare Exclusion list and the Licensee Lookup System prior to re-enrollment of provider.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Community Services Bureau

**Frequency of Verification:**

Upon initial enrollment and every three years.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

specified in statute.

**Service Title:**

Non-medical Transportation

**HCBS Taxonomy:**

**Category 1:**

15 Non-Medical Transportation

**Sub-Category 1:**

15010 non-medical transportation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Non-Medical Transportation means travel furnished by common carrier or private vehicle for non-medical reasons as defined in the member service plan. Non-Medical Transportation may be provided when required transportation services exceed the Montana State plan and Community First Choice or are unique to the Big Sky Waiver. Non-medical transportation may include bus passes, paratransit tickets, and taxi fares.

Medical transportation is available under the State Plan Medicaid program.

Transportation Services must meet the following criteria:

- 1) Be provided only after State Plan Medicaid or other publicly funded transportation programs have been exhausted or determined to be inappropriate; and
- 2) Be provided by the cost effective mode.

Transportation providers must provide proof of:

- 1) A valid Montana driver's license;
- 2) Adequate automobile insurance; and
- 3) Assurance that vehicle is in compliance with all applicable federal, state and local laws and regulations.

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

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Cabs, Home and Health Care Agencies, Vans & Buses, Ambulance Services

### Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Non-medical Transportation

**Provider Category:**

Agency

**Provider Type:**

Cabs, Home and Health Care Agencies, Vans & Buses, Ambulance Services

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

ARM 37.40.1488

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter or upon license renewal.

### Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Nurse Supervision for Personal Care Attendants

**HCBS Taxonomy:**

**Category 1:**

05 Nursing

**Sub-Category 1:**

05010 private duty nursing

**Category 2:**

05 Nursing

**Sub-Category 2:**

05020 skilled nursing

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

This service may be authorized if the member is receiving only BSW personal assistance and requires a nurse for the supervision of the BSW specific personal assistance. Some functions include direct service to the waiver participant and some as an administrative role supervising and training direct care workers.

Billable time for nurse supervision is:

1. Intake time – this includes the time to complete the plan for services and orient the member to the program in the member’s home;
2. Time spent in providing specific member orientation or training to an attendant if the service is agency based. This DOES NOT include going over the schedule;
3. Time spent charting specific to one member. This would include such activities as incident reporting and the person-centered service plan (defined under 42 CFR 441.301(b)(1)(i)) development; and
4. Time spent in case conferences with other providers and/or family members and/or the member.

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

This service is not available for individuals receiving Level 1, 2 or 3 residential habilitation, assisted living, or adult foster care.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Care/Health Care Provider
Individual	Licensed Practical Nurse, Registered Nurse

### Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Nurse Supervision for Personal Care Attendants**

**Provider Category:**

Agency

**Provider Type:**

Home Care/Health Care Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

A member’s legally responsible individual may provide nursing services if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process. ARM 47.40.1477

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter or upon license renewal.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Nurse Supervision for Personal Care Attendants**

**Provider Category:**

Individual

**Provider Type:**

Licensed Practical Nurse, Registered Nurse

**Provider Qualifications**

**License** (*specify*):

State of Montana LPN or RN License

**Certificate** (*specify*):

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

ARM 37.40.1477

A member's legally responsible individual may provide private duty nursing if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/IA/FM

**Frequency of Verification:**

Upon enrollment and license renewal.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Nutrition



**HCBS Taxonomy:**

**Category 1:**

06 Home Delivered Meals

**Sub-Category 1:**

06010 home delivered meals

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Services which consist of the provision of hot or other appropriate meals once or twice a day, up to seven days a week. In keeping with the exclusion of room and board as covered services, a full nutritional regimen of three meals per day will not be provided.

Nutrition providers must be nonprofits or public agencies that provide congregate or home delivered meals on a regular basis to people who cannot provide themselves with regular meals because of their functional needs. Nutrition providers must be enrolled as Medicaid providers.

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Meals on Wheels, Area Agencies on Aging, Restaurants, Retirement Homes

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Nutrition**

**Provider Category:**

Agency

**Provider Type:**

Meals on Wheels, Area Agencies on Aging, Restaurants, Retirement Homes

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1476

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Occupational Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11080 occupational therapy

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition** (Scope):

The scope and nature of these of these services do not otherwise differ from Occupational Therapy Services furnished under the State plan, except that palliative therapies and maintenance therapy will continue to be provided as previously approved. Montana's HELP Act was implemented January 1, 2016, and includes the removal of the limitations to restorative Occupational Therapy. Maintenance therapies continue to be provided under waiver services.

This service shall be authorized and delivered using person-centered practices.

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

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization.

A member's legally responsible individual may provide Occupational Therapy or Speech Therapy if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

The service is not available to individuals who are eligible to receive such services through Medicaid State Plan (including EPSDT benefits).

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

These services are not available for special education and related services that are required to be provided through a child's Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

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

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

**Provider managed**

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

**Legally Responsible Person**

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Agency	Home Care Agency
Agency	Hospital/Home Health Agency

**Appendix C: Participant Services**

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

Service Type: Other Service

Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License (specify):

State License

Certificate (specify):

Other Standard (specify):

ARM 37.40.1460  
 A member’s legally responsible individual may provide Skilled Nursing, Physical Therapy, Occupational Therapy or Speech Therapy if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and renewal of license

**Appendix C: Participant Services**

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

Service Type: Other Service

Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Home Care Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

ARM 37.40.1460

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Occupational Therapy**

**Provider Category:**

Agency

**Provider Type:**

Hospital/Home Health Agency

**Provider Qualifications**

**License** *(specify):*

Licensed as required by Montana law and regulations

**Certificate** *(specify):*

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

ARM 37.40.1460

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and license/certification renewal.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Pain and Symptom Management

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17990 other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

All treatments require written documentation by a health care professional indicating that the treatment will not harm the member prior to initial authorization and must meet evidence-based criteria as determined by the National Institute of Health (NIH).

This service allows for the provision of traditional and non-traditional methods of pain management. Treatments include:

1. Acupuncture;
2. Reflexology;
3. Massage Therapy;
4. Craniosacral Therapy;
5. Hyperbaric Oxygen Therapy;
6. Mind-body therapies such as hypnosis and biofeedback; and
7. Chiropractic Therapy;

This service shall be authorized and delivered using person-centered practices.

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

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.  
 These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Pain and Symptom Management**

**Provider Category:**

Agency

**Provider Type:**

Massage Therapists, Chiropractors, Acupuncturists, Specialized RN

**Provider Qualifications**

**License** *(specify):*

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

**Certificate** (specify):

**Other Standard** (specify):

ARM 37.40.1428

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and upon license renewal.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Pain and Symptom Management**

**Provider Category:**

Agency

**Provider Type:**

Psychologist, Counselor, Life Coach, Hypnotist

**Provider Qualifications**

**License** (specify):

Montana Board of Social Work Examiners and Professional Counselors  
Montana Board of Psychologists

**Certificate** (specify):

Certified Life Coach  
Certified Hypnotist

**Other Standard** (specify):

ARM 37.40.1428

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and upon every two years thereafter



**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Pain and Symptom Management**

**Provider Category:**

Agency

**Provider Type:**

Hospitals

**Provider Qualifications**

**License (specify):**

Montana Licensed Hospital

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and license or certification renewal.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Personal Emergency Response Systems

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14010 personal emergency response system (PERS)

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

The Personal Emergency Response System (PERS) is an electronic, telephonic or mechanical system used to summon assistance in event of an emergency. The system must alert medical professionals, support staff or other designated individuals to respond to a member's emergency. Montana State Plan Community First Choice 1915(k) services provide PERS under State Plan, a waiver PERS device would be available to waiver members only if the State Plan PERS do not meet the member's individual need.

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

Reimbursement is not available for purchase, installation or routine monthly charges of a telephone or cell phone.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	PERS provider

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Emergency Response Systems**

**Provider Category:**

Agency

**Provider Type:**

PERS provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1486

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Physical Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11090 physical therapy

**Category 2:**

**Sub-Category 2:**

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

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

**Service Definition** (*Scope*):

The scope and nature of these services do not otherwise differ from Physical Therapy Services furnished under the State plan, except those palliative therapies, and maintenance therapies to prevent deterioration, will continue to be provided by this waiver. Maintenance therapies continue to be provided as previously approved. Montana's HELP Act was implemented January 1, 2016, and includes the removal of the limitations to Physical Therapy. Maintenance therapies continue to be provided under waiver services.

This service shall be authorized and delivered using person-centered practices.

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

Any activities provided under this service must be tied to goals and objectives in the individualized service plan and necessary to avoid institutionalization. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

These services are not available for special education and related services that are required to be provided through a child's Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Agency or Hospital
Individual	Physical Therapist
Agency	Home Care Agency

### Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Physical Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency or Hospital

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

ARM 37.40.1461

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Conduent/State

**Frequency of Verification:**

Upon enrollment and renewal license/certification

### Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Physical Therapy**

**Provider Category:**

Individual

**Provider Type:**

Physical Therapist

**Provider Qualifications**

**License (specify):**

State license

**Certificate (specify):**

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

ARM 37.40.1461  
 A member’s legally responsible individual may provide Physical Therapy services if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Conduent/State

**Frequency of Verification:**

Upon enrollment and renewal of license.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Physical Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

ARM 37.40.1461

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Conduent/State

**Frequency of Verification:**

Upon enrollment and every two years thereafter

**Appendix C: Participant Services**

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Post Acute Rehabilitation Services

**HCBS Taxonomy:**

**Category 1:**

10 Other Mental Health and Behavioral Services

**Sub-Category 1:**

10070 psychosocial rehabilitation

**Category 2:**

11 Other Health and Therapeutic Services

**Sub-Category 2:**

11120 cognitive rehabilitative therapy

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Post-acute Rehabilitation is a residential or a non-residential program for persons with a traumatic brain injury, or other severe disability that would benefit from these services. It is intended to maximize functional independence through therapeutic intervention that provides intensive therapies three to five days a week.

Members are taught strategies to overcome barriers created by their disability, learn compensatory techniques for memory loss and behavior problems and relearn day-to-day living skills. The goal of this program is to facilitate integration into the community and in addition to reducing the level of disability of the member. Therapies provided under this service cannot duplicate those available under the State Plan nor will they be provided simultaneously with occupational, speech, or physical therapies provided under the waiver.

Post Acute Rehabilitation is provided by an agency under the direction of an interdisciplinary team consisting of a board certified psychiatrist, a licensed neuro-psychologist, or a licensed psychologist, occupational, speech, physical therapists, and other appropriate support staff. A provider of this service must be accredited by CARF as a Community Re-Entry Program of Persons with a Traumatic Brain Injury or receive such accreditation within two years of commencement of this service under the BSW program.

This service shall be authorized and delivered using person-centered practices.

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

Therapies provided under this service are not duplicative of those available under state plan nor will they be provided simultaneously with occupational, speech or physical therapies provided under this waiver.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Health Care Provider, Rehabilitation or Medical

### Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Post Acute Rehabilitation Services

Provider Category:

Agency

Provider Type:

Health Care Provider, Rehabilitation or Medical

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

ARM 37.40.1446

Verification of Provider Qualifications

Entity Responsible for Verification:

State/Conduent

Frequency of Verification:

Upon enrollment and every two years thereafter or upon license renewal.



## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Senior Companion

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08040 companion

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Senior Companion services are directed at providing companionship in the home. This service is not appropriate for a member who requires hands-on assistance with personal care needs or assistance with homemaking or the completion of tasks or chores.

The provision of Senior Companion service shall not include:

1. Activities provided in conjunction with an ADL, IADL, supervision or community integration;
2. Activities to support health and safety when the member has a medical or functional need for monitoring, supervision, or community inclusion;
3. Nursing care;
4. Activities to provide medical care; or
5. Personal Attendant Services available under State Plan Medicaid.

This service shall be authorized and delivered using person-centered practices.

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

This service will not be provided simultaneously with other BSW services.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Senior Companion Programs through Area Agencies on Aging.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Senior Companion**

**Provider Category:**

Agency

**Provider Type:**

Senior Companion Programs through Area Agencies on Aging.

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

Providers of these services are Senior Companion programs that are a part of Area Agencies on Aging.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Service Animals

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17010 goods and services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

A service animal, as currently defined under the Americans with Disabilities Act, is trained to do work or perform particular tasks, which benefit an individual with a disability or an individual who is aged. Examples of these tasks may include guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders or sounds, pulling a wheelchair or fetching dropped items or other tasks specific to the individual. The service animal is intended to increase autonomy, to decrease functional limitations, to access the home or public environment, to provide for safety and to reduce the risk of institutionalization. Service Animal supplies if specifically related to the performance of the service animal to meet the specific needs of the member. If not provided by the training organization, these supplies may include leashes, harness, backpack, and mobility cart may be provided under the specialized Medical Equipment and Supplies service.

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

Service animal supplies and care do not include:

1. Food to maintain the animal; and
2. Any supplies for the following:
3. Pets, companion animals, social therapy animals;
4. Guard, police, rescue, sled, tracking or any other animal not specifically designated as a service animal; and
5. Wild, exotic or any other animals not specifically supplied by a training program on the approved provider list.
6. Health and maintenance of a service animal including veterinarian care, transportation for veterinarian care, license and/or registration, and grooming.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Service Animal Training Provider

## Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Service Animals

**Provider Category:**

Agency

**Provider Type:**

Service Animal Training Provider

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

Training conforms with service animal criteria as outlined in the current Americans with Disabilities Act.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid Agency

**Frequency of Verification:**

Upon enrollment.

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Skilled Nursing

**HCBS Taxonomy:**

**Category 1:**

05 Nursing

**Sub-Category 1:**

05010 private duty nursing

**Category 2:**

05 Nursing

**Sub-Category 2:**

05020 skilled nursing

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**

Service provides nursing services by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) licensed to practice in Montana. These services are provided to a member at home or in an adult residential care facility. Private Duty Nursing services are medically necessary services provided to members who require continuous in-home nursing care that is not available from a home health agency. Private Duty Nursing service provided by an LPN must be supervised by an RN, physician, dentist, osteopath, or podiatrist authorized by State law to prescribe medication and treatment. Private Duty Nursing may be prescribed only when Home Health Agency Services, as provided in ARM 37.40.701, are not appropriate or available and must comply with the Montana Nurse Practice Act. Services are provided according to the members service and support plan, which documents the members specific health-related need for nursing. Use of a nurse to routinely check skin condition, review medication use or perform other nursing duties in the absence of a specific identified problem, is not allowable. General statements such a monitor health needs are not considered sufficient documentation for the service. Services are not available to individuals who are eligible to receive such service through the Medicaid State Plan(including EPSDT benefits) If Private Duty Nursing is not available under State Plan, i.e., Private Duty Nursing supervision or Private Duty Nursing respite, then waiver Private Duty Nursing is allowable. Private Duty Nursing is not a State Plan service for adults.

This service shall be authorized and delivered using person-centered practices.

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

A member’s legally responsible individual may provide private duty nursing if they are licensed in accordance with state regulations, in good standing and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Care/Health Care Provider
Individual	Licensed Practical Nurse, Registered Nurse

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Skilled Nursing**

**Provider Category:**

Agency

**Provider Type:**

Home Care/Health Care Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** (*specify*):

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

A member’s legally responsible individual may provide nursing services if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.ARM 47.40.1477

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter or upon license renewal.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Skilled Nursing**

**Provider Category:**

Individual

**Provider Type:**

Licensed Practical Nurse, Registered Nurse

**Provider Qualifications**

**License** (*specify*):

State of Montana LPN or RN License

**Certificate** (*specify*):

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

ARM 37.40.1477  
A member’s legally responsible individual may provide private duty nursing if they are licensed in accordance with state regulations and are enrolled as a Medicaid waiver provider through Conduent. Conduent verifies the provider is free of exclusions and criminal activity as part of the enrollment process.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/IA/FM

**Frequency of Verification:**

Upon enrollment and license renewal.

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Specialized Child Care for Children Who Are Medically Fragile

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04080 medical day care for children

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

**Service Definition (Scope):**



This service provides daycare for medically fragile children who, because of their disability, cannot be served in traditional childcare settings. This service is limited to medically fragile children and may not be used to provide services that are the responsibility of the parent.

This service need must be verified in writing by the child’s health care professional and the case management team must maintain a copy of the verification in the child’s chart. Payment for specialized childcare may be rendered by legally responsible individuals when such services are deemed extraordinary care.

Extraordinary care is defined here as:

- a. care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and
- b. which are necessary to assure the health and welfare of the participant and avoid institutionalization;
- c. that is the provision of day care, respite care, and other direct and supportive care to a member under 18 years of age who is medically fragile and who, due to medical and other needs, cannot be served through traditional childcare settings as verified through the member’s health care professional; and
- d. that does not require skilled nursing.

A provider of this service must be physically and mentally able to perform the duties required and must be literate and able to follow orders.

This service shall be authorized and delivered using person-centered practices.

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

Legally Responsible Persons can not be paid for this service.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Care Agency, PAS Provider

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Specialized Child Care for Children Who Are Medically Fragile**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency, PAS Provider

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

A person providing specialized child care for medically fragile children services must be:

- (a) physically and mentally able to perform the duties;
- (b) aware of emergency assistance systems; and
- (c) literate and able to follow written orders.

(3) A person providing specialized child care for medically fragile children services may be required, if appropriate to the circumstances of the consumer, to have:

- (a) knowledge of the physical and mental conditions of the consumer;
- (b) knowledge of the consumer's commonly needed medications and the conditions for which they are administered; and
- (c) the capability to administer basic first aid.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduit

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Specialized Medical Equipment and Supplies

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14031 equipment and technology

**Category 2:**

14 Equipment, Technology, and Modifications

**Sub-Category 2:**

14032 supplies

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Specialized medical equipment and supplies include devices, controls, or appliances specified in the service and support plan which enable members to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Also includes items for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under State Plan Medicaid. Items reimbursed with waiver funds shall be in addition any medical equipment and supplies furnished under the State Plan Medicaid and shall exclude those items, which are not of direct or remedial benefit to the member. All items shall be applicable standards of manufacture, design and installation.

Service Animal supplies if specifically related to the performance of the service animal to meet the specific needs of the member. If not provided by the training organization, these supplies may include leashes, harness, backpack, and mobility cart may be provided under the specialized Medical Equipment and Supplies service.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Specialized Medical Equipment and Supplies will be limited to a one-time purchase with the exception of supplies not covered by State Plan Medicaid services. The Division, at its discretion, may authorize an exception to this policy. Purchases in excess of \$5,000 must receive prior authorization from the RPO. This service is not duplicative of those services provided under environmental accessibility adaptations.

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

These services are not available for special education and related services that are required to be provided through a child's Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supplier of DME and Retailers

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Specialized Medical Equipment and Supplies**

**Provider Category:**

Agency

**Provider Type:**

Supplier of DME and Retailers

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Complete a Montana Department of Justice criminal background check and results maintained in the file.  
 Provider must have no felony convictions.  
 If providers fail to meet the required qualifications, fail the background check or have had their Montana business license revoked or lapsed, they will either not be enrolled or they will be terminated as a waiver provider.  
 The Department will check the Excluded Individual and Entities List, and the Medicare Exclusion list and the Licensee Lookup System prior to re-enrollment of provider.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Specially Trained Attendant

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17010 goods and services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

The Specially Trained Attendant (STA) service provides specialized supportive services to a member requiring providers specially trained to meet the unique needs of the member. Areas of special training may include assisting a member with a traumatic brain injury, dementia, or extensive physical disabilities. This service shall not duplicate or supplant services available through other BSW services, State Plan Medicaid, Vocational Rehabilitation, Department of Education, or other third-party payers. This service shall only be available to members whose needs exceed the services available through Community First Choice State Plan Personal Assistance Services. This service may be provided in the member's residence or community setting.

STA care services may include:

1. Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) and Socialization/Supervision for individuals whose disability requires services by an attendant with additional training. It is typically utilized for individuals with brain injuries, severe dementia or severe physical disabilities whose needs cannot be met by standard PAS.
2. STA/Life Coach that assist individuals to acquire, retain and improve self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings. These providers must have extensive knowledge of the community and community resources. They are not required to have basic PAS training.

It is the responsibility of the provider agency to ensure that attendants are appropriately trained under agency-based services or the member under the self-directed and member-directed programs. It is the responsibility of the Case Management Team to define, document and arrange for any specialized training for a Specially Trained Attendant. Verification of training shall be maintained in the member's case file.

This service shall be authorized and delivered using person-centered practices.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

STA ADL may not be used in conjunction with Community First Choice ADL.

**Retainer Days**

Providers of this service may be eligible for a retainer payment if authorized by the case management team or IA/FM.

Retainer payments allow providers to be reimbursed when the member is absent from the home or adult residential care facility due to entry to a hospital or nursing facility or on vacation (absence from services). Retainer payments are available to keep members from losing their caregivers or placement in a residential care facility.

Retainer days are limited to no more than 24 days per resident in each rate year (July 1 through June 30).

Retainer days for STA service:

1. ADL/IADL and Socialization/Supervision – only use retainer days when and if the attendants cannot work for others while the member is absent, and they would lose income.
2. STA/Life Coach – only use retainer days when and if the attendants cannot work for others while the member, they work with is absent and they would lose income.

Members residing in a Community Adult Group Home or Level 3 Facility shall not receive this service. Specially Trained Attendants may receive retainer payments when they cannot work for others while the member is absent, resulting in a loss of income for the attendant.

This service must not be provided when payment is being made for the member to receive Level 1, 2 or 3 services, Community Adult Group Homes, Adult Foster Care or Supported Living.

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

These services are not available for special education and related services that are required to be provided through a child's Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

**Service Delivery Method** (check each that applies):

**Participant-directed as specified in Appendix E**

**Provider managed**

Specify whether the service may be provided by (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Living Provider
Agency	Home Care Agency
Agency	Personal Assistance Agencies
Individual	Personal Assistant
Individual	Specially Trained Personal Assistant

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Specially Trained Attendant**

**Provider Category:**

Agency

**Provider Type:**

Supported Living Provider

**Provider Qualifications**

**License (*specify*):**

**Certificate (*specify*):**

**Other Standard (*specify*):**

The individual must:

- Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);
- Possess a valid Social Security Number;
- Be a US citizen or possess a valid work permit;
- Sign an affidavit regarding confidentiality and HIPAA;
- Possess the ability to communicate effectively with the member/personal representative;
- Possess the ability to complete documentation requirements of the program;
- Demonstrate to the member specific competencies necessary to perform paid tasks;
- Complete a self-declaration regarding infections and contagious diseases;
- At the discretion of the member agree to a state criminal background check;
- Possess a valid driver’s license and proof of automobile liability insurance if transporting the member;
- Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and
- Advocate for the member to assure that the member’s rights are protected, and the member’s needs and preferences are honored.

These attendants must have the following training and qualifications:

- a. Basic personal assistant services training as defined by the Community Services Bureau;
- b. Ten (10) hours of disability-specific training; and
- c. Four (4) hours of member-specific training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduit

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Specially Trained Attendant**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**



The individual must:

- Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);
- Possess a valid Social Security Number;
- Be a US citizen or possess a valid work permit;
- Sign an affidavit regarding confidentiality and HIPAA;
- Possess the ability to communicate effectively with the member/personal representative;
- Possess the ability to complete documentation requirements of the program;
- Demonstrate to the member specific competencies necessary to perform paid tasks;
- Complete a self-declaration regarding infections and contagious diseases;
- At the discretion of the member agree to a state criminal background check;
- Possess a valid driver’s license and proof of automobile liability insurance if transporting the member;
- Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and
- Advocate for the member to assure that the member’s rights are protected, and the member’s needs and preferences are honored.

These attendants must have the following training and qualifications:

- a. Basic personal assistant services training as defined by the Community Services Bureau;
- b. Ten (10) hours of disability-specific training; and
- c. Four (4) hours of member-specific training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduit

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Specially Trained Attendant**

**Provider Category:**

Agency

**Provider Type:**

Personal Assistance Agencies

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The individual must:

- Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);
- Possess a valid Social Security Number;
- Be a US citizen or possess a valid work permit;
- Sign an affidavit regarding confidentiality and HIPAA;
- Possess the ability to communicate effectively with the member/personal representative;
- Possess the ability to complete documentation requirements of the program;
- Demonstrate to the member specific competencies necessary to perform paid tasks;
- Complete a self-declaration regarding infections and contagious diseases;
- At the discretion of the member agree to a state criminal background check;
- Possess a valid driver’s license and proof of automobile liability insurance if transporting the member;
- Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and
- Advocate for the member to assure that the member’s rights are protected, and the member’s needs and preferences are honored.

These attendants must have the following training and qualifications:

- a. Basic personal assistant services training as defined by the Community Services Bureau;
- b. Ten (10) hours of disability-specific training; and
- c. Four (4) hours of member-specific training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduit

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Specially Trained Attendant**

**Provider Category:**

Individual

**Provider Type:**

Personal Assistant

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The individual must:

- Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);
- Possess a valid Social Security Number;
- Be a US citizen or possess a valid work permit;
- Sign an affidavit regarding confidentiality and HIPAA;
- Possess the ability to communicate effectively with the member/personal representative;
- Possess the ability to complete documentation requirements of the program;
- Demonstrate to the member specific competencies necessary to perform paid tasks;
- Complete a self-declaration regarding infections and contagious diseases;
- At the discretion of the member agree to a state criminal background check;
- Possess a valid driver’s license and proof of automobile liability insurance if transporting the member;
- Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and
- Advocate for the member to assure that the member’s rights are protected, and the member’s needs and preferences are honored.

These attendants must have the following training and qualifications:

- a. Basic personal assistant services training as defined by the Community Services Bureau;
- b. Ten (10) hours of disability-specific training; and
- c. Four (4) hours of member-specific training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Member and IA/FM

**Frequency of Verification:**

Upon enrollment and as necessary.

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Specially Trained Attendant**

**Provider Category:**

Individual

**Provider Type:**

Specially Trained Personal Assistant

**Provider Qualifications**

**License (specify):**

If a nurse, must be licensed by the state.

**Certificate (specify):**

**Other Standard (specify):**

The individual must:

- Be 18 years of age (exceptions that are applicable within state law may be granted by the Division);
- Possess a valid Social Security Number;
- Be a US citizen or possess a valid work permit;
- Sign an affidavit regarding confidentiality and HIPAA;
- Possess the ability to communicate effectively with the member/personal representative;
- Possess the ability to complete documentation requirements of the program;
- Demonstrate to the member specific competencies necessary to perform paid tasks;
- Complete a self-declaration regarding infections and contagious diseases;
- At the discretion of the member agree to a state criminal background check;
- Possess a valid driver’s license and proof of automobile liability insurance if transporting the member;
- Demonstrate knowledge of how to report abuse, neglect and exploitation and sign an affidavit regarding agreement to report all instances of suspected abuse, neglect or exploitation; and
- Advocate for the member to assure that the member’s rights are protected, and the member’s needs and preferences are honored.

These attendants must have the following training and qualifications:

- a. Basic personal assistant services training as defined by the Community Services Bureau;
- b. Ten (10) hours of disability-specific training; and
- c. Four (4) hours of member-specific training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Member and IA/FM

**Frequency of Verification:**

Upon enrollment and as necessary.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Vehicle Modifications

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14020 home and/or vehicle accessibility adaptations

**Category 2:**

**Sub-Category 2:**

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Vehicle modifications are modifications made to a personal vehicle that will allow the member to be more independent. These modifications would be specified in the service plan as necessary to enable the member to more fully integrate into the community and to ensure their health, safety and welfare. These adaptations would not include regularly scheduled upkeep and maintenance of a vehicle. This service does not include adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the member. This service does not include the purchase or lease of a vehicle and/or partial purchase of vehicle already modified.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by (check each that applies):**

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Automotive Repair Shops

### Appendix C: Participant Services

#### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Vehicle Modifications**

**Provider Category:**

Agency

**Provider Type:**

Automotive Repair Shops

**Provider Qualifications**

**License** (*specify*):

Auto repair shop licensed by the State of Montana.

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State/Conduent

**Frequency of Verification:**

Upon enrollment and every two years thereafter.

**Appendix C: Participant Services**

**C-1: Summary of Services Covered (2 of 2)**

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

**Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

**As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

**As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

**As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management will be provided under the authority of a 1915(b)(4) waiver to be providers of this service. The case management team is also eligible to provide Community Services at the choice of the member.

Case Management is provided by Medicaid enrolled provider agencies. In order to provide quality services, the agencies must have employees with the education, and competencies necessary to meet the needs of the individuals they serve. Case management teams must include a nurse licensed to practice in the State of Montana, a BSW social worker and appropriate clerical and support staff.

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

- b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

**No. The state does not conduct abuse registry screening.**

**Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**Note: Required information from this page is contained in response to C-5.**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver

participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

**No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*



The state makes payment to legally responsible individuals for the provision of extraordinary care when the care is in the best interest of the member. A legally responsible individual includes biological and adoptive parents of recipients under 18, spouses of adult recipients, and court appointed guardians.

Extraordinary care is defined as care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. Care can include line of sight supervision, night supervision or when not required by a person without a disability of the same age. Authorization of services are based on recommendations of the plan of care professional, as well as comparison to the developmental stage of an equivalent person without a disability of the same age.

The following services may be provided by a legally responsible person:

Personal Assistance Services (BSW/PAS)

Specially Trained Attendant

Homemaker

Homemaker Chore

A relative, spouse or legal guardian who is a member's authorized representative may not be paid to provide services.

To be paid for the provision of BSW services all the following authorization criteria and monitoring provisions must be met.

The service must:

1. Meet the definition of a service/support as outlined in the federally approved waiver plan;
2. Be necessary to avoid institutionalization;
3. Be a service/support that is specified in the member service and support plan;
4. Be provided by a parent or spouse who meets the provider qualifications and training standards specified in the waiver for that service;
5. Be paid at a rate that does not exceed what is allowed by the department for the payment of similar services;
6. Not be an activity that the family would ordinarily perform or is responsible to perform; and
7. The service(s) must be necessary to assure the health and welfare of the participant.

Montana ensures that the provision of personal care or similar services by a legally responsible individual is in the best interest of the participant by ensuring that appropriate informed consent was given during the process of planning process.

Services must address the following:

1. Services must include the promotion of independence, which allows legally responsible individuals to provide HCBS services empower participants to receive care and support within their own comfort and familiarity of their own homes.
2. Services delivered by legally responsible individual must enhance quality of care. Legally responsible individuals often have a deep understanding of the participant's unique needs, preferences, and routines. This intimate knowledge allows them to deliver care that is tailored to the individual, resulting in a higher quality of service provision.
3. Services delivered by a legally responsible individual must strengthen social supports because in many cases legally responsible individuals are family members or spouses that play a significant role in the participant's support network. Allowing them to provide HCBS services foster the continuation and strengthening of the social supports, which are crucial for the participant's overall well-being.
4. Services delivered by legally responsible individuals must be the most cost-effective services available, utilizing legally responsible individuals as caregivers for HCBS services can often be more cost-effective solution compared to hiring external caregivers or utilizing institutional care settings.
5. Services delivered by legally responsible individuals must be a participant centered choice and allows everyone to have the freedom to choose who will support them in their daily lives. This flexibility is essential for promoting participant choice and dignity.
6. Services delivered by legally responsible individuals can sometimes become the only way to ensure effective service delivery due to a lack of available services in the community, preventing caregiver burnout, and/or preventing institutionalization.

Claims billed and paid for services are screened to ensure that waiver participants received services within the scope, type, amount, and frequency of services authorized within the service plan.

For both the Agency Based and Self Direct personal assistance the family member must utilize the required EVV documentation for hours paid.

For authorized waiver services the difference between self-directed and agency-based service delivery by a legally responsible person is that services delivered through agency-based require that the person delivering the services received the required training by the Provider agency's training which is at least 16 hours and contains mandatory subjects.

Montana prioritizes proactive measures to address potential risks associated with service provision by legally responsible individuals by ensuring that individuals and their legal representatives are fully informed about potential risks by empowering them to make informed decisions through informed consent.

In certain situations, there may need to be a more nuanced approach to risk management. In such cases, the state utilizes the process of risk negotiated agreements, wherein all involved parties collaboratively discuss and agree upon strategies to mitigate risk while still meeting the individual's needs and preferences.

Additionally, risk mitigation is ingrained within the foundation of the person-centered planning approach. During the creation of person-centered plans, the process reactively identifies potential risks and develops comprehensive contingency plans to address them effectively. By incorporating these risk mitigation strategies, it can help ensure that individuals receive the support they need while minimizing potential harm.

Members are offered a choice of providers. Case managers are trained meet with participants privately to assure that they capture any concerns or choices the participant might express without undue influence from others who may benefit from the person's service plan. This meeting occurs at least annually and more often as requested or needed. In addition to case management, monitoring and reporting activities required for all waiver services, the following additional requirements are employed when a relative or legal guardian is paid as a care provider:

Every attempt is made to consult with the waiver participant to ensure person-centered planning methodology is used in the choice of providers or caregivers and in the best interest of the member. Although a member's age will determine whether he or she is able to assist in the development of their care plan, BSW will follow applicable federal and state regulations (specifically MCA 41.1.1401 MCA) regarding establishing the member's ability to consent to health services. If a minor does not want to involve a parent or guardian in their plan of care, BSW will consider the patient's rights with the parent's rights while maintaining the highest degree of HIPAA confidentiality available for the member.

#### **Self-directed**

#### **Agency-operated**

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

**The state does not make payment to relatives/legal guardians for furnishing waiver services.**

**The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

The family member who is a service provider will comply with the following:

- 1) For both Agency Based and Self Direct personal assistance the family member must utilize the required EVV system to document services delivered
- 2) Only services approved in the person centered service plan are reimbursable.
- 3) Be subject to quality assurance requirements, which may or may not involve a home visit.

Montana is currently contracted with Netsmart to develop a successful adoption of Electronic Visit Verification (EVV) for Montana providers. Montana completed a successful implementation of an EVV system for Montana providers. EVV registration opened 09/18/2023 and MT has 88% of providers registered and actively using the solution and will deny services submitted that are not compliance with the EVV mandate on 07/01/2024. BSW Services subject to EVV are, "Specially Trained Attendant; Respite Care; BSW Personal Assistance; Specialized Childcare for Children; and Supported Living."

**Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Providers that meet provider requirements are welcome to enroll as a Medicaid provider. All requests for enrollment in the Medicaid Program must be made to Conduent EDI Solutions, Inc. The provider enrollment process is managed online by Conduent via Montana's MPATH provider services system. Conduent assists providers to navigate the online system and provide status reports on the enrollment process. The enrollment forms must be completed in their entirety before Conduent can approve and process the enrollment application. Conduent will forward completed enrollment forms to the Senior and Long Term Care Division for approval, procedure codes and rates.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**i. Sub-Assurances:**

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are*

*identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number/percent of new providers required to be licensed/certified that were verified to initially meet state licensure/certification Assurances. The numerator is the number of new providers required to be licensed or certified that were verified to initially meet state licensure/certification Assurances. The denominator is the total number of the providers that require license or certification.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1122 1262 1205" type="text"/>
Other Specify: <input data-bbox="408 1346 647 1429" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1346 1262 1429" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1570 1262 1653" type="text"/>
	Other Specify: <input data-bbox="719 1794 954 1877" type="text"/> Monthly/Upon Enrollment	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

**Performance Measure:**

**Number/percent of providers required to be licensed or certified that were verified to continually meet state licensure/certification Assurances. The numerator is the number of providers required to be licensed or certified that were verified to continually meet state licensure/certification Assurances. The denominator is the total number of providers that require licensure or certification.**

**Data Source** (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  <input type="text"/>

<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number/percent of nonlicensed/noncertified providers that continually meet waiver requirements. The numerator is the number of nonlicensed/noncertified waiver providers that continually meet waiver requirements. The denominator is the total number of ongoing nonlicensed/noncertified waiver providers.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="Conduent"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

**Performance Measure:**

**Number/percent of new nonlicensed/noncertified providers that meet waiver requirements. The numerator is the number of new nonlicensed/noncertified waiver providers that meet waiver requirements. The denominator is the total number of new nonlicensed/noncertified waiver providers.**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

**Conduent**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  <input type="text"/>



<b>Other</b> Specify:  <input type="text" value="Conduent"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text" value="Upon Enrollment"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the*

*method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**The number/percent of Financial Managers (FM) who receive state approved waiver training. The numerator is the number of new FMs who receive state approved waiver training. The denominator is the total number of new FMs.**

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):  
**Training verification records**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>

<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**Number/percent of new case managers who receive state approved waiver training.**The numerator is the number of new case managers who receive state approved waiver training. The denominator is the total number of new case managers.

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="Case Management Teams"/>	Annually	<b>Stratified</b> Describe Group: <input type="text"/>
	Continuously and Ongoing	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify:	Annually

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number/percent of new specially trained attendants who receive state approved waiver training.**The numerator is the number of new specially trained attendants who receive state approved waiver training. The denominator is the total number of new specially trained attendants.

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="Optum System"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<p><b>Representative Sample</b> Confidence Interval =</p> <input type="text"/>
<p><b>Other</b> Specify:</p> <input type="text" value="Optum System"/>	<b>Annually</b>	<p><b>Stratified</b> Describe Group:</p> <input type="text"/>
	<b>Continuously and Ongoing</b>	<p><b>Other</b> Specify:</p> <input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	



**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="406 616 790 660" type="text" value="Optum System"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="869 862 1252 929" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Department does not do criminal background checks; however, Conduent EDI Solutions, Inc. checks with licensing entities within the Department of Labor and Industries, the Office of Inspector General (OIG), Excluded Individual and Entities List, and Medicare exclusion lists prior to enrolling a provider. The hardcopy of the Licensee Lookup System indicates any adverse action or information regarding the enrolled provider and may prevent that individual or agency from being enrolled as a waiver provider. When a provider's license is renewed Conduent will once again check the Excluded Individual and Entities List, Medicare Exclusion list and the Licensee Lookup System prior to re-enrollment of provider. Non licensed/certified providers will be re-evaluated every two years by Conduent to ensure that they still meet department standards. All contracts issued by the Department go through a review process to insure the potential contractor is not on the Federal list of debarred contractors. CSB and/or Conduent staff provide on-going training to agencies, as necessary, to ensure that agencies are informed of relevant changes in state and federal policy and procedure. They assist in the training of new agency oversight staff around program policy and procedure (at agency request).  
 Providers will not be enrolled if they:  
 a. Do not meet required qualifications;  
 b. Fail background checks; or  
 c. Have their license/certification revoked.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Providers that do not have the required qualifications, license, or certification for the specific waiver service cannot be enrolled as a waiver provider for that service. If a providers license/certification has been revoked, that agency/individual will no longer be allowed to provide the service. Repayment procedures will be initiated for payment of services provided after the license/certification expiration date. Members will be given a new choice of providers if available and assisted in the transition process.

Big Sky Bonanza Independence Advisors (IA) and Big Sky Bonanza Financial Managers (FM) will be trained and certified prior to enrollment as a provider. Case Managers (CM) will be trained within the first year of employment.

If an IA, FM or CM failed to go through the appropriate training a Quality Assurance Communication (QAC) will be issued and the provider must respond within 30 days explaining the reason for lack of training. Members will be given a new choice of providers. If the IA, FM or CM want to continue to provide the service they must participate in the next scheduled training.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix C: Participant Services**

**C-3: Waiver Services Specifications**

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

### Appendix C: Participant Services

#### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

**Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

*Furnish the information specified above.*

**Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

*Furnish the information specified above.*

**Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

*Furnish the information specified above.*

**Other Type of Limit.** The state employs another type of limit.

*Describe the limit and furnish the information specified above.*

### Appendix C: Participant Services

#### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the

future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

Montana submitted a Corrective Action Plan (CAP), pending CMS approval.

Montana understands that all Medicaid reimbursed HCBS settings within the state must be compliant with the following regulatory settings criteria:

- Privacy, dignity, respect, and freedom from coercion and restraint; and
- Control of personal resources.

Additionally, all provider owned/controlled Medicaid reimbursed HCBS residential settings must be compliant with the following criteria:

- A lease or other legally enforceable agreement providing similar protections,
- Privacy in their unit, including lockable doors, and freedom to furnish or decorate the unit,
- Access to food at any time,
- Access to visitors at any time,
- Physical accessibility, and
- Person-centered service plan documentation of modifications to relevant regulatory criteria.

Providers must be in compliance with these conditions by March 17, 2023, and this CAP does not request an extension of those regulatory requirements.

Montana is requesting continued time to perform re-validations, improve documentation and follow-up with providers currently implementing site specific remediation plans for all settings criteria not described above. The settings criteria in the scope of this CAP include:

- Access to the broader community,
- Opportunities for employment,
- Option for a private unit and/or choice of a roommate, and
- Choice of non-disability specific settings.

Each Setting is required to complete a Provider Self-Assessment (PSA) and SMA completes a Validation Tool and Onsite Visit. Facilities requiring a settings review include Assisted Living Facilities, Adult Foster Care and Group Homes which are all residential habilitation services. All BSW providers completed a Provider Self-Assessment (PSA) for each of their residential and non-residential settings. BSW quality assurance personnel completed at least one on-site visit using the Validation Tool assessment in the years preceding the March 2023 deadline for transitional settings and any new settings. The current site assessment results are as follows:

#### Compliant Settings

Day Supports and Activities-7

Supported Employment-4

Group Home-0

Supported Living-2

Assisted Living-230

Adult Foster-2

#### CAP Settings

Day Supports and Activities-3

Assisted Living-1

In 2024, Montana will be deploying an electronic assessment and case tracking solution with an anticipated go live date projected to be in the 2024 calendar year. This efficiency step will allow providers and the department to work effectively, using provider completed assessments, discrete site level documentation, document storage and routing, and documented follow-up and results tracking. Future iterations of the solution will assist in identifying high risk settings, at-risk situations, changes in ownership, or received grievance/complaints that will necessitate more frequent re-validations and/or site visits.

SMA monitor ongoing compliance by requiring Settings to complete a new Provider Self-Assessment and SMA completes a Validation Tool and Onsite Visit at least every three years. SMA and/or Case Management Teams provide additional monitoring when meeting with members in facilities and in their homes a minimum of every six months or as issues arise.

New providers would require a PSA and an onsite review as part of the provider enrollment process.

SMA monitors for Settings compliance by ensuring that each facility:

- Is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS;
- Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices; including but not limited to, daily activities, physical environment, and with whom to interact;

- Facilitates choice regarding services and who provides them.

The individual has a lease or other legally enforceable agreement providing similar protections. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

- The individual has privacy in their sleeping or living unit including:

Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

Individuals sharing units have a choice of roommates in that setting.

Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

- The individual has the freedom and support to control his/her own schedule and activities, including access to food at any time;
- The individual can have visitors of their choosing at any time; and
- The setting is physically accessible to the individual.

Case managers are trained annually on the Settings criteria and how to file a grievance. This would include what would constitute a violation and the reporting process to the SMA. Additionally, the person-centered plan of care process that occurs face to face at least annually will continue to capture member choices and ensure the Home Community Based Services Settings criteria is adhered to. Case managers are trained annually on compliance with the settings rule and the importance of face-to-face meetings which are held privately with members and or their personal representatives to ensure that they capture feedback from the member regarding the facility/providers compliance with settings regulations. The private meeting with the member ensures that the member can speak freely without parties who might benefit from service decisions being in attendance.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

#### State Participant-Centered Service Plan Title:

Service Plan

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

**Registered nurse, licensed to practice in the state**

**Licensed practical or vocational nurse, acting within the scope of practice under state law**

**Licensed physician (M.D. or D.O)**

**Case Manager** (qualifications specified in Appendix C-1/C-3)

**Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

**Social Worker**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

**Appendix D: Participant-Centered Planning and Service Delivery**

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**D-1: Service Plan Development (2 of 8)**

**b. Service Plan Development Safeguards. *Select one:***

**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Montana contracts for Case Management Teams. CMTs who are required by proposal response and subsequent state contract, to professionally provide and present non-biased information to members regarding all qualified service providers of services without influencing the member decision. The member makes the choice of provider.

Currently MT has two firms providing CM within in the state. Staff of the firms are required to notice individuals of all services and all options of providers for service and identify those that are associated with the CM firm. Due to the frontier status in many parts of Montana, a related firm maybe the only option to receive agency services, self-direct option can also be utilized in these situations, at the request of the member or member's representative. The CM still retains the responsibility to create the person centered plan.

If a member believes there is another entity to develop the person-centered plan, the individual has a right to a fair hearing. Fair hearing rights are provided and documented as provided at each meeting between the member and the CM. The member can file for a hearing which will be processed with an Administrative Review to examine all options, if the results are not in favor of the member, they're provided the directions to continue the appeal.

Montana meets requirements as with an approved 1915 (b)(4) that allows for selective contracting for case management. Currently MT has two firms providing CM within in the state. Staff of the firms are required to notice individuals of all options of providers for service and identify those that are associated with the CM firm. Due to the frontier status in many parts of Montana, a related firm maybe the only option to receive agency services, self-direct option can also be utilized in these situations, at the request of the member or member's representative. The CM still retains the responsibility to create the person centered plan.

The Quality Improvement Organization (QIO) provides information on the Big Sky Waiver (BSW) services initially requested by the applicant during the level of care visit.

Case Managers can provide CM services and community Transition. Community Transitions are also provided by Independent Living Centers

The CMT receives the referral from the QIO and schedules the on-site wait-list visit, at which time a full description of all Big Sky Waiver services, delivery options, eligibility requirements and exclusions are provided to the members.

Once an individual is determined eligible for services, members attend the admit visit, scheduled at the time and location convenient to the member, and begin working with the CMTs to develop their person-centered service plan, which includes the goals and desires of the member, services that are being furnished, the amount and frequency and duration of each service, and the type of provider who will furnish the services. The service plan is revised as necessary, modifying, adding or deleting services as necessary to meet the members desires and needs. Service plans are reviewed at least annually, or whenever necessary when there is a change in member needs.

After creating the service plan, members sign a client choice form confirming that, "The service plan addresses their needs and personal goals, including health and safety; that they made a free choice of services and qualified providers for services included in the service plan; they received a free choice between institutional care and HCBS; received information on abuse/neglect and exploitation and no matter reported; and agreeing that they had participate in the development of the service plan and agree with it." These selections are auto populated in a report that is run for performance measures and is also verified during both the quarterly chart audit by CMTs, as well as at least once every three years during the Quality Assurance Reviews.

- a. Performance measures have been established in the waiver application to ensure a direct oversight of the waiver application.
- b. BSW restricts the entity that develops the person-centered service plan from providing services without direct approval of the state.
- c. BSW requires the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)



- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Development of the member service is developed by the Case Manager and member/member representative. The member may choose to have a support team present to participate in the plan development. The support team may include the Independence Advisor, if the member has chosen to self-direct their services, family, friends, and anyone else of the member's choosing. The Case Management Team (CMT) will maximize the extent to which a member participates in the service planning process by explaining the person-centered planning process; assisting the member to explore and identify his/her preferences, desired outcomes, goals, and the services and supports that will assist him/her in achieving desired outcomes; identifying and reviewing with the member issues to be discussed during the planning process; and giving each member an opportunity to determine the location and time of planning meetings, participants attending the meetings, and frequency and length of the meetings. The member will have the authority to determine who is included in the process of service plan development. The member or his/her legal representative authorizes the service and support plan once it is completed.

Members selecting to direct their services, receive information and training to assist in service plan development during the participant-direction training. Members will develop the service plan with their CM and a support team. The support team may include the Independence Advisor, Financial Manager, family, friends, and anyone else of the member's choosing. The CM will maximize the extent to which a member participates in the service planning process by explaining the person-centered planning process; assisting the member to explore and identify his/her preferences, desired outcomes, goals and the services and supports that will assist him/her in achieving desired outcomes; identifying and reviewing with the member issues to be discussed during the planning process; and giving each member an opportunity to determine the location and time of planning meetings, participants attending the meeting and frequency and length of the meetings. The self-directing member is responsible for directing the plan development process. The CM will assist the member in the plan development but will not direct the process. The member will receive a copy of the final service plan and associated budget upon approval by the Department.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A service plan is a written plan for services developed by the Case Management Team (CMT) and members/representatives to assess and determine the member's status and needs. The service plan also outlines the services that will be provided to the members to meet their identified needs as well as the cost of those services. Planning meetings are scheduled at times and locations convenient to the member. An initial service plan must be developed prior to the member's enrollment. New service plans must be completed at least annually or when the member's condition warrants it. The CMT shall consult with the member and/or the member's representative and the attending health care professional. The CMT may also consult family members, relatives, psychologists, medical personnel, and other consultants as necessary, with the member's approval. The member signs off on the service plan and associated budget and receives a copy for his/her files.

Each individual service plan shall include at least the following components:

1. Diagnosis, symptoms, complaints, and complications indicating the need for services;
2. A description of the member's functional level;
3. Specific short-term objectives and long-term goals, including discharge potential or plan;
4. Discharge plan;
5. Any orders for the following:
  - a. Medication;
  - b. Treatments;
  - c. Restorative and rehabilitative services;
  - d. Activities;
  - e. Therapies;
  - f. Social services;
  - g. Diet; and
  - h. Other special procedures recommended for the health and safety of the member to meet the objectives of the service plan.
6. The specific services to be provided, the frequency of services and the type of provider;
7. A psychosocial summary describing member's social, emotional, mental, and financial situation attached to the initial service plan;
8. A cost sheet which projects the annualized costs of BSW services;
9. Signatures of all individuals who participated in the development of the service plan including the member and/or representative and the CMT.

All plans of care are subject to review by the Department. The Department has delegated the review function to BSW Program Managers or a designated Community Services Bureau (CSB) staff. The reviewer is responsible for reviewing all portions of the plan utilizing the criteria outlined below.

Review of the individual service plan will be based on the following:

1. Completeness of plan which includes all necessary services listed in terms of amount, frequency and planned providers;
2. Consistency of plan with screening information regarding the member needs;
3. Presence of appropriate signatures; and
4. Cost-effectiveness of plan.

The initial enrollment date is the date the member begins receiving waiver services. This date should be entered in the Service Plan form case notes. The CMT must notify CSB staff whenever a Medicaid member is being admitted in the waiver program. The Service Plan must provide documentation of the member's Service Plan costs after the plan is developed and this information must be made available to the member before the service plan is authorized. It includes all waiver services to be provided, the frequency, amount, and projected annualized cost of the services.

The cost sheet is created/updated:

- a. to determine initial program eligibility;
- b. when a Service Plan amendment is created; and
- c. when a Service Plan annual review is completed.

A copy of the service plan costs must be given to the member prior to finalization of the service plan.

The CMT will review the cost sheet with the member at the six-month visit. BSW Regional Program Officers prior approve high-cost service plans to maintain quality assurance standards and not for eligibility purposes. The Department determines the Service Plan cost limit. Members who exceed the Service Plan cost limit are not eligible for waiver services except as prior authorized by the Department.

A member cannot carry over a service from one service plan time-period to the next. Any unused services remaining at the end of the service plan time-period expire and cannot be used. Member cannot utilize services outside of the service plan time-period authorized; services cannot be used in once service plan period and accrued in a following service plan time-period.

The member is not officially admitted to the program until both the intake meeting has been held to a develop a service plan and the SLTC-55 form has been received from the Office for Public Assistance. The date of admit cannot be prior to the date of eligibility on the SLTC-55 eligibility form.

Members in the participant directed option will receive training in preparation for the greater role they play in the service plan and service delivery process. After the training, the CM will support the member to maximize his/her involvement in the service plan process. The member will actively participate in the definition of his/her needs through the assessment. The summary of member health status and risk factors, as reported by Mountain Pacific Quality Health during the initial level of care determination, will also be provided to the member and the CM to assist in the planning process. The member and CM will convene a service and support planning meeting with individuals of the members choosing, which may include family members, providers, consultants, advocates, and friends. The CM will support the member in directing the meeting to develop and complete the member's Service Plan. The Service Plan will describe the member's goals and outline the individualized supports to meet those goals. The CM will assure that the SSSP is complete and meets all the documentation requirements. Within 14 days following the meeting, the member with assistance from the CM as needed, will complete the service plan. The member and CM will review and sign off on the plan.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk identification and management, including an emergency backup plan, are included in the member's service plan. Appropriate emergency back up plans will be defined and planned for through the completion of the risk assessment form by the member and Case Manager. The emergency backup plan may include an assessment of critical services and a backup strategy for each identified critical service.

Back up may include:

1. Member backup incorporated into the plan;
2. Informal backup (family, friends, and neighbors);
3. Enrolled Medicaid provider network (personal assistant agencies); and
4. System level (local emergency response).

Back up services can be included and paid by Big Sky Waiver.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the development of the plan, the member selects providers from a list prepared by the Case Management Team (CMT). If the member is unsatisfied with the available agencies, the CMT or the member may solicit other providers for the service. These providers are required to enroll as a Medicaid provider.

**Appendix D: Participant-Centered Planning and Service Delivery**

**D-1: Service Plan Development (7 of 8)**

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

An in-depth review of a sample of service plans are reviewed for accuracy by the delegated Community Services Bureau staff during the on-site Quality Assurance Review process, which occurs at least once every three years. Review of participant service plans are also conducted when prior authorizations, risk negotiations, and/or serious occurrence reports are submitted to ensure that services are not only ensuring health and safety but assisting the member to accomplish service plan goals. These processes ensure that plans have been developed in accordance with applicable policies and procedures and each service plan ensures the health and welfare of waiver participants. For Big Sky Waiver participant service plans, an internal chart audit must be completed at least quarterly and summarized on the HCBS Chart Audit Report form. Each quarter the Case Management Team (CMT) is responsible for drawing a 10% random sample of active members from their caseload that were active during that quarter. Results of the Chart Audit are submitted to Community Services Bureau staff for review each quarter. Remediation efforts of noncompliance are tracked on the SLTC-899-2a (internal chart audit form), as well as the state annual performance measure report. When there has been a systemic issue of noncompliance found during chart audits, the CMT creates a Quality Improvement Project (QIP) to identify how the CMT intends on preventing future issues of noncompliance. Each QIP is submitted to the delegated Community Services Bureau staff for approval to ensure the project identified is specific, measurable, and relevant to improving waiver performance standards. Internal chart audits are completed by the CMTs on a quarterly basis as a separate quality assurance verification process to ensure accuracy of performance measures and Quality Improvement Strategy. The audit requires multiple standards review including Plan of Care Completeness (e.g. Recipient Identifying Information, Medical Information, Functional Overview, Orders for Medication, Specific Services, Goals and Objectives, Psychosocial Summary, Discharge Plan, Cost Sheet, and signatures).

**Appendix D: Participant-Centered Planning and Service Delivery**

**D-1: Service Plan Development (8 of 8)**

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

**Medicaid agency**

**Operating agency**

**Case manager**

**Other**

*Specify:*

Independence Advisors and Financial Managers.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Case Management Team (CMT) and Independence Advisor (IA), for members who choose to self-direct their services, monitor the implementation of the Service Plans. The CMT and IA meet with the member at least every six months to ensure that selected services are provided as outlined in the plan of care. These meetings also address health and welfare of the member. The monitoring visits will include a review of the member's service utilization history, a review of usage and effectiveness of the emergency backup plan and an evaluation of the quality and effectiveness of services. The CMT or IA will identify any problems that need to be addressed and document the strategy to attend to the issue and the work on resolution. Serious Occurrence Reports (SOR) are mandated for incidences in which the member's health and safety are at risk. These reports are sent to the State Regional Program Officer (RPO) for review. The RPO will assist in problem solving strategies, as needed, to assist in resolution of issues beyond the scope of the member, the CMT and IA. The semi-annual monitoring will also include a review of member access to non-waivers services identified in the service and support plan.

The CMT and IA/Financial Manager (FM) and service providers are mandatory reporters of abuse, neglect, and exploitation. The CMT and IA/FM will complete a SOR and file a report with the appropriate entity sending a copy of the report to the RPO for quality assurance monitoring.

In addition, the CMT and IA/FM shall consult with Central Office on any SOR:

- a. Not resolved at the local level;
- b. Requiring attention in response to reoccurring issues; or
- c. Requiring system changes.

The Big Sky Waiver program addresses the main Conflict of Interest issues, including:

- a. The waiver application reserves funds to ensure that members with high-cost plans may have their needs met without being limited to the case management team's budget limitations.
  - b. The waiver program utilizes the Client Choice form and process to support not only information and referral to all available providers but verification that choices are member driven.
  - c. Case management teams and providers are trained to identify signs of potential abuse, neglect, and exploitation.
- Person-centered planning is the foundation of service delivery consisting of multiple checks and balances to ensure that individual choice and autonomy is the primary driver of the service authorization and change.

Service Plan implementation and monitoring is a component of the quarterly chart audits and is completed during the performance assurance reviews at least once every three years.

- b. Monitoring Safeguards.** *Select one:*

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the

participant. *Specify:*

The entities are monitored by the State Regional Program Officers on an on-going basis and by the designated Community Services Bureau staff during the quality assurance process to ensure implementation of plan of care and member health and welfare. When an entity provides Case Management, Independence Advisor (for self-directed option) and other waiver services, they must assure Conflict of Interest standards are met. Members are to be offered non-biased information of all qualified providers available to provide services to the member. The member's chart must contain documentation the member had freedom of choice when selecting available providers.

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

#### a. Methods for Discovery: Service Plan Assurance/Sub-assurances

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

##### i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

##### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

##### Performance Measure:

**Number and percent of waiver participants whose Person-Centered Plan (PCP) address the needs as identified in the Level of Care Screen (LOC Screen) and determination. The numerator is the number of participants whose PCPs address the needs identified in the LOC screen & determination and the denominator is total # of waiver participants.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		<b>Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     95% confidence level with +/- 5% margin of error                 </div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		95% confidence level with +/- 5% margin of error
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**



**Number and percent of waiver participants whose PCPs address the waiver participant's personal goals N: Number of waiver participants whose PCPs address the waiver participant's personal goals D: Total number of waiver participants**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         95% confidence level with +/- 5% margin of error                     </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

**Performance Measure:**

**Number and percent of waiver participants whose PCPs address identified health and safety risks through a contingency plan. The numerator is the number of waiver participants whose PCPs address health and safety risks through a contingency plan and the denominator is the total number of waiver participants .**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  <input type="text"/>
Other	Annually	Stratified

Specify:  Case Management Team		Describe Group:  
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  

**b. Sub-assurance:** *The State monitors service plan development in accordance with its policies and procedures.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of waiver participants whose PCPs were developed with Case Management Teams in accordance with state policies and procedures. The numerator is the number of waiver participants whose PCPs were developed with Case Management Teams in accordance with state policies and procedures and the denominator is the total number of waiver participants.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         95% confidence level with +/- 5% margin of error                     </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<b>Other</b> Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

**Number and percent of waiver participants whose PCPs were developed with Independent Advisors and Financial Managers in accordance state policies and procedures. The numerator is the number of waiver participants whose PCPs were developed with Independent Advisors and Financial Managers in accordance with state policies and procedures and the denominator is the total number of waiver participants.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>

<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

*c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to*

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of waiver participants whose PCPs were reevaluated at least every 180 days, or revised as needed, to address changing needs. Numerator is the number of waiver participants whose PCPs were reevaluated every 180 days, or revised as needed, to address changing needs. The denominator is total number of participants .**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-top: 5px;">95% confidence level with +/- 5% margin of error</div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<b>Other</b> Specify:	



	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**d. Sub-assurance:** *Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number/percent of waiver participants whose scope and type of services are delivered as specified in the PCP. The numerator is the of waiver participants whose scope and type of services are delivered as specified in the PCP and the denominator is the total number of waiver participants.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     95% confidence level with +/- 5% margin of error                 </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
Specify: <input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number/percent of waiver participants whose amount of services is delivered as specified in the PCP. The numerator is the number of waiver participants whose amount of services is delivered as specified in the PCP. The denominator is the total number of waiver participants.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/> 95% confidence level with +/- 5% margin of error
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input style="width: 100px; height: 20px;" type="text"/>
	<b>Other</b> Specify: <input style="width: 100px; height: 20px;" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

Number/percent of waiver participants whose frequency and duration of services are delivered as specified in the PCP. The numerator is the number of waiver participants whose frequency and duration of services are delivered as specified in the PCP. The denominator is the total number of waiver participants .

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
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<i>(check each that applies):</i>		
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     95% confidence level with +/- 5% margin of error                 </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number/percent of waiver participants whose PCPs document a choice between/among HCBS waiver services and qualified waiver service providers. The numerator is the number Number of waiver participants whose PCPs document a choice between/among HCBS waiver services and qualified waiver service providers. The denominator is the total number of waiver participants .**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		95% confidence level with +/- 5% margin of error
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

# or % of waiver participants in a representative sample whose PCPs show a choice between/among HCBS waiver services and qualified waiver service providers. The numerator is the number of waiver participants in the sample whose PCPs show a choice between/among HCBS waiver services and qualified waiver service providers. The denominator is the total number of waiver participants in the sample.

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         95% confidence level with +/- 5% margin of error                     </div>
Other Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify:  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**



Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="405 577 799 663" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="868 864 1262 949" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Designated Community Services Bureau (CSB) staff will conduct on-site review of Case Management Teams (CMTs) at least every three years. However, if a significant issue or deficiency is discovered at any time, a targeted review would be completed and include on-site activities. Assessing the Service Plan is part of that process. The CSB staff will address any errors or missing information with the CMT for correction. When a plan is not developed in accordance with program policy and procedure, the CSB staff work with the CMT to take appropriate corrective action.

The CSB staff will respond to any immediate concerns related to the health and safety of the member. Data collected in the review will be entered into the quality assurance database and a report will be submitted to CSB for approval. Issues identified will be shared with CMTs through a Quality Assurance Communication (QAC). CMTs are required to respond to the QACs with resolution efforts according to the specified time frames. All QACs corresponding to a review must be resolved and returned to CSB prior to closure of the review. If a CMT identifies areas of non-compliance during their internal audits, they will act to immediately rectify the problem and update the Service Plan if necessary. If CSB staff identify a significant discrepancy between scope of services in plan and number of services actually provided the case will be referred to the Regional Program Officer for follow up with the CMT.

Case Management Teams are required to complete a Quality Improvement Project (QIP) quarterly and submit the QIP to the Regional Program Officer for review. The QIP topic identified must be specific, measurable, and relevant to the quality and/or policy implementation of waiver services provided to members participating in the program.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When plans do not indicate that the following performance measures were met the Case Management Team (CMT) or the Independence Advisor (IA), will immediately set up a meeting with the member to review the appropriate documentation and/or sign the Service Plan.

The performance measure requires the following:

- 1) Indication that the Service Plan meets personal goals and needs including health and safety;
- 2) Traditional service plans developed in conjunction with the CMT;
- 3) Indication that member received choice between institutional care and waiver home and community based services;
- 4) Indication that member received choice of services and service providers; and
- 5) 180 day service plan re-evaluation.

If there appears to be a pattern of failure to do this within a CMT, a written remediation plan will be required within 30 days describing initiated safeguards to ensure plans will meet the performance standards.

If during on-site reviews and meetings with members, the designated CSB staff determine that service plans do not sufficiently address members' needs, they will initiate a Quality Assurance Communication (QAC). The CMT will have 30 days to respond with a remediation plan to correct the deficiency. If necessary, the RPO will follow up with training or further instructions for the agency. When the service plan review is not completed within 180 days, the CSB staff will initiate a QAC. The CMT will have 30 days to respond with a remediation plan to correct the deficiency.

When paid claims indicate that services were not provided in type, scope, amount, duration, and frequency as indicated in the service plan, the designated CSB staff will immediately issue a QAC to the agency requesting an explanation of any discrepancy and remediation plan within 30 days.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

**Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

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**Applicability** (from Application Section 3, Components of the Waiver Request):

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (select one):

**Yes. The state requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

**E-1: a Description of Participant Direction:**

Participant-directed options are presented to all BSW members upon initial intake, at the member's annual service plan renewal, or at any time the member chooses.

Members living in a private residence or home of a family member may choose to self-direct some or all their waiver services via a common law employer authority. There are no age restrictions for members who may self-direct their services. Parents/legal representatives may choose to self-direct services for their children who receive waiver services.

In addition to the traditional provider management of services model for members/personal representatives who choose not to direct their services, Big Sky Waiver offers two participant direction opportunities: Agency with Choice Employer Authority and Employer with Budget Authority.

**Agency with Choice Employer Authority:** Members/personal representatives choosing the self-direct agency with choice option, work with the CM using a person-centered planning process to locate a qualified service provider to whom the member will refer staff for hiring. Staff providing direct services must be approved by the member and/or designated representative. The agency serves as the legal employer for all staff providing self-directed services in this option. The member partners with the BSW qualified service provider in scheduling the staff, orienting, and instructing staff in their duties, in accordance with waiver requirements, supervising the staff, evaluating staff performance, verifying time worked by staff, and discharging staff from providing services. Service agreements between the BSW service provider and the member are required and are designed to be flexible. A family or a waiver participant has flexibility in their plan of care to choose the services, from the service array in the Montana approved waiver, that best fit their assessed needs. The member may utilize their individual cost plan choosing services that help to achieve the outcomes that are important to and important for them and they may choose to return to traditional agency-based services at any time.

**Employer with Budget Authority:** Members/personal representatives who self-direct using this option, exercise control of their resource allocation, the schedule of service delivery, and the individuals who provide their direct support. Budgets are developed using a person-centered planning process and is individually tailored in accordance with the member's needs and preferences as established in the service plan. Budget authority allows the member, based on assessed needs, to identify the services, the number of services they will purchase, and the provider of the services. The member has flexibility to shift funds among the authorized services within the approved budget. The member/employer is responsible for hiring, training, supervising, scheduling, and terminating their employees.

Members may function as the employer, or the employer may be a personal representative or a family member. "Family member" means natural parents, adoptive parents, licensed foster parents, grandparents, stepparents, siblings, aunts, uncles, guardians, and individuals who have a legally granted conservatorship or properly executed power of attorney responsibility for overseeing the member's finances or general care.

Each member choosing this self-directed option will have a planning team consisting of a Case Manager (CM), an Independence Advisor (IA), and a Financial Manager (FM), to assist and support the member in successfully managing their services.

CMs provide information on the self-directed option to all members upon initial entry to the waiver, during annual service plan renewals, or anytime a member requests the information. CMs services will include an array of member directed support activities to ensure the ability of members to direct their care successfully. Information on the self-direct option is also available from the Big Sky Waiver (BSW) website, and from State BSW field staff, such as the Regional Program Officers, who are located across the State.

Members choosing participant directed services will be assisted by their CMs in establishing the level of individual involvement in self-directing their services. Members are provided with the advantages and disadvantages of the participant-directed option by the CM. Each member is given time to review the options before deciding if the self-directed model is their option of choice.

All BSW participants are required to receive/utilize case management services.

Case Management services include:

1. The determination of initial eligibility and reassessment of eligibility for member services. Case Managers utilize person centered processes to determine the member's health, psychosocial, environmental, and financial needs;
2. Member education regarding available service delivery options;
3. Initiating the process to evaluate and/or re-evaluate the member's level of care;

4. Assisting members in accessing BSW services, Medicaid State Plan services or other needed medical, social or cultural services regardless of spending source;
5. Authorization and monitoring of the expenditure of funds included in the approved service plan budget;
6. Development and annual reevaluation of the service plan, including a functional assessment and service delivery;
7. Ongoing monitoring of the provision of services included in the member's service plan and or participant health and safety;
8. Providing member education and choice of the service delivery options available through BSW.
9. Assisting the member in identifying risks and develop a plan to manage those risks;
10. Recognition and report of member abuse, neglect, and exploitation.
11. Annual review of the Freedom of Choice rights to ensure the member is aware of choice in the delivery of services; and
12. Annual review of the member's Fair Hearing Rights;

Case Managers provide the following additional services in support of members who choose to direct all or part of their waiver services:

1. Assist members in the development of the service plan utilizing a person centered process;
2. Authorization of any needed amendments to the service plan as needed;
3. Authorization and review service plan every 180 days or when member status requires reassessment;
4. Review budget reports and utilization summaries submitted by the Financial Manager and Independence Advisor;
5. Authorization of non-self-direct services as needed;
6. Work with the FM and IA to assure member's needs are met and health and safety are assured.

IA serves as a member of the support team for individuals electing the participant direction option. IA services include an array of member-directed support activities to ensure the ability of members/personal representatives to direct their care successfully. Members/personal representatives can choose from any qualified and enrolled provider. This is a mandatory service under the self-direct option.

Information provided by the IA to the member will cover:

- Person centered planning and how it is applied;
- Member choices and options for services and their delivery;
- Processes for changing plans of care and budgets;
- Grievance processes;
- Risks and responsibilities of self-direction;
- Freedom of choice of providers;
- Member rights;
- Reassessment and review of schedules; and
- Other information pertinent to the member/personal representative in managing and directing services.

The IA will assist the member with;

- Service plan development to assure the members needs and personal preferences are understood and met;
- Implementation of the approved service plan and budget;
- Identifying risks and developing a plan to manage those risks;
- Development of an individualized emergency backup plan;
- Making allowable purchases and ensure those purchases are listed in the spending plan; and
- Negotiating payments for necessary and allowable goods and services

The IA will also:

1. Monitor the provision of the services to ensure the member's health and welfare; and
2. Coordinate with the FM to ensure that member's or personal representative's budget appropriately to meet their needs as defined in the service plan.

The Financial Management Service provider acts as the common law employer and the member acts as the managing employer. The financial manager (FM) is responsible for all employee related expenses and liability risks that may be incurred if a worker's compensation or unemployment claim is filed. The FM is responsible for providing information to employers on their responsibilities, for processing employer and employee paperwork, and for maintaining documentation that staff hired meets the qualified provider requirements.

The FM must exhibit professional commitment to the described duties and successfully demonstrate the ability to:

1. Participate as a member of the member support team;
2. Instruct, counsel, and guide the member in employer and financial issues;
3. Review member spending and track expenditures to ensure that the member's budget remains on the correct trajectory to cover the member's expenses;
4. Review the List of Excluded Individuals and Entities (LEIE) and Medicare Exclusion Database (MED) and may request background checks on potential employees;
5. Process payroll and reimburses employees according to the electronic visit verification record and individual cost plan;
6. Withhold and pay all taxes and arrange for workers' compensation for all employees;
7. Recognize and report abuse, neglect, and exploitation and understand reporting responsibilities;
8. Comply with all Serious Occurrence Reporting policies and procedures;
9. Provides reports to the employer, CM, IA and state; and
10. Work with the IA to track service expenditures to ensure that the member's budget remains on the correct trajectory to cover the member's expenses.

The FM tracks the member's expenditures and provides monthly summary reports to the IA and CM.

The following services are provided by the Big Sky Waiver (BSW) and are available as participant directed options for member:

1. Financial Management
2. Independence Advisor
3. Personal Assistance
4. Private Duty Nursing
5. Nutrition Services
6. Homemaker Chore
7. Homemaker
8. Specialized Childcare
9. Transportation
10. Member Goods and Services
11. Specialized Medical Equipment and Supplies
12. Respite

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver.  
*Select one:*

**Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

**Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

**Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

- c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

**Waiver is designed to support only individuals who want to direct their services.**

**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

All BSW members are given the choice of a traditional provider-managed model of service delivery, or to manage some or all of their services by choosing either the self-direct common law employer with budget authority option or the self-direct agency with choice option.

Members are eligible based on the following criteria:

1. Be Medicaid eligible;
2. Elderly or physically disabled;
3. Have a need for services that can only be met through the Big Sky Waiver program;
4. Reside in the member's personal home or private residence;
5. Obtain a health care professional approval to self-direct BSW services and manager authorized health maintenance tasks (if appropriate);
6. Attend all self-direct option trainings; and
7. Exhibit an understanding of the participant directed option and their responsibilities regarding the option chosen.

Family members who are personal representatives cannot be paid for direct care services;

Members will not be excluded solely on the basis that they have specific cognitive or other disability.

Members will not be excluded solely based on an assessment that the individual, in isolation, is unable to carry out some of the responsibilities associated with participant direction.

For members who choose not to direct any of their services, Case Managers will provide assistance in securing provider managed services exclusively.

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the

benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

#### e. Information Furnished to Participant

The self-directed service option is available to members new to the waiver or currently enrolled in the waiver, subject to the criteria specified in E-1: c. A member's BSW resource allocation does not change as a function of enrollment in this service option.

Informational handouts are provided by case managers (CMs) and the Independence Advisor (IA) which outline the benefits and liabilities of self-direction, the responsibilities of the member/personal representatives, and the guidelines for enrollment, continued participation, and dis-enrollment in self-directed services. Members are provided information by the CM and/or the IA, on a timely basis, giving members sufficient time to weigh the benefits and disadvantages of self-direction and to allow participants to ask follow-up questions before making a final decision regarding service delivery.

Big Sky Waiver (BSW) provides a Self-Direct Employer Handbook which provides step by step information describing self-direction of waiver services. The case manager reviews this handbook with the member to ensure that all member questions are answered. This information is intended to assist CMs in consistently informing all waiver participants about the above-mentioned items and to then leave with the waiver participant for future reference.

The self-directed options are outlined to the member as part of the planning process and is reviewed by the member and/or representative (if applicable) and CM prior to the annual planning meeting. A reference to the self-directed service option is included on the Freedom of Choice and Consent Form and the supplemental addendum form. This form is completed annually with the member and or their representative by the BSW Quality Assurance staff or CM. The supplemental addendum included with the Freedom of Choice form includes more in depth, narrative information regarding: Big Sky Waiver Services in Montana, Fair Hearing Rights and Opportunities to Self-Direct.

The planning document for self-directed services implementation includes a narrative section describing the projected use of the resource allocation, services to be provided, proposed schedule and timeframes, additional training required for each employee, a description of how health and safety issues will be addressed, including back up, emergency and on-call systems, the role of the CM, and the responsibilities of the member and/or representative. The planning document must be signed off by the CM, and the member and/or representative as applicable. Once the member chooses the self-direct option and is approved by the CM to use this service option, the FMS provider is contacted for enrollment purposes.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

**The state does not provide for the direction of waiver services by a representative.**

**The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: (*check each that applies*):

**Waiver services may be directed by a legal representative of the participant.**

**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:



**Participant Direction by a Representative**

There are two types of representatives, legally responsible representative and non-legal representative.

A legally responsible representative may direct any waiver service that is allowed as a participant directed waiver service. However, legally responsible representatives cannot direct and be paid to deliver a waiver service simultaneously.

A responsible representative must be 18 years of age, have a knowledge of the member's care needs, an acceptance of the responsibilities in agreement with the member, and not act as the member's paid caregiver.

A member may freely choose a non-legal representative. The representative is approved by the planning team and will function as the representative if the planning team members are in consensus that the representative can continue to make decisions in the member's best interest. The non-legal representative cannot both direct and be paid to deliver a waiver service simultaneously.

The personal representative has the same decision-making authority as the member, if the member representative continues to serve at the request of, and on behalf of, the member. The member, and/or legal representative have the right to limit or terminate the authority of a non-legal representative, or appoint a new non-legal representative, at any time, for any reason.

The planning team has the right and the obligation to determine if the personal representative continues to function in the best interests of the member. This issue should be reviewed annually as part of the planning process which will include a private meeting held with the member without attendance of any party who would benefit from service decisions to ensure the member can speak freely. The team follows the incident management policies to determine if the personal representative is acting in the member's best interest, in that they look at whether there are concerns of abuse, neglect, or exploitation with the personal representative. If there are concerns of abuse, neglect or exploitation by the representative, the team will follow incident management protocols to report such issues.

A waiver member or his/her legal representative has the right to file a Fair Hearing request through the Department's Office of Fair Hearing if the planning team does not approve of the member's choice for a representative. All other planning team members may bring plan of care issues to the Big Sky Waiver Regional Program Officer who has oversight of the case management teams.

With the common law employer authority, the member or representative becomes the managing employer and is responsible for hiring, training, supervising, scheduling, and terminating their employees.

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Case Management		
Non-medical Transportation		
Homemaker Chore		
Independence Advisor - Self Direction		
Nutrition		
Specialized Medical Equipment and Supplies		
Homemaker		

Waiver Service	Employer Authority	Budget Authority
Respite		
Big Sky Waiver Personal Assistance		
Member Directed Goods and Services		
Financial Management Services - Self Direction		

**Appendix E: Participant Direction of Services**

**E-1: Overview (7 of 13)**

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

**Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

**Governmental entities**

**Private entities**

**No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** Do not complete Item E-1-i.

**Appendix E: Participant Direction of Services**

**E-1: Overview (8 of 13)**

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

**FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

Financial Management

**FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

## E-1-i: Provision of Financial Management Services

## i. Types of Entities:

The fiscal management service contractor must:

- a) be enrolled as an approved Medicaid provider;
- b) retain on staff a Certified Public Accountant (CPA) with at least five (5) years of experience; and
- c) be assigned a Federal Employer Identification Number (EIN) and National Provider Identifier (NPI) number.

Further, the contractor must:

- a) have a basic understanding of aging and disabled populations;
- b) understand the philosophy and practice of self-directed services in Montana;
- c) have sufficient funds necessary to make payroll on behalf of legal guardians at least twice monthly; and
- d) ensure staff and employees of members self-directing pass Medicaid required background investigations, including but not limited to the List of Excluded Individuals and Entities (LEIE) and Medicare Exclusion Database (MED).

The contractor must also have capabilities to help in the member's language of choice and capacity to communicate through TTY. The contractor must:

- a) possess federal designation as fiscal agent under IRS Rule 3504 (Acts to be Performed by Agents);
- b) comply with applicable IRS regulations;
- c) possess IRS approval for Agent status; and
- d) demonstrate effective internal controls and safeguards over the processing of transactions.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

iii. FMS are covered as the waiver service specifies in Appendix C-1/C-3. The FMS submit claims to the State of Montana Fiscal Agent and are paid by the day at the rate set by the State of Montana. Fee schedules are available publicly online.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

---

Supports furnished when the participant is the employer of direct support workers:

---

**Assist participant in verifying support worker citizenship status**

**Collect and process timesheets of support workers**

**Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

**Other**

*Specify:*

## iii Scope of FMS

FMS entities are enrolled as BSW providers. FMS are covered as the waiver service specified in Appendix C-1/C-3. (3) This is a mandatory service for the employer with budget authority option.

FMS verify service qualified provider standards, monitor appropriate use of Montana Code Annotated 39-3-406(p) which states that certain employers are exempt from paying minimum wage and overtime if an employee is employed in domestic service employment to provide companionship services, as defined in 29 CFR 552.6, or respite care for individuals who, because of age or infirmity, are unable to care for themselves as provided under section 213(a)(15) of the Fair Labor Standards Act, 29 U.S.C. 213, when the member providing the service is employed directly by a family member or an individual who is a legal guardian.

Specifically, FMS duties include:

- (1) The financial manager acts as the common law employer (employer of record) and the member acts as the managing employer. Since the financial manager is the employer, this entity is responsible for all employee-related expenses and liability risks that may be incurred if a worker's compensation or unemployment claim is filed.
- (2) On behalf of the member/personal representative the financial manager will:
  - (a) accept referral from the member/personal representative to process the employment packet;
  - (b) prepare and distribute an application package of information that is clear and easy for the potential employee to understand and follow;
  - (c) provide needed counseling and technical assistance regarding the role of the FM to member, their personal representatives, and others;
  - (d) process employment application package and documentation for prospective individual to be employed (as agency employee);
  - (e) complete criminal background checks on prospective member-referred worker and maintain results on file, if requested by the member;
  - (f) establish and maintain record for each individual employed and process all employment records;
  - (g) withhold, file, and deposit Federal Insurance Contributions Act (FICA), Federal Unemployment Tax Act (FUTA), and State Unemployment Tax Act (SUTA) taxes in accordance with Federal Internal Revenue Service (IRS), Federal Department of Labor (DOL), and state rules (if applicable);
  - (h) process all judgments, garnishments, tax levies or any related holds on a member's worker as may be required by local, state, or federal laws;
  - (i) generate and distribute IRS W-2s and 1099s, wage and tax statements and related documentation annually to all member-employed providers who meet the statutory threshold earnings, amounts during the tax year by January 31st;
  - (j) withhold, file, and deposit federal and state income taxes (if applicable) in accordance with federal IRS and state Department of Revenue Services rules and regulation;
  - (k) administer benefits for member-employed providers (if applicable);
  - (l) generate payroll checks in a timely and accurate manner, as approved in the member's self-direct spending plan, and in compliance with all federal and state regulations; develop a method of payment of invoices and monitoring expenditures against the self-direct spending plan for each member;
  - (m) develop a method of payment of invoices and monitoring expenditures against the self-direct spending plan for each member;
  - (n) receive, review, and process all invoices from individuals, vendors, or agencies providing member-directed goods or services as approved in the member's self-direct spending plan authorized by the division;
  - (o) process and pay non-labor-related invoices;
  - (p) generate utilization reports along with payroll reflecting accurate balances for a member/personal representative, independence advisor, the regional program officer (RPO), and the division;
  - (q) establish and maintain all member records with confidentiality, accuracy, and appropriate safeguards;
  - (r) respond to calls for member or their personal representatives and employees regarding issues such as withholdings and net payments, lost or late checks, reports, and other documentation;

- (s) file claims through the Medicaid Management Information System (MMIS) for member-directed goods and services and prepare checks for individually hired workers; and
- (t) generate service management and statistical information and reports.
- (4) The fiscal manager provider must be certified by the department to provide the service.

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget**
- Track and report participant funds, disbursements and the balance of participant funds**
- Process and pay invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

*Specify:*

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

*Specify:*

**iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

iv. Oversight of FMS Entities

The Big Sky Waiver quality assurance personnel will be responsible for monitoring the performance of the FMS through the quality assurance review tool. This occurs on an annual basis.

The state is currently undergoing the process of constructing a care management platform which will incorporate self-direct members, case managers, financial managers, and independence advisors. This platform has an anticipated delivery date of 6/1/2024. This process will have built-in performance monitoring systems for case manager financial managers, independence advisors, as well as incorporate traditional Big Sky waiver members as stakeholders in the process. Until that system is completed, the state will continue to utilize current monitoring activities, which includes oversight from the State Regional Program Officers when evaluating Support and Services Spending Plan (SSSP), amendments, and budget approvals. The state is also constructing an ongoing quality assurance chart review process for these members to ensure compliance with policy, performance measures, and state law.

**Appendix E: Participant Direction of Services**

**E-1: Overview (9 of 13)**

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

**Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

Case Managers are required to provide or arrange for the provision of a system of supports using a person-centered planning process, that is responsive to an individual's needs and desires for assistance in developing the person-centered service plan and budget plan, managing service delivery and in the case of member's who choose to self-direct, assistance in performing the responsibilities of an employer. Appendix C-3 provides a clear description of additional Case Management support activities.

Case Managers provide all members with information on the service delivery options available through the Big Sky Waiver, including the advantages and disadvantages of each option.

CMTs provide information on how the self-directed care program works; individual rights (freedom of choice) and responsibilities; and available resources; counseling; training; assistance, such as the use of the IA and financial management services (FMS). The amount and frequency with which an individual uses the available supports varies by person and circumstance. The Case Manager also provides information and assistance on the filing of grievances when the member chooses.

**Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Senior Companion	
Specialized Child Care for Children Who Are Medically Fragile	
Skilled Nursing	
Prevocational Services	
Occupational Therapy	
Adult Day Health	
Health and Wellness	
Post Acute Rehabilitation Services	
Case Management	
Community Transition	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Level 1 Assisted Living	
Respiratory Therapy	
Specially Trained Attendant	
Non-medical Transportation	
Money Management	
Nurse Supervision for Personal Care Attendants	
Homemaker Chore	
Environmental Accessibility Adaptations	
Day Habilitation	
Level 2 Assisted Living Behavioral Health Modification	
Pain and Symptom Management	
Family Training and Support	
Speech Therapy	
Consultative Clinical and Therapeutic Services	
Community Adult Group Homes	
Supported Employment	
Independence Advisor - Self Direction	
Nutrition	
Vehicle Modifications	
Specialized Medical Equipment and Supplies	
Adult Foster Care	
Homemaker	
Personal Emergency Response Systems	
Respite	
Level 3 Assisted Living Specialized Care	
Dietetic-Nutritionist Services	
Big Sky Waiver Personal Assistance	
Member Directed Goods and Services	
Financial Management Services - Self Direction	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Audiology	
Service Animals	
Physical Therapy	

**Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** (*select one*).

**No. Arrangements have not been made for independent advocacy.**

**Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

k. Independent Advocacy

Independence Advisors (IAs) must complete the Department's mandatory training before providing services. IA agencies must be able to assure that IA employees have no vested interest in who is selected to provide services and that members have the choice of providers and type of services. Before providing services, the IA Agency must provide the Department with a statement describing which self-direct services will be provided in addition to the IA services with assurance there are no other providers available to provide the service(s) in the geographical area. The statement must include assurances that the services are included in the member's service plan.

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**i. Voluntary Termination of Participant Direction.** Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:



**E-1-l: Voluntary Termination of Participant Direction**

Dis-enrollment from self-directed services for the purpose of enrollment in traditional services is always an available option for members choosing to self-direct their services. There is flexibility within this service for the member's family members and representatives to choose the level of their involvement in the recruiting, selection and hiring of the direct support staff and/or choose a new service provider, as reviewed annually on the Big Sky Waiver Freedom of Choice form.

Members and/or their representatives, or the employers, choosing to dis-enroll from a self-directed service option must contact the case manager to schedule a planning meeting. This meeting would determine how the member's needs may be met utilizing the traditional model of service delivery.

Under no circumstances will ongoing waiver-funded services be reduced or terminated if an individual is seeking a new provider or seeking a traditional waiver service delivery model.

**Appendix E: Participant Direction of Services****E-1: Overview (12 of 13)**

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

**E-1-m: Involuntary Termination of Participant Direction**

The plan of care document includes a brief section requiring a check off box for members choosing to self-direct one or more services. The boilerplate plan of care language provides advance notice to the member or representative that participation in self-directed services may be involuntarily terminated, in the event the member or representative does not abide by the Department requirements applicable to self-directed services. The signature page of the plan of care document indicates an understanding of, and agreement with, the need to comply with the Department requirements for participation in self-directed services. The case manager will review this section annually with individuals, family members, guardians or representatives who choose to self-direct one or more services.

If a member or his representative does not cooperate with, abide by, or utilize the services as outlined in the plan of care, a special planning meeting will be conducted by the case manager to discuss the non-compliance issues. A plan would be developed and implemented, serving to give the member an opportunity to remain in self-directed services for a specified period, contingent upon the member meeting agreed upon benchmarks written into the approved plan.

If health and safety issues pose undue risk to the member or others, and immediate intervention is deemed necessary by the planning team, the member would be immediately enrolled in traditional services. Additional supports deemed necessary by the planning team to ensure the health and well-being of the member would be provided.

Involuntary termination of participant direction is not a basis for termination from the Big Sky Waiver. The member still has a choice of option including traditional waiver services. In cases where the member is being considered for involuntary exit from the self-direct option due to immediate health and safety concerns, failure to implement the approved support plan or comply with Employer Authority requirements or any areas of immediate concern that places the member in jeopardy, the planning team (Case Manager, Independence Advisor and Fiscal Manager), the BSW Quality Improvement Specialist, the member and/or personal representative, will meet to discuss additional supports deemed necessary by the planning team to ensure the health and well-being of the member is provided.

**Appendix E: Participant Direction of Services****E-1: Overview (13 of 13)**

- n. Goals for Participant Direction.** In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		35
Year 2		40
Year 3		40
Year 4		45
Year 5		45

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant Direction (1 of 6)**

**a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

**Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

A Financial Management (FM) service entity functions as a self-direction with budget authority model.

**Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

**Recruit staff**

**Refer staff to agency for hiring (co-employer)**

**Select staff from worker registry**

**Hire staff common law employer**

**Verify staff qualifications**

**Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Costs for criminal background checks will be included in the reimbursement to the fiscal manager.

**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

**Determine staff wages and benefits subject to state limits**

**Schedule staff**

**Orient and instruct staff in duties**

**Supervise staff**

**Evaluate staff performance**

**Verify time worked by staff and approve time sheets**

**Discharge staff (common law employer)**

**Discharge staff from providing services (co-employer)**

**Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

**Reallocate funds among services included in the budget**

**Determine the amount paid for services within the state's established limits**

**Substitute service providers**

**Schedule the provision of services**

**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

**Identify service providers and refer for provider enrollment**

**Authorize payment for waiver goods and services**

**Review and approve provider invoices for services rendered**

**Other**

Specify:

b. Participant-Budget Authority

The methodology used to authorize payments for services, and to review and approve reimbursements to direct workers based on the delivery of agreed upon services will vary depending on the category of service. All services outlined in the service plan will correspond to a need outlined in the plan of care.

For members choosing to self-direct in family and private settings, self-direction can give the member, representative, or family members acting on the member's behalf, additional authority, as desired, to manage the delivery of services more fully.

i. Participant Decision Making Authority

- Recruit staff;
- Refer staff to agency for hiring (co-employer);
- Verify staff qualifications;
- Obtain criminal history and/or background investigation of staff: Costs for criminal background checks will be included in the reimbursement to the Financial Manager;
- Determine Staff duties consistent with the service specifications in Appendix C-1/C-3;
- Determine staff wages and benefits subject to state limits;
- Schedule staff;
- Orient and instruct staff in duties;
- Supervise staff;
- Evaluate staff performance;
- Verify time worked by staff and approve time sheets; and
- Discharge staff from providing services (co-employer).

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

#### b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Cost plans are calculated based on assessment of needed services.

The budget determination is the same process for both self-direct and non-self-direct individuals. Rates are determined by the State and provided on the publicly available fee schedule.

Services that are not available on the fee schedule may be negotiated and/or determined to be the most cost effective based on market value. The methodology of budget development is available to the public via policy manual posted online.

The legally responsible person is limited to 84 hours or paid care every 2 weeks.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

#### b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Participant Decision Making Authority

iii. Informing Participant of Budget Amount

The determination of a participant-directed budget is based on needed services and established rates publicly available on-line fee schedule. Services not available on the fee schedule may be negotiated based on the most cost-effective services available.

Case Managers (CM) determine the budget based on member assessed needs and the applicable rates for services to meet those needs. This information is given to the member/representative at intake. The CM reviews the service plan budget upon the annual renewal. All members/personal representatives are informed of the details of the member’s cost plan. The cost plan details are based on the and the planning process, which, in turn, is based on assessments and the expressed desires of the member. The service cost plan functions as the contract between the member and the department in the delivery of services.

If the quantity and type of services outlined in the cost plan are not considered adequate in meeting the needs of the member, additional services may be requested by the member. The CM and the Independence Advisor (IA) train members in the amendment procedure as part of the assistance they provide the member. The IA will work with the member to identify changes needed to meet the member’s needs and draft an amendment to the service plan and budget. The IA will submit the amendments to the CM who will approve or deny the changes. Any changes to the budget amount will be reported to the Financial Manager (FM). Members may request any needed service/budget amendments through the IA. The IA will submit the request to the CM within five days. The CM will provide approval or denial of the request within 10 days. The CM will inform the Fiscal Manager when the request is approved.

If request for an amendment is denied, a letter is sent to the member informing them of this decision and their right to request a fair hearing. Members are entitled to file a request for a Fair Hearing at any time they receive a service denial. Fair Hearing procedure information is provided on all denials or reductions for service delivery.

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant-Direction (5 of 6)**

**b. Participant - Budget Authority**

**iv. Participant Exercise of Budget Flexibility. *Select one:***

**Modifications to the participant directed budget must be preceded by a change in the service plan.**

**The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant-Direction (6 of 6)**

**b. Participant - Budget Authority**

**v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be

associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The member has the capacity to move funds between services outlined in the plan and to make changes in the service categories to be delivered. Both would require Case manager (CM) approval. The member and the CM would be responsible for monitoring the expenditure of the individual's cost plan.

The Financial Manager (FM) makes available an expenditure report, to the employer and the CM after each payroll that services occur to help in determining if adjustments are needed in spending patterns to prevent a shortfall or underutilization of the cost plan.

CM are provided with a monthly budget tracking report. The FM alerts both the Independence Advisor (IA) and CM of any concerns regarding the member's budget trajectory will prematurely deplete the budget. In cases where a member's budget trajectory will prematurely deplete the budget if not corrected, the IA provides necessary training and support to the member to assist in managing the self-direct budget. The IA will report the status of trainings to the CM.

Services such as Environmental Accessibility Adaptations must be prior approved through the State. The IA, the CM and the member/personal representative will meet to determine the services needed, and that requirements such as obtaining bids have been met before services will be approved. The CM will deny or approve services which require prior authorization by State Administrative Rule.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Members are notified of the fair hearing process when they complete the Medicaid application. They are also notified of the fair hearing process when they are notified of the choice of waiver vs. institutional services during the Mountain Pacific Quality Health level of care assessment.

If a member is denied services, disenrolled from the program, have services suspended, terminated, or reduced, they are again provided fair hearing rights in writing. In accordance with Administrative Rules of Montana (ARM) 37.40.1407, .1408, .1426, an adverse action notice is any action to terminate, decrease or deny Big Sky Waiver (BSW) services or coverage. Timely and/or adequate notice must be provided for all adverse actions. For termination of BSW coverage, a notice is sent to the member and/or representative with fair hearing rights. For termination, denial or decrease of a specific BSW service(s) a notice is sent to the member and/or representative with fair hearing rights.

Members may continue to receive services during the period of an appeal. A request for continuation of services must be made prior to the date given in the notice of the change in or termination of services. Interest in continuing to receive services during the period of the appeal must be indicated in the fair hearing request.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving

their right to a Fair Hearing. *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates an additional dispute resolution process**

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

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**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All persons employed by an agency participating in the Medicaid program, pursuant to MCA 52-3-811, are mandatory reporters of suspected abuse, neglect or exploitation of children, elderly, or members with disabilities. They are also required to complete a Serious Occurrence Report (SOR), utilizing the Quality Assurance Management System (QAMS) database, when a situation calls for it. A SOR must be completed anytime an individual's life, health, or safety has been put at risk. This includes all reports that meet the guidelines for suspected abuse, neglect, or exploitation (MCA 52-3-803) submitted to Adult Protective Services or Child Protective Services.

In addition, circumstances warranting a SOR include:

1. Suspected or known physical, sexual, emotional or verbal abuse;
2. Neglect of the member, self-neglect or neglect by responsible caregivers;
3. Sexual harassment by an agency employee or member;
4. Any injury that results in hospital emergency room or equivalent level of treatment. The injury may be either observed or discovered. A SOR would be required for any injury that occurred within the last 90 days;
5. An unsafe or unsanitary working or living environment which puts the worker and/or member at risk;
6. Any event which is reported to APS, CPS or Law Enforcement, the Ombudsman or QAD/Licensing;
7. Referrals to the Medicaid Fraud Control Unit (MFCU);
8. Psychiatric emergencies - admission to a hospital or a mental health facility for a psychiatric emergency;
9. Medication emergency when there is a discrepancy between the medication that a physician prescribes and what the individual actually takes, and which results in hospital emergency room or equivalent level of treatment or hospital admission; or any medication error occurring during the provision of Medicaid reimbursed nursing services;
10. Suicide, suicide attempt or suicide threat; and
11. Unexpected deaths.

All designated service providers are mandated to complete a Serious Occurrence Report utilizing the QAMS database within ten working days of receiving information or witnessing the incident. The provider agency must document cause and effect of the incident and the action plan to correct or prevent incidents from occurring in the future. The State Regional Program Officer is responsible for ensuring an appropriate response by the provider agency.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information on identifying, addressing, and protecting someone from abuse, neglect and exploitation and how to notify the appropriate authorities, is provided to members upon admission to the waiver and annually thereafter, by the case manager, independence advisor or the financial manager. Members can also access information on the Division's website at [www.http://dphhs.mt.gov/sltc](http://dphhs.mt.gov/sltc).

Additional information on incident management, abuse, neglect and exploitation and member protection may be covered as needed at ongoing member training sessions and Community Services Bureau member focus groups.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.



Investigations involving Abuse, Neglect and Exploitation and/or criminal activity:

Reports of abuse, neglect and exploitation are made to Adult Protective Services (APS) or Child Protective Services (CPS) for evaluation, reporting, and investigation. Adult and Child Protective Services are emergency intervention activities which may include investigating complaints, coordinating family and community support resources, strengthening current living situations, developing, and protecting personal financial resources and facilitating legal intervention. All reports come through a centralized intake hotline where trained staff assess the situation and send a report to field staff. Local APS or CPS social workers evaluate, assess, prioritize and follow-up on all cases within their jurisdiction.

Child Protective Services are provided to children under 18 years of age in the state of Montana. The timeline for response to CPS reports depends on the incident. Any report that is assessed at the level of imminent danger is responded to within 24 hours. For all other reports response time varies depending on the nature of the report, location, and whether local law enforcement is involved. Before a case is closed a safety assessment is conducted to assess whether appropriate action was taken.

Adult Protective Services are provided to persons over the age of 60 years, physically or mentally disabled adults (as defined by the Department through SSI or vocational rehabilitation) and adults with developmental disabilities who are at risk of physical or mental injury, neglect, sexual abuse, or exploitation. APS provides voluntary protective services to any individual in their jurisdiction. However, APS is unable to provide involuntary protective services to physically or mentally disabled adults. All APS reports are assessed by regional supervisors for imminent risk and capacity of the individual. Cases are triaged using social work methodology and serious cases are responded to first. A computer data system has a built-in alert system to track cases and open investigations. Any report that is referred for investigation has 90 days to be closed.

The Division coordinates with APS and CPS at their direction and request. Each investigation is different, and the Department is involved only to the extent that they direct. APS and CPS notify participants and/or their legal representatives concerning investigative results. Division staff would coordinate and assist at their request.

In situations where APS cannot follow up (i.e. incident is outside scope of APS jurisdiction, or the individual doesn't substantiate the report) the State Regional Program Officer is notified and provides necessary referral and follow up (see SOR below).

APS, CPS, Medicaid providers and State Regional Program Officers (RPO) make referrals, when necessary, to local law enforcement or other entities. Referrals to local law enforcement include illegal activities, theft, embezzlement, and incidents involving significant abuse.

Incidents and events outside the scope of APS, CPS or local law enforcement authority are reported to the pertinent provider agency. The agency investigates the incident and provides follow-up, when needed. The provider agency (or in the case of self-direct services, the Independence Advisor (IA)) and the member document the scope of the incident, the incident's cause and effect, and work with the member to develop an action plan to correct or prevent the incident from occurring in the future. This information is captured on a Serious Occurrence Report (SOR), within the Quality Assurance Management System (QAMS) database and must be submitted within 10 days of the incident (or knowledge of the incident). The IA follows up on SOR outcomes during the monthly member meeting and track follow-up activity in the member's file. When needed the IA assists with modifications to the member Service and Support plan to prevent future incidents. The RPO is responsible for ensuring an appropriate and timely response is provided by the provider agency and/or IA and member. On the SOR form, there is a section where the RPO may comment on the incident and mark any follow-up action taken, including providing training, case conference, and/or sanctions.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Community Services Bureau (CSB) Central Office is responsible for overseeing the operation of the serious occurrence incident management system. All critical events or incidents involving a member warrant a Serious Occurrence Report (SOR) that is entered into the Quality Assurance Management System (QAMS) database and submitted to the local State Regional Program Officer (RPO) who oversees the incident management process and ensures that appropriate reporting and follow-up occurs at the local level. The RPO will enter follow-up and resolution activities related to the SOR into the QAMS database. The QAMS database and summative reports will capture information on incident type, member characteristics, incident response time, remediation outcomes, and timeliness.

As necessary, Adult Protective Services (APS) or Child Protective Services (CPS), and Central Office Staff will work together to develop and implement strategies for prevention using reports from their respective databases. APS and Central Office Staff developed a parallel desk level procedure and ongoing communication strategy when an investigation into allegations of abuse, neglect, or exploitation involves a member on the Community First Choice program and/or Big Sky Waiver program. Letters of intent to investigate are sent to the Quality Assurance Program Manager to assure that critical incident reporting mandates are being followed, as well as closure letter results of the investigation. Closure letters indicating substantiated cases of abuse, neglect, or exploitation are tracked for trends, as well as federal reporting requirements.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

**The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Department of Public Health and Human Services/Senior and Long Term Care Division (SLTC) is responsible for detecting unauthorized use of restraints or seclusion. Community Services Bureau (CSB) designated staff perform routine quality assurance reviews that include home visits with members and standards for member satisfaction. CSB staff also provide ongoing training with providers and members to assure health and welfare. The Division operates a serious occurrence reporting system as a part of the overall quality management of the waiver. Serious occurrence reports (SOR) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the Quality Assurance reviews of providers to assure appropriate reporting and resolution of incidents.

Reflecting Level 2 Assisted Living services, behavior modification practices will be assured to always be void of all classes of restraint, retaliation, reprisal, abuse, and neglect. Personal liberties, resident rights, and freedom of movement will be supported by the facility and maintained per state and federal regulation.

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of

restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

**Appendix G: Participant Safeguards**

**Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)**

**b. Use of Restrictive Interventions.** *(Select one):*

**The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Public Health and Human Services/Senior and Long Term Care Division (SLTC) is responsible for detecting unauthorized use of restrictive interventions. Community Services Bureau (CSB) staff perform routine quality assurance reviews that include home visits with members and standards for member satisfaction. CSB staff also provide ongoing training with providers and members to assure health and welfare. The Division operates a serious occurrence reporting system as a part of the overall quality management of the waiver. Serious occurrence reports (SOR) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the Quality Assurance reviews of providers to assure appropriate reporting and resolution of incidents.

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

**Appendix G: Participant Safeguards**

**Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)**

**c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

**The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Department of Public Health and Human Services/Senior and Long Term Care Division (SLTC) is responsible for detecting unauthorized use of restraints or seclusion. Community Services Bureau (CSB) staff perform routine quality assurance reviews that include home visits with members and standards for member satisfaction. CSB staff also provide ongoing training with providers and members to assure health and welfare. The Division operates a serious occurrence reporting system as a part of the overall quality management of the waiver. Serious Occurrence Reports (SOR) are monitored on an ongoing basis to assure appropriate reporting and resolution of incidents. SORs are also reviewed as a standard in the Quality Assurance reviews of providers to assure appropriate reporting and resolution of incidents.

**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

- a. Applicability.** Select one:

**No. This Appendix is not applicable** (*do not complete the remaining items*)

**Yes. This Appendix applies** (*complete the remaining items*)

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Montana Licensed adult foster care homes, assisted living facilities, and group homes provide medication management and oversight. The licensed provider who employs trained and qualified staff is responsible for keeping track of medication management standards while ensuring the resident takes their medication safely as prescribed. Medications are to be safely secured and/or stored as required by the Department of Labor and Industry and as outlined within the applicable Administrative Rules of Montana (ARM).

Medication management standards can be reviewed with Administrative Rules of Montana (ARM)

- Assisted Living Facility Rules (37.106.2801 - 37.106.2898)
- Community Homes for Persons with Physical Disabilities (37.100.401 - 37.100.440)
- Adult Foster Care Homes (37.100.101 - 37.100.175)

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Montana State Licensing Bureau of the Medicaid Agency ensures appropriate medication management during quality assurance reviews. The reviews are conducted every 1-3 years. Case managers ensure that waiver members receive their medication as prescribed and report any mismanagement, harmful practices, or crimes to the appropriate authorities. Case managers are also required to complete a serious occurrence report (SOR) in those instances.

The SOR system is used as a repository for reporting and monitoring serious incidents that involve members. Information is analyzed to assist the member, family and provider agency in the development, implementation, and modification of the member's service plan and to assist the Department in program wide quality oversight, accountable and improvement efforts.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

##### i. Provider Administration of Medications. *Select one:*

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Licensed practical nurses, registered nurses and licensed medication aides administer medication in accordance with the Montana Nurse Practice Act. Under the self-directed Community First Choice/Personal Assistance Services (CFC/PAS) option the administration of medication by personal assistants is exempt from the Nurse Practice Act. Member requirements to participate in the CFC/PAS self-directed option:

ARM 37.40.1101 - 1135 CFC/PAS, Member Requirements

To qualify for self-directed CFC/PAS, the member must: have a medical condition which results in the need for personal assistance services; be capable of assuming the management responsibilities of assistants or have an immediately involved representative willing to assume this responsibility; have authorization from a physician or health care professional to participate in the program; and be capable of making choices about activities of daily living, understand the impact of these choices and assume the responsibility of the choices. The member must be capable of acting as though the personal assistant is their employee for the purposes of selection, management, and supervision of the personal assistant, although the personal assistant is the employee of a self-directed personal assistance provider. The member has the primary responsibility in the scheduling, training, and supervision of the personal assistant. The member has the right to require that a particular assistant discontinue providing services to the member. The member may have an immediately involved representative assume some or all responsibilities imposed by this rule. An immediately involved representative is a person who is directly involved in the day-to-day care of the member. An immediately involved representative must be available to assume the responsibility of managing the member's care, including directing the care as it occurs in the home.

37.40.1007 Self-directed Personal Assistance Services, General Requirements

The member may be authorized to have the personal assistant perform health maintenance activities. These include urinary system management, bowel treatments, administration of medications and wound care.

**iii. Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

*Complete the following three items:*

(a) Specify state agency (or agencies) to which errors are reported:

Serious Occurrence Reports must be submitted to the local Regional Program Officer of the Community Services Bureau whenever there is an issue concerning medication errors or possible mismanagement of medication.

(b) Specify the types of medication errors that providers are required to *record*:

Providers must record medication doses missed or refused by member and why, and unexpected effects of medication or medication error.

(c) Specify the types of medication errors that providers must *report* to the state:

Providers must report a Medication Emergency when there is a discrepancy between the medication that a physician prescribes and what the member actually takes, and this results in a hospital emergency room or equivalent level of treatment or hospital admission; or any medication error occurring during the provision of Medicaid reimbursed nursing (Private Duty Nursing, Home Health or Hospice) services.

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The State Medicaid agency is responsible for monitoring the performance of waiver providers. Licensed facilities are reviewed by the state Licensing Bureau and the State's fiscal intermediary, Conduent EDI Solutions, Inc.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

**a. Methods for Discovery: Health and Welfare**

*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

**a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**# or % of waiver participants (or families / legal guardians) who received information on how to report A/N/E, (Abuse, neglect, exploitation) and unexplained deaths. N: is the # of waiver participants (or family/legal guardians) who receive information on how to report A/N/E, (abuse, neglect, exploitation) and unexplained death. D: is the total # of waiver participants.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid	Weekly	100% Review

<b>Agency</b>		
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =



		<input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

# or % of abuse, neglect, exploitation and unexplained death incidents reported within the required timeframe. N: is the # of SORs including instances of A/N/E that received appropriate response and follow-up by waiver personnel within the required

timeframe. D: is the total number of reported SORs.

**Data Source** (Select one):  
**Critical events and incident reports**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):  
**Critical events and incident reports**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Agency</b>		
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	Specify: <input type="text"/>

**Performance Measure:**

# or % of A/N/E, (abuse, neglect, exploitation) and unexplained death trends where systematic intervention was implemented to reduce the number of future occurrences. N: is the # of reported incidents of abuse, neglect, exploitation, and/or unexplained death trends where systematic intervention was implemented.. D: is the total # of incident trends identified.

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

# or % of substantiated A/N/E (Abuse, Neglect, Exploitation) and unexplained death incidents where follow-up was completed to prevent future incidents. N: is the # of substantiated cases of A/N/E, and unexplained death incidents where required/recommended follow-up were completed. D: is the total # of substantiated cases of A/N/E and unexplained death incidents where follow-up was needed.

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative</b>

		<b>Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  	

**Data Source** (Select one):  
**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  
<b>Other</b> Specify:  	<b>Annually</b>	<b>Stratified</b> Describe Group:  
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b>	

	Specify:  <input style="width: 100%;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>

**b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**# or % of incidents reported where root cause was identified and corrective action items were implemented to prevent future occurrences from occurring. N: is the # of incidents where the root cause was identified and corrective action items were implemented to remove root cause to prevent future occurrences from from occurring again when possible. D: is the total number of incidents reported.**



**Data Source** (Select one):  
**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**# or % of incident trends where systematic intervention was implemented to prevent future similar serious occurrences from happening again. N: is the # of incident trends where systematic intervention was implemented to prevent future similar serious occurrences from happening again. D: is the total # of incident trends identified.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**% of members subject to prohibition of restrictive intervention where intervention was applied in accordance with policies/procedures. N: is the # of members subject to prohibition of restrictive intervention where the prohibition of restrictive intervention policies/procedures are followed. D: is the total # of members subject to prohibition of restrictive intervention.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>

<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**# or % of providers with policies and procedures in place that prohibit the use of restrictive interventions, including restraints and seclusion. N: is the # of providers with policies and procedures in place that prohibit the use of restrictive intervention. D: is the total # of providers.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1025 1262 1108" type="text"/>
Other Specify: <input data-bbox="408 1249 647 1332" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1249 1262 1332" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1473 1262 1556" type="text"/>
	Other Specify: <input data-bbox="719 1697 954 1780" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text"/>

d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number/percentage of wavier participants wanting to decrease use nicotine or tobacco products whom have been provided a referral to a nicotine cessation program. The numerator is the number of wavier participants wanting to decrease use of nicotine or tobacco products and the denominator is the total number of participants who have been provided a referral to a nicotine cessation program.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>



<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		<input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

# or % of waiver participants who received care from primary care physician within the past 12 months. N: is the total # of participants who had a received care from a primary care physician and a corresponding medical claim in the past 12 months. D:

is the total # of waiver participants.

Data Source (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

Data Source (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Agency</b>		
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Regional Program Officer (RPO) review all Serious Occurrence Reports (SORs), entered in the Quality Assurance Management System database, on an ongoing basis. They review for incident type, response time and remediation activities. Staff of the Community Services Bureau (CSB) will provide information to all members and providers on how to identify and report abuse, neglect, and exploitation. CSB staff provide technical assistance as needed and/or follow-up with the local State Regional Program Officers/Providers when an unreported incident has been identified.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

In instances in which members have not received the appropriate information, Serious Occurrence Reports (SOR) were not responded to in an appropriate time frame or SORs did not receive the appropriate follow-up, the State Regional Program Officer (RPO) issues a Quality Assurance Communication to which the provider must respond within a given time frame and complete action steps.

As part of the ongoing review of SORs, the RPO, when necessary, will take immediate and appropriate action to remediate situations when the health or welfare of a member have not been safeguarded. During the staff meetings, prevention strategies will be developed to respond to patterns and trends. As necessary, Adult Protective Services, Child Protective Services and CSB will work together to develop and implement strategies for prevention.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b>

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
	Specify:  <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 10px;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix H: Quality Improvement Strategy (1 of 3)**

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Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state

will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 3)

### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Community Services Bureau (CSB) of the Department conducts a comprehensive evaluation of services to recipients to meet the Bureau's quality assurance requirements. Department staff will perform announced quality assurance reviews. The purpose of the review is to ensure that optimal services are being provided to members and that program rules and policies are being followed. Quality assurance results are utilized to improve the programs and services.

The Quality Management (QM) process involves a strategy to ensure that individual members have access to and are receiving the appropriate services to meet their needs. This requires ongoing development and utilization of individual quality standards and working with Case Management Teams (CMTs, Independence Advisor, Financial Management (FM), and other providers to evaluate individualized personal outcomes and goals. CMTs and FMs are required to complete Quality Improvement Projects (QIP) and submit findings to designated CSB staff quarterly.

The QM process also involves the CSB Quality Assurance (QA) Reviews. The QA review is a strategy designed to collect and review data gathered from providers and individual members on quality assurance measures. Provider standards and quality indicators are used to ensure that quality assurances are met. In addition, at a regional level, the Regional Program Officer (RPO)/CMT will identify trends and systemic issues and provide remediation, as necessary.

Finally, the QM process involves the Central Office. The Central Office staff will perform five main QM functions: 1. Ongoing review of QM discovery information, 2. Monitoring of QA Review, 3. Review of data during staff meeting, and utilization of data to develop remediation strategies and establish priorities for quality improvement, 4. Evaluate and revise the QM strategy, and 5. work with the CSB staff to develop and implement performance indicators.

#### ii. System Improvement Activities

Responsible Party( <i>check each that applies</i> ):	Frequency of Monitoring and Analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify:  <input data-bbox="320 427 868 465" type="text" value="Case Management Teams"/>	<b>Other</b> Specify:  <input data-bbox="943 427 1490 465" type="text" value="Biennial QI Committee Meetings"/>

**b. System Design Changes**

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Review and Revision of the Quality Management Strategy

An evaluation of the effectiveness of system changes to the QM infrastructure will take place during the staff meetings. The review will occur as necessary, but at least on an annual basis. The Big Sky Waiver (BSW) Program Managers will gather information for the review using feedback from the Community Services Bureau (CSB) staff, information from discovery methods, and provider input. The review will evaluate the effectiveness, efficiency, and appropriateness of the QM system design changes.

The Quality Assurance (QA) team will review summaries of discovery information for trends, patterns, and areas of concern. As issues arise, they will be prioritized, and strategies developed to address them. An evaluation of the QA infrastructure will be a part of the staff meetings. This review will occur as necessary, but at least on an annual basis and will evaluate the effectiveness, efficiency, and appropriateness of the QA system.

At the regional level, the Regional Program Officers and Case Management Teams will identify trends and systemic issues and provide assessment information to the CSB on a quarterly basis. The delegated CSB staff will perform QA functions through ongoing review of discovery information; monitoring QA reviews; quarterly staff meetings and working with the QA team to develop and implement performance indicators. CMT's will keep CSB staff informed of effectiveness of design changes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Activities for the quality improvement:

1. Case Management Teams (CMTs) work with RPOs to establish and monitor performance standards;
2. CMTs conduct a program self-assessment to reflect upon how program structure and policies affect members and their ability to self-direct;
3. CSB staff assess trends in QA/QM at a state a federal level for best practices; and
4. Make recommendations on quality improvement strategies.

The Community Services Bureau staff will work with the CMTs to develop Quality Improvement Projects (QIPs) on a quarterly basis.

The waiver performance standards will measure quality-related to:

1. Independence/Choice;
2. Relationships (between members, workers, and support team);
3. Knowledge and support;
4. Health, Safety, and
5. Financial accountability.



## Appendix H: Quality Improvement Strategy (3 of 3)

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### H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

*Big Sky Waiver utilizes a member survey which is a state-developed tool. Member surveys are issued annually. Results are compiled by central office to evaluate setting satisfaction and utilized in the ongoing quality assurance review process.*

## Appendix I: Financial Accountability

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### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*The Department of Public Health and Human Services (Department) provides financial oversight to assure that claim coding and payment are in line with the waiver reimbursement methodology. The Department does not require waiver providers to secure an independent audit of their financial statements. Paid claims reports are run by the Senior and Long Term Care (SLTC) Division of the Department monthly (or as needed). These reports depict the services utilized, the number of waiver participants using each service, the number of units utilized, and the total dollar amount paid for each service. As a part of the quality assurance reviews, financial accountability is assessed. Case managers and Financial Managers are required to prior authorize waiver services.*

*Case Managers and BSB Financial Managers create an authorization for services and submitted to Conduent EDI Solutions of the allowed services, and the number of units or dollar amounts for which providers are permitted to bill for each member.*

*Case management providers are required to conduct internal audits of their records to ensure the waiver member files include the necessary documentation to support the member's identified needs. The person-centered plans must be accurate and complete; services must be aligned to address the identified needs; the cost sheet must match the services provided, and all required information must be included in the file. Scope is defined as the review of documents for accuracy. Case management teams, calculate a statistically valid number of charts based total caseload on 95% with a 5%+/-margin. Results are provided to the Quality Assurance Program Manager and lead Regional Program Officers. If issues of noncompliance are found during the quarterly chart audits, CMTs are responsible to document findings, as well as document the resolution for those findings. If a trend is identified during the quarterly chart audits, the CMTs are responsible for creating a Quality Improvement Project to prevent future incidents of noncompliance. The overpayment is approved by the Bureau Chief and recovered via claim credits.*

*Community Services Bureau (CSB) staff complete desk audits every three years or sooner if the CMT fails to meet an 86% compliance rating in either the member chart review portion and/or the provider prepared standard portion of the Quality Assurance Review. The desk audits include waiver paid claims by members and by service. Member's files are selected randomly based on a 95% confidence level with a 5%+/-margin and verified that they have not been selected as a sample during a previous quality assurance review. Claims for each sample member are pulled for a full calendar year. The State Plan expenditures are reviewed to ensure State Plan funds have been used prior to waiver funds. The claims are compared with the cost sheet and person-centered plan to ensure the waiver member is receiving the services identified on the cost sheet. Any discrepancies are discussed with the case management teams and they are aided in the development of a quality improvement plan. The overpayment is approved by the Bureau Chief and recovered via claim credits.*

*The Quality Assurance Division (QAD) of the Department conducts financial audits upon request of the SLTC Division. The Department requests audits as part of the quality assurance process when extenuating circumstances arise, such as a widespread pattern of overbilling for services or the incorrect service. Scope is defined at the time of referral based on state law, which includes the calculation of the statistically valid number of charts based on 95% with a 5%+/-margin. QAD audits are desk reviews. Results are communicated by SURS to program staff. The overpayment is approved by the Administrator and recovered via claim credits.*

*The Surveillance Utilization Review (SURS) of the Quality Assurance Division conducts provider audits by reviewing records provided by the provider. When an overpayment is identified through the SURS process, SURS staff discusses the overpayment details with the provider and requests the overpayment by formal notice. Providers are notified of their fair hearing rights through the notification from SURS staff. If fraud is identified providers can be sanctioned and be discontinued as Medicaid and Medicare providers. The findings are sent to the Office of Inspector General (OIG) and the licensing board of the provider.*

*Montana is currently contracted with Netsmart to develop a successful adoption of Electronic Visit Verification (EVV) for Montana providers. Montana completed a successful implementation of an EVV system for Montana providers. EVV registration opened 09/18/2023 and MT has 88% of providers registered and actively using the solution and will deny services submitted that are not compliance with the EVV mandate on 07/01/2024. BSW Services subject to EVV are, "Specially Trained Attendant; Respite Care; BSW Personal Assistance; Specialized Childcare for Children; and Supported Living."*

## **Appendix I: Financial Accountability**

### **Quality Improvement: Financial Accountability**

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

methods for discovery and remediation.

**a. Methods for Discovery: Financial Accountability Assurance:**

**The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.** (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

**i. Sub-Assurances:**

**a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number/percent of claims submitted using the appropriate procedure codes and rates. The numerator is the number of claims submitted using the appropriate procedure codes and rates. The denominator is the total number of claims submitted.**

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         95% confidence level with +/- 5% margin of error                     </div>
<b>Other Specify:</b>	<b>Annually</b>	<b>Stratified Describe Group:</b>

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  	

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 0 auto;">95% confidence level with +/- 5% margin of error</div>
<b>Other</b> Specify:  	<b>Annually</b>	<b>Stratified</b> Describe Group:  
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  

	<b>Other</b> Specify:  <input style="width: 100%; height: 30px;" type="text"/>	
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**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">                         95% confidence level with +/- 5% margin of error                     </div>
<b>Other</b> Specify:  <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input style="width: 100%; height: 30px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input style="width: 100%; height: 30px;" type="text"/>
	<b>Other</b> Specify:  <input style="width: 100%; height: 30px;" type="text"/>	

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<i>Responsible Party for data collection/generation (check each that applies):</i>	<i>Frequency of data collection/generation (check each that applies):</i>	<i>Sampling Approach (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i>  <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <i>95% confidence level with +/- 5% margin of error</i> </div>
<i>Other Specify:</i>  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	<i>Annually</i>	<i>Stratified Describe Group:</i>  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i>  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<i>Other Specify:</i>  <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

*Data Source (Select one):*  
**Financial records (including expenditures)**  
 If 'Other' is selected, specify:

<i>Responsible Party for data collection/generation (check each that applies):</i>	<i>Frequency of data collection/generation (check each that applies):</i>	<i>Sampling Approach (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>

<i>Sub-State Entity</i>	<i>Quarterly</i>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">                     95% confidence level with +/- 5% margin of error                 </div>
<b>Other Specify:</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<i>Annually</i>	<b>Stratified Describe Group:</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<i>Continuously and Ongoing</i>	<b>Other Specify:</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other Specify:</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Source** (Select one):

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<b>100% Review</b>
<i>Operating Agency</i>	<i>Monthly</i>	<b>Less than 100% Review</b>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">                     95% confidence level with +/- 5% margin of error                 </div>

<p><b>Other</b> Specify:</p> <input type="text"/>	<p><b>Annually</b></p>	<p><b>Stratified</b> Describe Group:</p> <input type="text"/>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other</b> Specify:</p> <input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Source** (Select one):

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<p><b>Representative Sample</b> Confidence Interval =</p> <input type="text"/> <p>95% confidence level with +/- 5% margin of error</p>
<p><b>Other</b> Specify:</p> <input type="text"/>	<p><b>Annually</b></p>	<p><b>Stratified</b> Describe Group:</p> <input type="text"/>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other</b> Specify:</p>



		<input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<p><b>Representative Sample</b> Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     95% confidence level with +/- 5% margin of error                 </div>
<p><b>Other</b> Specify:</p> <input type="text"/>	<b>Annually</b>	<p><b>Stratified</b> Describe Group:</p> <input type="text"/>
	<b>Continuously and Ongoing</b>	<p><b>Other</b> Specify:</p> <input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;"> <i>95% confidence level with +/- 5% margin of error</i> </div>
<i>Other Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	<i>Annually</i>	<i>Stratified Describe Group:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<i>Other Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i>	<i>Annually</i>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number/percent of claims that were paid in accordance with the approved reimbursement methodology on the date that services were provided. The numerator is the number of paid claims that were paid in accordance with the approved reimbursement methodology on the date that services were provided. The denominator is the total number of paid claims for individuals who receive waiver services.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<p><b>Representative Sample</b> Confidence Interval =</p> <input type="text"/>
<p><b>Other</b> Specify:</p> <input type="text"/>	<b>Annually</b>	<p><b>Stratified</b> Describe Group:</p> <input type="text"/>
	<b>Continuously and Ongoing</b>	<p><b>Other</b> Specify:</p> <input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i>  <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i>  <input type="text"/>

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number/percent of waiver claims coded and paid according to the approved reimbursement methodology in the approved waiver. The numerator is the number of waiver claims coded and paid according to the approved reimbursement methodology in the approved waiver. The denominator is the total number of paid waiver claims.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>

<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i>  <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% confidence level with +/- 5% margin of error</div>
<i>Other</i> <i>Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i>  <input style="width: 100%; height: 20px;" type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>
	<i>Other</i> <i>Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

*If 'Other' is selected, specify:*

<i>Responsible Party for data collection/generation (check each that applies):</i>	<i>Frequency of data collection/generation (check each that applies):</i>	<i>Sampling Approach (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i>

		95% confidence level with +/- 5% margin of error
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  95% confidence level with +/- 5% margin of error
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 0 auto;">95% confidence level with +/- 5% margin of error</div>
<b>Other</b> Specify:  	<b>Annually</b>	<b>Stratified</b> Describe Group:  
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  



	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

*Number of claims that are coded and paid only for services rendered. The numerator is the number of claims that are coded and paid only for services rendered. The denominator is the total number of claims coded and paid.*

**Data Source (Select one):**

**Record reviews, on-site**

*If 'Other' is selected, specify:*

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i>

		<p><i>Confidence Interval =</i></p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>95% confidence level with +/- 5% margin of error</p> </div>
<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p><b>Annually</b></p>	<p><b>Stratified</b> Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<p><b>Representative Sample</b> <i>Confidence Interval =</i></p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>95% confidence level with +/- 5% margin of error</p> </div>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**  
**Record reviews, on-site**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/> 95% confidence level with +/- 5% margin of error
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>

	<b>Other</b> Specify:  <input style="width: 100%; height: 30px;" type="text"/>	
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**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">                         95% confidence level with +/- 5% margin of error                     </div>
<b>Other</b> Specify:  <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input style="width: 100%; height: 30px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input style="width: 100%; height: 30px;" type="text"/>
	<b>Other</b> Specify:  <input style="width: 100%; height: 30px;" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

*Number/percent of paid waiver claims in the sample with adequate documentation that services were rendered. The numerator is the number of claims in the sample with adequate documentation of services rendered. The denominator is the total number of claims in the sample.*

**Data Source (Select one):**

**Record reviews, on-site**

*If 'Other' is selected, specify:*

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"><i>95% confidence level with +/- 5% margin of error</i></div>
<i>Other</i> <i>Specify:</i>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i>

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**  
**Record reviews, on-site**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/> 95% confidence level with +/- 5% margin of error
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>

	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

*Number/percent of claims in the sample submitted and paid that are consistent with the participant service plan. The numerator is the number of claims in the sample submitted and paid that are consistent with the participant service plan. The denominator is the total number of claims in the sample submitted and paid.*

**Data Source (Select one):**

**Record reviews, on-site**

*If 'Other' is selected, specify:*

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative</i>

		<p><b>Sample Confidence Interval =</b></p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>95% confidence level with +/- 5% margin of error</p> </div>
<p><b>Other Specify:</b></p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<p><b>Annually</b></p>	<p><b>Stratified Describe Group:</b></p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other Specify:</b></p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<p><b>Other Specify:</b></p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Source (Select one):**

**Record reviews, on-site**

*If 'Other' is selected, specify:*

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<p><b>Representative Sample Confidence Interval =</b></p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>95% confidence level with +/- 5% margin of error</p> </div>
<b>Other</b>	<b>Annually</b>	<b>Stratified</b>



<i>Specify:</i>  <input style="width: 100%; height: 20px;" type="text"/>		<i>Describe Group:</i>  <input style="width: 100%; height: 20px;" type="text"/>
	<b><i>Continuously and Ongoing</i></b>	<b><i>Other Specify:</i></b>  <input style="width: 100%; height: 20px;" type="text"/>
	<b><i>Other Specify:</i></b>  <input style="width: 100%; height: 20px;" type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

*If 'Other' is selected, specify:*

<b><i>Responsible Party for data collection/generation (check each that applies):</i></b>	<b><i>Frequency of data collection/generation (check each that applies):</i></b>	<b><i>Sampling Approach (check each that applies):</i></b>
<b><i>State Medicaid Agency</i></b>	<b><i>Weekly</i></b>	<b><i>100% Review</i></b>
<b><i>Operating Agency</i></b>	<b><i>Monthly</i></b>	<b><i>Less than 100% Review</i></b>
<b><i>Sub-State Entity</i></b>	<b><i>Quarterly</i></b>	<b><i>Representative Sample</i></b> <i>Confidence Interval =</i>  <input style="width: 100%; height: 40px;" type="text" value="95% confidence level with +/- 5% margin of error"/>
<b><i>Other Specify:</i></b>  <input style="width: 100%; height: 20px;" type="text"/>	<b><i>Annually</i></b>	<b><i>Stratified Describe Group:</i></b>  <input style="width: 100%; height: 20px;" type="text"/>
	<b><i>Continuously and Ongoing</i></b>	<b><i>Other Specify:</i></b>

		<input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<p><b>Representative Sample</b> Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     95% confidence level with +/- 5% margin of error                 </div>
<p><b>Other</b> Specify:</p> <input type="text"/>	<b>Annually</b>	<p><b>Stratified</b> Describe Group:</p> <input type="text"/>
	<b>Continuously and Ongoing</b>	<p><b>Other</b> Specify:</p> <input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;"> <i>95% confidence level with +/- 5% margin of error</i> </div>
<i>Other Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	<i>Annually</i>	<i>Stratified Describe Group:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<i>Other Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i>	<i>Annually</i>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number/percent of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology. The numerator is the number of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology. The denominator is the total number of rates adjusted reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/> 95% confidence level with +/- 5% margin of error
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<p><b>Representative Sample</b> Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     95% confidence level with +/- 5% margin of error                 </div>
<p><b>Other</b> Specify:</p> <input type="text"/>	<b>Annually</b>	<p><b>Stratified</b> Describe Group:</p> <input type="text"/>
	<b>Continuously and Ongoing</b>	<p><b>Other</b> Specify:</p> <input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;"> <i>95% confidence level with +/- 5% margin of error</i> </div>
<i>Other Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	<i>Annually</i>	<i>Stratified Describe Group:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<i>Other Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i>	<i>Annually</i>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="checkbox"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The CSB staff will conduct audits of every three years of participant records to ensure the waiver services are aligned to address the identified needs, the cost sheet matches services provided, and paid claims support services authorized.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Claims that do not have the appropriate procedure codes and/or rates are denied by the MMIS system. Claims that are suspended because of Medicaid eligibility are forwarded to the Department for review and action. Depending upon the number and reasons for denials, training will be made available to providers by Conduent EDI Solutions, Inc. or the Department. CSB staff will always assist providers who encounter on-going problems with the billing system.

In instances in which claims are incorrectly paid, providers will be required reimburse the Department. If the provider fails to do so, the amount owed will be recouped from future claims submitted.

ii. Remediation Data Aggregation

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="checkbox"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<b>Other</b> Specify: <div data-bbox="863 331 1335 416" style="border: 1px solid black; height: 38px; margin-top: 10px;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (1 of 3)**

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).



*The Home and Community Based Service, Big Sky Waiver (BSW) for the elderly and physically disabled waiver utilizes Fee-for-Service (FFS), negotiated market price, and public pricing rate methodologies. Each rate has a unit designation and reimbursement is equal to the rate multiplied by the number of units utilized. BSW FFS rate schedules are published and posted to the Departments website. There will be no interim rates, no prospective payments, and no cost settlements. Specialized Medical Supplies/Equipment, Health and Wellness, Pain and Symptom Management, Community Transition Services and Environmental Accessibility Adaptions – Home and Vehicle modifications, are under negotiated market prices. All other BSW waiver services are Fee-for-Service. These rates were originally determined by surveying current providers. Some of the same service providers provide waiver services to SDMI and BSW waivers and having the same fee schedule will ensure uniformity of rates. Following is the list of services that the SDMI BSW waivers Divisions share: Adult Day Health, Case Management, Community Transition, Consultative Clinic and Therapeutic Services, Environmental Accessibility Modifications for Home and Vehicles, Health and Wellness, Homemaker Chore, Nutrition (Meals), Pain and Symptom Management, Personal Assistance Attendant, Nurse Supervision for Personal Assistance Services, Personal Emergency Response System, Skilled Nursing, Skilled nursing supervision, Residential Habilitation – Assisted Living 1, L2 Assisted Living Behavioral Management, Assisted Living L3 – Specialized, Financial Manager(s) self direct only, Independence Advisor (Self-Direct only), Adult Foster Home, Community Adult Group Home, Respite Care, Specialized Medical Equipment and Supplies, Supported Employment, Specialized Childcare for Medically Fragile Children, Pre-vocational services, Day habilitation, and Non-Medical Transportation.*

*The rate methodology incorporates the following factors:*

*BASE WAGE Salary expectations for direct and indirect care workers is based on the Montana mean wage or the livable wage for Montana, whichever is higher, for each position, direct and indirect care hours for each position, productivity/capacity adjustments, the full-time equivalency required for the delivery of services to Medicaid members, and necessary staffing ratios. Finally, collaboration with policy staff ensures the salaried positions, wage, and hours required conform to the program or service design.*

*PRODUCTIVITY Communication with stakeholders, providers, and members aids in the determination of direct and indirect care hours required and the full-time equivalent of each position. In addition, a review of claims history aides in determining provider capacity. This includes supervisory requirements.*

*BENEFITS FACTOR The benefits factor is consistent with Montana health care markets.*

*ADMINISTRATIVE COSTS/OVERHEAD This is set at 18% based on common practice for Medicaid services. SLTC BSW does not have a geographical (rural) differential currently.*

*The Self-direction program may assist waiver participants that live in rural areas to access providers in their areas. The case management team and the waiver participant develop the Person-Centered Plan. The cost sheet is made available to the member as the services are identified. The member is aware of the reimbursement rate for each of their services identified in the PCP. The member must utilize an Independence Advisor for requested assistance in plan execution and Fiscal Manager to process claims and payment for goods and services. The IA and FM are reimbursed based on PMPM fee.*

*SLTC review the rates annually to ensure services remain consistent and are within our Montana Legislative appropriation. Proposed fee schedules are posted as part of the Administrative Rule of Montana process for public comment when fees are changed, added or deleted. Services are reimbursed according to fee schedule. The fee schedule identifies the maximum allowable rate. SLTC reviews annually information received through multiple sources including number of providers, feedback received from providers and members, member complaints, legislative appropriation, the state of Montana's Access Plan and outcomes from Legislative committee appropriations. In addition, claims history is reviewed of all providers for trends in the number of services utilized and monitor the provider enrollments and compare previous state fiscal year to current year to determine whether there has been a significant reduction of providers. Montana will research trend if the overall provider network decreases by 10 percent. In 2021-2022, the Department of Public Health and Human Services contracted a comprehensive rate study across Medicaid community services reimbursed by the Department, including its three operating 1915(c) waivers. The objectives of the rate models included in this study were to:*

- Recognize reasonable and necessary costs of providers*
- Standardize rates*
- Reflect participant needs*
- Increase transparency*

- Facilitate regular updates
- Provide fiscal stability for providers and the state.

The rate study included a provider cost and wage survey, distributed to all providers delivering services under review. The division and its contractor worked with key stakeholders from December 2021 to August 2022 to conduct the rate study and develop proposed waiver program rates.

Stakeholder involvement included the following workgroups:

- Rate Workgroup – Composed of small and large community providers who reviewed the survey design and materials, gave input on rate component assumptions, and developed related recommendations for consideration by the Steering Committee.
- Steering Committee – Composed of key state agency staff, the lieutenant governor, legislators, and consumer and provider representatives who reviewed and selected key rate assumptions based on materials developed by the contractor and recommendations from the Rate Workgroup. Rates were developed through an independent rate build-up methodology based on cost and wage data from providers and other state and national data sources. The independent rate build-up methodology comprises direct care and indirect care components and uses assumptions about types of employees; wage rates; employee-related expenses (ERE); direct care staff productivity; occupancy and absence factors; supervision; staffing patterns; staff mileage and client transportation costs, along with general program support and administration costs. Some components vary between services while others are the same across the services.

This rate determination methodology was used to calculate rates for the following services:

- Case Management
- Respite
  - Consultative Clinical and Therapeutic services
- Adult Day Health
- Behavioral Intervention Assistant
- Homemaker chore
- Nutrition (Meals)
  - Private duty nursing
- Personal assistant attendant-agency based and self-directed
- Residential habilitation
- Mental health group home
- Intensive mental health group home
- Assisted living/adult foster care
- Non-Medical Transportation-miles
- Life coach Available funding is being applied across all studied rates using the same methodology.

To reduce existing disparities in rates, this methodology increases rates by a percentage of the difference between current and benchmark rates. The department is able to fund about 69.5% of the gap between the current rate and the benchmark rate. Waiver services not subject to this rate determination method are services reimbursed at provider costs. These services include Environmental Accessibility Adaptations - Home Modifications, Community Transition Services, Personal Emergency Response Systems, and Specialized Medical Equipment and Supplies. Additionally, extended State Plan Waiver services are not subject to this rate determination method. They are reimbursed according to rates aligned with and published on Montana Medicaid's RBRVS professional services fee schedule and include Occupational Therapy, Physical Therapy, Special Therapy, Psychological Services, and Nutritionist Services.

The following services were excluded from the Guidehouse rate review because the service is reimbursed at cost: environmental accessibility adaptations, health and wellness, pain and symptom management, personal emergency response-rental, specialized medical supplies and transportation trip. Specialized medical equipment rate reimbursement aligns with state plan as follows: 75% of manufacturer suggested retail price.

All waiver services are preauthorized through a service authorization record in MMIS and are based on the person's Plan of Care. The member's cost plan identifies each service, the providers to deliver each service, and either the units identified as necessary or maximum cost allowable.

Services (DPHHS) has undertaken a robust public notice process in compliance with state and federal requirements. The

process for establishing a Medicaid budget is that of the Montana State Legislature. When approved, they will present to the overall Legislative body for inclusion and approval in the State budget. Services (DPHHS) has undertaken a robust public notice process in compliance with state and federal requirements. The process for establishing a Medicaid budget is that of the Montana State Legislature. When approve, they will present to the overall Legislative body for inclusion and approval in the State budget. The Chief Financial Medicaid Officer within DPHHS works to create an overall budget to present to the Legislative budget sub-committee for approval.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver service providers bill Montana Medicaid through the Montana Medicaid Management Information System (MMIS) managed by Conduent EDI Solutions, Inc.). Payments are issued directly to the providers; no funds are retained by the Department. All services are prior authorized by provider and by units. Edits are in place with MMIS to ensure all services are allowable and reimbursed at the appropriate rate. The providers are enrolled as Medicaid waiver providers in the MMIS. Each provider has a charge file of the services (procedure codes) that they are approved to provide. These files are updated annually with the appropriate fiscal year reimbursement rate and the services. Department staff provides the information to the fiscal intermediary for updating. Members are initially entered into the Medicaid eligibility system (CHIMES) as Medicaid and waiver eligible. The eligibility file is transferred nightly to the MMIS. MMIS has edits to ensure the person receiving the service is eligible for the service, and the prior authorization and provider charge file are reviewed. If all is appropriate, the claim is paid. If there is an error anywhere in this process, the claim is denied.

Montana is currently contracted with Netsmart to develop a successful adoption of EVV for Montana providers. The goal is to have open EVV registration by 09/11/2023 and have 80% of providers registered by 10/1/2023. A target date has been set for 01/01/2024 for providers to be in compliance with the EVV mandate. Obtaining formal CMS certification by Quarter two of 2024. Big Sky Waiver Services subject to EVV are, Specially Trained Attendant; Community Support Services; Respite Care; Personal Assistance Attendant (15 mins.); Personal Assistance Attendant-per Day; Specialized Childcare for Children; and Supported Living.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures (select one):**

**No. state or local government agencies do not certify expenditures for waiver services.**

**Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

**Select at least one:**

**Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

**Certified Public Expenditures (CPE) of Local Government Agencies.**

*Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The state's Montana Medicaid Management Information System (MMIS) (managed by Conduent EDI Solutions, Inc.) has a recipient eligibility system that verifies eligibility for Medicaid and the waiver. Case management teams or financial managers prior authorize all services in the member's service plan. These prior authorizations are submitted to the state's fiscal intermediary (MMIS). Case managers receive monthly utilization reports from providers documenting units of service provided. These reports are compared to individual service plans, compiled, and forwarded to the Community Services Bureau. The data is tabulated and further compared to paid claims data from MMIS.

Utilization reports, cost sheets and service plan for the sampled members are reviewed to determine the date of the claim is within the period authorized by the plan of care, in the amount and type of service as specified in the plan of care. Inappropriate claims billed will be recouped.

*Billing Validation Process:*

*Inappropriate payments are removed from claims for FFP:*

*Reimbursement by check:*

*The provider reimburses the department, the check is deposited and coded to the speed chart for the service and type (Medicaid or Expansion). The coding of the check directs the payment to a Medicaid cost center and records as revenue. This correction is picked up on the 64 report when the quarterly paid claims data is pulled, the repayment will offset paid claims and will lower total quarterly costs, therefore not obtaining extra FFP.*

*Reimbursement from claims:*

*Withheld from claims until paid in full – This direct reduction is referable. The claims are automatically adjusted, which will appear in the claims data pull and entered into the 64 report with paid claims reduced, therefore not collecting excess FFP.*

*Montana is currently contracted with Netsmart to develop a successful adoption of EVV for Montana providers. The goal is to have open EVV registration by 09/11/2023 and have 80% of providers registered by 10/1/2023. A target date has been set for 01/01/2024 for providers to be in compliance with the EVV mandate. Obtaining formal CMS certification by Quarter two of 2024. Big Sky Waiver Services subject to EVV are, Specially Trained Attendant; Community Support Services; Respite Care; Personal Assistance Attendant (15 mins.); Personal Assistance Attendant-per Day; Specialized Childcare for Children; and Supported Living.*

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

*a. Method of payments -- MMIS (select one):*

**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

**Payments for some, but not all, waiver services are made through an approved MMIS.**

*Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

**Payments for waiver services are not made through an approved MMIS.**

*Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

*Describe how payments are made to the managed care entity or entities:*

**Appendix I: Financial Accountability**

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**I-3: Payment (2 of 7)**

**b. Direct payment.** *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

*Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:*

*Financial Managers (FM) operate as limited fiscal agents and make payment for the member in the participant directed option. The FM submits claims to Medicaid for payment and monitors expenditures. Quarterly utilization reports are reviewed by the Case Management Team and Community Services Bureau staff.*

*The following is a list of services for which the fiscal manager makes payment:*

- a. Non-medical transportation*
- b. Homemaker Chore*
- c. Homemaker*
- d. Respite*
- e. Nutrition*
- f. Specialized Medical Equipment and Supplies*
- g. Member Directed Good and Services (other than supplies) that are not available under the state plan or waiver*
- h. Member Directed Good and Services Good and Services (supplies)that are not available under the state plan or waiver*
- i. BSW Personal Assistance Services*

***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

*Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.*

**Appendix I: Financial Accountability**

**I-3: Payment (3 of 7)**

**c. Supplemental or Enhanced Payments.** *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

***No. The state does not make supplemental or enhanced payments for waiver services.***

***Yes. The state makes supplemental or enhanced payments for waiver services.***

*Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.*

**Appendix I: Financial Accountability**

**I-3: Payment (4 of 7)**

**d. Payments to state or Local Government Providers.** *Specify whether state or local government providers receive payment for the provision of waiver services.*

***No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.***

*Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.*

*Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:*

*Nursing facilities that receive county tax dollars may provide respite services to members who are on the waiver. Local city-county health departments that receive city or county tax dollars may provide case management services or direct nursing services to members who are on the waiver.*

**Appendix I: Financial Accountability**

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**I-3: Payment (5 of 7)**

**e. Amount of Payment to State or Local Government Providers.**

*Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:*

*The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.*

*The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.*

*The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.*

*Describe the recoupment process:*

**Appendix I: Financial Accountability**

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**I-3: Payment (6 of 7)**

**f. Provider Retention of Payments.** *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

*Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.*

*Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.*

*Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.*

**Appendix I: Financial Accountability**

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**I-3: Payment (7 of 7)**

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:**

**No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

*Specify the governmental agency (or agencies) to which reassignment may be made.*

**ii. Organized Health Care Delivery System. Select one:**

**No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

*Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:*

**iii. Contracts with MCOs, PIHPs or PAHPs.**

**The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

**The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

*Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how**



payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (1 of 3)**

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

*Appropriation of State Tax Revenues to the State Medicaid agency*

*Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.*

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

**Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (2 of 3)**

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

*Not Applicable. There are no local government level sources of funds utilized as the non-federal share.*

**Applicable**

Check each that applies:

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Appendix I: Financial Accountability**

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**I-4: Non-Federal Matching Funds (3 of 3)**

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

*None of the specified sources of funds contribute to the non-federal share of computable waiver costs*

**The following source(s) are used**

Check each that applies:

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

**Appendix I: Financial Accountability**

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**I-5: Exclusion of Medicaid Payment for Room and Board**

**a. Services Furnished in Residential Settings.** Select one:

*No services under this waiver are furnished in residential settings other than the private residence of the individual.*

*As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home*

*of the individual.*

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

*The Department sets reimbursement for room and board in residential settings. Upon admission to Big Sky Waiver, providers are notified that the waiver will not cover the cost of room and board for the recipient. The method used by the program to exclude the costs of room and board include separating room and boards costs from service costs in determining payment rates.*

*The Montana Medicaid provider portal lists links to the Big Sky Waiver policy manual which notifies providers, "Medicaid reimbursement for room and board is prohibited."*

## **Appendix I: Financial Accountability**

### **I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

**No.** *The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.*

**Yes.** *Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.*

*The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*

## **Appendix I: Financial Accountability**

### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

**a. Co-Payment Requirements.** *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

**No.** *The state does not impose a co-payment or similar charge upon participants for waiver services.*

**Yes.** *The state imposes a co-payment or similar charge upon participants for one or more waiver services.*

**i. Co-Pay Arrangement.**

*Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):*

**Charges Associated with the Provision of Waiver Services** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

*Nominal deductible*

*Coinsurance*

*Co-Payment*

*Other charge*

*Specify:*

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

**b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

**No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

**Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration**

**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	21670.31	13624.00	35294.31	40262.00	2172.00	42434.00	7139.69
2	21998.26	13624.00	35622.26	40262.00	2172.00	42434.00	6811.74
3	22333.75	13624.00	35957.75	40262.00	2172.00	42434.00	6476.25
4	22660.17	13624.00	36284.17	40262.00	2172.00	42434.00	6149.83
5	23000.10	13624.00	36624.10	40262.00	2172.00	42434.00	5809.90

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 9)**

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	2783		2783
Year 2	2783		2783
Year 3	2783		2783
Year 4	2783		2783
Year 5	2783		2783

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (2 of 9)**

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The FY 2019 average length of stay was 315 days. The assumption was made that the ALOS may not be impacted by the slight increase in enrollment from the Money Follows the Person demonstration grant. The FY 2019 ALOS will be used in each waiver year for Appendix J.

The acuity of the BSW member has been changing, but it has been offset by members that we serve for a short period of time for a specific set of services. This includes case management, home modifications or specialized equipment not available through state plan Medicaid. The increase in short term members will stabilize the ALOS.

The FY 2019 ALOS will be used in each waiver year for Appendix J.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (3 of 9)**

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D was determined using the FY 2019 baseline data for service counts reflected in the most recent approved BSW 372 report in the absence of data unimpacted by the PHE. Under MOE requirements, the state must preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021. Due to these requirements, the program anticipates number of users and average units per user levels to remain within a relatively fixed amount through waiver years 1 and 2. The rates for services are the rates that will be in place as of 07/01/2024. The state will re-evaluate Factor D after the PHE has ended, and providers have been given the 365-day allowable billing period.

**ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was determined using the FY 2019 baseline data reflected in the most recent approved BSW 372 report in the absence of data unimpacted by the PHE.

**iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was determined using FY 2019 baseline service data and no increases were anticipated for years one through five. Calculation was updated to the FY 2024 NF rate.

**iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was determined using FY 2019 baseline data and no increases were anticipated for years one through five.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (4 of 9)**

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Health	
Big Sky Waiver Personal Assistance	
Case Management	
Community Adult Group Homes	
Day Habilitation	
Homemaker	
Prevocational Services	
Respite	
Supported Employment	
Audiology	

<i>Waiver Services</i>	
<i>Respiratory Therapy</i>	
<i>Speech Therapy</i>	
<i>Financial Management Services - Self Direction</i>	
<i>Independence Advisor - Self Direction</i>	
<i>Adult Foster Care</i>	
<i>Community Transition</i>	
<i>Consultative Clinical and Therapeutic Services</i>	
<i>Dietetic-Nutritionist Services</i>	
<i>Environmental Accessibility Adaptations</i>	
<i>Family Training and Support</i>	
<i>Health and Wellness</i>	
<i>Homemaker Chore</i>	
<i>Level 1 Assisted Living</i>	
<i>Level 2 Assisted Living Behavioral Health Modification</i>	
<i>Level 3 Assisted Living Specialized Care</i>	
<i>Member Directed Goods and Services</i>	
<i>Money Management</i>	
<i>Non-medical Transportation</i>	
<i>Nurse Supervision for Personal Care Attendants</i>	
<i>Nutrition</i>	
<i>Occupational Therapy</i>	
<i>Pain and Symptom Management</i>	
<i>Personal Emergency Response Systems</i>	
<i>Physical Therapy</i>	
<i>Post Acute Rehabilitation Services</i>	
<i>Senior Companion</i>	
<i>Service Animals</i>	
<i>Skilled Nursing</i>	
<i>Specialized Child Care for Children Who Are Medically Fragile</i>	
<i>Specialized Medical Equipment and Supplies</i>	
<i>Specially Trained Attendant</i>	
<i>Vehicle Modifications</i>	

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 9)**

**d. Estimate of Factor D.**

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							154552.69
Adult Day Health		15 minutes	29	1686.52	3.16	154552.69	
<b>Big Sky Waiver Personal Assistance Total:</b>							11323980.06
Big Sky Waiver Personal Assistance		15 minutes	1238	1020.87	8.96	11323980.06	
<b>Case Management Total:</b>							7714025.11
Specialized		day	23	218.37	25.81	129630.98	
Day		day	2442	271.25	11.45	7584394.12	
15 minutes		15 minutes	0	0.00	17.45	0.00	
<b>Community Adult Group Homes Total:</b>							1111499.14
Community Adult Group Homes		day	16	315.48	220.20	1111499.14	
<b>Day Habilitation Total:</b>							85404.43
Day Habilitation		day	13	59.18	111.01	85404.43	
<b>Homemaker Total:</b>							1432373.99
Homemaker		15 minute	503	374.20	7.61	1432373.99	
<b>Prevocational Services Total:</b>							149252.13
Prevocational Services		hour	19	666.84	11.78	149252.13	
<b>Respite Total:</b>							43313.47
Individual		15 minutes	14	447.87	6.02	37746.48	
Residential		day	3	4.61	402.53	5566.99	
<b>Supported Employment Total:</b>							26695.15
Supported Employment		15 minutes	10	185.77	14.37	26695.15	
<b>GRAND TOTAL:</b>							60308461.10
Total: Services included in capitation:							60308461.10
Total: Services not included in capitation:							2783
Total Estimated Unduplicated Participants:							21670.31
Factor D (Divide total by number of participants):							21670.31
Services included in capitation:							21670.31
Services not included in capitation:							305
Average Length of Stay on the Waiver:							



Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Audiology Total:</b>							0.00
Audiology		visit	0	0.00	58.81	0.00	
<b>Respiratory Therapy Total:</b>							0.00
Therapeutic Procedures		15 minutes	0	0.00	8.44	0.00	
Visit		visit	0	0.00	27.96	0.00	
<b>Speech Therapy Total:</b>							0.00
Speech Therapy		15 minutes	0	0.00	62.35	0.00	
<b>Financial Management Services - Self Direction Total:</b>							54967.10
Financial Management Services - Self Direction		month	30	10.07	181.95	54967.10	
<b>Independence Advisor - Self Direction Total:</b>							54958.03
Independence Advisor - Self Direction		month	30	10.07	181.92	54958.03	
<b>Adult Foster Care Total:</b>							185158.94
Adult Foster Care		day	8	185.53	124.75	185158.94	
<b>Community Transition Total:</b>							0.00
Community Transition		service	0	0.00	2236.19	0.00	
<b>Consultative Clinical and Therapeutic Services Total:</b>							2869.62
Consultative Clinical and Therapeutic Services		service	1	5.66	507.00	2869.62	
<b>Dietetic-Nutritionist Services Total:</b>							0.00
Dietetic Services		15 minutes	0	0.00	18.73	0.00	
<b>Environmental Accessibility Adaptations</b>							575999.11
<b>GRAND TOTAL:</b>							60308461.10
Total: Services included in capitation:							
Total: Services not included in capitation:							60308461.10
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							21670.31
Services included in capitation:							
Services not included in capitation:							21670.31
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Total:</b>							
Environmental Accessibility Adaptations		service	81	1.59	4472.39	575999.11	
<b>Family Training and Support Total:</b>							3349.61
Family Training and Support		15 minutes	5	55.92	11.98	3349.61	
<b>Health and Wellness Total:</b>							82905.38
Health and Wellness		session	95	4.46	195.67	82905.38	
<b>Homemaker Chore Total:</b>							96365.74
Homemaker Chore		service	82	3.55	331.04	96365.74	
<b>Level 1 Assisted Living Total:</b>							17404940.36
Level 1 Assisted Living		day	752	185.53	124.75	17404940.36	
<b>Level 2 Assisted Living Behavioral Health Modification Total:</b>							2942698.75
Level 2 Assisted Living Behavioral Health Modification		day	104	185.53	152.51	2942698.75	
<b>Level 3 Assisted Living Specialized Care Total:</b>							2788467.78
Level 3 Assisted Living Specialized Care		day	51	315.48	173.31	2788467.78	
<b>Member Directed Goods and Services Total:</b>							9015190.85
Member Directed Goods and Services		item	30	537.54	559.04	9015190.85	
<b>Money Management Total:</b>							64937.60
<b>GRAND TOTAL:</b>							60308461.10
Total: Services included in capitation:							60308461.10
Total: Services not included in capitation:							2783
Total Estimated Unduplicated Participants:							21670.31
Factor D (Divide total by number of participants):							21670.31
Services included in capitation:							21670.31
Services not included in capitation:							305
Average Length of Stay on the Waiver:							305

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Money Management		15 minutes	35	208.00	8.92	64937.60	
<b>Non-medical Transportation Total:</b>							271328.03
Trip		trip	95	42.63	14.90	60342.76	
Miles		mile	679	526.66	0.59	210985.26	
<b>Nurse Supervision for Personal Care Attendants Total:</b>							97006.00
Nurse Supervision for Personal Care Attendants		15 minutes	205	52.00	9.10	97006.00	
<b>Nutrition Total:</b>							668772.70
Nutrition		meal	397	187.80	8.97	668772.70	
<b>Occupational Therapy Total:</b>							0.00
Occupational Therapy		visit	0	0.00	82.78	0.00	
<b>Pain and Symptom Management Total:</b>							286040.85
Pain and Symptom Management		session	158	23.13	78.27	286040.85	
<b>Personal Emergency Response Systems Total:</b>							20685.52
Installation		item	7	0.65	111.82	508.78	
Monthly		month	52	5.03	77.14	20176.74	
Purchase		item	0	0.00	897.00	0.00	
<b>Physical Therapy Total:</b>							3394.38
Physical Therapy		15 minutes	1	41.41	81.97	3394.38	
<b>Post Acute Rehabilitation Services Total:</b>							0.00
<b>GRAND TOTAL:</b>							60308461.10
Total: Services included in capitation:							
Total: Services not included in capitation:							60308461.10
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							21670.31
Services included in capitation:							
Services not included in capitation:							21670.31
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Post Acute Rehabilitation Services		day	0	0.00	865.00	0.00	
<b>Senior Companion Total:</b>							2478.39
Senior Companion		15 minutes	6	212.92	1.94	2478.39	
<b>Service Animals Total:</b>							11180.95
Service Animals		service	1	5.00	2236.19	11180.95	
<b>Skilled Nursing Total:</b>							1260298.00
RN Supervision		15 minutes	0	0.00	20.97	0.00	
RN		15 minutes	164	201.53	19.30	637882.76	
LPN		15 minutes	173	254.80	14.12	622415.25	
<b>Specialized Child Care for Children Who Are Medically Fragile Total:</b>							267462.66
Specialized Child Care for Children Who Are Medically Fragile		15 minutes	20	1995.99	6.70	267462.66	
<b>Specialized Medical Equipment and Supplies Total:</b>							741073.37
Supplies		item	743	0.24	2236.19	398757.40	
Equipment		item	356	0.43	2236.19	342315.97	
<b>Specially Trained Attendant Total:</b>							1244304.32
Specially Trained Attendant		15 minutes	371	376.00	8.92	1244304.32	
<b>Vehicle Modifications Total:</b>							120530.91
Vehicle Modifications		service	35	0.77	4472.39	120530.91	
<b>GRAND TOTAL:</b>							60308461.10
Total: Services included in capitation:							
Total: Services not included in capitation:							60308461.10
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							21670.31
Services included in capitation:							
Services not included in capitation:							21670.31
Average Length of Stay on the Waiver:							305

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							156998.15
Adult Day Health		15 minutes	29	1686.52	3.21	156998.15	
<b>Big Sky Waiver Personal Assistance Total:</b>							11488278.88
Big Sky Waiver Personal Assistance		15 minutes	1238	1020.87	9.09	11488278.88	
<b>Case Management Total:</b>							7828590.61
Specialized		day	23	218.37	26.20	131589.76	
Day		day	2442	271.25	11.62	7697000.85	
15 minutes		15 minutes	0	0.00	17.71	0.00	
<b>Community Adult Group Homes Total:</b>							1144157.63
Community Adult Group Homes		day	16	315.48	226.67	1144157.63	
<b>Day Habilitation Total:</b>							86689.23
Day Habilitation		day	13	59.18	112.68	86689.23	
<b>Homemaker Total:</b>							1453078.47
Homemaker		15 minutes	503	374.20	7.72	1453078.47	
<b>Prevocational Services Total:</b>							151532.72
Prevocational Services		hour	19	666.84	11.96	151532.72	
<b>GRAND TOTAL:</b>							61221148.40
Total: Services included in capitation:							
Total: Services not included in capitation:							61221148.40
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							21998.26
Services included in capitation:							
Services not included in capitation:							21998.26
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Respite Total:</b>							43961.32
Individual		15 minutes	14	447.87	6.11	38310.80	
Residential		day	3	4.61	408.57	5650.52	
<b>Supported Employment Total:</b>							27103.84
Supported Employment		15 minutes	10	185.77	14.59	27103.84	
<b>Audiology Total:</b>							0.00
Audiology		visit	0	0.00	59.69	0.00	
<b>Respiratory Therapy Total:</b>							0.00
Therapeutic Procedures		15 minute	0	0.00	8.57	0.00	
Visit		visit	0	0.00	28.38	0.00	
<b>Speech Therapy Total:</b>							0.00
Speech Therapy		15 minutes	0	0.00	63.29	0.00	
<b>Financial Management Services - Self Direction Total:</b>							55782.76
Financial Management Services - Self Direction		month	30	10.07	184.65	55782.76	
<b>Independence Advisor - Self Direction Total:</b>							55782.76
Independence Advisor - Self Direction		month	30	10.07	184.65	55782.76	
<b>Adult Foster Care Total:</b>							187934.47
Adult Foster Care		day	8	185.53	126.62	187934.47	
<b>Community Transition Total:</b>							0.00
Community Transition		service	0	0.00	2269.73	0.00	
<b>Consultative Clinical and Therapeutic Services Total:</b>							2912.69
<b>GRAND TOTAL:</b>							6122148.40
Total: Services included in capitation:							6122148.40
Total: Services not included in capitation:							2783
Total Estimated Unduplicated Participants:							21998.26
Factor D (Divide total by number of participants):							21998.26
Services included in capitation:							21998.26
Services not included in capitation:							305
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services		service	1	5.66	514.61	2912.69	
<b>Dietetic-Nutritionist Services Total:</b>							0.00
Dietetic Services		15 minutes	0	0.00	19.01	0.00	
<b>Environmental Accessibility Adaptations Total:</b>							584639.63
Environmental Accessibility Adaptations		service	81	1.59	4539.48	584639.63	
<b>Family Training and Support Total:</b>							3399.94
Family Training and Support		15 minutes	5	55.92	12.16	3399.94	
<b>Health and Wellness Total:</b>							84151.06
Health and Wellness		session	95	4.46	198.61	84151.06	
<b>Homemaker Chore Total:</b>							97812.51
Homemaker Chore		service	82	3.55	336.01	97812.51	
<b>Level 1 Assisted Living Total:</b>							17665840.07
Level 1 Assisted Living		day	752	185.53	126.62	17665840.07	
<b>Level 2 Assisted Living Behavioral Health Modification Total:</b>							2986884.58
Level 2 Assisted Living Behavioral Health Modification		day	104	185.53	154.80	2986884.58	
<b>Level 3 Assisted Living Specialized Care Total:</b>							2830300.43
Level 3 Assisted Living Specialized		day	51	315.48	175.91	2830300.43	
<b>GRAND TOTAL:</b>							61221148.40
Total: Services included in capitation:							61221148.40
Total: Services not included in capitation:							2783
Total Estimated Unduplicated Participants:							21998.26
Factor D (Divide total by number of participants):							21998.26
Services included in capitation:							21998.26
Services not included in capitation:							305
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care							
<b>Member Directed Goods and Services Total:</b>							9150489.67
Member Directed Goods and Services		item	30	537.54	567.43	9150489.67	
<b>Money Management Total:</b>							65884.00
Money Management		15 minutes	35	208.00	9.05	65884.00	
<b>Non-medical Transportation Total:</b>							275795.02
Trip		trip	95	42.63	15.12	61233.73	
Miles		mile	679	526.66	0.60	214561.28	
<b>Nurse Supervision for Personal Care Attendants Total:</b>							98498.40
Nurse Supervision for Personal Care Attendants		15 minutes	205	52.00	9.24	98498.40	
<b>Nutrition Total:</b>							678465.06
Nutrition		meal	397	187.80	9.10	678465.06	
<b>Occupational Therapy Total:</b>							0.00
Occupational Therapy		visit	0	0.00	84.02	0.00	
<b>Pain and Symptom Management Total:</b>							290316.66
Pain and Symptom Management		session	158	23.13	79.44	290316.66	
<b>Personal Emergency Response Systems Total:</b>							20996.57
Installation		item	7	0.65	113.50	516.42	
Monthly		month	52	5.03	78.30	20480.15	
<b>GRAND TOTAL:</b>							6122148.40
Total: Services included in capitation:							
Total: Services not included in capitation:							6122148.40
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							21998.26
Services included in capitation:							
Services not included in capitation:							21998.26
Average Length of Stay on the Waiver:							305



Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Purchase		item	0	0.00	910.46	0.00	
<b>Physical Therapy Total:</b>							3445.31
Physical Therapy		15 minutes	1	41.41	83.20	3445.31	
<b>Post Acute Rehabilitation Services Total:</b>							0.00
Post Acute Rehabilitation Services		day	0	0.00	877.98	0.00	
<b>Senior Companion Total:</b>							2516.71
Senior Companion		15 minutes	6	212.92	1.97	2516.71	
<b>Service Animals Total:</b>							11348.65
Service Animals		service	1	5.00	2269.73	11348.65	
<b>Skilled Nursing Total:</b>							1279139.65
RN Supervision		15 minutes	0	0.00	21.28	0.00	
RN		15 minutes	164	201.53	19.59	647467.52	
LPN		15 minutes	173	254.80	14.33	631672.13	
<b>Specialized Child Care for Children Who Are Medically Fragile Total:</b>							271454.64
Specialized Child Care for Children Who Are Medically Fragile		15 minutes	20	1995.99	6.80	271454.64	
<b>Specialized Medical Equipment and Supplies Total:</b>							752188.52
Supplies		item	743	0.24	2269.73	404738.25	
Equipment		item	356	0.43	2269.73	347450.27	
<b>Specially Trained Attendant Total:</b>							1262438.80
Specially Trained						1262438.80	
<b>GRAND TOTAL:</b>							6122148.40
Total: Services included in capitation:							6122148.40
Total: Services not included in capitation:							2783
Total Estimated Unduplicated Participants:							21998.26
Factor D (Divide total by number of participants):							21998.26
Services included in capitation:							21998.26
Services not included in capitation:							305
Average Length of Stay on the Waiver:							

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant		15 minutes	371	376.00	9.05		
<b>Vehicle Modifications Total:</b>							122338.99
Vehicle Modifications		service	35	0.77	4539.48	122338.99	
<b>GRAND TOTAL:</b>							61221148.40
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							61221148.40
<i>Total Estimated Unduplicated Participants:</i>							2783
<i>Factor D (Divide total by number of participants):</i>							21998.26
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							21998.26
<i>Average Length of Stay on the Waiver:</i>							305

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							159443.60
Adult Day Health		15 minutes	29	1686.52	3.26	159443.60	
<b>Big Sky Waiver Personal Assistance Total:</b>							11665216.06
Big Sky Waiver Personal Assistance		15 minutes	1238	1020.87	9.23	11665216.06	
<b>Case Management Total:</b>							7949780.04
Specialized		day	23	218.37	26.59	133548.54	
Day		day	2442	271.25	11.80	7816231.50	
<b>GRAND TOTAL:</b>							62154836.67
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							62154836.67
<i>Total Estimated Unduplicated Participants:</i>							2783
<i>Factor D (Divide total by number of participants):</i>							22333.75
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							22333.75
<i>Average Length of Stay on the Waiver:</i>							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
15 minutes		15 minutes	0	0.00	17.98	0.00	
<b>Community Adult Group Homes Total:</b>							1144157.63
Community Adult Group Homes		day	16	315.48	226.67	1144157.63	
<b>Day Habilitation Total:</b>							87989.42
Day Habilitation		day	13	59.18	114.37	87989.42	
<b>Homemaker Total:</b>							1475665.18
Homemaker		15 minutes	503	374.20	7.84	1475665.18	
<b>Prevocational Services Total:</b>							153813.31
Prevocational Services		hour	19	666.84	12.14	153813.31	
<b>Respite Total:</b>							44610.42
Individual		15 minutes	14	447.87	6.20	38875.12	
Residential		day	3	4.61	414.70	5735.30	
<b>Supported Employment Total:</b>							27493.96
Supported Employment		15 minutes	10	185.77	14.80	27493.96	
<b>Audiology Total:</b>							0.00
Audiology		visit	0	0.00	60.59	0.00	
<b>Respiratory Therapy Total:</b>							0.00
Therapeutic Procedures		15 minutes	0	0.00	8.70	0.00	
Visit		visit	0	0.00	28.81	0.00	
<b>Speech Therapy Total:</b>							0.00
Speech Therapy		15 minutes	0	0.00	64.23	0.00	
<b>Financial Management Services - Self Direction Total:</b>							56619.58
<b>GRAND TOTAL:</b>							62154836.67
Total: Services included in capitation:							
Total: Services not included in capitation:							62154836.67
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							22333.75
Services included in capitation:							
Services not included in capitation:							22333.75
Average Length of Stay on the Waiver:							305

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services - Self Direction		month	30	10.07	187.42	56619.58	
<b>Independence Advisor - Self Direction Total:</b>							56619.58
Independence Advisor - Self Direction		month	30	10.07	187.42	56619.58	
<b>Adult Foster Care Total:</b>							190754.52
Adult Foster Care		day	8	185.53	128.52	190754.52	
<b>Community Transition Total:</b>							0.00
Community Transition		service	3	0.00	2303.78	0.00	
<b>Consultative Clinical and Therapeutic Services Total:</b>							2956.33
Consultative Clinical and Therapeutic Services		service	1	5.66	522.32	2956.33	
<b>Dietetic-Nutritionist Services Total:</b>							0.00
Dietetic Services		15 minutes	0	0.00	19.30	0.00	
<b>Environmental Accessibility Adaptations Total:</b>							593408.94
Environmental Accessibility Adaptations		service	81	1.59	4607.57	593408.94	
<b>Family Training and Support Total:</b>							3450.26
Family Training and Support		15 minutes	5	55.92	12.34	3450.26	
<b>Health and Wellness Total:</b>							85409.45
Health and Wellness		session	95	4.46	201.58	85409.45	
<b>Homemaker Chore Total:</b>							99279.65
Homemaker Chore		service	82	3.55	341.05	99279.66	
<b>GRAND TOTAL:</b>							62154836.67
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							62154836.67
<i>Total Estimated Unduplicated Participants:</i>							2783
<i>Factor D (Divide total by number of participants):</i>							22333.75
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							22333.75
<i>Average Length of Stay on the Waiver:</i>							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Level 1 Assisted Living Total:</b>							17930925.33
Level 1 Assisted Living		day	752	185.53	128.52	17930925.33	
<b>Level 2 Assisted Living Behavioral Health Modification Total:</b>							3031649.25
Level 2 Assisted Living Behavioral Health Modification		day	104	185.53	157.12	3031649.25	
<b>Level 3 Assisted Living Specialized Care Total:</b>							2872776.65
Level 3 Assisted Living Specialized Care		day	51	315.48	178.55	2872776.65	
<b>Member Directed Goods and Services Total:</b>							9287723.63
Member Directed Goods and Services		item	30	537.54	575.94	9287723.63	
<b>Money Management Total:</b>							66903.20
Money Management		15 minutes	35	208.00	9.19	66903.20	
<b>Non-medical Transportation Total:</b>							280302.50
Trip		trip	95	42.63	15.35	62165.20	
Miles		mile	679	526.66	0.61	218137.31	
<b>Nurse Supervision for Personal Care Attendants Total:</b>							99990.80
Nurse Supervision for Personal Care Attendants		15 minutes	205	52.00	9.38	99990.80	
<b>Nutrition Total:</b>							688902.98
<b>GRAND TOTAL:</b>							62154836.67
<i>Total: Services included in capitation:</i>							62154836.67
<i>Total: Services not included in capitation:</i>							2783
<i>Total Estimated Unduplicated Participants:</i>							22333.75
<i>Factor D (Divide total by number of participants):</i>							22333.75
<i>Services included in capitation:</i>							22333.75
<i>Services not included in capitation:</i>							305
<i>Average Length of Stay on the Waiver:</i>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutrition		meal	397	187.80	9.24	688902.98	
<b>Occupational Therapy Total:</b>							0.00
Occupational Therapy		visit	0	0.00	85.28	0.00	
<b>Pain and Symptom Management Total:</b>							316629.35
Pain and Symptom Management		visit	158	23.13	86.64	316629.35	
<b>Personal Emergency Response Systems Total:</b>							21310.33
Installation		item	7	0.65	115.20	524.16	
Monthly		month	52	5.03	79.47	20786.17	
Purchase		item	0	0.00	924.11	0.00	
<b>Physical Therapy Total:</b>							3497.07
Physical Therapy		15 minutes	1	41.41	84.45	3497.07	
<b>Post Acute Rehabilitation Services Total:</b>							0.00
Post Acute Rehabilitation Services		day	0	0.00	891.14	0.00	
<b>Senior Companion Total:</b>							2555.04
Senior Companion		15 minutes	6	212.92	2.00	2555.04	
<b>Service Animals Total:</b>							11518.90
Service Animals		service	1	5.00	2303.78	11518.90	
<b>Skilled Nursing Total:</b>							1298422.11
RN Supervision		15 minutes	0	0.00	21.60	0.00	
RN		15 minutes	164	201.53	19.88	657052.29	
LPN						641369.82	
<b>GRAND TOTAL:</b>							62154836.67
Total: Services included in capitation:							
Total: Services not included in capitation:							62154836.67
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							22333.75
Services included in capitation:							
Services not included in capitation:							22333.75
Average Length of Stay on the Waiver:							305

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 minutes	173	254.80	14.55		
<b>Specialized Child Care for Children Who Are Medically Fragile Total:</b>							275446.62
Specialized Child Care for Children Who Are Medically Fragile		15 minutes	20	1995.99	6.90	275446.62	
<b>Specialized Medical Equipment and Supplies Total:</b>							763472.69
Supplies		item	743	0.24	2303.78	410810.05	
Equipment		item	356	0.43	2303.78	352662.64	
<b>Specially Trained Attendant Total:</b>							1281968.24
Specially Trained Attendant		15 minutes	371	376.00	9.19	1281968.24	
<b>Vehicle Modifications Total:</b>							124174.01
Vehicle Modifications		service	35	0.77	4607.57	124174.01	
<b>GRAND TOTAL:</b>							62154836.67
Total: Services included in capitation:							62154836.67
Total: Services not included in capitation:							2783
Total Estimated Unduplicated Participants:							22333.75
Factor D (Divide total by number of participants):							22333.75
Services included in capitation:							22333.75
Services not included in capitation:							305
Average Length of Stay on the Waiver:							

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (8 of 9)**

**d. Estimate of Factor D.**

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							161399.96
Adult Day Health		15 minutes	29	1686.52	3.30	161399.96	
<b>Big Sky Waiver Personal Assistance Total:</b>							11842153.25
Big Sky Waiver Personal Assistance		15 minutes	1238	1020.87	9.37	11842153.25	
<b>Case Management Total:</b>							8064395.77
Specialized		day	23	218.37	26.99	135557.54	
Day		day	2442	271.25	11.97	7928838.22	
15 minutes		15 minutes	0	0.00	18.25	0.00	
<b>Community Adult Group Homes Total:</b>							1161319.74
Community Adult Group Homes		day	16	315.48	230.07	1161319.74	
<b>Day Habilitation Total:</b>							89304.99
Day Habilitation		day	13	59.18	116.08	89304.99	
<b>Homemaker Total:</b>							1498251.90
Homemaker		15 minutes	503	374.20	7.96	1498251.90	
<b>Prevocational Services Total:</b>							156093.91
Prevocational Services		hour	19	666.84	12.32	156093.91	
<b>Respite Total:</b>							45260.76
Individual		15 minutes	14	447.87	6.29	39439.43	
Residential		day	3	4.61	420.92	5821.32	
<b>Supported Employment Total:</b>							27921.23
Supported Employment		15 minutes	10	185.77	15.03	27921.23	
<b>GRAND TOTAL:</b>							63063244.91
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							63063244.91
<i>Total Estimated Unduplicated Participants:</i>							2783
<i>Factor D (Divide total by number of participants):</i>							22660.17
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							22660.17
<i>Average Length of Stay on the Waiver:</i>							305



Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Audiology Total:</b>							0.00
Audiology		visit	0	0.00	61.50	0.00	
<b>Respiratory Therapy Total:</b>							0.00
Therapeutic Procedures		15 minutes	0	0.00	8.83	0.00	
Visit		visit	0	0.00	29.24	0.00	
<b>Speech Therapy Total:</b>							0.00
Speech Therapy		15 minutes	0	0.00	65.20	0.00	
<b>Financial Management Services - Self Direction Total:</b>							57468.48
Financial Management Services - Self Direction		month	30	10.07	190.23	57468.48	
<b>Independence Advisor - Self Direction Total:</b>							57468.48
Independence Advisor - Self Direction		month	30	10.07	190.23	57468.48	
<b>Adult Foster Care Total:</b>							193619.11
Adult Foster Care		day	8	185.53	130.45	193619.11	
<b>Community Transition Total:</b>							0.00
Community Transition		service	0	0.00	2338.34	0.00	
<b>Consultative Clinical and Therapeutic Services Total:</b>							3000.71
Consultative Clinical and Therapeutic Services		service	1	5.66	530.16	3000.71	
<b>Dietetic-Nutritionist Services Total:</b>							0.00
Dietetic Services		15 minutes	0	0.00	19.59	0.00	
<b>Environmental Accessibility Adaptations</b>							602309.62
<b>GRAND TOTAL:</b>							63063244.91
Total: Services included in capitation:							
Total: Services not included in capitation:							63063244.91
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							22660.17
Services included in capitation:							
Services not included in capitation:							22660.17
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Total:</b>							
Environmental Accessibility Adaptations		service	81	1.59	4676.68	602309.62	
<b>Family Training and Support Total:</b>							3453.06
Family Training and Support		15 minutes	5	55.92	12.35	3453.06	
<b>Health and Wellness Total:</b>							86693.26
Health and Wellness		session	95	4.46	204.61	86693.26	
<b>Homemaker Chore Total:</b>							100767.18
Homemaker Chore		service	82	3.55	346.16	100767.18	
<b>Level 1 Assisted Living Total:</b>							18200196.15
Level 1 Assisted Living		day	752	185.53	130.45	18200196.15	
<b>Level 2 Assisted Living Behavioral Health Modification Total:</b>							3077185.74
Level 2 Assisted Living Behavioral Health Modification		day	104	185.53	159.48	3077185.74	
<b>Level 3 Assisted Living Specialized Care Total:</b>							2915896.46
Level 3 Assisted Living Specialized Care		day	51	315.48	181.23	2915896.46	
<b>Member Directed Goods and Services Total:</b>							9427054.00
Member Directed Goods and Services		item	30	537.54	584.58	9427054.00	
<b>Money Management Total:</b>							67922.40
<b>GRAND TOTAL:</b>							63063244.91
Total: Services included in capitation:							
Total: Services not included in capitation:							63063244.91
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							22660.17
Services included in capitation:							
Services not included in capitation:							22660.17
Average Length of Stay on the Waiver:							305

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Money Management		15 minutes	35	208.00	9.33	67922.40	
<b>Non-medical Transportation Total:</b>							284809.99
Trip		trip	95	42.63	15.58	63096.66	
Miles		mile	679	526.66	0.62	221713.33	
<b>Nurse Supervision for Personal Care Attendants Total:</b>							101483.20
Nurse Supervision for Personal Care Attendants		15 minutes	205	52.00	9.52	101483.20	
<b>Nutrition Total:</b>							699340.91
Nutrition		meal	397	187.80	9.38	699340.91	
<b>Occupational Therapy Total:</b>							0.00
Occupational Therapy		visit	0	0.00	86.56	0.00	
<b>Pain and Symptom Management Total:</b>							299124.10
Pain and Symptom Management		session	158	23.13	81.85	299124.10	
<b>Personal Emergency Response Systems Total:</b>							21629.46
Installation		item	7	0.65	116.93	532.03	
Monthly		month	52	5.03	80.66	21097.43	
Purchase		item	0	0.00	937.97	0.00	
<b>Physical Therapy Total:</b>							3549.25
Physical Therapy		15 minutes	1	41.41	85.71	3549.25	
<b>Post Acute Rehabilitation Services Total:</b>							0.00
<b>GRAND TOTAL:</b>							63063244.91
Total: Services included in capitation:							
Total: Services not included in capitation:							63063244.91
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							22660.17
Services included in capitation:							
Services not included in capitation:							22660.17
Average Length of Stay on the Waiver:							305

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Post Acute Rehabilitation Services		day	0	0.00	904.51	0.00	
<b>Senior Companion Total:</b>							2593.37
Senior Companion		15 minutes	6	212.92	2.03	2593.37	
<b>Service Animals Total:</b>							11691.70
Service Animals		service	1	5.00	2338.34	11691.70	
<b>Skilled Nursing Total:</b>							1317594.27
RN Supervision		15 minutes	0	0.00	21.93	0.00	
RN		15 minutes	164	201.53	20.18	666967.57	
LPN		15 minutes	173	254.80	14.76	650626.70	
<b>Specialized Child Care for Children Who Are Medically Fragile Total:</b>							279837.80
Specialized Child Care for Children Who Are Medically Fragile		15 minutes	20	1995.99	7.01	279837.80	
<b>Specialized Medical Equipment and Supplies Total:</b>							774920.53
Supplies		item	743	0.24	2338.31	416967.44	
Equipment		item	356	0.43	2338.34	357953.09	
<b>Specially Trained Attendant Total:</b>							1301497.68
Specially Trained Attendant		15 minutes	371	376.00	9.33	1301497.68	
<b>Vehicle Modifications Total:</b>							126036.53
Vehicle Modifications		service	35	0.77	4676.68	126036.53	
<b>GRAND TOTAL:</b>							63063244.91
Total: Services included in capitation:							
Total: Services not included in capitation:							63063244.91
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							22660.17
Services included in capitation:							
Services not included in capitation:							22660.17
Average Length of Stay on the Waiver:							305

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							163845.42
Adult Day Health		15 minutes	29	1686.52	3.35	163845.42	
<b>Big Sky Waiver Personal Assistance Total:</b>							12019090.44
Big Sky Waiver Personal Assistance		15 minutes	1238	1020.87	9.51	12019090.44	
<b>Case Management Total:</b>							8185635.42
Specialized		day	23	218.37	27.39	137566.55	
Day		day	2442	271.25	12.15	8048068.88	
15 minutes		15 minutes	0	0.00	18.52	0.00	
<b>Community Adult Group Homes Total:</b>							1178734.23
Community Adult Group Homes		day	16	315.48	233.52	1178734.23	
<b>Day Habilitation Total:</b>							90643.64
Day Habilitation		day	13	59.18	117.82	90643.64	
<b>Homemaker Total:</b>							1520838.61
Homemaker		15 minutes	503	374.20	8.08	1520838.61	
<b>Prevocational Services Total:</b>							158374.50
Prevocational Services		hour	19	666.84	12.50	158374.50	
<b>GRAND TOTAL:</b>							64009276.44
Total: Services included in capitation:							
Total: Services not included in capitation:							64009276.44
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							23000.10
Services included in capitation:							
Services not included in capitation:							23000.10
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Respite Total:</b>							45975.04
Individual		15 minutes	14	447.87	6.39	40066.45	
Residential		day	3	4.61	427.23	5908.59	
<b>Supported Employment Total:</b>							28329.92
Supported Employment		15 minutes	10	185.77	15.25	28329.92	
<b>Audiology Total:</b>							0.00
Audiology		visit	0	0.00	62.42	0.00	
<b>Respiratory Therapy Total:</b>							0.00
Therapeutic Procedures		15 minutes	0	0.00	8.96	0.00	
Visit		visit	0	0.00	29.68	0.00	
<b>Speech Therapy Total:</b>							0.00
Speech Therapy		15 minutes	0	0.00	66.18	0.00	
<b>Financial Management Services - Self Direction Total:</b>							58329.47
Financial Management Services - Self Direction		month	30	10.07	193.08	58329.47	
<b>Independence Advisor - Self Direction Total:</b>							58329.47
Independence Advisor - Self Direction		month	30	10.07	193.08	58329.47	
<b>Adult Foster Care Total:</b>							196528.22
Adult Foster Care		day	8	185.53	132.41	196528.22	
<b>Community Transition Total:</b>							0.00
Community Transition		service	0	0.00	2373.41	0.00	
<b>Consultative Clinical and Therapeutic Services Total:</b>							3045.70
<b>GRAND TOTAL:</b>							64009276.44
Total: Services included in capitation:							64009276.44
Total: Services not included in capitation:							2783
Total Estimated Unduplicated Participants:							23000.10
Factor D (Divide total by number of participants):							23000.10
Services included in capitation:							23000.10
Services not included in capitation:							305
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services		service	1	5.66	538.11	3045.70	
<b>Dietetic-Nutritionist Services Total:</b>							0.00
Dietetic Services		15 minutes	0	0.00	19.88	0.00	
<b>Environmental Accessibility Adaptations Total:</b>							611344.24
Environmental Accessibility Adaptations		service	81	1.59	4746.83	611344.24	
<b>Family Training and Support Total:</b>							3556.51
Family Training and Support		15 minutes	5	55.92	12.72	3556.51	
<b>Health and Wellness Total:</b>							87994.02
Health and Wellness		session	95	4.46	207.68	87994.02	
<b>Homemaker Chore Total:</b>							102277.99
Homemaker Chore		service	82	3.55	351.35	102277.98	
<b>Level 1 Assisted Living Total:</b>							18473652.53
Level 1 Assisted Living		day	752	185.53	132.41	18473652.53	
<b>Level 2 Assisted Living Behavioral Health Modification Total:</b>							3123301.07
Level 2 Assisted Living Behavioral Health Modification		day	104	185.53	161.87	3123301.07	
<b>Level 3 Assisted Living Specialized Care Total:</b>							2959498.95
Level 3 Assisted Living Specialized		day	51	315.48	183.94	2959498.95	
<b>GRAND TOTAL:</b>							64009276.44
Total: Services included in capitation:							64009276.44
Total: Services not included in capitation:							2783
Total Estimated Unduplicated Participants:							23000.10
Factor D (Divide total by number of participants):							23000.10
Services included in capitation:							23000.10
Services not included in capitation:							305
Average Length of Stay on the Waiver:							305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care							
<b>Member Directed Goods and Services Total:</b>							9568319.51
Member Directed Goods and Services		item	30	537.54	593.34	9568319.51	
<b>Money Management Total:</b>							68941.60
Money Management		15 minutes	35	208.00	9.47	68941.60	
<b>Non-medical Transportation Total:</b>							289317.48
Trip		trip	95	42.63	15.81	64028.13	
Miles		mile	679	526.66	0.63	225289.35	
<b>Nurse Supervision for Personal Care Attendants Total:</b>							102975.60
Nurse Supervision for Personal Care Attendants		15 minutes	205	52.00	9.66	102975.60	
<b>Nutrition Total:</b>							709778.83
Nutrition		meal	397	187.80	9.52	709778.83	
<b>Occupational Therapy Total:</b>							0.00
Occupational Therapy		visit	0	0.00	64.14	0.00	
<b>Pain and Symptom Management Total:</b>							303582.64
Pain and Symptom Management		session	158	23.13	83.07	303582.64	
<b>Personal Emergency Response Systems Total:</b>							21953.91
Installation		item	7	0.65	118.68	539.99	
Monthly		month	52	5.03	81.87	21413.92	
<b>GRAND TOTAL:</b>							64009276.44
Total: Services included in capitation:							
Total: Services not included in capitation:							64009276.44
Total Estimated Unduplicated Participants:							2783
Factor D (Divide total by number of participants):							23000.10
Services included in capitation:							
Services not included in capitation:							23000.10
Average Length of Stay on the Waiver:							305



Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Purchase		item	0	0.00	952.04	0.00	
<b>Physical Therapy Total:</b>							3602.67
Physical Therapy		15 minutes	1	41.41	87.00	3602.67	
<b>Post Acute Rehabilitation Services Total:</b>							0.00
Post Acute Rehabilitation Services		day	0	0.00	918.08	0.00	
<b>Senior Companion Total:</b>							2631.69
Senior Companion		15 minutes	6	212.92	2.06	2631.69	
<b>Service Animals Total:</b>							11867.05
Service Animals		service	1	5.00	2373.41	11867.05	
<b>Skilled Nursing Total:</b>							1337648.04
RN Supervision		15 minutes	0	0.00	22.26	0.00	
RN		15 minutes	164	201.53	20.48	676882.84	
LPN		15 minutes	173	254.80	14.99	660765.20	
<b>Specialized Child Care for Children Who Are Medically Fragile Total:</b>							283829.78
Specialized Child Care for Children Who Are Medically Fragile		15 minutes	20	1995.99	7.11	283829.78	
<b>Specialized Medical Equipment and Supplies Total:</b>							786548.07
Supplies		item	743	0.24	2373.41	423226.47	
Equipment		item	356	0.43	2373.41	363321.60	
<b>Specially Trained Attendant Total:</b>							1321027.12
Specially Trained						1321027.12	
<b>GRAND TOTAL:</b>							64009276.44
Total: Services included in capitation:							64009276.44
Total: Services not included in capitation:							2783
Total Estimated Unduplicated Participants:							23000.10
Factor D (Divide total by number of participants):							23000.10
Services included in capitation:							23000.10
Services not included in capitation:							305
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant		15 minutes	371	376.00	9.47		
<b>Vehicle Modifications Total:</b>							127927.07
Vehicle Modifications		service	35	0.77	4746.83	127927.07	
<b>GRAND TOTAL:</b>							64009276.44
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							64009276.44
<i>Total Estimated Unduplicated Participants:</i>							2783
<i>Factor D (Divide total by number of participants):</i>							23000.10
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							23000.10
<i>Average Length of Stay on the Waiver:</i>							305