Agenda Item 7.b: HJR 50 Study
Committee Review, Discussion, and Action

HJR 50: SENIOR AND LONG-TERM CARE SERVICES DRAFT FINAL REPORT

JUNE 2020

Children, Families, Health, and Human Services Interim Committee
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FINAL REPORT TO THE 67TH MONTANA LEGISLATURE

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Before the close of each legislative session, the House and Senate leadership appoint lawmakers to interim committees. The members of the Children, Families, Health, and Human Services Interim Committee, like most other interim committees, serve one 20-month term. Members who are re-elected to the Legislature, subject to overall term limits and if appointed, may serve again on an interim committee. This information is included in order to comply with 2-15-155, MCA.

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This report is a summary of the work of the Children, Families, Health, and Human Services Interim Committee specific to the Committee's 2019-2020 House Joint Resolution 50 study as outlined in the Committee's 2017-18 work plan and HJR 50. Members received additional information and public testimony on the subject, and this report is an effort to highlight key information and the processes followed by the Committee in reaching its conclusions.

To review additional information, including audio minutes, briefing papers, and exhibits, visit the HJR 50 Study page of the Committee's website: https://leg.mt.gov/committees/interim/2020cfhhs/hjr-50-senior-and-long-term-care/.

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OVERVIEW

During the 2019 legislative session, the appropriations subcommittee charged with reviewing the budget for the Department of Public Health and Human Services (DPHHS) heard a myriad of concerns related to the funding for and policies of the Senior and Long-Term Care Division. That division administers a range of programs serving older Montanans and people with physical disabilities, including programs that allow individuals to remain in their homes or communities and avoid placement in a nursing home or other, higher level of care.

The concerns heard throughout the 2019 session were encapsulated in House Joint Resolution 50, which noted that DPHHS had:

- changed some senior and long-term care services through policy changes or new interpretations of longstanding policies; and

- not spent some of the money appropriated to the Senior and Long-Term Care Division in past years, despite a waiting list for the division's services.

HJR 50 asked for a study of matters related to the Senior and Long-Term Care Division. The resolution suggested that the study look at:

- access to services offered under the Community First Choice, Personal Assistance Services, and Big Sky Waiver programs, including the availability of both basic and assisted living waiver slots;

- barriers that prevent individuals from accessing services and that prevent the division from fully using money appropriated for the Big Sky Waiver, including workforce issues and Medicaid reimbursement rates;

- recent changes to the division's policies and interpretations of policy and how those changes have affected the level of services offered under home and community-based services programs;

- the manner in which Big Sky Waiver slots are created and filled and the process for selecting people for the program when waiver slots open up;

- the status of cuts that were made in services because of budget issues in the 2019 biennium and the way DPHHS used funds that were restored to the budget during that two-year budget period;

HJR 50 stemmed from concerns over both funding and policy changes for long-term care services.

- access to aging services programs for seniors of all ages; and

- other matters related to senior and long-term care services as determined appropriate during the study process.

The study ranked ninth out of 27 study resolutions in the post-session poll of legislators. The Legislative Council assigned the study to the Children, Families, Health, and Human Services Interim Committee (Committee), which decided to spend about one-fourth of its meeting time on the study.

During the interim, the Committee reviewed briefing papers on the study topics, heard from DPHHS and others involved in senior and long-term care services, and reviewed appropriation and budget trends for the division.

(ITALICIZED TYPE = LANGUAGE FOR COMMITTEE REVIEW AND APPROVAL)

In March 2020, the Committee was scheduled to brainstorm ideas for addressing the issues that were raised and the suggestions that were made during the study. However, that meeting was canceled due to the emerging public health concerns related to the novel coronavirus. Just hours after the committee canceled its scheduled March meeting, the first coronavirus cases in Montana were confirmed. In the following weeks, the governor instituted a number of emergency directives that resulted in the temporary closure of schools and nonessential businesses and a two-week quarantine of anyone entering Montana from out of state.

At the Committee's May 2020 meeting, members learned DPHHS had change some Medicaid rates and waiver policies. Also at that meeting, it was apparent that state revenue collections would decline significantly because of the steps taken at the national, state, and local levels to address the coronavirus public health emergency. Committee members agreed that any study proposals involving new appropriations were unlikely to advance in the 2021 Legislature and decided against proposing any new or expanded programs.

However, members agreed to advance as committee bills some ideas suggested by stakeholders as low-cost ways to alleviate some of the concerns raised during the study. The bills would:

- *require DPHHS to notify Big Sky Waiver participants 30 days in advance of a planned termination of services so participants can provide information showing why services were still needed;*

- *clarify that people qualifying for Medicaid under the Medically Needy program could either make a cash payment or count medical costs toward the amount they must spend before qualifying for Medicaid;*

- *require that any substantive changes to existing waiver practices and policies must be made through the administrative rulemaking process, rather than internal policy changes; and*

- *establish that the Legislature intends that waiver services as a whole, not individually, must allow a person to remain in the home or community and prevent placement in a nursing home or other institutional level of care.*

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HOME AND COMMUNITY-BASED CARE

Montana has long operated Medicaid-funded programs that help older individuals and people with physical disabilities remain in their homes or communities by paying for nonmedical, supportive services. The state started two programs in 1982 and created a third program in 2014, after the federal Patient Protection and Affordable Care Act added another avenue for such services.

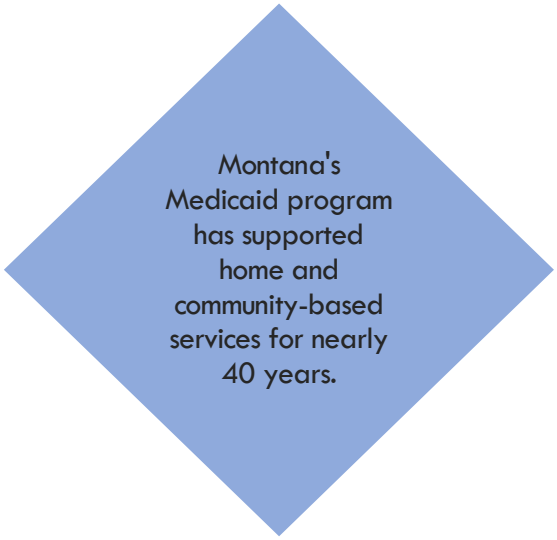
One program operates under a waiver that limits the number of people who can be served. The other two programs are options under the state's traditional Medicaid program and do not have enrollment caps.

Big Sky Waiver

First approved by the federal government in 1982, the Big Sky Waiver serves Montanans who would otherwise need to receive care in a nursing home or other institutional setting, such as a hospital. Individuals are screened to determine how independently they can handle Activities of Daily Living (ADLs), such as bathing and dressing, and to assess their functioning capabilities in a number of areas, including the degree of their mobility, responsiveness, and memory loss.

In addition, a person must have an unmet need for assistance that can only be provided through a home or community-based service, such as housecleaning or personal assistance.

The waiver allows Montana to limit the number of individuals served under the program in order to remain within the funds appropriated by the Legislature. About 2,600 people are served by the waiver, and the waiting list in calendar year 2019 averaged 207 people.



Both the federal government and state government pay for Medicaid services. At the beginning of the federal fiscal year that started on Oct. 1, 2019, the federal government was paying 64.78% of the costs of Big Sky Waiver services, while the state paid 35.22%. The matching rate for non-Medicaid expansion waiver participants was temporarily increased by 6.2%, effective January 1, 2020, under a coronavirus relief bill passed by Congress.

Personal Assistance Services Program

Also started in 1982, the Personal Assistance Services (PAS) Program pays for long-term supportive services that help people with their ADLS and with a limited number of tasks, such as grocery shopping and laundry, to help them remain at home. Participants can receive the services without needing a nursing home level of care.

Because the program is an option under the traditional Medicaid program, enrollees are entitled to coverage under the program if they meet other eligibility requirements. Enrollment is not capped, and no waiting list exists for the program's services. However, PAS services are more limited than those offered under the Big Sky Waiver.

As with the waiver, the federal government pays the regular matching rate for these services. The rate for the current federal fiscal year was originally set at 64.78% for Montana and increased, for non-expansion enrollees, to 70.98% under the federal Families First Coronavirus Response Act (FFCRA). Participation in PAS has declined with the emergence of another Medicaid option that covers similar services but offers a higher federal matching rate — the Community First Choice Program, or CFC.

Community First Choice

CFC combines elements of both the Big Sky Waiver and PAS programs. As with the waiver, participants must need a nursing home level of care to qualify. But like PAS, it's an option within the traditional Medicaid program and so enrollment is not capped. Also like PAS, it pays for a more limited range of services than does the waiver.

However, states receive a permanent additional federal match of 6% for services provided to CFC participants. That means the matching rate for CFC at the beginning of Federal Fiscal Year 2020 was 70.78%. Under FFCRA, it was temporarily increased to 76.98%.

How the Programs Stack Up

The three programs combined serve about 6,000 Montanans. However, PAS participants make up just a tiny fraction of the total. When the Committee first reviewed these programs in September 2019, slightly fewer than 50 individuals receive services through that program. CFC served about 3,300 people, and the Big Sky Waiver served about 2,600.

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DPHHS provided an update on program statistics in June 2020, as shown in the table below.

FY 2019	Big Sky Waiver	CFC	PAS
Date Implemented	1982	2014	1982
Number Served	2,586	3,238	293
Number on Waiting List (as of 3/30/20)	180	No Enrollment Cap	No Enrollment Cap
Average Length of Time on Waiting List	193 Days	Not Applicable	Not Applicable
Average Cost	$16,084 per slot	$11,368 per person	$1,809 per person
Total Cost of Services (FY 2019 To Date)	$40,278,930	$36,809,234	$530,015

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KEY STAKEHOLDER CONCERNS

Throughout the interim, the Committee scheduled presentations by representatives of the individuals and agencies that use and provide the services administered by the Senior and Long-Term Care Division. The presentations provided an overview of the services offered throughout the state as well as the barriers that exist to both providing services and accessing services.

Primary concerns focused on:

- the reimbursement rates that DPHHS pays for all Medicaid-funded services, ranging from nursing home care to personal assistance services;
- difficulties in recruiting and retaining workers who provide direct care services, whether the care is provided in a person's home, an assisted living facility, or a nursing home;
- requirements related to the Medically Needy program , which allows people to qualify for Medicaid if they have extensive medical costs that reduce their incomes to the Medicaid income eligibility level;
- changes to a number of DPHHS policies regarding waiver eligibility and services; and
- the lingering effects of budget cuts made during the 2019 biennium.

Reimbursement Rates

At their November 2019 and January 2020 meetings, Committee members heard from providers of all types about the problems caused by Medicaid reimbursement rates that don't cover the cost of providing care — particularly the way rates can limit a person's access to home and community-based services.

Providers stressed that people who can't obtain services in the home or community are likely to end up receiving services in a nursing home, at a much higher cost to the state. Nursing home care is a mandatory service under the state Medicaid program. Unlike the waiver, the state cannot cap the number of people receiving nursing home care and must cover the costs of that care if lower-cost alternatives are not available.

Nursing Homes and Assisted Living Facilities

Representatives of nursing homes and assisted living facilities detailed their concerns at the November meeting. They noted that the nursing home rate, which averaged slightly above $200 a day, was fairly well matched to the average $235 daily cost of providing care.[i] However, they said the

assisted living rate typically falls far short of the average $133 daily cost of care. At that time, Montana used a base rate that was adjusted to reflect the level of care a person needs, up to a maximum of $78.80 a day. But stakeholders said the adjusted rate typically was not much higher than the base rate.

As a result, providers said they either don't accept Medicaid enrollees in their assisted living facilities or limit the number of Medicaid clients they accept. Often, they allocate 25% or fewer of their beds for Medicaid recipients.

And many providers said they can't take Medicaid recipients who need memory care. Montana's Medicaid program does not pay a higher rate for that type of care. However, providers noted that individuals with Alzheimer's disease or other dementias generally require higher staffing levels and more secure settings, making the costs of such care higher than that provided for a typical assisted living or nursing home resident.

Home Care Agencies

Services provided by home health agencies generally are reimbursed at an hourly rate. Providers noted that the rates don't cover some of the services provided, particularly nurse oversight of some tasks such as client intakes, annual reviews of services, and coordination of care. They also noted that caring for rural residents can be difficult because the reimbursement rate doesn't factor in the time an employee must spend traveling to and from homes in rural or remote areas.

Representatives of small agencies and agencies that serve a limited number of Medicaid consumers said they have more difficulty covering nurse wages through the reimbursement rates than do larger agencies that have multiple branches or providers who serve a large number of Medicaid consumers.

Providers suggested, among other things, that:

- the base reimbursement rate be increased to recognize that time is spent on nonbillable activities such as traveling to serve rural clients or reviewing service plans;
- agencies be allowed to bill for nurse supervision activities; and
- agencies be allowed to bill for time that employees must spend observing a person for potential complications after providing a specific medical service that is a payable service, in addition to the actual time spent providing the service.

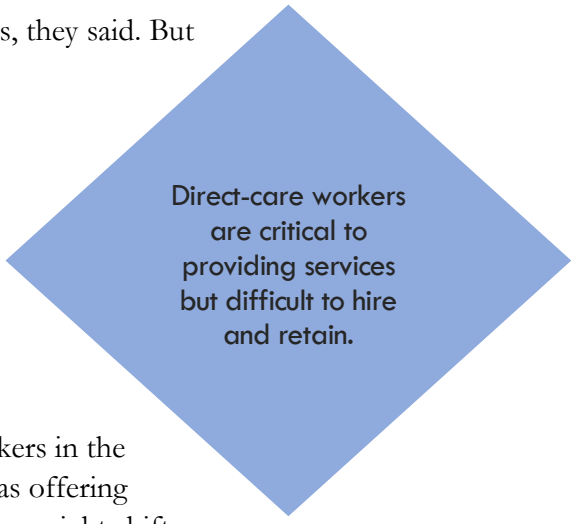
The Direct-Care Workforce

The Legislature has long recognized that home and community-based services can't exist unless providers are able to hire and keep workers who provide the care that allows people to remain in their homes. Lawmakers have frequently appropriated funds to increase wages for direct-care

workers and to support health care insurance for those workers. Yet providers told the Committee that it's becoming more difficult to recruit and retain direct-care workers.

Much of the problem ties back to the base reimbursement rates, they said. But other factors also come into play, including:

- the difficulty of the work;
- the availability of higher paying, entry-level jobs in other, less demanding and less stressful industries; and
- the cost of living in some areas of the state.



Providers who spoke to the Committee said they pay new workers in the range of $11 to $13 an hour. However, at least one provider was offering newly hired employees in Bozeman $17 an hour and a $2 an hour night shift differential but was still having difficulty recruiting and keeping employees because of the high costs of housing in the area.

Even programs designed to increase direct-care wages haven't necessarily worked as intended.

Providers noted in January 2020 that some agencies choose not to participate in the direct-care worker wage programs funded by the Legislature because of the complexities of applying and accounting for the funds. They also noted that the extra funding is based on a snapshot of costs and the number of employees at a specific point in time in the *previous* year. If a provider later wants to increase the size of the business and hire more people to do so, the reimbursement rate doesn't cover the cost of paying the new employees the higher wage. In addition, they said many employers aren't certain the funding will continue from year to year, making it less attractive to take part in the program.

DPHHS officials noted the programs are burdensome to administer and the funds appropriated for the wage increases have at times not covered the actual costs of the increases.

The Medicaid "Spend-Down" Amount

Some individuals with significant health needs can qualify for Medicaid coverage even if their monthly income is higher than the amount allowed by law. These people qualify under what's known as the Medically Needy program and often called the "Medicaid spend-down" program. They begin receiving Medicaid coverage each month when their spending on medical expenses reduces their income to the Medicaid eligibility standard. Under state and federal law, they also can make a cash payment to reduce their income by the "spend-down" amount rather than incur the equivalent amount of medical expenses before qualifying.

Unlike medical expenses, a cash payment made on the first of the month qualifies the person for the entire month. A person qualifying by using their medical expenses is eligible on the date that their spending lowers their income to the Medicaid level.

Essentially, a person's medical spending or cash payment acts as a deductible that must be paid each month before Medicaid coverage kicks in for the remainder of the month.

The expenses or cash payment must reduce the person's monthly income to $645 a month. That amount reflects a base income limit of $525, calculated according to federal law, and $120 in income exclusions, as allowed under Montana law. The amount of the income exclusion is set by the DPHHS based on legislative appropriations; it was last increased in 2007.

The example below shows that a person with a $1,000 monthly income would need to spend $365 on medical expenses each month to qualify for the program.

$1,000	Monthly Income
- $120	General Exclusion
$880	Countable Income
- $525	Medically Needy Limit
$365	Required Medical Spending or Cash Payment

Stakeholders noted that many people with disabilities receive Social Security Disability Insurance (SSDI) payments that are based on their past work history. The maximum SSDI benefit in 2020 is $3,011 a month, but payments generally range from $800 to $1,800 a month and average $1,258 a month.[ii] Advocates say that because the Medically Needy income exclusion hasn't increased for more than a decade, people who are receiving cost-of-living adjustments in their SSDI payments have to spend down a greater amount of their income each year to qualify for Medicaid. That, in effect, reduces their ability to use the increases in their SSDI benefits for other living expenses, which also may be increasing.

Policy Changes

In recent years, the Senior and Long-Term Care Division has made changes to the policies governing various aspects of the Big Sky Waiver. Both service providers and service recipients repeatedly called attention to specific policies that they said have made it more difficult for waiver participants to obtain services. They cited in particular changes that:

- required most waiver participants in assisted living slots to make a cash payment to qualify for the Medicaid spend-down program and affected the use of medical expenses that people could use to qualify for that program;

- required social supervision hours and nonmedical transportation miles to be used in two-week increments, rather than on an annual basis;

- prohibited payment for purchase of an already modified vehicle; and

- revised the authorization procedures for waiver eligibility and services.

At the request of the Committee, legislative staff undertook a review of the policy changes and the underlying federal and state laws and regulations to determine if changes in those laws or regulations required DPHHS to change its policies. The review showed that most of the underlying laws and regulations had not changed substantively in recent years, although DPHHS had received federal guidance that led to revisions in the vehicle modification policies.

The changes and the issues raised by stakeholders are outlined below.

Qualifying for the Medically Needy Program

Since January 2019, DPHHS has not allowed waiver participants to count the costs of their waiver-covered services toward the amount they must spend on medical expenses to qualify for Medicaid under the Medically Needy program. Additionally, DPHHS notified case management team supervisors in late 2017 that most waiver participants in assisted living slots would be making a cash payment to qualify for Medicaid benefits.

Before then, waiver participants could make a cash payment, count most of their medical expenses toward the spend-down amount, or use a combination of medical expenses and a cash payment. Both federal and state law allow for all three options, and the state law hasn't changed since 1991. At that time, lawmakers added the cash payment option for the program.

Stakeholders have said the change violates state law and administrative rules and has left waiver participants with less income for many medical expenses, because they now must use their income for the cash payment rather than counting the medical costs toward the spend-down amount. DPHHS has said the change:

- allows people to qualify for Medicaid at the beginning of the month rather than after they've paid for many medical services; and

- alleviates issues assisted living facilities were having in receiving payment before people had met their spend-down amount.

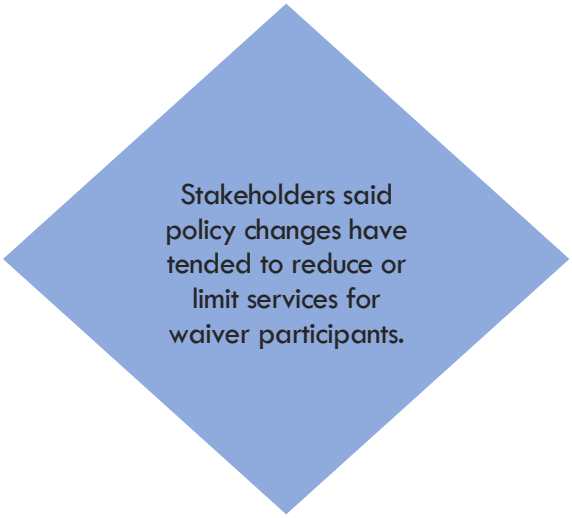
Service Caps

In January 2018, DPHHS changed its waiver policies to prevent people from carrying over unused services from one 2-week period to the next. It also instituted caps on social supervision hours and nonmedical transportation miles, limiting those to 20 hours and 50 miles every two weeks, respectively.

Before that, people could "bank" their unused social supervision hours and nonmedical miles for use at a future time. For example, someone who didn't want to go out regularly in the winter months could save the unused hours from that time period for use at a later date. Now, those hours and miles expire if they aren't used in the two-week period. A person who wants to use more hours or miles during a 2-week period must either ask for an amendment to his or her service plan or request prior authorization for the change.

Consumers say the change has given them less flexibility in using those waiver services. DPHHS says the previous practice of saving hours for later use was never part of an approved federal waiver.

DPHHS notes that the Big Sky Waiver language, as approved by the Centers for Medicare and Medicaid Services (CMS), says that each person's service plan will list the specific services to be covered and how often each service will be provided. In addition, it requires the state to meet performance measures, including one related to the number of waiver participants who receive services with the frequency specified in their service plans.



The waiver was last approved in 2018. The administrative rules cited in the policy changes haven't changed significantly since 2000.

Vehicle Modifications

Until 2015, waiver participants who needed a vehicle adapted for their physical capabilities were able to use waiver funds to buy a used vehicle that was already modified. DPHHS changed that approach in 2015, in a memo to case management teams. The agency followed up in 2016 with changes to its waiver application and its policies, making it clear that the waiver wouldn't pay for the purchase or lease of a vehicle or the partial purchase of a vehicle that was already modified.

During the public comment period on the 2016 waiver application, many people opposed the new language on already modified vehicles. DPHH subsequently sought additional guidance from CMS.

The CMS regional office in Denver told DPHHS in an e-mail that waiver funds "cannot pay for the vehicle even if it is already modified or if only the modifications that have already been made are

considered in the amount that is being supplied via the waiver. If a vehicle that already has modifications is purchased by the recipient and further modifications are medically necessary then the waiver could pay for those and only those modifications."[iii]

Eligibility and Service Reviews

In January 2019, DPHHS changes its policy on prior authorizations by the division's Community Services Bureau to:

- require case management teams to obtain approval from DPHHS before placing anyone under 21 years of age on the waiver waiting list; and

- include a new standard for authorizing services, requiring that each proposed waiver service in and of itself prevent a person from being placed in a hospital or nursing home.

Stakeholders said the changes prevented some children with disabilities from being accepted into the waiver. Other children already on the waiver were told they were no longer eligible for services. And stakeholders said some waiver services were being denied to people of all ages because the service, on its own, would not prevent an institutional level of care.

Advocates also said that waiver services are intended to be reviewed as a whole and must be authorized if, taken together, they would prevent a higher level of care and allow a person to successfully remain in the community.

The laws and regulations governing waiver services have not changed significantly since 2000.

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PAST BUDGET CUTS AND RESTORATIONS

HJR 50 asked that the Committee look at the cuts that affected senior and long-term care services during the first year of the 2019 biennium, as well as how DPHHS used money restored in the second year of that biennium when state revenues were in a better position.

Committee members received that information in May 2020, when they reviewed a briefing paper outlining the budget reductions and restorations and heard from both DPHHS and the Legislative Fiscal Division about recent budget trends.

2019 Biennium Budget Changes

Before adjourning, the 2017 Legislature passed a bill to automatically cut state spending in a variety of ways if state revenues for Fiscal Year 2017 came in lower than anticipated. Senate Bill 261 triggered different levels of cuts, depending on the degree to which revenues were lower.

All of the SB 261 cuts for FY 2018 went into effect, and three of them specifically affected senior and long-term care services:

- Funding was eliminated for the House Bill 17 (2017) increase in Big Sky Waiver slots and reimbursement rates, including funding to create a higher rate for memory care.

- A direct-care worker wage increase of $1.50 an hour, approved in HB 638 (2017), was delayed for a year.

- Reimbursement rates for all Medicaid providers, including providers of senior and long-term care services, were reduced 2.99%.

Those cuts totaled nearly $2.2 million. In addition, Governor Bullock announced in September 2017 that he would further reduce state spending as allowed under 17-7-140, MCA, because of continued budget concerns. In November 2017, he called a special session to take other budget-related actions and said he would cut state spending 6.61% after the special session.[iv]

During the special session, lawmakers formalized the governor's planned 17-7-140 reductions in HB 2. They also transferred funds, imposed certain fees, and provided an avenue to restore the 17-7-140 cuts planned for FY 2019 if revenues for FY 2018 came in higher than expected.

The governor's 17-7-140 cuts further reduced the Senior and Long-Term Care Division's spending for FY 2018 by about $1.4 million. The budget restorations made in Senate Bill 9 of the special session put nearly $3.4 million back into the division's budget for FY 2019, when revenues hit the target level.

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The tables below show the budget cuts and restorations in the 2019 biennium.

Senate Bill 261 Cuts	FY 2018 State Funding
Medicaid provider rate cut of 2.99%	$1,168,387
HB 17 increase in Big Sky Waiver slots and reimbursement rates voided	$585,064
HB 638 direct care worker wage increase of $1.50 an hour delayed for a year	$427,144
Total	**$2,180,595**

17-7-140 Cuts	State Funding	
	FY 2018 Actual	FY 2019 Planned
Reduce Big Sky Waiver services	$571,730	$1,743,460
Reduce Medicaid Community First Choice costs by streamlining the authorization process and reducing household support services and mileage	$463,865	$927,731
Reduce Medicaid personal assistance services	$206,383	$412,766
Reduce SLTC personal services for Medicaid provider support	$124,500	$18,500
Reorganize Adult Protective Services by closing one-person offices	$68,600	$102,209
Total	**$1,435,078**	**$3,373,747**

Senate Bill 9 Restorations	FY 2018 State Funding
Restore Medicaid Big Sky Waiver services (including 2.99% provider rate cut)	$1,805,144
Restore CFC services (including 2.99% provider rate cut)	$991,604
Increase direct care worker wages by $1.50 an hour as provided in HB 638	$426,999
Restore SLTC personal services for Medicaid provider support	$150,000
Total	**$3,373,747**

Other Aging Services Programs

HJR 50 asked that the Committee look at access to other aging service programs for senior citizens, and the Committee heard in May 2020 about non-Medicaid programs that offer an array of services.

DPHHS Programs

DPHHS offers protective services to vulnerable adults through the Adult Protective Services Bureau of the Senior and Long-Term Care Division. The bureau looks into allegations of mistreatment involving any adult who is over the age of 60 or who has a disability, regardless of the type of setting in which the person lives.

The bureau works with law enforcement when the allegations involve a criminal act. It has the ability to examine evidence such as medical and bank records if the allegations involve abuse, neglect, or financial exploitation. When the allegations are found to be true, the bureau works with the victim on a plan to stop the abuse or exploitation and address the person's health and safety needs. If necessary, the bureau can act as the person's legal guardian if no other person is able to do so.

If the allegations are not founded, the bureau often still refers the person to other agencies for services and supports.

The Committee heard that the number of cases opened by the bureau has increased in recent years, from about 7,200 in FY 2017 to 11,000 in FY 2019.

Aging Services Programs

Representatives of the state's Area Agencies on Aging, AARP, and the Montana chapter of the Alzheimer's Association also talked with the Committee in May about the services they offer and the needs they see in the state.

They suggested that the Committee should consider supporting:

- collection of data on the prevalence of Alzheimer's disease and other dementias to gauge the number and types of services that may be needed to care for those individuals in the future;
- training to create a "dementia-capable" workforce that could better handle the needs of individuals suffering from dementia;
- investments to support and improve the workforce, including better pay and improved state oversight of programs and facilities serving the elderly; and
- strategies that will allow more people to age at home rather than in facilities.

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MID-INTERIM POLICY AND RATE CHANGES

As the interim progressed, the Committee learned DPHHS was making changes that addressed some of the matters raised by stakeholders during the study process. Those changes ranged from higher Medicaid reimbursement rates to revamping of the prior authorization policy.

Reimbursement Rates

DPHHS put together stakeholder working groups early in the interim to discuss reimbursement rates and other topics of concern. Barb Smith, administrator of the Senior and Long-Term Care Division, reported in May 2020 that the agency had recently increased assisted living rates and was working with nursing homes on developing a rate for memory care patients. By the end of May, DPHHS had proposed administrative rule changes for nursing home rates.

Effective May 1, 2020, the assisted living rates increased from an adjustable rate with a maximum of $78.80 a day to a flat rate of $104 a day.[v] The change eliminated the previously used process of evaluating a person's level of care and adjusting the base rate to reflect the degree to which a person needed help with ADLs and other activities. Administrative rules published May 15 continued the $104 daily rate through FY 2021.[vi]

DPHHS also proposed administrative rules in late May to revise the nursing home reimbursement rate and add an option to increase reimbursement rates for residents who have more intensive needs, including behavior-related needs or a diagnosis of traumatic brain injury.[vii] The Committee heard throughout the interim that individuals with dementia or traumatic brain injuries often have behaviors that are more difficult to handle and that require higher staffing levels.

The basic nursing home rate will be based on two factors: a flat $208.06 daily rate and a quality component based on two of the elements — staffing and quality — included in the 5-star rating system that CMS uses for evaluating and rating nursing homes. DPHHS is making about $3 million available for the quality component of the funding. Each nursing home with a rating of 3 to 5 stars will receive the following quality payment in addition to the $208 daily rate:

★ ★ ★ ★ ★ *$3 per Medicaid bed day*

★ ★ ★ ★ *$2.25 per Medicaid bed day*

★ ★ ★ *$1.50 per Medicaid bed day*

A Medicaid bed day is equal to one person occupying a nursing home bed for one day. A nursing home that had seven beds occupied by Medicaid patients for a week would have the equivalent of 49 Medicaid bed days. Sixty-nine nursing homes current serve about 4,100 Medicaid residents. Initial calculations show they could receive quality payments ranging from $0 to $177,600. The average payment would be about $45,000.[viii]

The additional payment for behavior-related needs or brain injury diagnoses would be made on a daily basis as follows:

Condition	Symptoms	Add-On Amount
Traumatic Brain Injury *(TBI diagnosis and at least one behavior that is not present in the average nursing home resident)*	• *Self-Abuse* • *Injures Others* • *Escapes* • *Disruptive Sounds*	*$75 a day*
Behaviors	• *Verbal Aggression; and/or* • *Escapes More than 3 Times a Week*	*$75 a day*
	• *Sexual Behaviors*	*$80 a day*
	• *Danger to Self or Others*	*$100 a day*

Funding for the rate adjustments is within the department's current Medicaid budget authority.[ix]

Policy Changes

On April 1, 2020, the Senior and Long-Term Care Division changed its prior authorization policy for Big Sky Waiver services in several ways that appear to address stakeholder concerns about:

- notification of denial or termination of waiver services;
- placement of children on the waiting list; and
- consideration of the total, rather than individual, effects of waiver services when deciding whether to approve a service.

The table on the following page shows, in italicized type, language that was added to the policy on April 1. Language in parentheses summarizes additional new language.

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Jan. 1, 2019	April 1, 2020
The service must be medically necessary and relate specifically to the member's medical diagnosis.	The *service(s)* must be medically necessary and relate specifically to the member's medical diagnosis *or is necessary for the member to access the member's home and/or community.*
The service must be such that without the service the member would require institutionalization.	The service must be such that without the *service(s)*, the member would require institutionalization *and/or results in the member's decreased access to their home and/or community.*
The Case Management Team (CMT) must pursue all other third-party sources of coverage, including non-waiver Medicaid programs.	The *Medicaid member* must pursue all other third-party sources of coverage. (If the member is under 21 years of age: • the member must have pursued and received a decision on EPSDT supplies other than home or vehicle modifications and service animals; and • all information related to hours billed to other programs must be uploaded into the case management system.)
CMTs must request prior authorization for children under 21 requesting placement on the wait list.	CMTs must request prior authorization for *wait list placement for individuals under 21.*
Prior authorization requests must be submitted to DPHHS at least 10 calendar days prior to the need for services.	Prior authorization requests must be submitted to DPHHS *for review with sufficient advance notice to:* • *provide DPHHS with at least 10 days to review the request prior to the need for services and/or the end of the current Service Plan; and* • *provide the member with timely notice of a decrease, denial, or termination of services as indicated in BSW 412.* o BSW 412, on adverse actions, defines timely notice as written notice mailed at least 10 calendar days before the decrease, denial, or termination of services.

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TRIBAL PERSPECTIVES

The Committee agreed at the start of the interim to include the perspectives of Montana's Native Americans in the study by having tribal representatives discuss the approaches they take to providing senior and long-term care services. During the interim, tribal providers of senior and long-term services shared the following information with committee members.

- The number of people who would need a nursing home level of care if home-based services weren't available on reservations would far outstrip the number of available nursing home beds, meaning people would have to leave the reservation to receive care otherwise if home and community-based services weren't available to them.

- Tribal members have benefited from the Medicaid-funded home and community-based services programs offered through the state.

- Tribal senior and long-term care programs are able to provide services with cultural sensitivity.

- Diversity training is important for the state employees who interact with tribal programs.

- Some tribal programs have a difficult time competing with non-tribal home care programs because the tribes require background checks and drug tests for direct-care workers while the state does not have a similar requirement for home care agency employees.

- Tribal providers face the same difficulty with reimbursement rates and hiring direct-care workers as do non-tribal providers.

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COMMITTEE RECOMMENDATIONS

For its May 2020 meeting, the Committee received a summary of all suggestions made by stakeholders during the course of the study. The list contained nearly three dozen suggestions, and stakeholders offered several more in May. While some suggestions did not fit neatly into a specific category, most of the ideas touched on one of the following areas:

- *access to services;*
- *workforce issues;*
- *changes or additions to the types of services offered;*
- *DPHHS rules and policies; and*
- *eligibility for services.*

By that same meeting in mid-May, Montana was deep into its response to the novel coronavirus pandemic. Governor Bullock had ordered schools to close on March 15. On March 20, he ordered closure of health clubs, swimming pools, theaters, bowling alleys, bingo halls, and casinos, and he limited businesses serving food and drink to offering only take-out or delivery services. On March 26, he closed all non-essential businesses and ordered Montanans to stay at home except for certain essential activities, effective March 28. And on March 30, he instituted a 14-day self-quarantine for anyone entering Montana from another state or country. Some of those restrictions had just been lifted when Committee members gathered in May, and many were still in place.

The closures led to a sharp jump in unemployment claims and predictions by economists that state revenues would drop more significantly in the coming months than they had in 2017and during the Great Recession of 2008.

Noting the lack of certainty over the state's financial situation and predicting the 2021 Legislature will face revenue shortfalls, Committee members decided in May that any far-reaching, costly changes to senior and long-term care services would be unlikely to gain traction in the next legislative session. However, they agreed to review four smaller-scope bill drafts in June. (After taking public comment at the June 2020 meeting, the Committee agreed in August 2020 to recommend that the 2021 Legislature approve the following bill drafts:

- *HJR 50-1, requiring DPHHS to notify Big Sky Waiver participants 30 days in advance of a planned termination of services so participants can provide information indicating why services were still needed;*

- *HJR 50-2, clarifying that people qualifying for Medicaid under the Medically Needy program could either make a cash payment or count medical services and items toward the amount they must spend before qualifying for Medicaid;*

- *HJR 50-3, requiring that any substantive changes to existing waiver practices and policies must be made through the administrative rulemaking process, rather than internal policy changes; and*

- *HJR 50-4, establishing that the Legislature intends that waiver services as a whole, not individually, must allow a person to remain in the home or community and prevent placement in a nursing home or other institutional level of care.)*

[i] "Nursing Home Facts." Montana Healthcare Association. Presented at the Nov. 14, 2020, meeting.
[ii] "How Much in Social Security Disability Benefits Can You Get?" Available at https://www.disabilitysecrets.com/how-much-in-ssd.html#:~:text=Your%20SSDI%20payment%20depends%20on%20your%20average%20lifetime%20earnings.&text=Most%20SSDI%20recipients%20receive%20between,your%20payment%20may%20be%20reduced. Accessed June 3, 2020.
[iii] E-mail to DPHHS from Cynthia Riddle, Centers for Medicare and Medicaid Services. May 16, 2016.
[iv] "Call to the 65th Legislature for a Special Session." Governor Steve Bullock. Nov. 6, 2017.
[v] Discussion with DPHHS Senior and Long-Term Care Administrator Barb Smith. May 20, 2020.
[vi] MAR Notice No. 37-916. May 15, 2020.
[vii] MAR Notice No. 37-919. May 29, 2020.
[viii] Ibid.
[ix] E-mail from Barb Smith, Administrator, DPHHS Senior and Long-Term Care Division. June 11, 2020.