DEVELOPMENTAL DISABILITIES PROGRAM: EMERGING ISSUES AND EASTMONT STATUS

A Report Prepared for the

Legislative Finance Committee

By

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March 10, 2004

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INTRODUCTION AND PURPOSE

The purpose of this report is to inform the Legislative Finance Committee (LFC) of a number of significant system events that are occurring simultaneously within the developmental disabilities (DD) system. Each of these events individually has the potential to change the DD system. However, when combined these events are likely to result in a very different service delivery system compared to the current system and pose a number of complex budgetary and public policy issues. At this time, precisely which issues may rise to the level of legislative intervention is unknown. However, it is anticipated that significant public policy and budgetary issues regarding this service deliver system will be presented to either the 2005 or 2007 legislature, or perhaps both.

This report informs the LFC of the current status of issues within the DD system and suggest next steps that the LFC may wish to pursue in preparation for public debate which will likely occur as issues or proposals are brought forward for legislative consideration. Staff has attempted to present the information in this report clearly and concisely. However, the magnitude and interrelationship of the changes pending in this system are such that some level of detail must be provided in order for the reader to appreciate the scope, magnitude and complexity of the issues.

There are a number of catalysts for the changes occurring in DD.

- Centers for Medicare and Medicaid (CMS) review of the Montana's Home and Community Based Service (HCBS) waiver for developmentally disabled individuals
- Evolving changes in the population and needs of the population served within the DD system, particularly changes in the population being served by the Montana Developmental Center (MDC)
- Settlement agreement in the Travis D. litigation

Each of these catalysts is discussed in the sections that follow.

This report, while focusing largely on changes that will occur in this service delivery system during the next three to five years, also provides updated information on:

- Historical expenditures and funding pressures
- Agency-wide Medicaid redesign efforts as they relate to the DD system
- Status of the closure of Eastmont
- Potential de-certification for Medicaid reimbursement of some MDC residents

Lastly, given that:

- A great deal of pressure is being exerted upon the DD system from a variety of sources
- The average annual growth rate in this service delivery system has been slightly more than five percent per year
- This system is current supported by appropriations totaling more than $93 million

This report provides the LFC several options it may wish to pursue related to study, monitoring and control of expenditure growth within this service delivery system.

MAJOR CATALYSTS FOR CHANGE

This section discusses the major catalyst for change within the DD system.

CMS REVIEW AND RESULTING SYSTEM REDESIGN

This section of the report discusses the ramifications of one of the most significant CMS findings regarding Montana's HCBS waiver serving individuals with developmental disabilities and the redesign of the system that is currently in the planning stages. This redesign, incorporating the concept of a "self-directed model of care", will result in changes in how client needs are assessed, how resources are allocated to clients, and how providers are reimbursed for services. How the DD system, its clients and providers do business will change. These changes bring with them the potential for consumers to experience both positive and negative consequences of their decisions, and that the introduction of competition into the system may impact the financial viability of some providers.

In 2000[1], CMS reviewed Montana's HCBS waivers that serve developmentally disabled individuals. This review resulted in a number of findings and as a consequence Montana negotiated and entered a plan of corrective action. DPHHS continues to implement portions of that corrective action plan. At this time the department's primary focus, and a portion of the corrective action plan yet to be completed, deals with provider reimbursements and consumer freedom of choice, also sometimes referred to as portability of client services.

One significant CMS finding was related to Montana's system of contracting with a limited number of providers, reimbursement of those providers per contract, the "slot" system of placement, and the impact these items have on consumer freedom of choice. Under Medicaid regulations a consumer must be free to choose from among a list of qualified providers[2]. While the state may, within guidelines, establish criteria for a provider to be considered qualified, any provider who meets those criteria may participate in the service delivery system and consumers may choose among qualified providers. In contrast with general Medicaid regulations, Montana's DD system was built based upon:

- Providers responding to a request for proposal
- The department selecting and entering contracts with some respondents
- The negotiation with each provider of contract terms and dollars
- Consumers being limited in choice to those providers with a contract, and even further restricted to those providers with an opening or "slot" available

This system, as it was when reviewed by CMS, does not:

- Allow any/all qualified providers to participate in the DD service delivery system
- Include a consistent statewide reimbursement method where the same service is reimbursed at the same rate for all providers statewide, or as an alternative specify a rationale basis for differing rates among providers
- Does not allow consumers to purchase services from the qualified provider of their choice
- Does not facilitate portability (the ability of the consumer to move fluidly from provider to provider) of consumer benefits

[1] The final CMS report of the results of this review are dated April 30, 2001. However, the actual review was conducted in 2000.

[2] Under certain circumstances a state may request a waiver from Medicaid freedom of choice requirements. Montana does not have such a waiver approved for developmental disability services.

To remedy this situation, CMS indicated DPHHS should implement a system that complies with general Medicaid requirements and facilitates consumer freedom of choice among providers and portability of benefits. In the time elapsed between the CMS review and today, the department has implemented changes such as: development and implementation of criteria and a process to determine providers that are qualified to participate in the DD service delivery system; and freedom of choice (portability) among providers within a service category. For example, a consumer utilizing group home services may choose from among the qualified providers of group home services.

As part of its effort to develop and implement a revised reimbursement method that assures consumer choice of providers and portability of benefits, the department has entered into a contract with Mercer Government Human Services Consulting (Mercer). The primary products that Mercer will provide the department are: 1) assessment tools (one for youth and one for adults) that will determine on a statewide, consistent and equitable basis, the level of support and funding each client receiving services requires; and 2) establishment of uniform statewide rates and methods for reimbursement of providers. The implementation of these two products will lead to significant changes in the DD service delivery system that will impact both consumers and providers. These system changes are significant for a number of reasons, including:

- The DD system is rich in history and has traditionally implemented change slowly. These changes by their nature and the need to enter into compliance with CMS requirements may be implemented more quickly than has been traditional in this service delivery system. The success of implementation of these changes will be impacted by how members of the team (the department, providers, and consumers) embrace the changes and it is likely to be uncomfortable and difficult for some team members to embrace these changes.
- Consumers will be empowered. Individual consumers will have choices among services and providers and a greater ability to select and move between services and providers themselves. This empowerment will likely lead to more risk for consumers, particularly those consumers that are their own guardian. While the system will make every effort to assure client safety, it is probable that consumers will have the power to make decisions that caretakers, relatives, and friends may consider unwise. It will likely be uncomfortable for some to empower a group that by the nature of their disability experience limitations in functioning. This choice among services and providers is the central concept and objective of "portability".
- An element of competition among providers that has not previously been present in the DD system will now be present. For example, rather than a group home provider entering into a contract to serve a specified number of individuals and being reimbursed based upon that contract, the provider will now be reliant on the consumer seeking to obtain their services and a reimbursement system that is more closely driven by consumer usage than a predetermined contract.
- The computer system currently employed by the division is not capable of supporting the envisioned changes in the DD system. A new computer system that supports the DD systems new way of doing business will be developed[3]. Currently, it appears that this system design, development, and testing will occur in a fairly short timeframe after major policy decisions have been made and prior to implementation of the new way of business.

[3] Department staff indicated that a new system must be developed regardless of the changes in business process because the current system is based upon outdate technology.

Policy and Procedure Issues and Changes

It is clear to see that there are many areas of administrative rule, policy, and procedure to be discussed and decisions to be made. A change of this magnitude will lead to many revisions of existing policies and procedures, which must be adopted and implemented. In order to facilitate discussion and solicit input from stakeholders, the department has created an advisory committee for this project. The committee, which meets monthly, consists of department staff, provider staff, parents, advocates, and legislators. A number of subgroups and work groups have been formed to make recommendations on various components of this project. The department has also implemented processes to conduct focus group meetings to obtain input from consumers, the public and case managers. Focus group meetings were held in January and February 2004 in various locations in the state.

While the advisory group will provide recommendations to the division regarding policy and procedure decisions, it is anticipated that some decisions will be brought forward for legislative consideration or that the legislature may choose to weigh in on some decisions. For example some of the policy and procedure questions that are currently being studied are:

- How will the changes impact workloads and staffing for both providers and the department?
- What items should be incorporated into the reimbursement rates?
    - Reimbursement for days the client is absent?
    - What level of direct care wages will be incorporated into the reimbursement rates?
    - What level of employee benefits will be incorporated into the reimbursement rates?[4]
- What time frame and process will be used to transition the system from its current practices to the new practices?[5]
- How and/or will the reimbursement structure and methodology combine concepts from fee for service, contract and other reimbursement methods?

Timing

While the vision, purpose and look of the assessment tool is fairly well developed, much of the reimbursement structure and methodology is in the process of being created. The contractor is currently in the process of testing the draft assessment tools prior to finalization. The project timetable calls for Mercer to complete the work it is currently contracted to do by June 30, 2004. The department has indicated that a pilot of these changes will likely begin in January 2005 with full implementation occurring over the following one or two year period. Logistical challenges faced by the department include: completion of the computer system to dovetail with the implementation of the changes in business processes; and implementation timing that eases the change in business practice but also results in complete implementation prior to the expiration of the life cycle of the rates and assessment tool.

EVOLVING NEEDS AND DESIRES OF CONSUMERS

This section of the report discusses some of the changing characteristics of the population served by the DD system. These changes, which co-exist with the planned changes in portability and consumer choice, impact when and how services are delivered and the role of the state institution in the service

[4] Initial data complied by Mercer indicates employee benefits paid by Montana DD providers range from 6 to 18 percent of direct care salaries. Mercer staff also indicated that a "fully-loaded" employee benefit package normally costs about 31 percent of direct care salaries. Data and comments presented at the January 22, 2004 Rate Methodology Project Advisory Committee meeting by Norm Davis, Mercer Project Leader.

[5] January 22, 2004 Rate Methodology Project Advisory Committee meeting, a Mercer staff person commented that the average life cycle of provider reimbursement rates is about three years. Thus, it would seem that it would be wise to accomplish this transition within three years of the rate development so that the provider rates are not obsolete prior to implementation throughout the entire state.

delivery system. The "forensic" type population served by MDC continues to increase, which could impact general fund revenues from institutional reimbursement.

On one hand the characteristics of the consumer population in the DD system is changing while on the other hand the services desired by consumers are also changing. The portion of the population with severe behavioral needs including criminal and violent behaviors is increasing. This observation is supported by the commitment of an individual to MDC under criminal statutes rather than civil procedures, which occurred in 2002 for the first time.[6] Additionally, department staff indicate that there are two individuals that are likely to be criminally committed to MDC in the near future.[7] Department staff is currently contemplating options for remodeling existing facilities as they become available to provide more secure beds within the MDC setting.[8] As this population grows it is likely that the legislature may be called upon to: establish public policy regarding the treatment of this population; the level and type of resources needed to support this population; and consider the general fund impact of decreased institutional reimbursements since services provided to these clients is probably not eligible for Medicaid reimbursement.

While this portion of the population is growing, how the DD system serves clients is also changing. The downsizing and closure of institutions and movement of individuals to eight bed group homes has resulted in clients being served in smaller group settings. And, in recent years there has been a shift in group home size. The group homes more recently developed are four bed group homes. More options for living in community settings such as apartments and single-family dwellings with necessary supports have been developed. Additionally, some provisions of the Travis D. settlement agreement prohibit the department from funding congregate homes for eight or more residents.

These changes will also challenge providers to deliver services differently. For example, with services in individualized settings, staffing concepts may change. Having a group of shift staff on duty in a group home serving multiple individuals allows for some flexibility in coverage in the event a staff member is ill or on vacation. This staffing model may not work in a system where services are more individualized and consumers are not in congregate living situations.

Additionally, data indicates that about 60 percent[9] of developmentally disabled individuals' primary caregivers are relatives and the living situation is a family home. As caregivers age and the life expectancy of individuals with developmental disabilities increases, the demand for publicly funded services will likely increase. As a part of its market analysis[10] for Montana, Mercer has estimated approximately 11,728[11] Montana's have a developmental disability. Montana currently provides services for about 4,000 individuals, or about one-third of the estimated developmentally disabled in the state. While comparison of 2002 national and Montana recipients per 100,000 population indicate that

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[6] Legislative counsel reviewed and prepared an analysis of the court order in this instance. As a result of this legal review, the Interim Children, Families, Health, and Human Services Committee introduced legislation that was adopted by the 2003 Legislature changing statutory provisions of criminal proceedings involving individuals with developmental disabilities.
[7] Personal conversation with Jeff Sturm, DD Program Director and Gail Briese-Zimmer, DSD Fiscal Bureau Chief on February 27, 2004 and personal conversation with Gail Briese-Zimmer, DSD March 10, 2004.
[8] Ibid
[9] Comments made by Mercer staff
[10] Mercer Human Resource Consulting, Stakeholder Meeting Preliminary Data – Discussion Draft, January 22, 2004, page 1
[11] This estimate is derived by applying data regarding the prevalence of developmental disabilities per 100,000 persons to Montana's census. Jeff Sturm, DD program manager, indicated he does not believe the number of developmentally disabled individuals in Montana is this large. Furthermore, Mr. Sturm believes that most developmentally disabled individuals in Montana are known to the DD system.

Montana is serving more recipients (183) per 100,000 of population that is the national average (136)[12] it is likely that the system will continue to be pressured to serve more individuals.

Litigation, Travis D. Settlement Agreement

This section of the report outlines some of the provisions of the settlement agreement in the Travis D. litigation. This settlement agreement requires the department to undertake many activities and has a number of implications to both the DD system and the Medicaid system. Additionally, legislative legal counsel has identified some areas of concern as a result of preliminary review of the settlement agreement. Areas of concern that have been identified by legislative legal counsel are not addressed in this report.

On February 5, 2004 the court ordered settlement of the Travis D. lawsuit was signed. Travis D. was a class action lawsuit filed by the Montana Advocacy Program (MAP) in 1996. Defendants in this suit included the state of Montana, MDC, Eastmont, and key personnel. This lawsuit sought to protect the civil rights of individuals with disabilities and the provision of appropriate community services for individuals with disabilities. The terms of the settlement agreement between the executive branch and the plaintiffs include requirements for the department to:

- Develop and present to the legislature:
    - In 2005, a statutory change in commitment laws removing from the definition of "seriously developmentally disabled" in 53-20-102, MCA, a person with self-help deficits requiring near total care
    - In 2005, a budgetary proposal to provide funding for the placement in community services of all persons continuing to reside at MDC whose commitment is due to self-help deficits so severe as to require near total care and who have been referred for community services by their professional treatment team
    - In 2007, a proposal seeking funding and any necessary statutory changes to implement models of developmental disability community services for persons with sexually offending behaviors
- Close unit 16AB on the MDC campus and move 45 residents to community settings by December 31, 2007
- Offer and if accepted provide services to all members of the plaintiff class currently without services[13]
- Take reasonable actions to maximize federal funding for developmental disabilities community services, through payments of services with federal program funds (Medicaid, Title XX, etc) and through efforts to assist persons not currently eligible for Medicaid to become Medicaid eligible
- Train various department and provider staff, and development of policies and/or programs related to various topics including: behavior management, dually diagnosis individuals, and developmental disability community services for individuals with sexually-offending behaviors
- Not fund development of any seven or more person community homes (except multiplex apartments) or contract with any provider to serve more than eight residents in an existing community home for persons with developmental disabilities

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[12] Mercer Human Resource Consulting, Stakeholder Meeting Preliminary Data – Discussion Draft, January 22, 2004, page 3

[13] DPHHS staff indicated there are about 225 – 250 individuals in the plaintiff class and that most of those clients who wish to receive services are receiving services. The initial department estimate of the costs to serve individuals in the plaintiff class who are not already receiving services is about $40,000. Per personal conversation with Jeff Sturm, DDP manager and Gail Briese-Zimmer, DSD Fiscal Bureau Chief on February 27, 2004.

The settlement agreement in the Travis D. litigation impacts the DD system in a multitude of areas including:

- Operation and population of the state institution
- Provision of community services to individuals with specific types of needs
- Requiring statutory and budgetary proposals be brought forward for legislative consideration
- Administration and use of the Medicaid program
- Policy and procedures for administration of the DD system
- Contracting with service providers

Certainly, it is too soon to estimate and evaluate completely the magnitude of the settlement on the DD system. However, it is clear that the agreement requires a number of changes in the DD system and includes issues that may impact department-wide operations (such as Medicaid administration).

Department staff indicate completion of some tasks required by the settlement agreement are in progress and others are in the planning stages. The department has developed a list of tasks to be completed and required completion dates. The department plan to move 45 residents from MDC to the community includes the movement of: 10 residents by July 1, 2004; an additional 16 residents and closure of Unit C by March 31, 2005; and an additional 20 residents and closure of Unit AB by December 31, 2006. This plan would achieve movement of 45 residents to community settings one year earlier than required by the settlement agreement.

The department proposes movement in this fashion so that general fund savings can be maximized by closure of portions of the campus and these general fund savings can be used to support the costs of community services for these residents. The department hopes to minimize any reductions in force that may be necessary by eliminating vacant positions as staff turnover occurs and by utilizing temporary employees if possible within the terms of the collective bargaining agreements.

The department has not yet developed complete estimates of the financial impact of the movement of 45 residents to community services. However, there may be a net general fund loss because Medicaid revenue to the general fund will decrease more than the general fund appropriated to support MDC. The movement of 45 residents to community services represents a decrease in MDC's population of about 50 percent.

Developmental Disability Program Travis D. Settlement	
Institutional Costs (Held Constant at 2005 Appropriation Level)	$ 15,969,726
Initial Estimate - General Fund Needed to Serve 45 Residents in Community Services	(2,300,000)
Expenditure Reduction Needed to Offset Potential Loss of General Fund Revenue from Medicaid*	(4,000,000)
Remaining Institutional Budget Resulting in no Net General Fund Impact	$ 9,669,726
Percent of Fiscal 2005 Appropriation	61%

As the figure at the right illustrates, preliminary broad stroke estimates indicate that institutional costs would have to be cut roughly 40 percent in order for the offsetting general fund revenue and expenditure impacts to net to zero. However, this estimate does not attempt to estimate the change in reimbursement that will occur as costs per patient day increase, which should result in an increase in the reimbursements received because institutional reimbursements are costs based. Given the need to separate residents by gender and treatment/behavioral needs and the level of fixed costs experienced in an institutional setting, it seems questionable whether this level of expenditure reductions will be possible. When revenue and expenditure impacts are combined, it is possible that there may be a net general fund loss. The amount of net loss is likely to be greatest in fiscal 2005 through 2007 while

residents are gradually transitioned from MDC to the community. The net general fund loss due to these changes should stabilize in fiscal 2008 and later years after movement of the 45 residents to community services is complete.

Historical Expenditures and Funding Pressures

This section of the report provides information regarding historical expenditure growth and pressures within the DD system that may lead to requests for additional funding. Additionally, this section considers whether the LFC may wish to study and take action to assure that the legislature is in a position to contain costs and system growth if it wishes. This section presents several options for further study that the LFC may wish to consider.

While historic expenditure growth in the DD system has averaged about five percent per year (see the appendix to this document for additional information on expenditures and the number of clients served), future growth is difficult to predict. Department staff has indicated emerging issues such as the DD system redesign[14] and conditions of the Travis D. settlement are expected to be budget neutral.[15] While the costs related to the settlement agreement may be budget neutral from an expenditure view, it seems likely that there will be a net general fund loss when both revenue and expenditure sides of the equation are combined. Additionally, the possible de-certification for Medicaid reimbursement of some residents at MDC has general fund revenue and expenditure impacts including potential impact on funding for community services for this group of individuals. Lastly, it seems that the pressures existing within this system will likely lead to requests for increased funding, particularly for items such as inflationary adjustments at the state institution, and increased community services and provider reimbursement rates.

Options for LFC Consideration

If the pressures within this system lead to requests for increased funding, the legislature may wish to take actions to guide or control general fund growth of the system. If so, further questions arise such as:

- What mechanisms are currently in place to control and guide general fund expenditure growth?
- Are these mechanisms effective?
- Will these mechanisms withstand legal challenges?
- What additional mechanisms are available and desirable?
- Is the guidance provided by statute regarding who is served and how they are served adequate?

This report does not attempt to analyze or address these questions. However, these are questions and issues the legislature may wish to study. Several options for LFC consideration are provided.

Options the LFC may wish to consider are:

1) Request that the department provide an update on the DD system at each LFC meeting. This would allow the LFC to: receive the most current information on a regular basis; monitor system activity; and provide feedback to the department and executive. Although this feedback would not be binding upon the department it would be an opportunity for the LFC to influence potential executive branch actions.

[14] Also known as the Rate Methodology project.

[15] Based upon verbal comments by department staff during DD Advisory group meetings and an email dated February 20, 2004 from Scott Sim, DPHHS to Lois Steinbeck, LFD.

2) Appoint a subcommittee of the LFC and request that the Interim Children, Families, Health, and Human Services Committee (Children and Families) also appoint a subcommittee to review this report and provide both committees with a recommended course of action.

   Given the time remaining in this interim the review of issues within the DD system by this group would likely be somewhat constrained and might not be as comprehensive as desirable. However, the advantage of this option is that it would allow the legislature to make some determination regarding which are the most critical issues requiring immediate action as opposed to issues that may be more appropriately addressed at a later date.

3) Request that the Interim Children and Families Committee review this report, monitor DD system activities, and report back to the LFC on any actions taken by the Children and Families Committee and/or with recommendations to the LFC.

4) Request that during the 2005 legislative session the Joint Appropriations Subcommittee on Health and Human Services examine issues related to the DD system including budgetary and public policy issues and bring forward recommendations for consideration by the 2005 legislature.

   This option has the advantage of occurring in a concise time period and within a body that already exists without the need for the LFC to appoint an additional subcommittee. Conversely, this concise time frame, combined with the demands of the legislative session, would likely limit the scope of the review.

5) Defer action at this time and review the issues related to this service delivery system at a future LFC meeting.

   A number of the items covered by the report are emerging issues that may or may not be addressed by work groups convened by the executive branch. The LFC may wish to revisit items covered in this report and take action at a later date. The disadvantage of this option is the limited time that would be available to develop proposals for the 2005 legislative session if action is delayed until a future meeting. Furthermore, a complete picture of executive proposals in this area may not be available until the legislature convenes in January 2005. This would increase the difficulty in development of a thoughtful, well-analyzed proposal for legislative consideration.

6) Take no action

   As always, the LFC has the option to take no action.

OTHER ISSUES

The remainder of this report provides the LFC with informational updates on other DD related issues.

Agency-wide Medicaid Redesign

This section discusses implications of the DD system, as one portion of the state Medicaid program, on Medicaid redesign efforts and potential implication of Medicaid redesign on the DD system.

The 2003 legislature passed House Joint Resolution 13 (HJR 13), requesting that DPHHS conduct a study regarding the health programs administered by the department and provide a report to the 59th Legislature, outlining options that may be undertaken to redesign those health programs. The study being conducted in accordance with HJR 13 has become known as the Medicaid Redesign project. A Public Health Care Advisory Council was formed and began meeting in September 2003. This group has been considering concepts for changes in Montana's Medicaid program.

At this time it is unclear how DD system changes and the Medicaid redesign will be integrated. However it would seem desirable that these two Medicaid related projects be closely integrated given the potential impact of one project on the other. While the HJR 13 advisory council has received general information about the pending changes in the DD system it appears that this group may not review or provide input or recommendations on potential changes in Medicaid related DD policies.

Some of the options brought forth for the HJR 13 group consideration could impact Medicaid eligibility of individuals in the DD system and could potentially shift costs from Medicaid matched dollars to 100 percent general fund dollars depending upon policy decisions regarding eligibility for services.[16] There are also some differences between systems in the application of Medicaid criteria for eligibility determination and there does not seem to be a clear public policy statement of explanation for these differences. Rather the differences seem to be based upon historical practice. For example, within the DD system, family resources are not counted when determining the child's eligibility for Medicaid. However in the case of a physically disabled child or child disabled due to mental illness, family resources are counted in determining whether or not the child is Medicaid eligible. To date, these types of issues have not been a topic included in the Medicaid redesign project.

The HJR 13 group is considering the feasibility of a Health Insurance Flexibility and Accountability (HIFA) waiver. It is important to note that changes in the DD system must be considered when considering a HIFA waiver because one condition of a HIFA waiver is that the state must agree to limit growth in Medicaid to a predetermined per person increase. CMS informed department staff this increase would be limited to no more than eight percent per year at this point in time. Any DD system changes resulting in cost increases or utilization changes would be part of the calculation to determine if the growth cap in Medicaid expenditures was exceeded under a HIFA waiver agreement.

Further information on these issues and options for LFC consideration may be found in the February 18, 2004 report prepared for the LFC titled "Update on Medicaid and Medicaid Redesign".

Update on Status of Closure of Eastmont

This section provides an update on the status of the Eastmont facility, and its former residents and staff.

House Bill 727, passed by the 2003 Legislature, directed DPHHS to discontinue usage of Eastmont as an institution for developmentally disabled individuals. This legislation also transferred ownership of the building to the Department of Corrections (DOC).

DPHHS presented the Joint Appropriations Subcommittee on Health and Human Services with a plan to implement the primary provision of HB 727, closure of Eastmont. The plan provided for the phased movement of some Eastmont residents to MDC and to group homes in Glendive, which would be developed to maintain some residents in the Glendive community. The department's plan also included

[16] A shift increasing general fund costs could occur if an individual in the DD system lost Medicaid eligibility and was maintained in services funded by the state.

one-time costs such as termination payout and incentives for employees to continue working at Eastmont until closure. The legislature appropriated $580,000 as a one-time-only appropriation to cover these costs. Additionally, the department estimated and the legislature appropriated $2 million general fund less than was requested in the executive budget for provision of services to the group of clients residing at Eastmont. As of January 2004, 8 residents had relocated from Eastmont to new group homes in Glendive, 2 transferred to other community services, and 19 residents had relocated to MDC.

HB 727 also included provisions that DOC, whenever possible, employ former Eastmont employees in a new program utilizing the facility and that the legislature intended that DPHHS have access to the personal services contingency fund in HB 13 to address severance pay and reduction in force provisions for Eastmont employees. Approximately 100 individuals were employed by Eastmont at the time HB 727 was passed and approved. As of February 2004, the status of former Eastmont employees based upon DPHHS knowledge was:

- 4 employees transferred from Eastmont to MDC (per the department most former Eastmont employees were offered employment at MDC)
- 18 employees obtained employment with community service providers in Glendive
- 6 employees obtained employment elsewhere
- 16 employees retired
- 34 employees have accessed retraining funds
- 53 employees filed for unemployment benefits

Ownership of the Eastmont facility transferred to the DOC at the end of calendar year 2003. At this time, DOC continues to work toward placing the facility in use as a treatment facility for individuals in the correctional system with chemical dependency addictions and is maintaining the physical plant. A weekly walk-through of the facility is performed by DOC staff to assure that building maintenance and repair issues are identified and addressed on a timely basis. In the event that DOC is unable to utilize the facility as chemical dependency treatment facility, it is likely that they will request legislation to dispose of the building.

Medicaid Reimbursement for MDC

This section provides information regarding the potential decertification for Medicaid reimbursement of some residents at MDC and the impact that this may have on general fund revenues, and expenditures for developmental disabilities community services.

Potential decrease in general fund revenue

Historically, the costs of operating MDC have been paid from the general fund and Medicaid billed for the services provided to those residents who qualify for Medicaid reimbursement. Medicaid revenues are used first to repay bonds that were issued to construct the facility. Any revenue in excess of the bond repayment is deposited to the general fund. In recent years the general fund has received about $10 million annually in Medicaid reimbursement for MDC services. This general fund revenue may decrease due to changes in determination of which residents are eligible for Medicaid reimbursement.

During February 2003 CMS conducted an on-site review of the needs and care rendered to individuals at MDC. At that time CMS informally notified DPHHS staff that 19 of the residents of MDC (about 20 percent) did not meet the criteria for Medicaid reimbursement of services. DPHHS staff indicate that: 1) CMS has had similar findings in other states and 2) this finding is based upon a change in the interpretation and application of the criteria used to determine whether an individual qualifies for Medicaid reimbursement. It is DPHHS' intention to appeal this finding. However, such an appeal cannot

be filed until Montana receives formal notification from CMS of its findings. Because DPHHS has not been formally notified of this finding, they have continued to bill and receive Medicaid reimbursement for service to these individuals. Whether or not any of these funds may have to be repaid once formal notification is received is unknown.

To date, two states have received formal notification of decertification for Medicaid reimbursement for institutional residents based upon the same rationale Montana was notified of informally. In these states formal notification was received about one year after the CMS on-site review. If this same pattern is experienced by Montana, formal notification of CMS findings may be received in the near future. In the event that Montana is not successful in it's appeal and this CMS finding stands, about 20 percent of the residents at MDC will be ineligible for Medicaid reimbursement and Montana's general fund revenue will decrease about $2 million per year.

In addition to their plan to appeal the CMS finding, Montana staff has been working at a national level with other states impacted by the CMS decision. Currently, Montana is one of four states participating in a task force working to establish alternative licensing standards for clients with behavioral problems. This task force was formed at the request of the head of CMS certification and licensure.

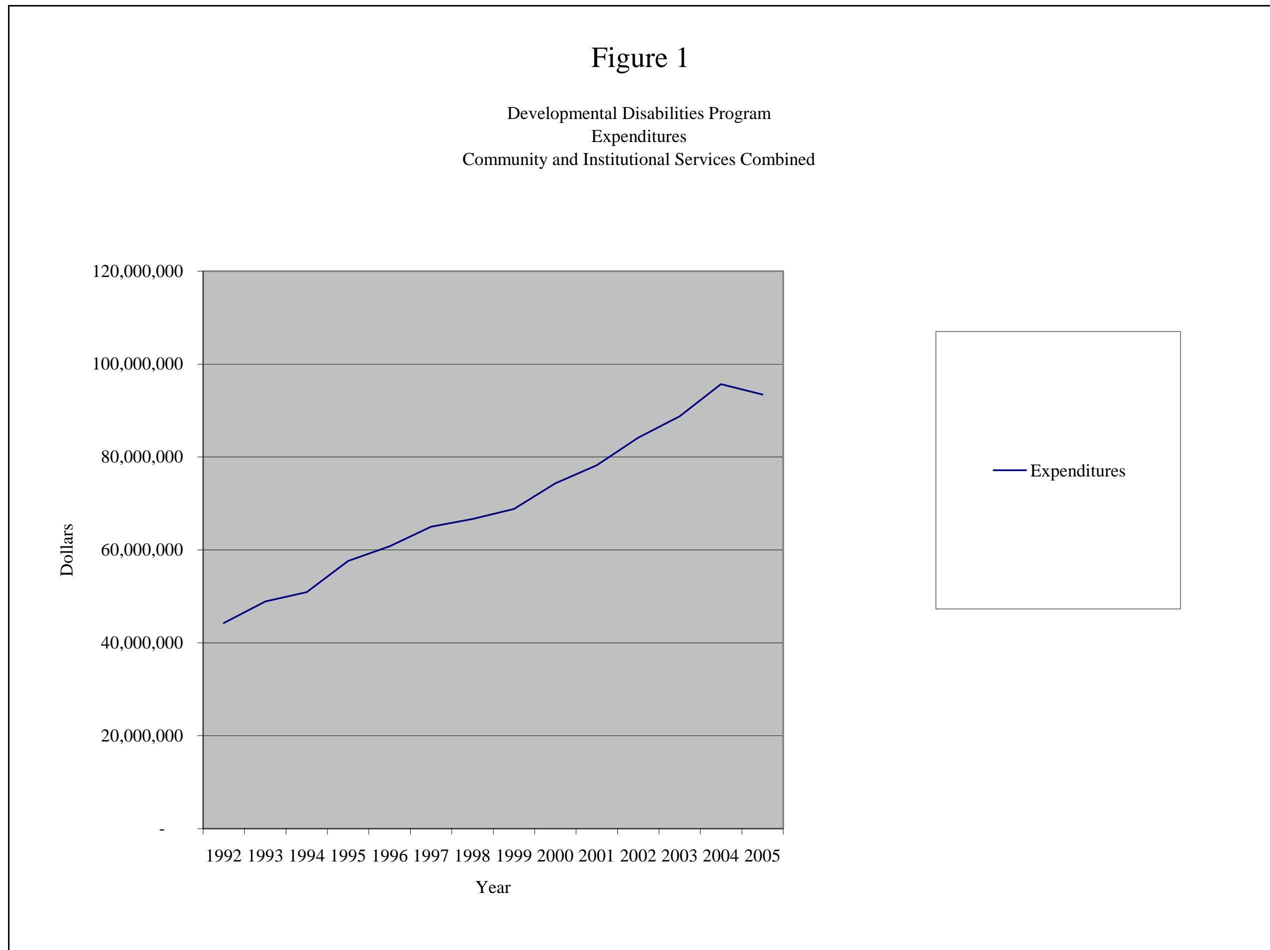
Potential increase in demand for general fund supported community services

In addition to the potential impact on general fund revenues, this CMS finding has a potentially large impact on funding for community services. The Medicaid HCBS program allows for Medicaid reimbursement of a broad range of community-based services for individuals with developmental disabilities. States are eligible to receive this waiver of Medicaid regulations because recipients of these services qualify for Medicaid reimbursement of institutional care, which is generally more expensive than community care. Thus, the approval of a waiver is of financial benefit to the federal Medicaid program. However, Medicaid reimbursement of community services under a waiver is only available for individuals at risk of Medicaid reimbursed institutional care. If these individuals cease to be eligible for Medicaid reimbursement in the institutional setting they may cease to be eligible for Medicaid reimbursement of community services. If this is the case, and any of these individuals move to the community, the costs of community-based services would be borne entirely by the general fund. The potential magnitude of costs implications related to this issue has not been estimated.

The LFD will continue to update the LFC on this issue as it progresses.

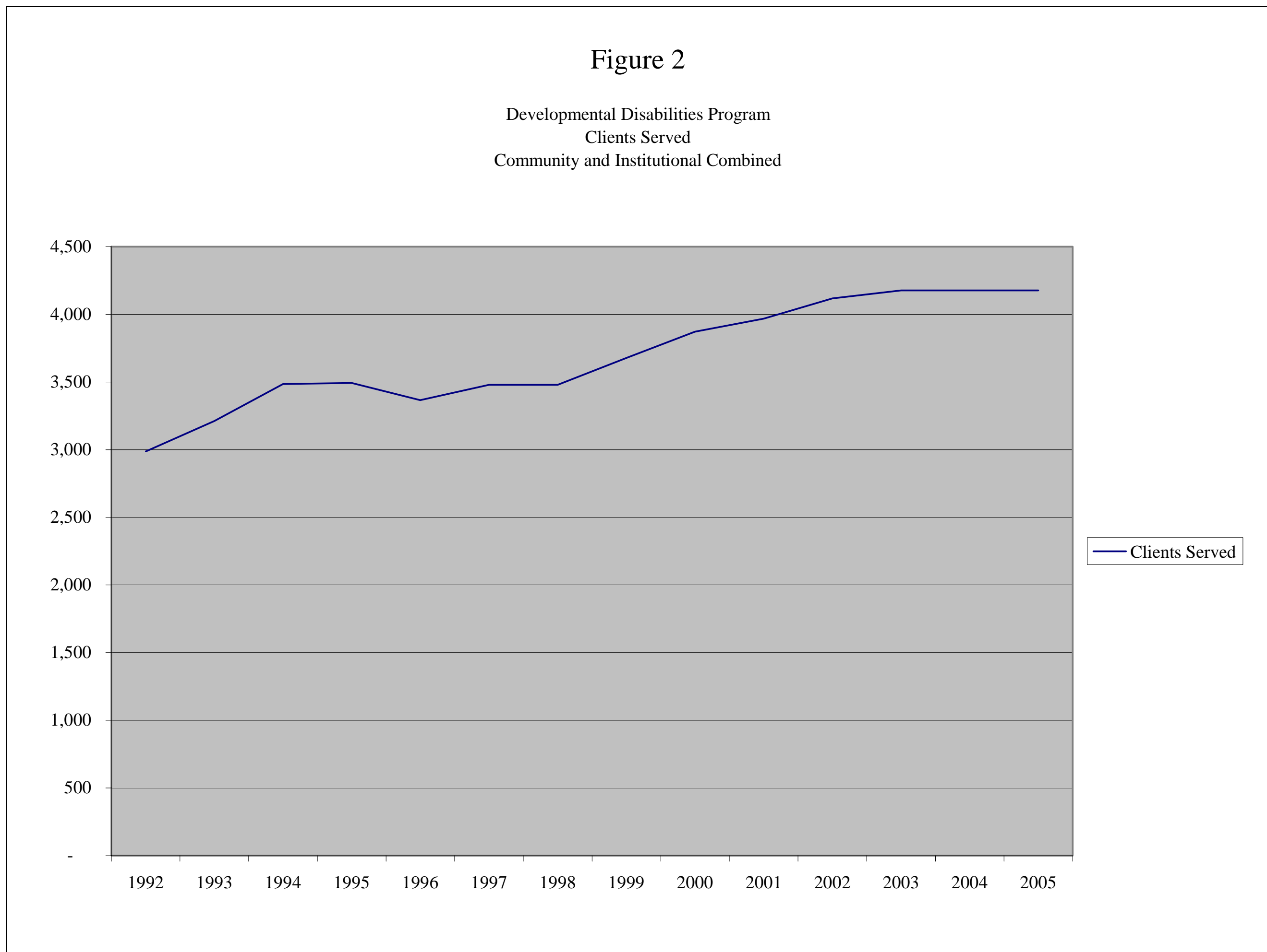
APPENDIX – HISTORICAL COSTS

Funding for DD services has consistently increased since 1992. Figure 1 illustrates the increase in combined funding for community and institutional developmental disabilities services[17] between 1992 and 2005, with 2005 data being based upon legislative appropriations in HB 2. In 1992 total expenditures for developmental disabilities services was $44.3 million, while fiscal 2005 appropriations for these services is $93.4 million or more than twice what was expended 14 years earlier in 1992. The average annual growth rate in funding for these programs was 5.5 percent between 1992 and 2005. The majority of this growth has occurred in expenditures for community-based services.



[17] Per data provided by Gail Briese-Zimmer, DSD Fiscal Bureau Chief

Figure 2 illustrates the increase in the number of clients receiving services within the DD system[18]. While the fiscal 2005 costs are anticipated to be more than twice what was expended in 1992 the number of clients projected to receive services in 2005 (4,177) is about 1.4 times the number served in 1992 (2,987). The average cost per person has increased from approximately $14,800 in 1992 to approximately $22,500 in 2005. It is likely that a number of factors have increased average cost per person including direct care worker wage increases, provider rate increases, and changes in service utilization and needs of clients.



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[18] Per data provided by Gail Briese-Zimmer, DSD Fiscal Bureau Chief