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DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

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DPHHS Response to HB 29 Transition Review Committee Requests for Information

1. What Medicaid waivers are currently available in Montana to support individuals with traumatic brain injury or dementia?

    - *The Big Sky Waiver (BSW) administered through the Senior and Long-Term Care Division (SLTC) is available to support individuals with brain injury or dementia if eligibility criteria are met. To be eligible, the individual must have a need that can only be met by the BSW and must be at risk of institutionalization if the service is not provided.*

    - *The 0208 Comprehensive Waiver for individuals with intellectual and developmental disabilities is administered through the Behavioral Health and Developmental Disabilities Division (BHDD). Waiver services may be available for individuals with traumatic brain injury (TBI) if the brain injury occurs before the age of 18 and other eligibility criteria are met, including Medicaid eligibility, an IQ of around 70 or lower, and risk of institutionalization if the service is not provided.*

    - *The Severe Disabling Mental Illness (SDMI) Waiver administered through BHDD does not specifically exclude individuals with a TBI or dementia diagnosis from evaluation for entry into the program. Still, applicants must have a severe disabling mental illness diagnosis as outlined in ARM 37.90.409.*

2. What are the policies and procedures for approving (or denying) behavioral health Medicaid add-ons for community placements outside a facility?

    The following information pertains to SLTC:

    - *Specific to SLTC, effective October 1, 2024, Level 2 services are available in Assisted Living Facility (ALF) categories A, B, and C. Level 2 services include behavior management support services and an enhanced rate to reimburse facilities for added supports to address patients with disruptive behaviors.*

- *Level 2 services are provided to support patients who reside in an ALF and exhibit adverse behaviors that place the member, staff, or other residents' health and safety at risk. Adverse behaviors are defined as disruptive behaviors related to a medical diagnosis that occur four or more times a week.*

- *When the ALF determines Level 2 services are required for health and safety, it will contact the Case Management Team (CMT) to initiate a discussion regarding the behavioral issues. This discussion will include the member or member's representative. The ALF will provide the CMT with a documented history of discussions between the facility and the member regarding the behaviors in question and what actions have been taken to remedy the situation.*

- *The CMT will determine if the information submitted by the ALF is appropriate for a referral for Level 2 ALF support. The CMT will submit the prior authorization request to DPHHS's contracted Quality Improvement Organization (QIO), which is currently Mountain Pacific Quality Health (MPQH). The QIO will perform a review of the related medical diagnosis, agreed-upon supports to help the patient remedy the adverse behaviors, and other pertinent documentation necessary to support the request. The QIO will contact the patient within five calendar days of referral and other individuals to appropriately assess the patient's condition and need for Level 2 ALF services.*

- *The QIO completes the Level 2 assessment within five calendar days of initial contact with the patient and provides the assessment to the CMT. The CMT will review the assessment by the next business day. Upon approval of the prior authorization request for Level 2 services, the CMT will notify the facility and the patient to coordinate a service plan amendment meeting.*

- *These services will remain in place as long as necessary to ensure the patient's success in mitigating the adverse behaviors. The case is reviewed monthly by the CMT and quarterly by the Regional Program Officer (RPO) to ensure the patient's health and safety needs are met.*

The following information pertains to BHDD:

- *Through the SDMI Waiver, administered through BHDD, there are no specific add-ons; however, there are levels of residential habilitation services with different rates available through the SDMI program, which include:*
    - *Assisted Living Facilities and Adult Foster Homes*

- *Adult Group Homes*
- *Mental Health Group Homes*
- *Intensive Mental Health Group Homes (IMHGH)*

- *The case manager determines which service is most appropriate for the individual. The IMHGH service does require prior authorization from the SDMI program staff, which includes documentation that the individual has:*
  - *a history of repeated unsuccessful placements in less intensive community–based programs, impaired interpersonal or social functioning, impaired occupational functioning, impaired judgment, poor impulse control, or a lack of family, other community, or social supports.*
  - *at least one full year combined of institutionalization within the past three years; and*
  - *exhibited an inability to perform activities of daily living in an appropriate manner due to the member's SDMI diagnosis.*

2a. Are there add-ons available that could help patients receive care at home or in a relative's home?

Services such as private duty nursing and Community First Choice/personal assistance services are available that could help patients receive care at home or in the home of a relative; however, no additional add-on payments are currently available for in-home services.

3. Committee discussion often returns to the idea of pre-placement visits. What would the Department and Montana State Hospital (MSH) require to implement pre-placement visits?

The oft-referenced concept of a" pre-placement visit" derives from a practice that was abandoned after legal review. While not fully understood, the genesis of the "pre-placement visit" concept appears to have derived from a misapplication of the Montana statutes allowing for a conditional release for outpatient care, which could not be provided at MSH. It appears to have also been implemented to address patient occupancy concerns. Inasmuch as a" pre-placement visit" would envision a" trial run" for a placement in a different facility, the practice is prohibited by law.

Montana law currently allows a court to involuntarily commit an individual to MSH when they have been found to be or are at risk of becoming a danger to themself or others. This means the individual needs to be on-premises and under the care and treatment of professionals at MSH until they are deemed safe to return to their community.

To implement a system that includes a conditional release as part of the MSH treatment protocol, the following would need to be addressed:

- *New statutes would need to be introduced to allow for an altered version of conditional release. However, any legislative concept that would seek to introduce a "trial run" placement while a patient is still in the legal custody of MSH would run afoul of federal prohibitions.*
- *Current statutes would need to be updated to include appropriate language to allow for the altered conditional release construct and refer to new statutes.*
- *Criteria for an individual to participate in a conditional release would need to be defined, and the process of working with the courts with a conditional release system would need to be created.*
- *Judges, county attorneys, and the patient's counsel would need to be educated and commit to the process.*
- *At the community level, providers will want a backup plan to address a failed conditional release. Such things that could support providers include:*
  - *Keeping several beds open at MSH designated for those on conditional release.*
  - *Working with facilities in the community, such as hospitals, to help address a backup plan.*
  - *Developing a step-down service located in communities, but it would still be under the Department's direction and the conditional release requirements.*
  - *Further development of community providers' knowledge, skills, and abilities to care for these individuals and address periodic behavior issues to ensure longevity in the community placement.*
  - *The ability to support community providers with services such as ongoing case management, the ability to get one-on-one care for brief periods of time, the ability to access the expertise for addressing issues in the community setting, and other identified supports as needed.*

3a. What are the barriers at the state and federal level?

Please see above.

3b. What other barriers exist?

Please see above.

3c. Is there anything the Legislature or judiciary could do to mitigate custody-related concerns?

In order to respond appropriately, the Department requires clarification of the meaning of the term "custody-related concerns."

4. The committee discussed allowing community providers to evaluate the patient at MSH as an alternative to a pre-placement visit. What would the Department and MSH require of a community provider before the community provider may evaluate a patient at MSH?

    - *MSH would require the community provider to offer the necessary services for the patient. This is typically determined before the patient or POA/Guardian is offered community provider options for selection. Once a selection is made, the community provider is contacted to begin their assessment.*

    - *Evaluation by community providers for admission to their facility is currently happening at MSH. To evaluate patients, providers must collaborate with the POA/Guardianship if applicable. The Department's Complex Care Coordinators and MSH's Director of Social Services currently assist in scheduling community providers to interview a patient for appropriate placement. This provides a positive relationship between the community provider and the patient, which can create a successful discharge plan if the community provider can meet the patient's needs.*

4a. Are there any other requirements before providers may perform these evaluations at MSH?

Regulatory requirements include the patient or POA/Guardian being offered a list of community providers from which to choose. Then the patient or POA/Guardian must sign documents granting authorization for the community provider to meet in person or via teleconference. This authorization allows for the community provider to review confidential medical records and to schedule appointments with the Director of Social Services.

5. The committee is curious about the add-on decision-making process at Mountain Pacific. The committee requests:

    a. a copy of the rubric MPQH uses to evaluate add-on requests.

    - *The criteria for the complex care add-on structure is outlined on page two of the Medicaid Nursing Facility Add-on Application. The application and required documentation are included on pages three and four.*

- *All requests are reviewed by a Registered Nurse (RN) reviewer. Cases are either approved, reduced, or denied.*
- *If the RN determines a case does not meet criteria at the complex care level requested, the case is sent to a physician peer reviewer.*
- *If the physician peer reviewer determines the request meets complex care criteria, the RN denial is overturned, and the case is approved.*
- *If the physician peer reviewer determines the request does not meet the complex care criteria, the request is denied or reduced to a lower level of care. The denial letters include the physician peer reviewer's comments as well as a detailed description of the determination from the RN review.*

b. *specific details about why add-on requests were denied.*

Typical denial reasons include documentation does not meet criteria, no documentation of extreme behaviors, no extraordinary or continuous behavior documented, behavior pattern is not extreme, number of behaviors are not extreme, and only few episodes exist that do not rise to extreme need.

c. *the rate of denials made by MPQH when it reviewed add-on requests.*

Add-on request reviews transitioned to MPQH on June 1, 2023, with SLTC staff reviewing through the end of June 2023 to ensure a smooth transition. Prior to review from MPQH, SLTC staff reviewed add-on requests. The following are MPQH denials as requested:

FY 2024 Total:	Authorized Amount	Approved	Denied	Total Requests	% Denied
Behavior/TBI	$1,126,690.00	70	58	128	45%
Wound Care	$571,015.00	56	10	66	15%
Bariatric	$357,901.30	22	7	29	24%
Medical Complexity	$9,100.00	1	0	1	0%
Total	$2,064,706.30	149	75	224	33%

d. *the rate of denials made by the Department when it reviewed add-on requests.*

FY 2023 Total:	Authorized Amount	Approved	Denied	Total Requests	% Denied
Behavior	$898,050.00	74	77	151	51%

TBI	$77,625.00	7	17	24	71%
Wound Care	$116,520.00	57	9	66	14%
Bariatric	$4,665.80	15	2	17	12%
Total	$1,096,860.80	153	105	258	41%

6. In what ways does the Department work with community supports – facilities, nonprofits, churches and religious organizations, AmeriCorps service programs, and other entities and resources – to support individuals with dementia and traumatic brain injury who are at risk of being committed to the Montana State Hospital?

    - *SLTC works closely with Area Agencies on Aging (AAAs) across Montana to build support groups in their planning and service areas, as well as supporting communities and caregivers through services funded by the Older Americans Act. This limited caregiver funding can provide information and assistance, counseling, respite, public outreach, and supplemental services, such as meals, assistive devices, incontinence supplies, and/or a reasonable request that would make life easier for caregivers.*

    - *SLTC provides and maintains 178 related community resources on a public resource directory. SLTC also helps support trained dementia care navigators in some of the AAAs located around the state.*

    - *STLC administers the Lifespan Respite program. The Lifespan Respite voucher is available to caregivers for up to $700 per calendar year to help cover the costs of respite care. Caregivers can also request up to $150 for items to help entertain, challenge, or ease anxiety. In addition to the voucher, the program can provide additional respite services such as mobile respite retreats and respite food box programs.*

    - *The Department participates in multiple work groups, coalitions, and committees aimed at improving community education and access to care for individuals with Alzheimer's, dementia, and brain injury including Building Our Largest Dementia (BOLD) grant Steering Committee and the Alzheimer's Disease and other Related Dementias (ADRD) Coalition.*

        - *The Department is exploring the development of a transition grant program for long-term care providers. As part of the evaluation process, the Department is considering long-term funding sustainability for a grant program of this nature.*