Montana Health Care Association

36 S. Last Chance Gulch, Suite A ■ Helena, MT 59601 ■Tel 406 443 2876 ■ Fax 406 443 4614 ■ E-mail info@mthealthcare.org

October 24, 2023

TRANSITION REVIEW COMMISSION

HB 29

For the record, I am Rose Hughes, Executive Director of the Montana Health Care Association (MHCA). MHCA represents the long term care continuum, including skilled nursing facilities, assisted living facilities, memory care facilities and home care agencies located throughout the state.

The state of Montana has expressed its intent (Title 53, chapter 21, part 4) that geriatric Montanans who don't need intensive psychiatric care be treated in nursing homes in the community and appears to envision nursing homes created specifically for this purpose in communities throughout the state. However, those specific types of nursing homes were never created. The Montana Mental Health Nursing Care Center appears to be the only licensed skilled nursing facility specifically for people with mental illness who need nursing care, and their admissions are limited.

This panel is about "alternatives" to involuntary commitment to the Montana State Hospital (MSH) for people with Alzheimer's and related dementias (ADRD) who may not require intensive psychiatric care. Alternatives that I am aware of include:

1. **Category D Assisted Living.** The legislation that created Category D Assisted Living anticipated this type of licensure could resolve the issue of placement of those who might otherwise be subject to involuntary commitment to the state hospital. The legislation was passed in 2017 and the rules governing this level of care were not adopted until September of 2022.

There are currently no facilities licensed for Category D.

Barriers to serving those who are at risk of involuntary commitment (Category D Assisted Living):

a. No one is licensed to offer this service.
b. Given the regulatory framework, the cost will be high.
c. Medicaid covers assisted living under the Big Sky Waiver which does not cover room and board, so individuals must have funds to pay the room and board part of the costs. Also the assisted living rate under the waiver is insufficient to cover the cost of this service.

2. **Category C Assisted Living.** This licensure category serves individuals who may have severe cognitive impairment that renders the individual incapable of expressing needs or of

making basic care decisions and may be at risk of leaving the facility without regard for personal safety. Locked units are allowed. However, the individual may not be a danger to self or others. There are about 75 Category C facilities licensed in Montana. Of those, 21 have separate Category C Units, and the remainder allow Category C residents throughout the facility. In assisted living, the resident is categorized as being a Category A, B, or C resident, so we have no data about how many individuals living in facilities licensed for Category C actually require the Category C level of care. Also, individuals with Alzheimer's or other dementias can be served in Category A and B facilities if they don't meet the Category C definition. In general, assisted living facilities care for many, many individuals with Alzheimer's and related dementias - but whether an individual with dementia is appropriate for assisted living placement depends on the needs of the individual.

Barriers to serving those who are at risk of involuntary commitment (Category C Assisted Living):

a. These facilities are precluded from serving individuals who are a danger to themselves or others.

b. The cost of providing this level of care and additional staffing is high. To the extent these individuals depend on Medicaid for their care, the rates paid are often not sufficient to persuade the facility to accept these individuals.

c. Medicaid adopted a "behavior management rate" for assisted living on July 1, 2022, but has not adopted rules for the implementation of the rate. Assisted living facilities are still unable to access the behavior management rate.

3. **Skilled nursing facility.** Skilled nursing facilities also provide services for people with Alzheimer's and related dementias. It is estimated that dementia affects 50-70% of all nursing home residents, and about one-third of nursing home residents have problematic behaviors that include being verbally or physically abusive, acting inappropriately in public, resisting necessary care and wandering. The median age of nursing home residents is 85 years old. About 85% of nursing home residents are over the age of 65 (although the population at the Montana Mental Health Nursing Care Center (MMHNCC) is younger with only about 65% being over the age of 65). Skilled nursing facilities are clearly allowed to provide services to the individuals this commission is concerned with. Nursing homes are required to evaluate all applicants (with specified exceptions) for serious mental illness (SMI) and/or intellectual disability (ID). The process requires the facilities to add "specialized services" beyond services typically provided in a nursing facility in order to address the individual's SMI.

Barriers to serving those who are at risk of involuntary commitment (Nursing Homes):

a. Individuals with serious behaviors could threaten the safety of other residents being served, and could require one on one staff to keep them and others safe.

b. The cost of providing this intensity of care and additional staffing is very high. To the extent these individuals depend on Medicaid for their care, the rates paid may not cover the cost of serving these individuals.

c. Medicaid implemented a behavior "add-on" to account for the increased cost of caring for those with significant behaviors. However, many of our nursing homes report that they are unable to access these add-ons.

d. To the extent the individuals to be served would be deemed through the preadmission screening process to require "specialized services" to address a serious mental illness (SMI), the facility would have to access the services which often are not readily available

in communities and pay for them. Depending on the specific specialized services, there may not be a source of payment.

d. Medications. Federal regulations have stringent limitations on the use of psychotropic and other medications and require drug holidays. Facilities will have to jump through many hoops to handle medications (depending on what medications the individuals need) and are likely to end up with survey deficiencies and potentially fines and penalties related to the use of the drugs.

e. Behaviors. If a facility accepts a resident with difficult behaviors and there is an incident between the resident and another resident, it is likely that the facility will be cited for physical, verbal or sexual abuse resulting from the incident (even if it is minor). Again, federal regulations prevail and are stringent and unforgiving on this issue. If abuse is cited, CMS posts a red flag warning on its website with the facility information.

Important factors for the Commission to consider:

1. We don't have enough information about those who are being admitted to MSP with dementia as either a primary or secondary diagnosis:

a. What specific mental health diagnoses do these individuals have in addition to dementia - both for those whose dementia is the primary diagnosis and for those for whom it is a secondary diagnosis? How many do not have a mental health diagnosis other than dementia?

b. What specific behaviors and issues led to the involuntary commitment? How many were committed based on a situation in which the person or someone else was in imminent danger of death or bodily harm? or, because the individual has a mental disorder and is substantially unable to provide for the person's own basic needs of food, clothing, shelter, health, or safety?

c. How old are they? Younger individuals with SMI and ADRD may express more aggressive behaviors, be stronger, be sexually inappropriate, etc., and generally not be a good fit for a senior care facility.

2. What payments sources can be made available for this level of care?

3. With the critical work force shortage in senior care facilities, but also across most health services, will there be staff available to serve the needs of these individuals in their communities?

4. This study addresses a very small number of individuals, but there are many more individuals with late stage Alzheimer's who exhibit difficult behaviors and are also having difficulty finding services. What should we be doing to help them?

Thank you for the opportunity to comment on this issue. I would be happy to answer questions you may have.

MONTANA HEALTH CARE ASSOCIATION
SURVEY - OCTOBER 2023

Yes	No	# of Patients accepted	# who succeed-ed	Initial Contact	Comment
x		1	1	Family	This individual was previously at another nursing home and then to St. Peter's behavioral unit and then to MSP. We trained staff prior to admission but it was not easy. A supportive family helped. Staff is now able to deal with this resident quite well. In terms of future admissions reimbursement, local mental health services, and more staff training would help and a separate unit would be helpful.
x		1	1	State	1) The referral packet often paints an entirely different picture than the issues the resident exhibits. 2) They will not take the resident back to adjust meds etc. if we have further difficulty with the resident. 3) We already have SEVERAL mental health residents in the facility that we are not able to get mental health services – 4) Follow up services and ongoing services are either nonexistent or the wait list to get them in is lengthy. 5) We try to balance the risks – Do we risk a citation/fines when we have no solid community support for the resident? 6) Will the behaviors affect the resident rights of the other residents and making current residents/ families upset? 7) Many of these residents are Medicaid and require a private room due to behaviors/ needs 8) We can't access mental health services for the residents we already have so hesitate to take on more
x		5	4	Facility	We are happy to continue to review referrals from the state hospital. Need at least a 30 day readmit agreement. Additional reimbursement would be helpful. In process of submitting for addons.
x		1	1		More information about resident's normal behavior. Should offer add-on -the application to receive an add-on takes time and is often unsuccessful. For example, if normal behavior is to resist care, it is likely they will refuse medications and become violent or exhibit other intense behaviors. In process of submitting for addon.
x		3	2		In process of submitting for addon. No add-on was offered.
x					Additional reimbursment would be necessary as well as local mental health services, access to staff training on behavior management.
	x				Have never been contacted by state hospital to take anyone but probably would be unable. Our resident population is very heavily frail female individuals with mild dementia. Probably wouldn't mix well with individuals with a psychiatric diagnosis.
x					We are more than willing to visit with the Spratt Unit on admissions as long as they provide a 30 day preplacement visit.
x					We would like to visit with the state about accepting residents from the state hospital and perhaps creating a separate single room unit in our facility to serve those with difficult behaviors. Financial, training and mental health resources will be necessary.
x		1	1	State	They said they would pay additional but never did. Received no room and board for first 25 days. No support after placement. Individual went to MSH from Billing psych unti and had been at MSH about 9 months.
x					Have not admitted anyone from MSH nor been contacted to do so. Challenge would be proper staffing for safety and needs and appropriate reimbursement. Mental health services would have to be available. Staff training.
x					Experience at MT Mental Health NCC. Would need significant reimbursement, specialized dementia training, higher staff ratios including 1:1 care; MSH would have to agree to re-admit the resident. Normally MMHNCC and MSH only agree to a 30-day preplacement stay. MT code would need to change to have MSH recommit someone they had discharged from Spratt under this Alzheimer's/dementia exception.
	x				
	x				
	x				Category A only facility
x		a few			We have placed a few clients from MSH. I usually request a 30-day trial period. If the individual has severe behaviors it would be important to assess the additional costs.
x					We are a category A facility so we would assess the individual to make sure it is the correct fit. Those with very serious behaviors likelywould not work.

MONTANA HEALTH CARE ASSOCIATION
SURVEY - OCTOBER 2023

Yes	No	# of Patients accepted	# who succeed-ed	Initial Contact	Comment
x					We have taken residents from the state hospital in the past and mostly had success with them. We would continue to take them as long as they are discharged with the proper tools to help us and them be successful such as medications and follow up appointments with mental health professionals. Funding for additional staff and training would be needed.
x					We are not opposed to serving these individuals but we do not have a category C endorsement. It would depend on the individual's needs and the reimbursement. Staffing remains a problem for us.
x					I am willing to accept a resident from the state hospital if appropriate for assisted living upon assessment and physician order.

Licensing Assisted Living Facilities

50-5-227. Licensing assisted living facilities. (1) The department shall by rule adopt standards for licensing and operation of assisted living facilities to implement the provisions of **50-5-225** and **50-5-226**.

(2) The department may deny, suspend, or revoke the license of an assisted living facility if the department finds a demonstrated pattern of noncompliance with the employee background check requirements of **50-5-225**.

(3) The following licensing categories must be used by the department in adopting rules under subsection (1):

(a) category A facility serving residents requiring the level of care as provided for in **50-5-226**(2);

(b) category B facility providing skilled nursing care or other skilled services to five or fewer residents who meet the requirements stated in **50-5-226**(3);

(c) category C facility providing services to residents with cognitive impairments requiring the level of care stated in **50-5-226**(4); or

(d) category D facility providing services to residents with mental disorders who may be a temporary harm to themselves or others and who require the level of care stated in **50-5-226**(5).

50-5-226(4) Category C Assisted Living

(4) An assisted living facility licensed as a category C facility under **50-5-227** may not admit or retain a category C resident unless each of the following conditions is met:

(a) The resident has a severe cognitive impairment that renders the resident incapable of expressing needs or of making basic care decisions.

(b) The resident may be at risk for leaving the facility without regard for personal safety.

(c) Except as provided in subsection (4)(b), the resident may not be a danger to self or others.

(d) The resident may not require physical or chemical restraint or confinement in locked quarters, but may consent to the use of safety devices pursuant to Title 50, chapter 5, part 12.

50-5-226(5) Category D Assisted Living

(5) (a) An assisted living facility licensed as a category D facility under **50-5-227** may not admit or retain a category D resident unless each of the conditions in subsections (5)(b) and (5)(c) is met or a court has ordered diversion as provided in subsection (5)(d).

(b) The resident must be dependent on assistance for two or more activities of daily living and may require skilled nursing care or other services that may be provided or arranged for by either the facility or the resident or provided for in the facility agreement.

(c) The resident must be assessed by a practitioner or adjudged by a court as having been or potentially being a danger to self or others. The practitioner shall submit both a health care assessment, renewed on a monthly basis, and a written order for care that:

(i) provides information on behavioral patterns under which the category D resident may pose a threat to others and may need to be kept separate from other category D residents or residents in other categories of assisted care;

(ii) lists the conditions under which the category D resident can be reasonably, temporarily restrained, using protective restraints, medications, or confinement to avoid harm to the resident or others;

(iii) includes a reason why a category D assisted living facility is more appropriate than other options for care and provides an assessment of the resident's needs and plan for care; and

(iv) indicates the timeframe over which the resident's health care status has remained the same or changed.

(d) A court may order a diversion from an involuntary commitment to Montana state hospital or from the Montana mental health nursing care center as provided in **50-5-224** or **53-21-127**. A diversion ordered pursuant to **50-5-224** may be an involuntary commitment but must be treated as provided in **53-21-181**.

MCA, 50-5-101(56) Definition of Skilled Nursing Care

(56) "Skilled nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed registered nurse on a 24-hour basis.