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Children, Families, Health, and Human Services Interim Committee
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HJR 50: SENIOR/LONG-TERM CARE POLICY CHANGES AND THEIR ORIGINS

BACKGROUND

Some stakeholders in the House Joint Resolution 50 study of the Senior and Long-Term Care Division have raised concerns about changes the division has made to policies for the Big Sky Waiver. That Medicaid waiver program pays for home and community-based services for elderly and physically disabled people who otherwise would need to receive care in a hospital or nursing home.

This briefing paper reviews the laws and regulations behind the following policy changes cited most frequently by stakeholders:

- requirements for the Medically Needy program;
- limitations on use of social supervision hours and nonmedical transportation miles;
- payments related to vehicle modifications; and
- requirements for waiver eligibility and services.

MEDICALLY NEEDY PROGRAM

People whose income is higher than the Medicaid eligibility standard may still qualify for the program if they:

- meet a nonfinancial requirement, such as age or disability; and
- have significant medical costs that lower their incomes to the Medicaid eligibility level.

These individuals qualify on a monthly basis under what's known as the Medically Needy program, which is often referred to as the Medicaid "spend down" program.

Since January 2019, DPHHS has not allowed Big Sky Waiver participants to count the costs of their waiver-covered services toward the amount that they must spend on medical expenses to qualify for the Medically Needy program. A Nov. 1, 2018, memo to case management team supervisors said most waiver participants would instead be making a cash payment to qualify for Medicaid benefits on the first of each month.

Before the change, waiver participants could either make a cash payment, count most of their medical expenses toward the spend-down amount, or use a combination of cash and medical costs. DPHHS says they can still count non-waiver medical expenses toward the spend-down amount.

WHAT DO STAKEHOLDERS SAY?

Stakeholders say the policy change violates state law and administrative rule. They also say it has left people with less income for many medical expenses because they now must first use their income for the cash payment to qualify for Medicaid. Then they still need to pay for some medical expenses or items that they used to be able to count toward the spend-down amount.

WHAT AUTHORITIES DOES DPHHS CITE?

DPHHS lists Appendix B of the Big Sky Waiver application and ARM 37.85.415 as references for the change to its Medically Needy eligibility policy. That rule is found in the Administrative Rules of Montana (ARM) chapter governing general Medicaid services and outlines the types of medical expenses that Medicaid will cover. The rule says Medicaid will only pay for medical expenses to the extent allowed by Medicaid. The Senior and Long-Term Care Division says this rule limits medical expenses to those covered by the traditional Medicaid program, so services covered by the Medicaid waiver program can't be counted toward the spend-down amount.

Appendix B of the waiver application notes that Montana's waiver will cover medically needy individuals. The application form references three federal regulations that allow states to make Medicaid available to people who are aged, blind, or disabled if they meet the Medically Needy income eligibility standards that are spelled out in a separate subpart of the Code of Federal Regulations (CFR).

ARE OTHER PROVISIONS AT PLAY?

Both state and federal law and regulations address eligibility requirements for the Medically Needy program.

FEDERAL REQUIREMENTS

The federal law establishing the Medicaid program allows states to cover medically needy individuals. Under 42 USC 1396a(r)(1)(A), a state that provides coverage to these individuals must take into account the costs a person incurs for medical expenses, including:

- Medicare and other health insurance premiums, deductibles, or coinsurance; and
- "necessary medical and remedial care recognized under state law but not covered under the state plan under this subchapter, subject to reasonable limits the state may establish" on the amount of costs.

The law is found in the subchapter of the Social Security Act that authorizes state Medicaid programs, including programs of home and community-based services offered under a Medicaid waiver.

A corresponding federal regulation, 42 CFR 435.831, requires states to also count toward the spend-down amount expenses for medical services that are covered by the Medicaid plan but that exceed the scope, duration, or amount of services allowed under the plan.

STATE REQUIREMENTS

Section 53-6-131(1)(e), MCA, says a person may qualify for the Medically Needy program if the person will have an income that meets the eligibility standard after either incurring medical expenses or making a cash payment to DPHHS that reduces the person's income to the medically needy income level.

Similarly, the Medicaid Eligibility chapter of the agency's administrative rules contains ARM 37.82.1107. This rule says a person whose income exceeds the Medically Needy income standard becomes eligible for Medicaid either:

- on the first day of the month if the person pays the cost-share amount through a cash payment; or
- "after a medical expense incurment is satisfied" based on the person's spending for:
  - Medicare and other health insurance premiums, deductibles or co-insurance;
  - the costs of "necessary medical and remedial services" that are recognized under Montana law but not covered "under this chapter;" and
  - expenses for necessary medical and remedial services that are covered "under this chapter."

HAVE THE LAWS OR RULES CHANGED?

The table below shows when the laws and rules related to the Medically Needy program were enacted and changed.

Law/Rule	Enacted/Adopted	Last Relevant Revision
Big Sky Waiver: Eligibility Groups Served	1988	None
42 CFR 435.831: Income Eligibility	1994	None
53-6-131(1)(e), MCA: Medically Needy Category	1989: Medical expenses only	1993: Cash option added
ARM 37.82.1107: Medically Needy Income Eligibility	1991	1993: Cash option added
ARM 37.85.415: Allowable Medicaid Payments	1989	None

CAPS ON SOCIAL SUPERVISION HOURS AND TRANSPORTATION

On Jan. 1, 2018, DPHHS changed Big Sky Waiver policies to prohibit waiver participants from carrying over unused services from one time period to the next. The agency also put into place what it termed "soft caps" that limited social supervision services to 10 hours a week and nonmedical transportation mileage to 25 miles a week. Later that year, DPHHS changed the caps to 20 hours and 50 miles every two weeks.

Before the limits were in place, waiver participants could "bank" unused social supervision hours and non-medical mileage for use at a future time. For example, someone who didn't want to use all of the approved hours in the winter months could save the extra hours and use them at a different time of the year to extend the number of hours available for outings or a vacation.

Now, if those hours or miles aren't used in a two-week period, they expire and cannot be used in the future. Anyone who wants to use more hours or miles in a two-week period must instead request prior authorization or an amendment to the service plan -- an option available to them in the past, as well.

WHAT DO STAKEHOLDERS SAY?

Consumers say they now have less flexibility in using the services included in their service plans and that their plans authorize services on annual basis. They've questioned why the changes were necessary when the state's waiver application and the laws and regulations on these aspects of the waiver haven't changed over time. They've also questioned whether DPHHS should have submitted the limits to the federal government for approval because the limits substantively changed the services provided under the waiver.

WHAT AUTHORITIES DOES DPHHS CITE?

In a Nov. 8, 2018, memo to providers and case management team supervisors, DPHHS cited its Big Sky Waiver application and information from the federal Centers for Medicare and Medicaid Services (CMS) to explain the reasons behind the changes. CMS oversees state Medicaid plans and waivers.

The waiver application says each person's service plan will include the specific services to be covered and will specify how often each service will be provided. It also requires the state to meet performance measures, including one related to the number of members who receive services with the frequency specified in their service plans. DPHHS says that while service plans authorize services on an annual basis, they also list how frequently the services should be provided.

The 2018 DPHHS memo said that banking of hours and miles is not an official policy of the waiver program and that waiver services must be provided according to the frequency suggested in a person's service plan. It also said that CMS "relayed if a Service Plan establishes the frequency of a service as weekly, the service must be utilized within a week at the amount allowed."

Four waiver policies were changed to reflect the limitations. They reference the following administrative rules:

- 37.40. 1407, requiring that a service provider be enrolled as a Medicaid provider in order to receive reimbursement for waiver services;
- 37.40.1408, establishing enrollment requirements for waiver participants and making the person's need for available services an element of the enrollment determination;
- 37.40.1420, establishing requirements for individual service plans, including requiring each plan to include the specific services to be provided, the frequency of the services, and the projected annualized cost of each service;
- 37.40.1421, allowing DPHHS to limit the cost of individual and collective service plans to remain within the program budget and prohibiting the total annual cost of services for a participant from exceeding the maximum amount set by DPHHS except in special, specified circumstances;
- 37.40.1447, establishing requirements for personal assistance services;
- 37.40.1449, setting requirements for specially trained attendant care, which includes assisting participants with socialization activities; and
- 37.40.1488, governing nonmedical transportation.

ARMs 37.40.1447 and 37.40.1488 most directly deal with the hours and mileage limits. ARM 37.40.1488 establishes requirements for nonmedical transportation but does not set specific mileage limits. ARM 37.40.1447 governs personal assistance services. While it does not set any limits on the number of hours to be used in a specific time period, it does say that the services must be provided as outlined in several other administrative rules that govern the Personal Assistance Services (PAS) and Community First Choice (CFC) programs.

However, the rules referenced in ARM 37.40.1447 were repealed in 2014 and replaced with uniform regulations for the PAS and CFC programs, which are both offered under the state Medicaid plan, rather than a waiver program. One of the 2014 rules, ARM 37.40.1135, limits personal assistance services for PAS and CFC to 80 hours in a two-week period unless additional hours are requested and authorized ahead of time. The earlier versions of the repealed PAS and CFC rules allowed reimbursement of up to 40 hours of personal assistance services each week.

HAVE THE LAWS OR RULES CHANGED?

The table below shows when the cited references were adopted and changed.

Law/Rule	Enacted/Adopted	Last Relevant Revision
ARM 37.40.1406: Waiver Services	1983	2000
ARM 37.40.1407: Provider Requirements	1983	2011: Payment to family members allowed
ARM 37.40.1408: Enrollment Requirements	1983	2000
ARM 37.40.1420: Service Plan Requirements	1983	2000
ARM 37.40.1421: Cost of Service Plan	1983	1990
ARM 37.40.1447: Personal Assistance Requirements	1983	2000
ARM 37.40.1488: Nonmedical Transportation	1983	2000

VEHICLE MODIFICATIONS

Many Big Sky Waiver participants use vehicles that have been modified to accommodate their particular disability. Until 2015, participants were able to use waiver funding to assist with paying for modifications that had already been made to a vehicle they were purchasing.

In a May 20, 2015, memo to case management teams and regional program officers, DPHHS said it had reviewed its policies on adapted, modified, and specialized equipment and determined they did not allow payment for vehicles that were already modified. In 2016, DPHHS changed its waiver application and its policies to reflect this determination.

WHAT DO STAKEHOLDERS SAY?

Stakeholders say that under this interpretation, some waiver participants can't afford to obtain a vehicle that meets their needs. They note that a person now must pay the full cost of buying a new or used vehicle and then send the vehicle to a manufacturer that can make the necessary modifications. They also say that the manufacturers generally won't modify vehicles that are more than 5 years old and that the policy change actually costs the waiver more money than did the past practice of paying for modifications that were already made to a vehicle.

WHAT AUTHORITIES DOES DPHHS CITE?

DPHHS says that because of federal guidance, it made changes to its 2011 and 2016 applications for renewal of the Big Sky Waiver to try to clarify that the waiver couldn't pay for adaptions that had already been made to a vehicle. Before the 2011 renewal, the waiver description for Specialized Medical Equipment and Supplies included "the provision of adapted vans." That language was removed in the 2011 application.

In the May 20, 2015, memo, DPHHS said it was clarifying the policies on modified equipment in order to comply with the waiver language and with two administrative rules:

- 37.40.1430, requiring case management teams to ensure quality, cost-effective services and allowing for prior authorization of services; and

- 37.40.1485, requiring environmental accessibility adaptations, which includes modifications to a personal vehicle, to be the most cost-effective option among those available to the waiver participant.

In its 2016 application to renew the waiver, DPHHS then added the following language to the description of the Vehicle Modifications service category: *This service does not include the purchase or lease of a vehicle and/or the partial purchase of vehicle already modified.*

During the 2016 waiver renewal process, much of the public comment the department received suggested that DPHHS should remove the new language related to already modified vehicles. The agency then sought additional guidance from CMS.

In a May 16, 2016, e-mail to CMS, DPHHS asked whether the waiver could pay for "only the modification to an already modified vehicle if we ensure that the modification was not previously paid with waiver funds and that the modification portion was adequately priced to include depreciation?"

In a response that same day, Cynthia Riddle of the CMS regional office in Denver told DPHHS 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."

EARLIER CMS GUIDANCE

The question of using waiver funding to pay part or all of the costs of an already modified vehicle had come up in earlier years, as the state was submitting waiver renewals to CMS and clarifying policies on specialized medical equipment, accessibility modifications, and consumer-directed goods and services.

CMS said in a Nov. 25, 2009, e-mail that use of waiver funding to buy vehicles was available only to participants who were using self-directed services, rather than obtaining waiver services through a provider agency. CMS also referred DPHHS to the instructions for home and community-based services waiver applications. Those instructions exclude the purchase or lease of a vehicle as an acceptable vehicle modification.

In a June 3, 2011, e-mail, CMS asked DPHHS to clarify in its waiver renewal application that the vehicle purchase option was only available to people in the self-directed program and not allowed for provider-managed services.

HAVE THE LAWS OR RULES CHANGED?

The table below shows when the cited references were adopted and changed.

Law/Rule	Enacted/ Adopted	Last Relevant Revision
Big Sky Waiver: Participant Services	1988	2011: Adapted van language removed (Specialized Equipment Category) 2016: No partial vehicle purchases (Vehicle Modifications Category)
ARM 37.40.1430: Case Management Requirements	1983	2000
ARM 37.40.1485: Environmental Accessibility Adaptations	1990	2000

ELIGIBILITY REQUIREMENTS AND SERVICE AUTHORIZATION

In January 2019, DPHHS changed its Prior Authorization by the Community Services Bureau policy 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 reviewing services to be provided to waiver participants.

PRIOR AUTHORIZATION FOR CHILDREN

Individuals generally are placed on the waiting list if case management teams verify that they meet all the criteria established in the state's Wait List Criteria Tool, which evaluates waiver applicants in 11 areas. In four of those areas, applicants are rated on their need for services that are not available through other funding sources and that are not usually performed by legally responsible individuals.

With the 2019 change, DPHHS now reviews all case management team determinations for individuals under 21 years of age to decide whether the person should be placed on the waiver waiting list.

PRIOR AUTHORIZATION OF SERVICES

The revised prior authorization policy also requires that each waiver service subject to prior authorization must -- in and of itself -- prevent a person from being placed in a hospital or nursing home, rather than in the home or community. The policy also requires case management teams to pursue all other potential sources of payment for the service, including natural supports. Natural supports typically means assistance from family or friends.

WHAT DO STAKEHOLDERS SAY?

Stakeholders say the changes have affected both children applying for the waiver and those already enrolled. Some children with disabilities aren't being accepted into the waiver program, while others have been told they're no longer eligible for services. Stakeholders say DPHHS has at times denied eligibility or services on the grounds that parents or other individuals should be providing the service or task as part of their regular parenting or caretaking duties, even when the service involves a task that a family member or friend would not be expected to perform for a nondisabled person of the same age.

Stakeholders also say some services are being denied to waiver participants of all ages because the service on its own would not prevent the person from receiving care in a hospital or nursing home. They maintain that waiver services are intended to be reviewed as a whole and must be authorized if, taken together, they would prevent a person's placement in a higher level of care or allow them to successfully remain in and be a part of the community.

WHAT AUTHORITIES DOES DPHHS CITE?

DPHHS references the Big Sky Waiver and various administrative rules in the revised policies.

The waiver application says that selection for the waiver is based on a prioritized need determined by the criteria in the Wait List Criteria Tool. It describes the tool as evaluating a person's need for formal paid services, the informal supports available to the person, and the relief that a primary caregiver needs.

The Wait List Criteria policy also cites ARM 37.40.1408, which governs enrollment in the waiver program. This rule allows the department to consider the status of services currently being purchased or provided to an individual by other sources, including "support from family, friends, and community." The rule also allows DPHHS to remove someone from the waiver program if the department or case management team determines that the services are no longer appropriate for the person's needs.

The prior authorization policy cites the following administrative rules:

- 37.40.1407, which allows immediate family members and legally responsible individuals who meet the provider qualifications and standards to be paid for providing up to 40 hours a week of services for certain services that are identified in the waiver, are specified in the person's service plan, and do not supplant tasks customarily performed by legally responsible individuals.
- 37.40.1420, which governs service plans and says the service plan "describes the needs of the consumer and the services available through the program and otherwise that are to be made available to the consumer in order to maintain the consumer at home and in the community."
- 37.40.1421, which gives DPHHS the authority to limit the cost of individual service plans and requires that the cost of the services to be provided is determined before the plan of care is put in place.

ARE OTHER PROVISIONS AT PLAY?

The laws and regulations authorizing home and community-based services generally refer to payment for services that help people remain in the community and aren't specific as to whether each service must accomplish that goal.

Section 1915(c) of the Social Security Act provides the federal authority for home and community-based services waivers. It says a state may obtain a waiver to pay for home and community-based services for an individual if a determination has been made that "but for the provision of such services, the individual would require the level of care provided in a hospital or a nursing facility…."

Similarly, 53-6-402, MCA, allows DPHHS to establish home and community-based services programs for certain populations who need ongoing or frequent specialized health services, personal assistance "and other supportive services necessary to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations."

Other administrative rules governing approval of waiver services include:

- ARM 37.40.1406, which says DPHHS may determine the services to authorize based on a recipient's "need for a service generally and specifically," the risk of significant harm if the service isn't provided, and the likelihood of placement in a more restrictive setting if the service isn't provided. The rule also lists five specific reasons for denying a service. The fact that a service by itself does not prevent hospital or nursing home care isn't one of the reasons listed for denial. However, the rule also says DPHHS is not limited to the five specified reasons when deciding whether to deny a service.

- ARM 37.40.1425, which governs goods and services offered through the consumer-directed option, rather than through provider agencies. It says the items must meet identified needs and outcomes, be cost-effective, benefit only the consumer, and "collectively must provide an alternative to institutional placement."

HAVE THE LAWS OR RULES CHANGED?

The table below shows when the cited references were adopted and changed.

Law/Rule	Enacted/Adopted	Last Relevant Revision
Big Sky Waiver: Participant Access and Eligibility	1988	None
Social Security Act Section 1915(c): HCBS Waivers	1983	None
53-6-402, MCA: Medicaid HCBS Waivers	1983	None
ARM 37.40.1406: Services	1983	2000
ARM 37.40.1407: Provider Requirements	1983	2011: Payment to family members allowed
ARM 37.40.1408: Enrollment	1983	2000
ARM 37.40.1420: Service Plan Requirements	1983	2000
ARM 37.40.1421: Cost of Service Plan	1983	1990
ARM 37.40.1425: Consumer-Directed Services	2011	None

FEDERAL REQUIREMENTS FOR WAIVER CHANGES

Some stakeholders have suggested that the changes to the waiver policies were substantive enough that DPHHS should have amended the Big Sky Waiver. Under 42 CFR 441.304, a state must submit an amendment to an existing waiver if it makes "substantive changes" to the services available, including "reduction in the scope, amount, and duration of any service…or a constriction in the eligible population."

The state also must allow for a public input process for any changes in the services or operations of a waiver. The process must be sufficient "to ensure meaningful opportunities for input" from waiver participants and the public. The process is supposed to be completed at least 30 days before a proposed change goes into effect or is submitted to CMS.

The change to the vehicle modification policy was included in the state's 2011 and 2016 applications to renew the Big Sky Waiver, and the state received a number of comments related to that change in 2016. Those comments prompted DPHHS to seek further guidance from CMS, as noted on Page 6.

The changes to the policies involving social supervision hours, nonmedical transportation, the Medically Needy program, prior authorization for wait list placement of youth under the age of 21, and the need for each service to prevent hospital or nursing home care were made through policy changes enacted by the department. The state did not amend its waiver to implement the changes.

NEW STATE REQUIREMENT

In 2019, the Legislature passed House Bill 529 to prohibit DPHHS from modifying the waiting list policies established in administrative rule without going through the administrative rulemaking process.

Sources

The following sources were used for this briefing paper, in addition to the specific statutes and regulations cited throughout the paper:

- Discussions with Barb Smith, Administrator, DPHHS Senior and Long-Term Care Division, and Jill Sark, Community Services Bureau Chief, DPHHS Senior and Long-Term Care Division. March 2-5, 2020.
- Written testimony of Travis Hoffmann, Advocacy Coordinator, Summit Independent Living. Provided to the Children, Families, Health, and Human Services Interim Committee on Jan. 16, 2020.
- BSW 403, Prior Authorizations by the Community Services Bureau. *Big Sky Waiver Policy Manual.* Jan. 1, 2019.
- BSW 406, Wait List Criteria. *Big Sky Waiver Policy Manual.* Jan. 1, 2019
- BSW 407, Medically Needy Billing Procedures. *Big Sky Waiver Policy Manual.* Jan. 1, 2019.
- BSW 702, Service Limitations and Exclusions. *Big Sky Waiver Policy Manual.* Jan. 1, 2019.
- BSW 711, Environmental Accessibility Adaptations. *Big Sky Waiver Policy Manual.* April 1, 2018.
- BSW 718, Non-Medical Transportation. *Big Sky Waiver Policy Manual.* Jan. 1, 2019.
- BSW 722, Personal Assistance Services. *Big Sky Waiver Policy Manual.* Jan. 1, 2019.
- BSW 733, Specialized Medical Equipment, Supplies and Technology. *Big Sky Waiver Policy Manual.* July 1, 2018.
- BSW 737, Vehicle Modifications. *Big Sky Waiver Policy Manual.* April 1, 2018.
- Memo from Jill Sark, Community Services Bureau Chief, DPHHS Senior and Long-Term Care Division, to Big Sky Waiver Case Management Team (CMT) Supervisors and Big Sky Waiver Personal Assistance and Non-Medical Transportation Providers. Nov. 8, 2018.
- Memo from Kimberly Box, Benefis Spectrum Medical, to waiver providers. Aug. 14, 2018.
- "2016 Big Sky Waiver Renewal Summary of Comments on Waiver Renewal and Department Responses." *Senior and Long-Term Care Division Community Services Bureau.* Undated.
- E-mail correspondence between Mary Eve Kuwalik, DPHHS, and Cynthia Riddle, Centers for Medicare and Medicaid Services (CMS). May 16, 2016.
- Letter from LaDawn Whiteside and Kieran Roberts, DPHHS Program Managers, to Case Management Team (CMT) Leads and Regional Program Officers (RPO). May 20, 2015.
- "Application for a 1915(c) Home and Community-Based Services Waiver: Instructions, Technical Guide and Review Criteria Version 3.5." *Centers for Medicare and Medicaid Services*. January 2015.
- E-mail correspondence between Cecilia Cowie, Program Manager, DPHHS Home and Community-Based Services Bureau, and Diana Friedli, CMS. June 2010.
- Letter from Mary Dalton, Montana State Medicaid Director, to Richard Allen, Associate Regional Administrator, CMS Division of Medicaid and Children's Health Operations. June 11, 2010.
- E-mail from Diana Friedli, CMS, to Cecilia Cowie, DPHHS. Nov. 25, 2009.

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