GREG GIANFORTE
GOVERNOR

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

CHARLIE BRERETON
DIRECTOR

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DPHHS Response to HB 29 Transition Review Committee Recommendations and Requests for Information[1]

Recommendations

1. Replace the current policy of not granting Level III add-ons with a policy allowing Level III add-ons.

   There are no policies that restrict Skilled Nursing Facility (SNF) Level III add-ons.

2. Allow add-ons for all categories of assisted living for this population. Consider that the add-on is for the person who needs care wherever they can find a bed.

   Although not considered an add-on, effective October 1, 2024, Level II services are available in Assisted Living Facility (ALF) categories A, B, and C. ALF Level II services include behavior management support services, which have an enhanced rate to reimburse facilities for added support for patients who have disruptive behaviors. ALFs fall under a different Medicaid authority than SNFs. A change to the ALF rate structure and methodology would require administrative rule changes and a waiver amendment.

3. Provide rejected add-on applicants with opportunities to file a grievance or have a hearing to restate their case.

   Administrative Review and Fair Hearing Rights are available to all denied or reduced add-on applicants. The letter provided to the requesting facility includes information on requesting an administrative review or a fair hearing.

4. Encourage assisted living facilities to apply for Medicaid add-ons for eligible patients through DPHHS marketing of these opportunities and add-on application guidance.

[1] **Recommendations and Requests for Information issued via letter to Director Brereton on November 7, 2024.**

Add-on payments are not currently available for ALFs; however, three ALF rates are available to address the unique needs of patients served in these settings.

The Department conducted a Big Sky Waiver (BSW) training for providers on November 13, 2024, that included information on the newest rate, ALF Level II services. The Department will continue to educate providers and Case Management Teams (CMTs) on available ALF services.

5. Develop a continuation plan for add-on rates to help maintain a level of care that best meets the needs of patients. Successful continuation plans should include flexibility to allow for changing patient needs, including higher or lower care levels. Continuation plans should not include artificial barriers (such as standardized facility caps on add-ons or short approval periods before required renewal).

   The SNF add-on payment program intends to stabilize the patient at the baseline level of care. However, some patients may meet add-on criteria in the long term based on their unique needs. The current process allows patients to move between support levels and extend the authorization for additional time frames. These transitions are authorized based on documentation to support the level of need. The Department will continue to assess the efficacy of the SNF add-on program.

Requests for Information

1. Of the patients at Montana State Hospital, how many need to transition to a skilled nursing facility?

   As of November 13, 2024, 10 of the HB 29 patients are currently ready to transition to a SNF.

1a. For how many would an assisted living facility be the appropriate level of care?

   As of November 13, 2024, four of the HB 29 patients are currently ready to transition to an ALF.

2. Why does the Department outsource add-on determinations?

   DPHHS currently contracts utilization review for many Medicaid services that require prior authorization. This contracted third-party entity provides a conflict-free review of the medical necessity criteria according to program-specific criteria and applicable regulations. The reviews conducted by licensed clinicians through the utilization review contract would not otherwise be available via state program staff.

In addition to reviewing for medical necessity, the contractor provides call center support, a web-based provider portal for ease of prior authorization submission, tracking of requests, quick access to determination decisions, web-based training, one-on-one assistance with issues, integration with the Medicaid payment system, reporting, and many other support services. The Department considers contracted utilization review to be a standard and best practice.

2a. How much does it cost to outsource add-on determinations?

The Department pays $34,250/year for SNF add-on reviews.

2b. How much did it cost to process add-on applications "in-house" by Department staff?

The previous process was completed by Senior and Long-Term Care (SLTC) staff, which included a claims specialist with oversight from a section supervisor. SLTC does not employ clinical staff. The approximate cost, including salary and benefits, is $31,100. The cost to process SNF add-on requests "in-house" by the Department using the same level of licensed staff provided under the utilization review contract would be considerably higher than the salary and benefits for the SLTC claims specialist position.

2c. Who is responsible for the decision to make tier 3 add-ons "very rare?"

There has never been a decision to make SNF Level III add-ons "very rare". Criteria for the SNF Level III add-on rate are such that most patients do not meet medical necessity criteria based on documentation submitted for review. SNF Level III is intended for patients who require a very high level of care, including extensive and frequent assistance, assistance with administering medications, performing medical treatments, help with all activities of daily living (ADLs), management of daily difficult behavior, intense assistance to redirect and assure the safety of the patients, weight threshold, and major assistance with ADLs for bariatric and specific medical treatment/interventions for wound care. No restrictions exist on the number of authorizations allowed for SNF Level III.

3. How many assisted living facilities have applied for add-on rates for Level II services?

As of November 12, 2024, zero ALFs have applied for ALF Level II services.

3a. How many Level II applicants were approved for Level II add-ons, and how many Level II applicants were approved for Level I?

As of November 12, 2024, zero ALFs have applied for ALF Level II services.

3b. How many were denied for add-ons at all levels, and for what reasons?

As of November 12, 2024, zero ALFs have applied for ALF Level II services.

4. The Department provides grants to community facilities, primarily for training staff to work with patients who have dementia or traumatic brain injury. What other types of grant funding for facilities has the Department implemented?

The Department is implementing a transition grant program that is expected to be available before the end of CY2024. Because this grant program is not yet available, the Department has yet to receive or approve any applications.

Additionally, through the Civil Monetary Penalty (CMP) grant program, SNFs or other organizations that partner with SNFs can apply for funds (up to $5,000 per year) to support training efforts and projects that directly benefit nursing home patients. CMP applications are submitted to the Centers for Medicare and Medicaid Services (CMS) for approval.

4a. How many grant applications has the Department received?

Seven complete CMP applications were submitted during the 2024 CMP cycle. Three grants were for training and would serve 22 SNFs; four were for other projects involving 23 SNFs.

4b. How many have been approved?

CMS approved six CMP applications, and one is pending approval.

4c. How many grants, and how much total funding, has been distributed?

The total funding for the approved CMP grants is $326,918.55 over the next three years. Funds will be distributed once contract processes are complete and awardees submit invoices.

5. The Department indicated that iCare is for “difficult to place” patients. What criteria will be used to assess who is “difficult to place”?

The Department is engaged in preliminary discussions with iCare and has not yet determined specific clinical criteria for placement.

5a. How will those criteria ensure that patients are not sent to iCare if it is an inappropriately restrictive setting for them?

Please see the answer to question five.

6. Could the iCare facility be placed at the Montana State Hospital?

The Department is engaged in preliminary discussions with iCare and has not yet determined the exact location for a facility.

7. How will iCare serve the needs of justice-affiliated patients while providing less restrictive care for other patients?

Based on the exploratory work conducted by the Department of Corrections (DOC) and, more recently, by DPHHS, the Department is confident in iCare's ability to effectively meet the needs of justice-affiliated patients and those who require a less restrictive level of care. Since 2013, iCare has successfully served such patients in a manner that complies with legal, clinical, and health care regulations.