MT FLEX PROGRAM SUMMARY OF NOVEMBER 2019 COP CHANGES

The following information is an unofficial review and summary of recently released changes in COPs and should not be considered to represent the actual law or policy. Preliminary verbiage and information was provided by CMS via resources noted. MT Flex has provided this review and summary to Flex-eligible CAH organizations and will continue to provide additional information on changes to Conditions of Participation as they are made available. Font in bold is an explanation of changes and the following text is COP verbiage.

Resources (*indicates CMS official publication):

*Discharge Planning – 84 FR 51836: https://www.federalregister.gov/documents/2019/09/30/2019-20732/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals

*Discharge Planning CMS Fact Sheet: https://www.cms.gov/newsroom/press-releases/cms-discharge-planning-rule-supports-interoperability-and-patient-preferences

*Program Efficiency (QAPI, et al) – 84 FR 5173: https://www.federalregister.gov/documents/2019/09/30/2019-20736/medicare-and-medicaid-programs-regulatory-provisions-to-promote-program-efficiency-transparency-and

*Program Efficiency (QAPI, et al) CMS Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/omnibus-burden-reduction-conditions-participation-final-rule-cms-3346-f

Nebraska Medicine: https://asap.nebraskamed.com/cms-finalized-new-conditions-of-participation-for-hospitals-and-critical-access-hospitals/

Resource Use Measures: https://www.qualityforum.org/News_And_Resources/Endorsement_Summaries/Efficiency_Resource_Use_Endorsement_Summary.aspx

CDC Core Elements of an Antibiotic Stewardship Program: https://www.cdc.gov/antibiotic-use/healthcare/pdfs/core-elements.pdf

*Long Term Care Critical Element Pathways: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTC-Survey-Pathways.zip

State Operations Manuals:

State Operations Manual Appendix W (CAH): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

State Operations Manual Appendix PP (LTC Facilities): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

State Operations Manual Appendix G (Rural Health Clinics): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

State Operations Manual Appendix Z (Emergency Preparedness): https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf

Revisions to Requirements for Discharge Planning for Hospitals, CAHs, and Home Health Agencies, and Hospital and CAH Changes to Promote Innovation, Flexibility and Improvement in Patient Care
CFR Changes: 42 CFR 482, 42 CFR 484, 42 CFR 485
Federal Register: 84 FR 51836
Published: 9/30/2019
Effective: 11/29/2019
STATE OPERATIONS MANUAL: APPENDIX W

§ 485.635 Condition of Participation: Provision of Services

Add component (viii) regarding details that written policies must address post acute care needs of patients receiving CAH services.

(a)(3)(viii) Policies and procedures that address the post-acute care needs of patients receiving CAH services.

§ 485.642 Condition of Participation: Discharge planning

Section 485.642 added.

Refer to CMS' Critical Element Pathway for discharge planning in LTC (link on page 1) to provide guidance or a template for development or process and policies, as well as definitions of appropriately qualified personnel. NOTE: These pathways should be only a guide and each CAH is responsible for comparing with CAH specific regulations to ensure everything is met appropriate.

In discussions between MT Flex, MT DPHHS, and a representation of CAH staff, it is fully understood that the (a)(8) is difficult for CAHs to meet in two ways. The first, explicit in these regulation updates, is the lack of clarity provided on frequency of quality measure review, and the lack of resources a CAH may have in the local community to discharge a patient to. On the other hand, if a CAH is being reviewed for a referral to swing bed from another CAH or tertiary center, there is frequently not large enough caseloads for data to appear on Hospital or Nursing Home Compare and there is a concern on the impact of referrals to a CAH's swing bed from outside of the community.

MT DPHHS will request clarification on the frequency of quality measure review and the intent of CMS so that MT CAHs may develop appropriate policies, systems, and documentation to fully meet this regulation.

While not defined in the regulations by CMS, the National Quality Forum does provide a definition and explanation of Resource Use Measures. Readers can find a link to the resource on page 1.

A Critical Access Hospital (CAH) must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment

preferences, ensure an effective transition of the patient from the CAH to post-discharge care, and reduce the factors leading to preventable CAH and hospital readmissions.

(a) *Standard: Discharge planning process.* The CAH's discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician.

(1) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-CAH care will be made before discharge and to avoid unnecessary delays in discharge.

(2) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-CAH services, including, but not limited to, hospice care services, post-CAH extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.

(3) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(4) Upon the request of a patient's physician, the CAH must arrange for the development and initial implementation of a discharge plan for the patient.

(5) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.

(6) The CAH's discharge planning process must require regular re-evaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(7) The CAH must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs.

(8) The CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

(b) *Standard: Discharge of the patient and provision and transmission of the patient's necessary medical information.* The CAH must discharge the patient, and also transfer or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.

Medicaid & Medicare Programs: Hospital and CAH Changes to Promote Innovation, Flexibility and Improvement in Patient Care
Federal Register: 84 FR 51732
Published: 9/30/2019
Effective: 11/29/2019
§ 482.42(b) & § 485.640(b) Effective: 3/30/2020
§ 485.641 Effective: 3/30/2021
STATE OPERATIONS MANUAL: APPENDIX W

§485.625 EMERGENCY PREPAREDNESS: (Long term care requirements remain annual.)

MT DPHHS is attempting to align the state rule with the federal rule for frequency changes from annually to every two years.

Change required frequency of the emergency plan from annually to every two years.
(a)Emergency plan. The CAH must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must do all of the following:

Remove requirement that facilities document efforts to contact local, tribal, regional, State, and Federal emergency preparedness officials as part of the facility's planning efforts.
(a) (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.

Change required frequency of reviewing and updating the emergency preparedness policies and procedures, set forth by emergency plan from annually to every two years.
(b) Policies and procedures. The CAH must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.

Change required frequency of reviewing and updating the emergency preparedness communication plan and testing and training program from annually to every two years.
(c) Communication plan. The CAH must develop and maintain an emergency preparedness communication plan that complies with Start Printed Page 51827Federal, State, and local laws and must be reviewed and updated at least every 2 years.

(d) Training and testing. The CAH must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and

the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

(d)(1)(ii) Provide emergency preparedness training at least every 2 years.

Change required frequency of emergency preparedness training from annually to every two years. Adds requirement for CAHs to conduct training in the event policies and procedures are significantly updated.
(v) If the emergency preparedness policies and procedures are significantly updated, the hospital must conduct training on the updated policies and procedures.

Adds requirement of CAHs to conduct exercises (additional options) to test the emergency plan at least twice per year.

(2)Testing. The hospital must conduct exercises to test the emergency plan at least twice per year. The hospital must do all of the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.

(B) If the CAH experiences an actual natural or man-made emergency that requires activation of the emergency plan, the CAH is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an annual additional exercise, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the CAH's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the CAH's emergency plan, as needed.

§485.627 Condition of Participation: Organizational Structure

Removes requirement that CAHs disclose names and addresses of their owners, or those with a controlling interest in the CAH or in any subcontract in which the CAH directly or indirectly has a 5% or more ownership interest. This information is still required in the Medicare enrollment process, so the purpose of removing the separate requirement from this CoP is to avoid redundancy.
Remove paragraph (b)(1); thus renaming paragraphs (b)(2) and (b)(3) as (b)(1) and (b)(2).

§485.632 Staffing and Staff Responsibilities

Adds standard that mandates a CAH require a doctor to review quality an appropriateness of diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants.

(d) *Standard: Periodic review of clinical privileges and performance.* The CAH requires that—

(1) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialist, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH.

Adds standard that mandates a CAH must require quality and appropriateness of the diagnosis and treatment furnished by doctors at the CAH.

It is noted that meeting regulation (d)(2)(v) has the potential to be difficult. Agreements are in place but it is often difficult to obtain information for evaluation. Other concerns for section (d)(2) include review for facilities with a small number of providers and that participation in programs offered to CAHs often brings additional chart review.

(d)(2) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by—

(i) One hospital that is a member of the network, when applicable;

(ii) One Quality Improvement Organization (QIO) or equivalent entity;

(iii) One other appropriate and qualified entity identified in the State rural health care plan;

(iv) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patient under an agreement between the CAH and a distant-site hospital, the distant-site hospital; or

(v) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, one of the entities listed in paragraphs (d)(2)(i) through (iii) of this section.

(d)(3) The CAH staff consider the findings of the evaluation and make the necessary changes as specified in paragraphs (b) through (d) of this section.

§485.635 Condition of participation: Provision of Services

Removes requirement that CAHs maintain policies on their system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. Rule adds a new, separate COP on infection prevention and control.

Remove paragraph (a)(3)(vi); thus renaming subsequent paragraphs. See §485.640 for new COP on infection prevention and control.

Adds specificity to requirement for policy on nutritional needs. Previously, regulations required patient nutritional needs be met in accordance with "the orders of the practitioner responsible for the care of patients."

MT Flex notes on this section that CMS refers to the requirement of § 483.25(i) of the long term care Appendix PP, however this references respiratory care and may be an error in the CMS documents. The more logical reference would be to § 483.25(g) for assisted nutrition and hydration.

(a)(3)(vi) Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices. All patient diets, including therapeutic diets, must be ordered by the practitioner responsible for the care of the patients or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff in accordance with State law governing dietitians and nutrition professionals and that the requirement of § 483.25(i) of this chapter is met with respect to inpatients receiving post CAH SNF care.

Revised require a CAH's professional personnel to, at a minimum, conduct a biennial review of its policies and procedures instead of an annual review.

MT DPHHS is attempting to align the state rule with the federal rule for frequency changes from annually to every two years.

(a)(4) These policies are reviewed at least biennially by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.

§485.640 Condition of Participation: Infection Prevention and control and antibiotic stewardship programs.

Adds section to replace current CAH requirements for infection control in order to reflect nationally recognized standards of practice.

CMS estimates that leadership from 0.4 full-time equivalent (FTE) of physician and 1.0 FTE of clinical pharmacist (both with the appropriate training and/or experience) are necessary to initiate and maintain an antibiotic stewardship program in an average-sized hospital (~124 beds). For a 25-bed CAH, CMS estimates that leadership from 0.45 FTE of clinical pharmacist and 0.19 FTE of physician are necessary to initiate and maintain an antibiotic stewardship program in this setting.

CMS encourages CAH collaboration with other hospitals in their network for pharmaceutical support as feasible, to work with their respective quality improvement network(s)/organization(s) and health departments for additional support and resources and to use the technical assistance available from their State Flex Program.

MT Flex and DPHHS both recommend using the CDC's Core Elements of an Antibiotic Stewardship program as the nationally recognized standard of practice. Link to information available on page 1.

Though the CAH regulations do not provide an outline as to what constitutes appropriate infection prevention staff, CAHs can refer to the Long Term Care Clinical Element Pathways for guidance.

MT CAHs have indicated that they are well set up to meet these regulations with the statewide work of the ABS Collaborative, however there is concern over the ability of smaller CAHs to meeting pharmacy oversight requirements. Solutions are unique to each CAH facing this problem and will most likely require some outside contracting.

The CAH must have active facility-wide programs, for the surveillance, prevention, and control of HAIs and other infectious diseases and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic-resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in coordination with the facility-wide quality assessment and performance improvement (QAPI) program (see §485.641).

(a) *Standard: Infection prevention and control program organization and policies.* The CAH must demonstrate that:

(1) An individual (or individuals), who is qualified through education, training, experience, or certification in infection prevention and control, is appointed by the governing body, or responsible individual, as the infection preventionist(s)/infection control professional(s) responsible for the infection prevention and control program and that the appointment is based on the recommendations of medical staff leadership and nursing leadership;

(2) The infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the CAH and between the CAH and other healthcare settings;

(3) The infection prevention and control includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and that the program also addresses any infection control issues identified by public health authorities; and

(4) The infection prevention and control program reflects the scope and complexity of the CAH services provided.

(b) *Standard: Antibiotic stewardship program organization and policies*. The CAH must demonstrate that:

(1) An individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body, or responsible individual, as the leader(s) of the antibiotic stewardship program and that the

appointment is based on the recommendations of medical staff leadership and pharmacy leadership;

(2) The facility-wide antibiotic stewardship program:

(i) Demonstrates coordination among all components of the CAH responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services;

(ii) Documents the evidence-based use of antibiotics in all departments and services of the CAH; and

(iii) Documents any improvements, including sustained improvements, in proper antibiotic use;

(3) The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use; and

(4) The antibiotic stewardship program reflects the scope and complexity of the CAH services provided.

(c) *Standard: Leadership responsibilities.*

(1) The governing body, or responsible individual, must ensure all of the following:

(i) Systems are in place and operational for the tracking of all infection surveillance, prevention and control, and antibiotic use activities, in order to demonstrate the implementation, success, and sustainability of such activities.

(ii) All HAIs and other infectious diseases identified by the infection prevention and control program as well as antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the CAH's QAPI leadership.

(2) The infection prevention and control professional(s) is responsible for:

(i) The development and implementation of facility-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines.

(ii) All documentation, written or electronic, of the infection prevention and control program and its surveillance, prevention, and control activities.

(iii) Communication and collaboration with the CAH's QAPI program on infection prevention and control issues.

(iv) Competency-based training and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAH, on the practical applications of infection prevention and control guidelines, policies and procedures.

(v) The prevention and control of HAIs, including auditing of adherence to infection prevention and control policies and procedures by CAH personnel.

(vi) Communication and collaboration with the antibiotic stewardship program.

(3) The leader(s) of the antibiotic stewardship program is responsible for:

(i) The development and implementation of a facility-wide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics.
(ii) All documentation, written or electronic, of antibiotic stewardship program activities.
(iii) Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as the CAH's infection prevention and control and QAPI programs, on antibiotic use issues.
(iv) Competency-based training and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAHs, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.

§485.641 Condition of Participation: Quality assessment and performance improvement program (QAPI)

Section revised to reflect requirements of a proactive QAPI program and the change reflects industry standards. CMS believes that much of the work and resources required to fulfill the current periodic evaluation and quality assurance CoPs can be utilized. CMS specifically refers to State Flex Programs and the MBQIP (Medicare Beneficiary Quality Improvement Project) for technical assistance and services. CMS intends to issue subregulatory guidance on QAPI requirements.

MT Flex's MBQIP program and the HIIN project are resources for program data collection.

MT CAH input indicates they have been using this process for years, but formalizes into a new name/format.

One concern is section (b)(3) for contracted services. CAHs must review contract and internal processes to ensure quality is provided by the contractor, but is not responsible for the contractor's internal quality assurance. If issues are identified with the contract, they must be investigated and evaluated.

The CAH must develop, implement, and maintain an effective, ongoing, CAH-wide, data-driven quality assessment and performance improvement (QAPI) program. The CAH must maintain and demonstrate evidence of the effectiveness of its QAPI program.
(a) *Definitions*. For the purposes of this section—
Adverse event means an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof.
Error means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems; and
Medical error means an error that occurs in the delivery of healthcare services.

(b) *Standard: QAPI Program Design and scope*. The CAH's QAPI program must:
(1) Be appropriate for the complexity of the CAH's organization and services provided.
(2) Be ongoing and comprehensive.

(3) Involve all departments of the CAH and services (including those services furnished under contract or arrangement).
(4) Use objective measures to evaluate its organizational processes, functions and services.
(5) Address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmissions.

(c) *Standard: Governance and leadership*. The CAH's governing body or responsible individual is ultimately responsible for the CAH's QAPI program and is responsible and accountable for ensuring that the QAPI program meets the requirements of paragraph (b) of this section.

(d) *Standard: Program activities*. For each of the areas listed in paragraph (b) of this section, the CAH must:
(1) Focus on measures related to improved health outcomes that are shown to be predictive of desired patient outcomes.
(2) Use the measures to analyze and track its performance.
(3) Set priorities for performance improvement, considering either high-volume, high-risk services, or problem-prone areas.

(e) *Standard: Program data collection and analysis*. The program must incorporate quality indicator data including patient care data, and other relevant data, in order to achieve the goals of the QAPI program.

§485.645 Special requirements for CAH providers of long-term care services ("swing-beds")

CMS had determined that some cross-references LTC requirements for hospitals and CAH swing-bed providers are unnecessary and burdensome and not relevant to swing beds.

A CAH must meet the following requirements in order to be granted an approval from CMS to provide post-CAH SNF care, as specified in § 409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph (c) of this section.

Remove requirement for a facility to request or allow swing-bed patients to perform services for the facility.
(d)(1) Resident rights (§ 483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2) and (4), (f)(4)(ii) and (iii), (g)(8) and (17), (g)(18) introductory text, and (h) of this chapter).

Remove requirement for facility to provide an ongoing activities program directed by a qualified professional. Unneeded as the patients activity needs are addressed in the care plan
(d)(4): Removed

Remove requirement for facilities with more than 120 beds to employ a qualified social worker on a full time basis. This does not apply to CAHs due to bed limits.
(d)(5): Removed; redesignated as (d)(4)
(d)(4) Social services (§ 483.40(d) of this chapter).

Remove requirement for facilities to assist residents in obtaining routine 24-hour emergency dental care because of existing requirements for hospitals and CAHs to provide care in accordance with the needs of the patient (emergent and non-emergent).
(d)(7) Dental services (§ 483.55(a)(2), (3), (4), and (5) and (b) of this chapter).

§491.9 RHC & FQHC Review of Patient Care Policies

Changed to require professional personnel to, at a minimum, conduct a biennial review of its policies and procedures instead of an annual review.
(b)(4) These policies are reviewed at least biennially by the group of professional personnel required under paragraph (b)(2) of this section and reviewed as necessary by the RHC or FQHC.

§491.11 RHC & FQHC Program Evaluation

Change frequency of required RHC or FQHC evaluation from annually to every other year.
(a)The clinic or center carries out, or arranges for, a biennial evaluation of its total program.

Summary dated: 12/6/2019

For questions, please contact MT DPHHS Quality Assurance Division at (406) 444-2037.

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