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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-14-001

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

Region VIII

July 10, 2014

Mary Dalton, Medicaid & Health Services Manager
Montana Department of Health & Human Services
1400 Broadway
PO Box 202951
Helena, MT 59620

Re: SPA MT-14-001

Dear Ms. Dalton:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-14-001. This SPA implements the addition of Community First Choice Services as a Medicaid funded service option.

Please be informed that this State Plan Amendment was approved July 8, 2014 with an effective date of October 1, 2013. We are enclosing the summary page and the amended plan page(s).

If you have any questions regarding this SPA please contact Laurie Jensen at 303-844-7126.

Sincerely,

/s/

D. Stephen Nose, CPA
Acting Associate Regional Administrator
Division for Medicaid and Children's Health Operations

Cc: Richard Opper, Department Director
Duane Preshinger
Jo Thompson
Mary Eve Kulawik

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 14-001

2. STATE: Montana

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/1/2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☒ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 441
Section 2401 of the Affordable Care Act
1915 (k) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 14: $38,445,850
b. FFY 15: $39,643,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement to Attachment 3.1 K Page1-22
Attachment 4.19B, Page 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

N/A

10. SUBJECT OF AMENDMENT:
New State Plan to add Community First Choice Services as a Medicaid funded service option.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Single Agency Director Review.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: **Mary E. Dalton**

14. TITLE: **State Medicaid Director**

15. DATE SUBMITTED: 12-20-13

16. RETURN TO:
Montana Dept. of Public Health and Human Services
Mary E. Dalton
State Medicaid Director
Attn: Jo Thompson
PO Box 4210
Helena, MT 59604

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **12/20/13**

18. DATE APPROVED: **07/08/14**

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **10/01/13**

20. SIGNATURE OF REGIONAL OFFICIAL: **/s/**

21. TYPED NAME: **D. Stephen Nose**

22. TITLE: **Acting ARA, DMCHO**

23. REMARKS:

FORM HCFA-179 (07-92)

MONTANA

1. In-State Community First Choice Services (CFCS)

a. CFCS Reimbursement

The CFCS rates for (1) CFCS attendant service, (2) CFCS mileage, and (3) CFCS Personal Emergency Response System (PERS) are set fees established by the Department based upon historical costs. Fee schedule rates are effective for the dates listed below. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Community First Choice Services.

The Department assures there is no duplication of Personal Care Services (PCS) and Transportation with CFCS attendant services and CFCS mileage.

1. The Department will pay a provider for each Medicaid unit of CFCS attendant service. A unit of CFCS attendant service means a unit of attendant service that is an on-site visit specific to a client. A unit of attendant service is 15 minutes. The unit rate includes the planning and oversight components related to direct service.

   Medicaid payment for CFCS attendant services is not allowable for services provided in a hospital or nursing facility as defined in 50-5-101, MCA and licensed under 50-5-201, MCA.

   The agency's fee schedule rate for CFCS attendant services was set as of October 1, 2013 and is effective for CFCS provided on or after that date. All rates are published on the agency's website www.mtmedicaid.org.

2. The Department will pay a provider for mileage incurred while transporting a client. A CFCS mileage unit of service is a minimum of one mile and means that a provider's employee used their personal vehicle or an agency-owned vehicle to provide transportation to a client during the provision of CFCS.

   The agency's fee schedule rate for CFCS is the same as the Medicaid Transportation mileage rate. The Medicaid Transportation mileage rate was set as of July 1, 2013. This rate is effective for CFC services provided on or after October 1, 2013. All rates are published on the agency's website www.mtmedicaid.org.

3. The Department will pay a provider for a CFCS PERS unit. The PERS unit is electronic, telephonic, or mechanical system used to summon assistance in an emergency situation. The CFCS PERS unit must be connected to a local emergency response system with the capacity to activate emergency medical personnel.

   The agency's fee schedule rate for CFCS PERS is the same as the Elderly and Physically Disabled Waiver PERS rate. The Elderly Physically Disabled Waiver PERS rate was set as of July 1, 2013. This rate is effective for CFCS provided on or after October 1, 2013. All rates are published on the agency's website www.mtmedicaid.org.

b. CFCS Direct Care Wage Add-on Funding

Additional payments will be made to CFCS providers for direct care wage reimbursement effective on or after October 1, 2013 through June 30, 2015. These funds will be distributed proportionally to the participating CFCS provider based on the number of units of Medicaid CFCS provided by each provider. The calculated pro rata amount is distributed to each participating provider two times a year. Providers select the two distribution dates from the available distribution periods identified by the Department.

Example: If the total to be distributed was $500,000

Provider	Units	Percentage	Allocation Formula	Annual Pro Rata Share	First Payment	Second Payment
A	15,000	30%	$500,000 x.30	$150,000	$75,000	$75,000
B	15,000	30%	$500,000 x.30	$150,000	$75,000	$75,000
c	20,000	40%	$500,000 x.40	$200,000	$100,000	$100,000
Total	50,000	100%		$500,000	$250,000	$250,000

Payments will be made according to the following schedule and pool amount:

		Available distribution dates (provider selects two for each distribution period)
October 1, 2013 - June 30, 2014	$ 720,484	December 2013 January 2014 April 2014

July 1, 2014 - June 30, 2015	$ 960,646	September 2014 December 2014 January 2015 April 2015

The Department assures there is no duplication of CFCS Direct Care Wage Add-on Funding and PCS Direct Care Wage Add-on.

c. CFCS Health Insurance for Health Care Worker Funding

Additional payments will be made to Community First Choice providers for health insurance for health care workers reimbursement, for the purpose of providing health insurance coverage to eligible CFCS workers. This reimbursement will be effective on or after October 1, 2013 through June 30, 2015. These funds will be distributed proportionally to the participating Community First Choice providers based on the number of units of Medicaid CFCS provided by each provider according to the following schedule and pool amounts. Payments are made monthly.

October 1, 2013 - June 30, 2014	$3,374,446
July 1, 2014 - June 30, 2015	$4,499,261

Example: If the total to be distributed was $500,000

Provider	Units	Percentage	Allocation Formula	Annual Pro Rata Share	Monthly Payment
A	15,000	30%	$500,000 x.30	$150,000	$12,500
B	15,000	30%	$500,000 x.30	$150,000	$12,500
C	20,000	40%	$500,000 x .40	$200,000	$16,667
Total	50,000	100%		$500,000	$41,667

The Department assures there is no duplication of CFCS Health Insurance for Health Care Worker Funding and PCS Health Insurance for Health Care Worker Funding.

2. Out of State Community First Choice Services

Reimbursement for CFCS for services provided outside the borders of the State of Montana is established by the Department and published on the agency's website at www.mtmedicaid.org. Consideration may be given to reimburse out of state CFCS providers, up to their state's established Medicaid usual and customary reimbursement rate, if Montana established rates are lower.

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Note: Community First Choice (CFC) and Community First Choice Option (CFCO) are used interchangeably in this document to reference Montana's Community First Choice State Plan Option.

i. Eligibility

To receive Community First Choice (CFC) services and supports individuals must meet the following requirements:

(a) Be eligible for medical assistance under the State Plan;

(b) As determined annually—

(1) Be in an eligibility group under the State Plan that includes nursing facility services; or

(2) If in an eligibility group under the State Plan that does not include such nursing facility services have an income that is at or below 150 percent of the Federal poverty level (FPL).* In determining whether the 150 percent of the FPL requirement is met, States must apply the same methodologies as would apply under their Medicaid State Plan, including the same income disregards in accordance with section 1902(r) (2) of the Act; and

(*) Nursing facility services are included in the State Plan services for Categorically Needy and Medically Needy groups under Montana Medicaid. Because Montana provides coverage for nursing facility services to all categorically needy and medically needy individuals to whom the services may be offered, no individuals at present meet the description in (b)(2) under Montana's State Plan.

c) Receive a determination, at least annually, that in the absence of the home and community-based attendant services and supports provided under this subpart, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State Plan.

(d) For purposes of meeting the criterion under paragraph (b) of this section, individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915(c) requirements and receive at least one home and community-based waiver service per month.

(e) Individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State Plan, waiver, and grant or demonstration authorities.

The Quality Improvement Organization performs level of care assessments for nursing facility placement, preadmission screening, CFC functional assessments, and utilization and review of multiple Medicaid contracts. They coordinate with medical professionals, nursing facilities and hospitals; as well as community members and Medicaid eligible individuals to provide information

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and assistance on long term care options. A primary component of their contract work is to assure eligible consumers are counseled in long term care options; including Community First Choice supports and services.

ii. Service Delivery Models

__x__ Agency Model - The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract.

The State elects to choose two options for service delivery within the Agency Model. The first is the traditional Agency Model, where services are delivered based on the person–centered assessment of need. The traditional Agency Model is a model of service delivery whereby the services and supports are provided by entities enrolled with the State Medicaid agency via a provider agreement. The agency provides the services directly through their employees.

The traditional Agency Model is an important service option in the spectrum of home based service delivery because it provides assistance and support to individuals who are not interested or able to take a comprehensive role in directing their services. It also provides a registered nurse to assist in the training of staff and supervision of services where an individual may feel additional medical oversight is needed in service delivery.

In order to comply with CFC statue in section 1915 (k)(1)(A)(iv)(II) and 42 CFR 441.545(a) the State has established a variety of mechanisms to assure that services are controlled, to the greatest extent possible, by the individual or their representative., The person-centered planning (PCP) process includes the opportunity for the individual to identify skills, training, and schedule preference for their workers. Individuals or their representatives are also encouraged to sign all service delivery records (time sheets) to ensure participation in the oversight and delivery of their service. The service planning section of the PCP process includes discussion with the individual about choice with regards to the type of service that is needed, skill-set and preference of worker to deliver the service, and schedule. The individual is also encouraged to refer workers for employment.

The second service delivery option is the agency-with-choice Agency Model where services are delivered based on the person–centered assessment of need. The agency-with-choice Agency Model is a model of service delivery whereby the services and supports are provided by entities enrolled with the State Medicaid agency via a provider agreement. In order to comply with CFC statue in section 1915 (k)(1)(A)(iv)(II) and 42 CFR 441.545(a) the State has established a variety of mechanisms to assure that services are controlled, to the greatest extent possible, by the individual or their representative. The agency provides the services through a co-employment relationship with the individual. The agency is the

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employer of record and the individual assumes the responsibility to hire, fire, schedule, train and manage the workers.

The State provides qualified individuals with the opportunity to switch between the two models of service at any time; thereby supporting consumer choice and control to the greatest extent possible.

_____ Self-Directed Model with service budget – This Model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.
____ Direct Cash
_____Vouchers
____ Financial Management Services in accordance with 441.545(b)(1).

_____ Other Service Delivery Model as described below:

iii. Service Package

A. The following are included CFCO services:

1. Assistance with activities of daily living (ADL), instrumental activities of daily living (IADL), and health related tasks through hands-on assistance supervision, and/or cueing. Reimbursable ADL supports include bathing, personal hygiene, dressing, eating and meal preparation, mobility, positioning and transferring, toileting, assistance with exercise routines performed in the home environment such as walking, and medication assistance. Medical escort service; which ensures an individual who needs hands on assistance is able to make it safely to his/her medical appointments are reimbursable. Reimbursable IADL supports include light housekeeping, laundry, yard hazard removal, personal finance assistance and community inclusion services. Community inclusion services are delivered with the intent of promoting individual integration in the community, such as taking someone to a community event. Mileage for travel in conjunction with medical escort and community inclusion service transportation approved in the person centered plan is reimbursable.

The State will reimburse health related tasks through the Nurse Practice Act exemption and consistent with Montana State law. These tasks are considered health maintenance activities (HMA) and are available under the agency-with-choice agency model through exemption from the State's Nurse Practice Act. HMA tasks are also available in the traditional Agency Model when delivered in accordance with the regulatory requirements for skilled nursing service delegation as permitted in the State's Nurse Practice

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Act. HMA tasks include medication administration, wound care, urinary system management, and bowel program.

2. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks.

The service is available to a physically and mentally capable individual in order to achieve greater independence by potentially performing the tasks for him or herself. The support is time-limited and available only when there is a reasonable expectation that the individual will acquire the skills necessary to perform the task at the end of a three month time period. Services may be re-authorized if medically necessary.

3. Back-up systems or mechanisms to ensure continuity of services and supports.

Electronic back-up services include:

- Personal Emergency Response Systems (PERS) to provide back-up for individuals who live alone or are alone for significant periods of time. PERS are authorized through the functional assessment based on an individual's living situation and health and functional status. The service, when authorized, must be provided 365 days per year. The State does not place any individual limit on PERS.

4. Voluntary training on how to select, manage, and dismiss attendants.

Voluntary training on how to select, manage, train, and dismiss attendants will be discussed with individuals during the initial person-centered planning process and during reassessments. The CFC provider will discuss the options and benefits for voluntary training during these meetings. The CFC provider will provide the training modules; which will be available at any time, per individual request. The training will be available in multiple formats, including a written handbook and website link.

iv. Support System Activities

A team that includes one or more of the following: the Quality Improvement Organization (QIO), CFC enrolled service providers, and CFC Plan Facilitators, will perform the following support activities:

- The QIO will provide assessment and counseling to an individual before enrollment in CFC;
- The QIO will provide the consumer the ability to freely choose from available home and community-based attendant providers and available service delivery models. The CFC Plan Facilitator and CFC provider will provide additional information and support, as needed, during planning and oversight meetings;

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- The CFC Plan Facilitator and CFC provider will provide appropriate information, informal counseling, training and assistance to ensure an individual is able to participate in the planning process to the greatest degree possible; and is able to manage the services and service authorization budget;
- All support system staff, including the QIO, CFC Provider and CFC Plan Facilitators will communicate information to the individual in a manner and language that is understandable by the individual;
- The CFC Plan Facilitator is responsible to provide person-centered planning; including defining goals, needs, priorities and preferences;
- The CFC Plan Facilitator and CFC provider are responsible to incorporate functional assessment material into the person-centered planning process and that the planning process identifies risks. When necessary, a risk assessment form will be used to ensure that identified risks are assessed and mitigated through a person centered process that takes into consideration consumer choice, independence, health and safety ;
- The QIO and CFC Plan Facilitator will assist the individual to define goals, needs and preferences for CFC services and supports;
- The QIO will provide an initial outline for range and scope of individual choices and options. The CFC Plan Facilitator and CFC provider will provide additional information and support, as needed, during planning and oversight meetings;
- The CFC Plan Facilitator will assist in the development of a personalized backup plan with support from the CFC Provider;
- The CFC Plan Facilitator will provide a process for changing the person-centered service plan;
- The CFC Plan Facilitator will review individual rights and responsibilities;
- The QIO, CFC Provider and CFC Plan Facilitator will provide information on the grievance process, depending on the issue involved;
- The QIO, CFC Provider and CFC Plan Facilitator will review the risks and responsibilities of the different service options, depending on the issue involved;
- The PCP Plan Facilitator is responsible for identifying and assessing services, supports, and resources;
- The CFC Provider and CFC Plan Facilitator are responsible for recognizing and reporting critical incidents;
- The CFC Plan Facilitator is responsible for making information available on advocates or advocacy systems; and

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- The QIO, CFC Provider and CFC Plan Facilitator are responsible for ensuring compliance with reassessment and review schedules

v. Permissible Services

The State elects to include the following CFCO permissible service(s):

1. ____Expenditures relating to a need identified in an individual's person-centered plan of services that substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance.

2. ____Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides.

vi. Service Limits

CFC ADL, IADL, and health related task services are limited to 84 hours (336 units) of attendant services per two week period per individual.

IADL tasks are authorized in conjunction with direct personal care services. IADL tasks may not exceed one-third of the total CFC hours authorized or a maximum of 10 hours (40 units) per two week period, whichever is less.

Services may only exceed this limit when prior authorized by the Department based on medical necessity. Medical escort service can exceed this limit without prior authorization. The Department provides exceptions to the prior authorization process in emergency situations that affect consumer health and safety. In emergency situations, the CFC service provider is able to exceed the original authorization through use of a temporary authorization process using an approved form.

Services under the category of skill acquisition, maintenance and enhancement are limited to a three-month time-frame and may not exceed 25 hours per three-month time frame. Services

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exceeding this limit may be re-authorized by the Department if medically necessary and there is a reasonable expectation of skill acquisition.

vii. Use of Direct Cash Payments

A. ___ The State elects to disburse cash prospectively to CFCO participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. _x_ The State elects not to disburse cash prospectively to CFCO participants.

viii. Assurances

(a) The State assures that any individual meeting the eligibility criteria for CFCO will receive CFC services.

(b) The State assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and assures financial accountability for funds expended for CFCO services.

(c) The State assures the provision of consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.

(d) With respect to expenditures during the first full year in which the State Plan amendment is implemented, the State will maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding year.

(e) The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports. See Quality Assurance section for details.

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(f) The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.

(ii) The number of individuals that received such services and supports during the preceding fiscal year.

(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State Plan or under a waiver.

(v) Data regarding the impact of CFC services and supports on the physical and emotional health of individuals being served.

(vi) The collection and reporting of information, including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State Plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

(g) The State assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws.

(h) The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A) and assures that it consults and collaborates with the Council when developing and implementing any State Plan amendment to Community First Choice service and supports. The council is primarily comprised of consumers who are individuals with disabilities, elderly individuals and their representatives.

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(i) Individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid state plan, waiver, grant or demonstration authorities.(j) The State assures that medical escort, transportation for medical appointments, and travel around and participation in the community is authorized based on the functional assessment completed by the Quality Improvement Organization and delivered according to the person-centered service plan. The State, as part of the CFC provider quality assurance review process, conducts retroactive reviews to provide a check and balance for utilization of this service in comparison with utilization of the Non-Emergency Medical Transportation service.

ix. Assessment and Service Plan including the Person Centered Planning Service Planning Process

The person centered planning process will be administered in accordance with 441.540.

Level of Care Assessment

The State assures level of care for all individuals in CFC prior to delivery of CFC services.

Level of care assessments for nursing facility level of care are conducted by the Quality Improvement Organization (QIO). The QIO completes a Preadmission Determination and Functional Assessment to determine if the individual meets level of care requirements for admission to CFC. Preadmission determination and functional assessment involves systemic analysis of the individual's medical, functional, and environmental resources and limitations. The same assessment tool is used for establishing level of care for HCBS 1915(c) waiver services and State Plan services. The level of care is assessed annually. Qualifications for the individuals who perform the initial assessment for level of care are either a licensed nurse or a bachelor's in social work.

Re-assessments for level of care for anyone who meets nursing facility level of care are conducted by the CFC Plan Facilitator. The CFC Plan Facilitator is either a waiver case manager or a CFC provider trained in person-centered planning. The criteria for a case manager is either a licensed nurse or a person with a bachelor's degree in social work or a related behavioral science and one-year experience in a health care or community based services setting. The criteria for a CFC Provider Plan Facilitator is one year experience in a health care or community based services setting and training in Person-Centered Planning and CFC functional needs assessment and service authorization. If a CFC Plan Facilitator suspects during

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an annual visit that a participant's level of care status has changed they will make a referral to the QIO for a full level of care re-assessment.

Level of care assessments for people with developmental disabilities (DD) are conducted in three stages. Initially, the DD Eligibility Specialist establishes if an applicant meets the State definition of developmental disability. Persons employed in this position have a BA degree from an accredited college in human resources, business administration, public administration or other related field and a minimum of three years of job related experience. Next, the Quality Improvement Specialist (QIS) is responsible for completing the level of care evaluations. The QIS must possess the following qualifications: Bachelor's degree and three years of job related experience, and preference for two years' experience in the field of services for individuals with developmental disabilities. Re-assessments for level of care for anyone who is a participant on the DD waiver are done by the QIS.

Level of Care assessments will occur prior to or during implementation of the CFC service plan.

Functional Assessment and Service Plan
The State shall reimburse home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living (ADL), instrumental activities of daily living (IADL), and health related tasks through hands-on supervision, and/or cueing using the person-centered planning process. The planning process includes two critical areas; the functional needs assessment and person-centered planning (PCP) process.

(i) Functional Needs Assessment

The State assesses individual's functional needs using a process conducted by contract nurses through the quality improvement organization (QIO) every 12 months, or at the request of the individual, the individual representative, or the CFC provider. The QIO may assess functional need at the same time as determining level of care. The QIO, in conjunction with the CFC needs assessment will conduct the following:

- Evaluate and discuss the preference and ability of the individual to self-direct;
- Identify a personal-representative, when necessary;
- Verification of individual choice of service setting and alternative settings is reviewed;
- CFC service authorization in units;
- Service model selection; and
- CFC provider selection.

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The initial functional needs assessment is conducted at the individual's primary residence at a time that is convenient for each individual. Reassessments occur at least every 12 months and more often if needed when an individual's support needs or circumstances change significantly necessitating revisions to the person-centered service plan, and at the request of the individual, the individual representative, the QIO, the CFC provider or the CFC Plan Facilitator.

CFC referrals are made to the QIO and processed within 30 working days. In the case where a consumer's health and welfare are jeopardized without services, a CFC provider may institute a temporary CFC service plan until the full CFC planning process can be implemented.
The QIO provides long term care navigation services with every CFC functional assessment and includes information on long term service and residential settings options. The QIO manages all CFC referrals and documents that every individual receives information and options on the following:

- Home based, alternative residential and institutional settings;
- CFC services and personal assistance services; and
- List of enrolled CFC service providers.

The QIO is a contract entity and is free of all conflict of interest standards as outlined in 441.555(c)(5). The QIO services are rendered through a contract with the State and services are claimed at the medical administrative claiming rate.

(ii) Person Centered Service Plan Development Process

The CFC person-centered planning process is facilitated by the CFC Plan Facilitator. The CFC Plan Facilitator will be a pre-existing case manager for any individual receiving either State Plan case management or waiver case management. For individuals who are not currently receiving case management services, the individual will be assigned a CFC Plan Facilitator associated with the primary CFC agency provider. The State requires all CFC Plan Facilitators implement conflict of interest standards to ensure individuals receive appropriate CFC person-centered planning facilitation.

In the case where the CFC Plan Facilitator will be a pre-existing case manager conflict of interest standards are met through the process outlined in each of Montana's approved 1915(c) waivers. The 1915(c) waiver protection includes the following:

- In all cases case managers are prohibited from providing direct CFC service to the individual;

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- In circumstances when case management and other CFC and waiver services are provided by the same entity, the assurance of conflict of interest is met through established administrative separateness criteria;
- The 1915 (c) waiver quality assurance process includes consumer satisfaction surveys, case manager satisfaction surveys, and conflict and grievance policy to identify and address areas of conflict; and
- All individuals are provided information for their right to a fair hearing to file a formal grievance with the Department.

In the case where the CFC Plan Facilitator is employed by the CFC Provider agency the following safeguards are in place to ensure compliance with the conflict of interest standards for the person-centered planning process:

- The CFC Plan Facilitator is not related by blood or marriage to the individual, or to any paid caregiver of the individual;
- The CFC Plan Facilitator is not financially responsible to the individual;
- The CFC Plan Facilitator has no authority to make financial or health-related decisions on behalf of the individual; and
- The CFC Plan Facilitator will not benefit financially from the provision of assessed needs and services.

In these cases the State also requires that the CFC Plan Facilitator, when employed by the CFC Provider agency; will comply with the following separation of roles between the CFC Plan Facilitator and other duties at the CFC Provider agency:

- The CFC Plan Facilitator will not be employed as a CFC direct care worker at the CFC Provider Agency;
- The CFC Plan Facilitator will not have the authority to authorize CFC services; except on a temporary basis (not to exceed 28 days);
- The CFC Plan Facilitator will go through CFC Plan Facilitator training; which includes a section on conflict of interest standards of practice; and
- The CFC Plan Facilitator will not have a majority ownership stake in the CFC Provider agency.

Last, as a safeguard to ensure a protection of participant interest, every CFC Plan Facilitator will complete and sign a CFC Plan Facilitator and Consumer Roles and Responsibility form which identifies the CFC Plan Facilitator's responsibilities on behalf of the CFC participant.

The person-centered plan of services and supports is based on the functional needs assessment and is fully disclosed in writing and agreed to by individuals, or as appropriate, their designated

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representative. In accordance with CFR 441.550(b)(9), the plan is signed by all individuals and the CFC providers.

The CFC Plan Facilitator develops and monitors the person-centered plan during the initial planning process, during the annual planning process and as necessary throughout the year. The person-centered planning process includes the completion of a person-centered planning form that identifies the individual's strengths, preferences, goals and needs. The form must be completed and signed by the individual and the CFC Plan Facilitator. The form must be completed initially and annually thereafter, or at the request of the individual or Plan Facilitator based on a significant life changing event.

The initial person-centered planning process includes pre-planning documents that are sent to the individual prior to scheduling the planning meeting. These documents include the following:

- Information to assist the individual in understanding the person centered planning process;
- Information on how to advocate for individual needs throughout the process and contact information for advocacy organizations;
- Information and strategies for resolving conflicts or disagreements in the planning process; and
- The state's fair hearing process for formal grievances.

The preplanning documents also includes information on who can be involved and participate in the process to support the individual at the planning meeting and options for when and where to schedule the meeting. It is the responsibility of the CFC Plan Facilitator to coordinate the planning meeting and ensure that the people identified by the individual are included in the meeting. The CFC provider is also expected to participate at the planning meeting. The initial planning visit and annual planning visits are conducted at a time and location that is convenient for the individual and their identified support people.

The person-centered planning process includes the development of a service plan; which identifies the type of service to be provided, the amount, frequency and duration of each service, and the type of provider to furnish each service. The service plan must be evaluated every 180 days by the primary CFC provider. The service plan authorizes service delivery. If a change in condition or circumstance occurs the CFC provider can implement an immediate change to service delivery using a temporary authorization process.

Every individual signs a CFC Plan Facilitator and Consumers Roles and Responsibility form. The form includes information for the consumer to assist them in being informed and active participants in the planning process. The form is sent to the individual with the pre-planning documents and is reviewed and signed during the initial planning meeting. The form includes the following:

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- The individual's right to have other people present at the planning meeting for support and assistance;
- The individual's right to schedule a planning meeting should the individual's circumstances change;
- The individual's right to have the planning process reflect their cultural considerations and preferences;
- The individual's right to know the QIO, Plan Facilitator and CFC provider agency's process for handling conflict and disagreement; and
- The individual's right to know the state's formal grievance process.

x. Home and Community-Based Settings

CFC services will be provided in residential settings; which will be limited to those in which the State determines that the setting requirements outlined in 42.CFR 441.530 are met. The State has established CFC Residential Criteria to ensure compliance with this requirement. If a setting does not meet the CFC Residential Criteria it is not deemed "residential" and, therefore, is ineligible for CFC services. CFC residential settings include individual homes, apartment buildings, retirement homes, and group living environments that meet the CFC Residential Criteria. CFC services are not available in any of the settings outlined in Section 1915(k)(1)(A)(ii) of the Act; nursing facility, institution for mental diseases, hospitals providing long-term care services, or an Intermediate Care Facility for Individuals with Intellectual Disability. In addition, CFC services are not available in developmental disability group homes, mental health group homes, adult foster homes and assisted living environments. These settings are explicitly excluded because they do not meet one or more of the criteria outlined above for CFC residential settings.

xi. Qualifications of Providers of CFCO Services

Qualifications for providers of CFC services are established through the provider enrollment process. All providers of CFC Services and CFC personal emergency response service must enroll as a CFC Medicaid provider to be qualified to deliver CFC services. The CFC quality assurance process assures that CFC providers maintain their qualifications to provide CFC services. If a CFC service provider fails to comply with the benchmarks established through the quality assurance process and fails to re-establish their qualifications for compliance as outlined in the state's remediation plan they may be dis-enrolled as a CFC service provider.

xii. Quality Assurance and Improvement Plan

Quality Improvement Strategy

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CFC Quality Improvement Summary:
The State has developed a comprehensive and effective quality improvement (QI) strategy to ensure quality and a consumer-centered focus in every aspect of the CFC process; from service access, assessment and planning to service delivery and outcomes evaluation. Montana's CFC QI strategy is based on a continuous monitoring process that includes the key components outlined in the CMS federal framework for HCBS services. This process includes: 1) design; 2) discovery; 3) remediation; and 4) improvement.

The CFC QI strategy includes a design that assesses quality assurance in the following nine areas:

1. Intake
2. Assessment
3. Person Centered Planning (PCP)
4. Independence and Choice
5. Service Plan and Delivery
6. Health and Welfare
7. Consumer Experience
8. Provider Qualifications
9. Fiscal Accountability

The CFC QI strategy includes performance measures that capture and evaluate data in each of the nine quality assurance (QA) areas. The performance measures are a critical piece of the QI system's discovery process. The systems discovery includes a process of data collection that highlights successes and areas of excellence as well as identifying areas that need remediation. Discovery tools include a variety of data collection methods currently in use by the HCBS waiver and state plan personal assistance services programs, such as critical incident database reports; consumer file review, consumer interviews, claims review and provider prepared standards. These methods include a combination of quantitative and qualitative data for both individual-level and system level measurement.

The CFC QI strategy includes a process of remediation that capitalizes on the current remediation process utilized in the developmental disabilities, serious disabling mental illness, and Big Sky HCBS waivers and state plan personal assistance program. Remediation in all of these programs includes documentation of the infraction, the plan to address the infraction, and review and follow-up to determine whether the remediation activity had the desired effect and outcome. Rather than create a duplicative process, the CFC QI strategy synthesizes the unique statewide systems to provide one comprehensive approach to QI. The implementation of the CFC QI

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strategy will use CFC data elements to capture and evaluate performance measures across disability and service systems. This enables the State to target remediation efforts specific to disability populations, as is the case currently; but also across disability and service systems.

In the QI strategy, the State will employ improvement strategies to address situations where pervasive gaps in performance measures and/or gaps in remediation strategies exist. CFC will bring together program managers across disability and service systems to address the gaps. The CFC Steering Committee, which consists of the state staff representatives from each of the disability-specific HCBS waivers and the CFC program manager; will analyze QA information and establish recommendations for remediation and improvement. Information from these meetings will be reported to the CFC Stakeholder Council, for input and suggestions. This information will feed directly back into the QI process with necessary changes to policy, procedures, and performance measures to ensure a healthy and robust system for monitoring quality service delivery.

Roles and Responsibilities:

Generating Data

There are six key players in the CFC QI strategy. They are responsible for generating data and information used in the quality assurance (QA) process.

1. Quality Improvement Organization
2. CFC Plan Facilitator
3. CFC Provider
4. CFC Consumer, Family, Representative(s)
5. CFC Steering Committee
6. CFC Council

1. Quality Improvement Organization

The quality improvement organization (QIO) is a contracted entity that meets the conflict of interest standards outlined in 441.555(c). The role of the QIO is critical in the quality assurance system for a variety of reasons. The role it plays is twofold.

- The QIO entity receives referrals for anyone who may need long term care services and assists them in navigating the long-term care service options. They provide information, education, options counseling, and choices to everyone they contact. The QIO acts as a navigator in the system to ensure a proper match with the recipient and their service and setting option

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- The QIO conducts the CFC Functional Assessment on all CFC consumers. The QIO conducts the CFC functional assessment via a registered nurse; which ensures that a comprehensive assessment of functional health and safety and service needs are documented. The QIO conducts CFC functional assessment annually, which ensures third-party monitoring of consumer health and welfare and reassessment of consumer needs when a change in condition occurs.

2. CFC Plan Facilitator

The CFC Plan Facilitator has a critical influence on CFC quality assurance. They ensure that the person-centered planning (PCP) process is followed in CFC service planning and service delivery. They develop the CFC Plan; which incorporates consumer choice, goals, and preferences. They also ensure that the needs of the consumer identified in the CFC functional assessment are addressed in the CFC Plan. They are on the ground; assessing health and welfare and whether a person can safely remain at home and maintain their independence. They are a consumer's link to the community; vis-à-vis CFC services and also other community and Medicaid resources.

By design, the CFC Plan Facilitator is a person intimately familiar with the consumer and their service needs. In order to capitalize on the current service delivery system the state has established the role of CFC Plan Facilitator within the current HCBS waiver case management structure. Anyone on waiver services will have their current HCBS case manager act as their CFC Plan Facilitator. For those CFC consumers who are not on waiver the CFC Plan Facilitator will be someone from the CFC agency who is trained in the PCP philosophy and framework of service delivery.

The CFC Plan Facilitators operate at the direct consumer level to provide individual-focused information and support to empower the consumer to achieve their greatest potential for health and community integration. They ensure that consumer choice, options, and individual preferences are the framework for CFC service delivery. They are also responsive to the consumer when challenges and complaints arise.

3. CFC Provider-ADL/IADL Services

The CFC providers work directly with consumers in the day-to-day delivery of services. As such, they are critical to the program's success, particularly consumer health and safety and satisfaction. The CFC provider has access to consumer service delivery records (time sheets); which detail the daily services a consumer receives. The service delivery record is the

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communication link between the consumer and worker and the CFC provider. The service delivery record is where service access is captured. The QIO assesses the service needs and the CFC Plan Facilitator plans for the service; but the CFC provider delivers, tracks and monitors that service through the service delivery record.

The CFC provider is responsible for the implementation of the CFC plan. The CFC plan outlines the consumer's daily service needs and preferences and desires for receiving those services. In addition, the CFC provider compares service delivery records to the service profile to ensure proper utilization of services. This review is ongoing; but occurs at a minimum of every six months. The CFC provider is the key to coordinated CFC service delivery. They communicate with the QIO when functional needs change; they communicate with the CFC Plan Facilitator when consumer planning needs change; and they communicate with workers and consumers to ensure service delivery is appropriate and specific to the consumer's individual needs.

4. Consumer, Family, Representative

The consumer, family and representatives are valued as a part of the quality assurance process. Quality means different things to different people and the CFC PCP process assures that each consumer has an active role in defining quality. The CFC Plan Facilitator and CFC provider are accountable to quality parameters, as defined by the consumer in the CFC Plan.

5. CFC Steering Committee

The CFC steering committee is comprised of State staff representatives from each of the HCBS waivers (elderly/physically disabled, developmentally disabled and serious disabling mental illness) and the CFC program manager. The CFC program manager compiles CFC QA management reports; which are presented to the CFC steering committee. The CFC steering committee, in turn, is responsible for responding to the reports with appropriate remediation plans that are disability specific and state-wide in nature; depending upon the nature of the discovery and remediation that is captured.

6. CFC Council

As directed in 42 CFR 441.575 the CFC Council is an active group of consumers, representatives, stakeholders, and providers that advise the State on development and implementation of the CFC program. This includes providing counsel and direction regarding CFC strategies. The CFC program manager will provide QA management reports to the CFC council and receive feedback on QI strategies.

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Data Collection, Evaluating and Remediation

The CFC QI process is managed by QA staff. QA staff are State employees responsible for collecting and reviewing performance measurement data, overseeing remediation efforts, and reporting outcomes.

The CFC QI system utilizes QA staff that currently operates in the HCBS waiver and state plan QI systems; thereby drawing on strengths of pre-existing systems and eliminating duplication between federally mandated QI processes. The QI system also capitalizes on the authority for remediation and improvement structured in pre-existing service delivery systems. Each QA staff member has a different role and authority in the QA process; which is critical to the success of the QI system as a whole.

There is a tiered system of QA staff; which includes field staff and program management.

The QA field staff consists of staff with skills and knowledge about a range of disabilities and the local provider and consumer community. QA field staff are responsible for reviewing local CFC providers and CFC Plan Facilitators around the performance standards and overseeing remediation at the consumer and provider/planner level. They also conduct CFC consumer visits and interviews to ensure health and safety standards are met and to assess consumer satisfaction.

The second tier in the system is the QA program managers who manage quality standards at a system-wide level. Program managers review the work of local field staff and aggregate data to assess, evaluate and report on performance measures at the statewide level. They also provide a disability-specific knowledge and service-delivery system expertise. This expertise is used as part of the development of statewide system-level strategies for remediation and improvement when performance measures are unmet.

Below is an outline of the QA staff and their responsibility and authority in the QI system:

1. Field Staff
    a. Regional Program Officers (RPO)- Elderly and Physically Disabled (E/PD)
        i. Responsible for CFC Provider performance measures
        ii. Responsible for CFC Plan Facilitator (CFC Provider and HCBS PD/Elderly waiver) performance standards
        iii. Responsible for CFC Consumer Interviews
        iv. Responsible for review of CFC claims data
    b. Quality Improvement Specialist (QIS)- Developmental Disabilities (DD)
        i. Responsible for CFC Plan Facilitator (DD case management) performance measures
    c. Community Program Officer (CPO)-Serious Disabling Mental Illness (SDMI)

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i. Responsible for CFC Plan Facilitator (HCBS waiver-SDMI) performance measures

2. Program Management
   a. Waiver Program Manager- Development Disabilities
      i. Responsible for oversight of remediation efforts and the design and implementation of QI strategies related to DD- specific performance measures
      ii. Responsible for oversight of QIS QA review activity
      iii. Responsible for monitoring critical incident data for DD consumers
   b. Waiver Program Manager- Serious Disability Mental Illness
      i. Responsible for oversight of remediation efforts and the design and implementation of QI strategies related to SDMI- specific performance measures
      ii. Responsible for oversight of CPO QA review activity
      iii. Responsible for monitoring critical incident data for SDMI consumers
   c. Waiver Program Manager- Physically Disabled and Elderly
      i. Responsible for oversight of remediation efforts and the design and implementation of QI strategies related to PD/E- specific performance measures
      ii. Responsible for oversight of RPP PD/E QA review activity
      iii. Responsible for monitoring critical incident data for PD/E consumers
   d. CFC Program Manager
      i. Responsible for synthesizing data on performance measures and the design and implementation of QI strategies
      ii. Responsible for oversight of RPO CFC Plan Facilitator/CFC Provider performance measures
      iii. Responsible for oversight of RPO Consumer interviews
      iv. Responsible for developing CFC QA management report
      v. Responsible for conducting QA meetings with CFC Steering Committee
      vi. Responsible for review of CFC claims data
      vii. Responsible for CFC provider enrollment and records
      viii. Responsible for presenting QA management to CFC Council and soliciting feedback

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QA Data Collection

The CFC QI plan will collect and evaluate data relevant to performance measures using the following data systems:

1. CFC Functional Assessment
2. Critical Incident Reporting
3. CFC Plan Facilitator File
4. CFC Consumer Service Record
5. CFC MMIS Report
6. CFC Provider File
7. CFC Council Notes
8. CFC Consumer Interviews

1. The CFC Functional Assessment captures an extensive amount of data that assists in the evaluation of QA standards related to Intake, Assessment, Independence and Choice, Health and Welfare, and Consumer Experience.

2. The Critical Incident Reporting Systems include the database program used by the developmental disability population and a second database program used by the physically disabled, elderly, and serious disabling mental illness population. These two reporting systems are electronic databases that capture critical elements in an incident reporting process; including the time between incident and incident report, description of the incident, action taken as a result of the incident, and QA staff review. The database systems provide the appropriate staff (case managers, CFC Plan Facilitators and CFC providers, and QA staff) access to consumer-specific remediation efforts. The database systems also provide program managers aggregate data to use in system-wide remediation activity. Data from the critical incident reporting system assists in the evaluation of the Health and Welfare QA standard.

3. The CFC Plan Facilitator File includes the documentation necessary to ensure that CFC services are rendered under the philosophy of PCP and that community inclusion, service access, consumer choice and independence are paramount to the planning process. It also contains the necessary documentation on CFC Plan Facilitator training. It ensures that CFC Plan Facilitators meet the criteria established through policy to perform CFC planning functions. Review of the documentation also ensures that the CFC functional assessment is incorporated into the service delivery plan. The CFC Plan Facilitator consumer file assists in the evaluation of the QA standards related to Person-Centered Planning; Independence and Choice; Health and Welfare; and Provider Qualifications.

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4. The CFC Consumer Service Record includes the documentation necessary to ensure that CFC services are delivered according to the CFC Plan, that regular monitoring occurs, and that a registered nurse signs off on all agency-based services and a qualified Health Care Professional signs off on all agency-with-choice services. The CFC consumer service record assists in the evaluation of the QA standards related to Service Plan/Delivery and Health and Welfare.

5. CFC MMIS data is reviewed to ensure that services are billed by qualified providers, with proper rates and procedure codes. Claims data is matched to service delivery records from the CFC provider files to ensure that billed services have required supporting documentation. MMIS data also captures information on qualified providers enrolled in CFC services. The State reviews MMIS claims data on an annual basis to verify that qualified CFC providers are billing CFC services with proper rates and procedure codes. CFC MMIS data assists in the evaluation of the Provider Qualification and Fiscal Accountability QA standard.

6. The CFC Provider file contains the necessary documentation to ensure that CFC providers have participated in the requisite training requirements and that a consumer survey is conducted on an annual basis. The CFC provider file assists in the evaluation of the Consumer Experience and Provider Qualifications QA standards.

7. CFC Council Notes are used to ensure Council participation in the QI design and implementation process. The CFC council notes assist in the evaluation of the Consumer Experience QA standard.

8. CFC Consumer Interviews are utilized to provide direct contact and feedback from CFC consumers. Interviews are conducted in the home to gather qualitative data on the consumer's experience. The CFC consumer interview assists in the evaluation of the Consumer Experience QA standard. The CFC consumer visit occurs in conjunction with the CFC provider agency quality assurance review. A 5% sample of the CFC provider agency caseload or minimum of two visits, whichever is greater, is used to determine the number of consumer visits per provider agency review. The consumer interviews for a provider agency occur at intervals of six months to three years, depending upon the outcome of that standard from the previous review.

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Performance Measures

As previously mentioned, the QI strategy includes nine QA standards. Each standard includes the collection of data around key performance measures to reflect what is most critical. The performance measures for QA standard are listed below.

1. Intake (3)
    - CFC enrollments meet level of care
    - CFC enrollments receive contact with a nurse assessor within 10 working days
    - CFC referrals that screen eligible for CFC receive an in-home CFC functional assessment within 30 working days
2. Assessment (4)
    - CFC functional assessments include a level of care screen
    - CFC functional assessment include a complete assessment of ADL and IADL needs
    - CFC functional assessment include assessment of community integration
    - CFC consumers will receive an annual CFC functional assessment and an amendment to the annual functional assessment if there is a change in health status
3. Person-Centered Planning (4)
    - CFC consumers have a CFC Plan completed and signed by the consumer, CFC Provider and CFC Plan Facilitator
    - CFC Plan will be reviewed and updated on at least an annual basis
    - Participant Rights and Responsibility form signed by CFC Plan Facilitator and consumer
    - CFC Plan Facilitator trained in PCP process
4. Independence and Choice (5)
    - Consumer will be provided choice of CFC or state plan personal assistance services
    - Consumer will be provided choice of settings (including institution and other community-based)
    - Consumer will be provided choice of CFC providers
    - Each consumer will sign a Participant Rights and Responsibility form
    - Consumer will be provided choice of CFC service delivery model (agency-based and agency-with-choice)
5. Service Plan/Delivery (4)

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- Consumer will have a CFC service record
- CFC Service record includes consumer and provider signature
- CFC service records are assessed at least every 6 months

6. Services delivered according to CFC service profile Health and Welfare (8)
   - Health, safety and service needs identified in the CFC functional assessment are identified and addressed in the CFC Plan
   - CFC Plan reviews for risks and has a plan for minimizing risks, when necessary
   - Critical incidents types are reported according to incident report policy
   - Critical incidents are reported in the time-frame specified in incident report policy
   - Agency-with-choice consumer service record includes a Consumer Agreement form signed by the consumer or a qualified representative
   - Agency-with-choice consumer service record includes a Health Care Professional Authorization form
   - Agency-based consumer service record includes authorization by a licensed nurse
   - CFC functional assessment identifies a CFC Plan Facilitator and CFC Provider
7. Consumer Experience (3)
   - CFC provider administers annual consumer survey
   - CFC quality assessment indicators are collected during initial and annual CFC functional assessment
   - CFC quality assessment indicators are collected during consumer interviews
8. Provider Qualifications (3)
   - CFC Providers pass minimum qualifications prior to enrollment
   - CFC Providers of ADL/IADL services participate in CFC Provider training prior to delivering CFC services and, when necessary, as indicated during the quality assurance review process
   - CFC Plan Facilitators meet training requirements
9. Fiscal Accountability (3)
   - Services are billed according to service delivery record
   - Billed services are coded correctly
   - Services are billed at the correct rate

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1. **Method to continuously monitor the health and welfare of each individual who receives HCBS attendant services, including process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports**

   The CFC QI strategy includes a health and welfare standard and provides eight performance measures to evaluate the efficacy of CFC service planning and service delivery system. Two of these standards are specific to critical incident reporting. CFC Plan Facilitators and CFC providers are mandatory reports of abuse, neglect and exploitation. The State will rely on systems that are currently in place; which provide for a comprehensive process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of services and supports. The State will ensure that the CFC Plan Facilitator is notified of any incident that is reported in an incident system. The QI process ensures that appropriate steps are taken to document, manage and remediates all incidents.

2. **Measure individual outcomes associated with the receipt of HCBS attendant services as set forth in the person-centered plan, particularly for the health and welfare of the consumers**

   A majority of the CFC QI strategy is designed to employ performance measures that support individual outcomes associated with service delivery that is established through a person-centered planning approach that addresses consumer health and safety. Six of the nine QA standards (assessment, person-centered planning, independence and choice, service plan and delivery, health and welfare, and consumer experience) utilize performance measures that capture data to measure this objective. The performance measures associated with these QA standards ensure the PCP process and service delivery model support consumer health and safety, while reflecting consumer independence and choice. These QA standards utilize the full array of staff in the CFC system (QIO, CFC Plan Facilitator, CFC Provider, CFC Consumer/Family member/Representatives) and multiple data sets (CFC FA, CFC Plan Facilitator consumer files, CFC Provider consumer files, CFC Provider files, Consumer interviews, and MMIS data) to ensure this objective measured and evaluated.

3. **Standards for all service delivery models for training, appeals for denials and reconsideration procedures for an individual's person-centered plan**

   The CFC program will use the fair hearing process for reconsiderations to the CFC Plan. This information will be provided by the CFC Plan Facilitator.

   Appeals for denials related to the CFC functional assessment will occur through the QIO and fair hearing process will be provided by the QIO.

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The QIO will provide information to consumers so they can make informed choices about service delivery options.

4. **Use methods that maximize individual independence and control**

The CFC QI strategy includes a QA standard on Consumer Independence and Choice; which includes five performance measures to evaluate the efficacy of choice and independence in the service planning and service delivery system. The Person-Centered Planning QA standard includes four performance measures to ensure CFC services are developed and delivered within a framework that capitalizes on individual preferences, strengths and goals.

5. **Elicit and incorporate feedback from individuals and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others to improve the quality of the HCBS services and supports benefits**

The CFC QI strategy includes the Consumer Experience QA standard, which is designed to elicit and incorporate feedback from consumers and their representatives and the larger community base. There are four performance measures specific to this standard to capture feedback from a broad array of consumers and stakeholders. In addition, the CFC Council, comprised of over 50% consumers and their representatives, is an integral component of the State's overall CFC QI strategy.