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Department of Public Health and Human Services

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2016 Montana Big Sky Waiver Renewal (MT 0148)
Home & Community Based Services 1915(b)(4) and (c)

Summary of Comments on Waiver Renewal and Department Responses

The Community Services Bureau (CSB) values the commenters' suggestions, questions and concerns. The CSB received a total of 108 HCBS 1915(c) Waiver comments with 55 through the online comment form, 25 via Email, and 28 from the public hearing. All commenters providing input at the public hearing also provided their comments and suggestions through the online comment form. The public meeting was attended by a total of 41 individuals with 17 attending in-person and 26 via the WebEx telephone conference call.

Two HCBS 1915(b)(4) Waiver comments were received through the online comment form.

HCBS 1915(c) Comments:

Comment: The State received multiple comments regarding the definition of vehicle modification and purchases. Comments included a request to pursue additional language in the vehicle modification service definition that supports the State's ability to approve the modification/adaptation components of a new or used accessible van with assurance that these components costs are completely separate from the cost of the purchase. It is more cost effective and a higher quality of modification if done as part of production rather than after the fact. These costs can be separated out by the provider/dealer.

Response: Vehicle modifications continue to be an allowed service of the waiver for new and used vehicles. The Centers for Medicare and Medicaid Services (CMS) prohibit the partial purchase of an accessible vehicle with separated costs of adaptive components versus the cost of the vehicle for members in the 1915(c) waiver. Based on the number of comments received the State has requested clarification from CMS regarding allowing payment for the cost of modifications that have already been made to a vehicle that is being purchased by a member.
Waiver Renewal 2016 language states "Vehicle modifications are modifications made to a personal vehicle that will allow the member to be more independent. These modifications would be specified in the service plan as necessary to enable the member to more fully integrate into the community and to ensure their health, safety and welfare. These adaptations would not include regularly scheduled upkeep and maintenance of a vehicle. This service does not include adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the member. This service does not include the purchase or lease of a vehicle and/or partial purchase of vehicle already modified." The State will keep this definition for this waiver service pending the clarification from CMS.

Comment: Several comments were received in support of the State's continued maintenance of the Supported Living (AL) services in the waiver renewal.

Response: Supported Living service was previously approved in the State's HCBS 1915(c) waiver and remains as a service in the HCBS 1915(c) waiver renewal.

Comment: Several comments were received regarding Assisted Living/Adult Residential services related to member choice of private rooms in these residential settings. A request for the State to provide direction and information within the service definition and transition plan that guides providers and case management teams in the selection of qualified providers for this service and gives consumers more choice of private settings. Incorporate the feedback from consumers, families and case managers in the determination of "meets setting requirements".

Response: Members will have the choice of a private room in settings that meet the HCBS Settings Regulations. The Montana Statewide Transition Plan (STP) that is being developed and reviewed by CMS addresses the requirement for members to request a single occupancy room if the member choses a single occupancy room. Additionally there are requirements for the member to be involved in the choice of a roommate when shared living is the option chosen by the member. The settings that are deemed in compliance with all of the HCBS settings requirements will be considered qualified providers for these residential services and as such will be able to continue to participate in the Medicaid program. An extensive STP is available for review at http://dphhs.mt.gov/sltc.

Comment: Multiple comments were received with suggestions about the need for services for people who have Traumatic Brain Injury (TBI). They included:

- Please provide equal access for all Montanans to receive specialized residential habilitation while attending brain injury rehabilitation services at the two comprehensive brain injury day treatment programs in Missoula (Bridges) and Billings (Headway).
- Provide funding to facilitate Waiver payment for a short term transitional care slot while receiving comprehensive rehabilitation services at the above locations.
- Provide respite funding for this temporary need of residential supports while receiving specialized brain injury rehabilitation services. This would be a model for providing Montana residents who live in rural areas equal access to intensive and specialized brain injury rehabilitation services. Currently Montanans who live outside of Missoula and Yellowstone Counties do not have the necessary residential supports needed that allows them to attend comprehensive brain injury programs.
- Pay for residential care while members across the state utilize the Bridges program. Develop community-based post-acute residential TBI rehab (the Community Bridges residential program in Missoula closed several years ago due to Waiver being the primary funding source and rates not keeping up with program costs); clarify rules on utilizing Bridges/Headway funding (policy currently allows only day treatment services and case management fees while a member is participating in the program to come out of Bridges/Headway budget).
- Expand services to include Specially Trained Attendant (STA) services (non-medical transportation, specialized medical equipment and respite) which would better utilize funding.

- Allow Waiver to pay for temporary residential placements (i.e., short-term rent or room and board in an Assisted Living Facility (ALF)) while a member is participating in the day treatment program (it is cost prohibitive for members from communities outside Missoula to attend Bridges since they have to pay for lodging while still covering their housing expenses at home).

Response: The current approved 1915(c) waiver provides for services directed specifically at members with TBI. The Residential Habilitation, Supported Living, Supported Employment and other restorative services for TBI members are continuing to be included in the 1915(c) renewal. While there is currently no active provider for the Residential Habilitation service the ability to offer this service and continue to work with Medicaid for the delivery of this service delivery option continues to exist. The State is open to further discussions regarding how to target appropriate services to individuals that have head injuries and TBI's.

Funding was not discontinued for the Bridges and Headways programs. These providers made business decisions about their ability to continue to offer this service under the Medicaid program. Funding for TBI services is not limited to these programs and providers.

Using respite services while a member is in a program similar to Bridges or Headways is not appropriate use of respite services**.**

Comment: One comment requested the State to develop a TBI waiver available through CMS and in place in other states. The commenter strongly encouraged the State to consider this for the future. Until then, we request that you strive to make the best use of state funds by referring people with brain injuries to the resources in this state that are committed and best equipped to meet their specific needs with a dedication to assisting them to maximize independence through a continuum of care. Given the high numbers of Montanans with brain injuries we are very concerned about the low numbers estimated for services such as Supported Living, Supported Employment, and therapies.

Response: The State is not currently considering the addition of a waiver specific to Traumatic Brain Injury but will continue to discuss this and other options for TBI directed services with interested providers.

Comment: Ensure that TBI residents that are living in assisted living facilities or being cared for in the home are receiving care by specially trained caregivers. Please consider the need for well-trained caregivers when working with TBI individuals.

Response: The State agrees that well trained caregivers are a key component to providing quality care to Medicaid members. We will evaluate if there are any specific trainings that would be appropriate for this population and determine how to provide those resources to providers and caregivers that work with TBI residents.

Comment: Several comments were submitted requesting the ability to utilize the HCBS service of non-medical transportation for medical appointments when Medicaid transportation has been denied either due to the member showing inactive in the system (due to lack of receipt or processing of their incurment payment) or when the member loses the ability to maintain a local doctor**.**

Response: Medical Transportation is a State Plan covered service not a benefit of the waiver. Members are required to utilize State Plan services to the extent those services are available to meet their needs.

Comment: Several comments were submitted asking for clarification on the intent/purpose of the quality assurance changes with this renewal including Quality Improvement Projects (QIPs) and the addition of a Financial Accountability standard in the Quality Assurance Review process. Additionally it was questioned why the Regional Program Officer (RPO) has been removed from the QAR process.

Response: Data collection and monitoring of Federal Assurances are required by CMS. Federal Assurances include financial accountability. A QIP is a process where the Case Management Teams (CMTs) are expected to be in control of a portion of the quality assurance process.

The description of each CMT's quality control system was a significant portion of the required response to the most recent Request for Proposal (RFP) when the State selected CMTs to provide services to HCBS Waiver members. The State believes the QIP process is similar to the description of quality control systems provided by CMTs in their responses to the RFP.

Contracts between the State and CMTs stemming from the RFP process include section 22 that requires the CMT to cooperate with the State including audit, inspection or other investigative purposes. The contract also includes section 25 involving performance assessments and corrective actions. This section states that a CMT is considered to have failed to perform by refusal or failure to participate in any aspect of a site visit, quality assurance review, audit, corrective action or investigation. The State does not believe the QIP process is shifting quality improvement activities from the State to CMTs.

The State has provided an updated policy manual section describing the QIP process and also provided training via a WebEx meeting in January 2016 to CMTs explaining the expectations of CMTs in the quality assurance procedures.

The quality assurance process will be conducted by a CSB designee including both Central Office staff and/or RPOs. The process has not eliminated the involvement of RPOs.

Comment: Comments were received around developing a mechanism for CMTs to be compensated for oversight requirement of waitlist activities

Response: Services provided under the category of case management are only billable once a member is Medicaid eligible and enters a waiver placement. Case management service has always included the responsibility of oversight of the waiver waitlist of potential members seeking to access the waiver. While under other programs such as the Money Follows the Person (MFP) grant there are demonstration services that provide funding for pre-transition activities and a Regional Transition Coordinator role, at this time there is not enough information available from the MFP grant for the State to scope the parameters of this service, determine if this is a valuable services and determine the appropriate reimbursement for this service if it is to be included in the 1915(c) waiver. Through the remaining months of the MFP grant, which will end in 2019, the State will have the opportunity to continue to evaluate pre-transition services and the Regional Transition Coordinator role in order to determine if these services are valuable and can be sustained within the waiver budget. If it is determined that

this type of pre-placement activity is a viable service we will evaluate if this can be added through the waiver amendment

Comment: Multiple comments were submitted requesting the waiver renewal to include the addition of MFP demonstration services such as Regional Transition Coordinator, community transition, goods and services to include first month's rent and information technology.

Response: The 1915(c) waiver includes services for community transition, environmental accessibility adaptations and specialized medical equipment which provides the necessary services for members entering the Waiver program. Money Follows the Person (MFP) demonstration services are being piloted through a grant to determine whether these services can be sustained. At this time, there is not enough information available from the MFP grant for the State to scope the parameters of this service, determine if this is a valuable service and determine the appropriate reimbursement rate for these services should they be added to the waiver renewal. Through the remaining months of the MFP grant, which will end in 2019, the State will have the opportunity to continue to evaluate pre-transition services and the Regional Transition Coordinator role in order to determine if these services are valuable and can be sustained within the waiver budget. If it is determined that this type of pre-placement activity is a viable service, the State will evaluate if this can be added through the waiver amendment process. Payment of board and room is prohibited by CMS for individuals in the waiver and is currently only available in the form of first month's rent or deposit in the MFP grant.

Comment: Several comments were received addressing a CMT rate increase to ensure shared services remain consistent across SLTC and AMDD**.**

Response: The rate structure and fees for HCBS waivers in the Senior and Long Term Care Division and the Addictive and Mental Disorders Division are consistent and the same to the extent the services being delivered are similar or the same. In areas where the requirements for the service delivery are different, or there are additional or differing services approved as part of the waiver package, there are differences in the reimbursement structure. The requirements for case management services are different between these two waivers and the Department has created different rate structures to reimburse for those differences. At the time the SDMI waiver was approved the requirements for case management services were different than those included in the SLTC waiver. Those rate structure differences have been maintained due to the ongoing differences in these requirements for case management under these two distinct waivers. Case management rates are adjusted with the funding that is provided by the Legislature in the form of provider rate increases, as are other HCBS services.

Comment: The waiver rate determination methods (pages 166-167) stated in the renewal state that: Rates will be "sufficient to enlist enough providers". The staffing shortage for CFC/PAS and the decreasing number of ALF's accepting Medicaid don't support this rate methodology and there is no discussion or support indicated for a rate increase in coming years. HCBS case management assesses consumer need for services and authorizes appropriate hours/services to meet these needs. Waiver hours often cannot be covered due to staffing shortages of PCA's and appropriate assisted living providers become increasingly difficult to identify or they have reduced the number of waiver consumers they will serve, if at all. These issues have multiple factors, but rate would seem to be the most identifiable as needing restructured. There is also a lack of specialized services within the state to meet the

needs of consumers with TBI, Alzheimer's, significant physical needs and other specialized needs.

Response: The rate that is being reimbursed for HCBS waiver services has been determined to be adequate to maintain and attract new providers enrolling to deliver services under the HCBS waiver program and to maintain access to waiver services statewide for Medicaid members. Provider enrollment continues to grow in the HCBS waiver program. Provider rate increases are distributed when appropriated by the Montana Legislature and support increases to reimbursement rates for providers under Medicaid for increases in cost of delivering services. The State will continue to monitor the availability of providers and the number of new providers enrolling to provide waiver services in order to maintain access to waiver services by eligible members. Additionally, Senate Bill 216 passed in the 2015 Legislative session requires the State to develop a process for gathering cost information from providers of personal assistance or attendant services or supports, inclusive of the home and community based services waiver program. While the process for gathering this information is not yet in place, once the process is established, this data may be helpful in assisting the State in determining cost for delivery of services in the HCBS waiver program as well as other attendant service programs.

Comment: It is important to consider an increase to reimbursement rates for personal care attendants. The waiver renewal speaks of payment reimbursement being based on "efficiency, economy and quality of care" to enlist providers but this same assurance is not filtering down to hands-on caregivers caring for physically disabled and elderly populations. As case managers we are hearing more often than not that providers do not have enough workers to provide quality care to our members; moreover, those caregivers who do offer quality care are not getting paid enough to experience the recognition that should come with their compassionate and caring performance and their longevity in the caregiving field.

Response: To address the concerns related to the direct care workers Montana has provided funding for direct care wage increases and funding for health insurance under our Health Care for Health Care Workers program for many years. These initiatives are targeted at addressing this lower paid direct care work force and were implemented to provide sustainability to this important workforce and to address high turnover rates. These funds are specifically targeted at the providers that provide these funds directly to their direct care staff. Rates were also adjusted for Personal Assistance and Community First Choice (CFC) providers when the new state plan was approved for CFC in Montana. These adjustments in provider rates were specifically provided to incentivize the increased level of work that was being required for the person centered planning process and other requirements being implemented through the CFC program.

Comment: Reimbursement rate increases for case management daily rate should be made. The expectations and responsibilities placed on the contract agencies and case managers have grown exponentially while the daily rate has not increased accordingly. More reports, quality assurances, higher caseloads and combined efforts between waiver entities and providers have climbed without any positive correlation to case management fees. The negative effect trickles down to lower wages or wages not increasing at a rate that keeps up with other jobs available to the same professionals being hired as case managers. This in turn creates decreased efficiency and lower quality of care provided to waiver members.

Response: This comment is not specifically addressed at the waiver renewal. Case management rates have been adjusted with the funding appropriated by the Montana Legislature for the current rate year, as well as being adjusted with the new requirements for case management providers under the implementation of the new Community First Choice State Plan option. The State believes that it has compensated for new requirements with appropriate reimbursement increases for case management services.

Comment: The State should develop adult foster care service (this is needed in anticipation of having to relocate members from assisted living facilities that do not come into compliance with the transition plan) and allow foster families to be paid for time off.

Response: The State will include, through the Statewide Transition Plan that is required under the HCBS Setting regulations, a process for settings to remediate areas of non-compliance with the setting regulations. To the extent that there are settings that can no longer meet these requirements there is a process established for member transitions to appropriate settings, that the member chooses, that are in compliance with the settings requirements. The settings that are deemed in compliance with all of the HCBS settings requirements will be considered qualified providers for these residential services and as such will be able to continue to participate in the Medicaid program. An extensive STP is available for review at http://dphhs.mt.gov/sltc .

Comment: The State should devise more accurate system of reporting monthly utilization since CMTs are reliant on providers to accurately report numbers and data out of MMIS can be up to a year behind.

Response: The Community Services Bureau **(**CSB) is open to suggestions on alternative processes, or ways to incentivize providers to provide accurate information to the Case Management Team (CMT). This data is used by CMT's and CSB staff to make decisions about the HCBS program. This is one set of data that is available to determine utilization of services and approximate how much of the authorized budget is being utilized in service delivery during various points in the year.

Comment: A comment was submitted asking for changes to the case management service definition. The commenter requested the following additional duties be added to the current definition:

- Facilitate person centered planning process and completion of necessary forms as required by CFC program.
- Submit mandatory serious occurrence reports by required deadlines in QAMS.
- Participate in quality assurance reviews and follow up on quality assurance communication.

Response: The CSB believes that the current waiver language in the definition of Case Management includes the level of detail necessary to describe this service adequately. The current definition includes assisting members in gaining access to HCBS and other State Plan services, as needed, ensuring health and safety and monitoring the implementation of the service plan for quality assurance. Additionally, the expectations of CMT's are included in the contract between the CMT's and the State. The State is always interested in finding ways to

deliver services in the most economical and efficient manner possible and would look at ways that could eliminate administrative burden without compromising the program requirements.

Comment: Several comments were received requesting the waiver allow homemaker and respite services to be self-directed by the member. Commenters cited the same direct care worker or workers who provide State Plan services also provide some or all of the homemaker services, which can occur during the same shift. It was stated that it was impossible for the member, the direct care worker and the self-directed provider agency to handle homemaker services in a truly agency-based fashion when the member has hired the employee and is directing all other aspects of the services. It was noted that agency-based providers often struggle to provide consistent services in rural areas due to limited workers in these isolated areas. With regard to respite services it was noted that these services are not an entirely different set of services just the same services provided by a different caregiver. The commenter stated there is no practical reason this type of respite cannot be handled through the self-directed model.

Response: Self direction is provided for in the State Plan services of Personal Assistance and Community First Choice, as well as in extended State Plan under the 1915(c) waiver. The services of homemaker and respite are not State Plan services or extensions of State Plan services under the waiver. The ability to manage and direct these two services exists under the Big Sky Bonanza Option in the waiver, where the entire service package is managed by the member. The State will continue the discussion around how these two services could be self-directed under the waiver as well as how the reimbursement for these services would be calculated if they were included. Self-directed services typically have a different reimbursement structure that would need to be addressed if these waiver services were to be added to the menu of services that could be self-directed.

Comment: There are situations that arise when a member may require an emergency stay at an assisted living facility for a short amount of time but live alone and do not have a primary unpaid caregiver to relieve through respite services. This typically leaves them in a situation where they may require to be admitted in a nursing home facility, which at times can be traumatic for them or not appropriate. It was suggested a service added to the waiver for a member in an urgent situation that needs services in an assisted living facility for a short-time to maintain their independence and quality of life under a "respite" type service.

Response: This is a difficult situation as the waiver is not allowed to pay for room and board under Medicaid and this situation does not meet the criteria for reimbursing this stay under the definition of a respite service. The State will continue to address these difficult situations on a case by case basis when they occur.

Comment: One comment was received asking the State to allow for the purchase of and training for companion animals under specialized medical equipment**.**

Response: The State recognizes that companion animals are important to many individuals. However the State is not at this time planning to include companion animal in the waiver as a covered waiver service.

Comment: The waiver PERS service includes a statement that “if State Plan PERS does not meet the individual needs” then the waiver PERS service can be provided. The CMT assesses the needs and recommends waiver PERS when State Plan does not meet this need

for mobility, travel and purchase of equipment for individual reasons. It appears that this assessment ability is becoming more restricted for some individuals and their choice of providers is limited to what is available under State Plan**.**

Response: Montana was the fourth state in the nation to have approved a Community First Choice (CFC) State Plan. As a requirement of CFC, Personal Emergency Response Systems (PERS) are a benefit of the State Plan. As with all State Plan services they must be used prior to utilizing services under the waiver, if they are appropriate to meet the needs of the individuals. There is very little difference of available PERS providers between waiver and CFC. Waiver can still be an option for individuals that are not appropriate to receive PERS under CFC.

Comment: It has been more difficult for members to obtain specialized equipment that benefits them. Even when a professional such as a Speech Therapist, physician, OT or PT recommends a certain item for health and safety that is not covered by Medicaid/Medicare, if that item costs over the set limit the process for getting it approved by the State CSB is difficult even if the CMT's budget allows for the purchase. These items do not have to be the cheapest, lowest quality item that is only provided or allowed by Medicaid.

Response: The State is not limiting access to medically necessary specialized equipment or services. The State is however requiring that a determination is made that State Plan services are considered to meet the needs of individuals prior to utilizing waiver services to fund these items. Additionally, the criteria is that if a service is covered by Medicaid and there is a fee schedule established for that service, that this fee should be utilized in determining the amount that Medicaid would pay for this item and service under the waiver. Reimbursement for these services at a Medicaid rate or under the State Plan is no indication that the item is inferior or cheaper but insures that the State is being a good steward of the Medicaid dollars and providing services in the most cost effective and efficient manner possible to meet member needs.

Comment: Remove the requirement per HCBS 899-11 to add ICD codes for secondary diagnoses on the service plan.

Response: Current policy does not require entering a secondary diagnoses code but does require an ICD-10 code for billing purposes as required by federal regulations.

Comment: A commenter requested that the State institute an ongoing focus group at the state level composed of members and stakeholders to advise CSB on members' priorities and satisfaction of services, philosophical awareness and identification of system wide issues along with ways to address these issues. Issues include statewide caregiver shortages, CFC coordinated visits, rate issues for waiver service providers, lack of quality waiver providers and/or alternative ways to access needed member services and communication among all waiver entities.

Response: Several public processes already exist where providers, members and stakeholders are provided the opportunity to provide information and feedback on the programs offered by the State. Some ways that the CSB solicits information are through annual member satisfaction surveys that are part of the responsibility of the CMT under the waiver. CMTs in turn report the findings of this survey to CSB in the Quality Assurance Review process. Additionally, member interviews continue to be a valuable part of the review

process and are conducted by CSB staff. During the state HCBS conference, CSB develops a questionnaire that is distributed to members by a third party entity. The third party entity then gathers and summarizes the information and provides CSB with this information. Ongoing discussions via in person meetings and WebEx discussions occur throughout the year to focus on many of the areas suggested in the comments. The State is always open to comment and discussion with providers, members and stakeholders and will continue those processes.

Comment: Several comments were focused on the policies that have been updated within the waiver over the last year. These changes in policies seem to lead to less choice for the member and more focus on financial accountability. Choice of providers and services have always been a focal point of the waiver, but this has become limited with changes which require two bids for equipment or home modifications and also require the member to go with the lower bid, even if the product is sub-standard or they do not like dealing with that particular provider.

Response: The State is not limiting access to medically necessary specialized equipment or home modification services or limiting member choice of qualified providers. The State is however requiring that a determination be made that a State Plan service is considered to meet the needs of individuals prior to utilizing waiver services to fund these items. Additionally the criteria is that if a service is covered by Medicaid and there is a fee schedule established for that service that this fee should be utilized in determining the amount that Medicaid would pay for this item and service under the waiver. Requesting two bids for projects that are over $5,000 is not an unreasonable request as many of these projects consist of home modifications that are very expensive and would require a level of expertise to deliver that should be considered through soliciting a bid for the project. Reimbursement for these services at a Medicaid rate or through a lowest reasonable bid process is no indication that the lowest bid is somehow sub-standard. The State has provided a process where the lowest bid is not required to be selected if the other bids received are within a reasonable dollar threshold or if there is some extenuating circumstance that a specific provider is more appropriate for the member. The State is being a good steward of the Medicaid dollars and providing services in the most cost effective and efficient manner possible to meet member needs.

Comment: The program has always been consumer driven. The hallmark has been consumer choice and creative problem solving. The commenter would like to see individuality kept or focused on in the waiver to ensure the waiver does not become a “one size fits all”. Also to allow case managers the ability to adapt the Service Plan to meet the cultural, regional, religious and personal preferences of the person being served. The commenter feels that consumer choice is no longer on the forefront as it once was and consumers have lost their choice on many different levels.

Response: The program continues to be a member driven program with focus on a person centered planning process in the development and delivery of services to each member. There are no changes being proposed in the waiver renewal that would limit member choice or lessen the focus on the member being involved in making decisions about their services under the waiver program. Case managers are charged with making sure that the waiver plan that is developed with the member is truly being developed with member input and feedback. Additionally while members are the focus of the program, these are Medicaid

funded services and the State is also charged with utilizing these finite dollars in the most effective manner to provide services to the most members possible under the waiver program.

Comment: Several comments were received regarding the process for pass-through expenditures. It was suggested to add language allowing pass-through expenditures in a similar way as the BSB option through a limited fiscal agent. This could either be the case management entity or a fiscal agent identified by the State. Commenters felt this would allow increased consumer direction of these services, access to non-Medicaid providers for alternative services, use of the internet and non DME providers for certain equipment and supplements. It would be more cost effective than the mark up through DME providers and offer increased consumer choice for services that are approvable waiver-only services. The base of consumers for non-traditional and alternative waiver services is not usually sufficient for providers to want to pursue the lengthy process to become a Medicaid provider and they do not typically have billing staff to complete the process.

Response: Pass through is not a service option under the waiver. Services of the waiver program may only be provided by a provider that is enrolled as a Medicaid provider. The Administrative Rule of Montana at ARM 37.40.1407 provides that in "rare instances", a provider with whom the department is contracting for home and community based case management may bill the Medicaid program for a pass through. The use of the pass through process has been scrutinized recently and the State is making great efforts to solicit providers to enroll directly with the Medicaid program to reduce the use of the pass through process. The Medicaid provider enrollment process ensures that providers are eligible in accordance with debarment lists and background checks to be a Medicaid approved provider. The pass through process is currently utilized for instances when all other payment alternatives have been exhausted or access to a service for a member would be difficult without this process being utilized. Medicaid waiver is the payer of last resort and eliminating automatic pass through focuses case management teams on making sure all other payment sources are eliminated prior to requesting a pass through.

Comment: As the primary provider of the Big Sky Bonanza (BSB) option, we feel this service is highly under-utilized. In order to increase selection of the BSB option among members, we would advocate for increased awareness of and promotion for this more advanced form of self-direction**.**

Response: The CSB has made efforts to inform members about the benefits of the BSB option, and will continue to work with this commenter on ways to encourage more members to understand the benefits from this program option.

Comment: Experience tells us that direct care workers are often an under-utilized resource that can help produce positive outcomes in all aspects of each member's health, not just the daily living activities traditionally associated with home and community-based services. We believe direct care workers could be especially effective in helping to improve the health of members who have chronic conditions such as COPD, diabetes and mental health issues, many of whom received waiver services. In addition to improving health, direct care workers are a valuable untapped resource that could help reduce Medicaid expenditures for primary and acute care services to high cost members with chronic conditions. We ask that the State continue to look for ways to incorporate a broader role for direct care workers in helping to influence the overall health of members served through the waiver and other in-home services

such as State Plan Personal Assistance. We would ask DPHHS to consider ways in which direct care workers who work with the member in their home can be accessed to better coordinate a broader definition of medical care in order to ensure members living at home are as healthy and happy as possible.

Response: The State agrees with the commenter that direct care workers are valuable team members for service delivery to members in the waiver program. These workers become involved with not only the day to day services for our individuals but also become an asset to the member they serve as they become more and more familiar with the member and their individual strengths and needs. The State is open to feedback on how we can continue to support this valuable work force. As previously stated we do provide funding in the form of direct care worker wages and Health Insurance for Health Care Workers as opportunities to maintain and sustain the turnover of this hands-on work force.

Comment: A commenter stated they appreciated the adoption of the CFC option for Medicaid service delivery and believed that Person Centered Planning (PCP) is one of the most valuable components of this delivery option. They promote PCP whenever possible across programs, and appreciate the ways this initiative has already impacted service delivery for members. This method of service planning and provision has already helped ensure that case managers, other providers, and state partners are present and engaged in the member's care and in the room at the same time. Additionally, the inclusion of PCP values across both State Plan and Waiver PAS enables members to experience State Plan and Waiver PAS in the same coordinated way. Finally, the inclusion of CFC and PCP principles in the Waiver ensure that professionals interacting with the member to provide care are trained and versed in PCP principles, which furthers the coordinated and tailored care experience for members.

Response: The State CSB agrees with commenter that the PCP process is one of the most valuable components of the State's delivery of waiver and State Plan services. This process focuses on the individual receiving services and puts them in the driver's seat on how the services they receive should be delivered. CSB will continue to research, develop, support and provide ongoing training to case management teams and other waiver providers in the PCP processes.

Comment: The role of Regional Program Officer (RPO) should be kept in the Quality Assurance Process. The RPO is vital link with CMTs. Commenter recommends continuing to support and build the regionally developed networks, services, authorizations and connections with the RPO. It builds local networks and enhances timeliness of communication and services for consumers.

Response: RPOs are a very valuable asset to CMTs, providers and CSB. CSB relies on RPOs to be the liaison between CSB and entities that are providing HCBS services. RPOs continue to be a part of the Quality Assurance Process in conjunction with other CSB staff. CSB will continue to utilize RPOs as the direct contact between CMTs, other HCBS providers and CSB.

Comment: The focus of the program should be on the quality of service to the member.

Response: The State agrees that the quality of the services being delivered under the waiver to members is very important. To ensure that the services being delivered are of quality,

annually there is a member survey that solicits feedback on members experience with the waiver program.

Comment: A commenter suggested to improve service delivery by providing more training to direct care workers in the personal assistance or assisted living agencies on methods of providing quality personal assistance. It was also suggested to provide direct care workers with incentives through bonus pay for delivery of quality service.

Response: The State will take under consideration this comment and looks forward to feedback on ways to incentivize training for the work force on quality care. As previously stated we do provide funding in the form of direct care worker wages and Health Insurance for Health Care Workers as opportunities to maintain and sustain the turnover of this hands-on work force.

Comment: Another suggestion to improve service delivery was to have one unit at the Office of Public Assistance (OPA) dedicated to HCBS Waiver eligibility.

Response: In recent discussions with OPA regarding HCBS waiver eligibility issues, it has been determined that HCBS Waiver eligibility will be managed by a specialized Long Term Care OPA unit in the future. We are unsure when this transition will take place, and once we are made aware of the timing of this change we will communicate this information to the CMTs and other waiver providers.

Comment: Consumer participation, input and involvement in the creation and ongoing provision of HCBS waiver services has been a longstanding premise of this program. A memo dated February 4, 2016 addressed to members, providers and stakeholders announced the renewal process for this waiver and the avenues available to provide public comment to the Department. It appears this memo was not individually mailed to HCBS waiver consumers, legal representatives, guardians or other interested family members of HCBS waiver consumers. Placing the notification on the DPHHS website does not meet the notification standard or needs of these consumers. Many do not have access to technology or no ability to use, and even if they did, how would they know that this information had been posted? HCBS Case Management Teams (CMTs) could have helped to facilitate this notification if they had been directed to by the Department. HCBS CMTs have historically assisted with facilitation of this notification process and assisting consumers to understand the process and their opportunities for input. Why was the decision made to not directly notify consumers and allow this opportunity for input and feedback?

Response: The State values member input and we solicit this input in various ways. Information regarding the waiver renewal has been published in the newspaper, posted on the Department web site, distributed in the form of a tribal notice and through direct mailings to providers, case managers, field staff and varied stakeholders. Additionally, we have held a public meeting to solicit feedback on the waiver renewal. Any and all of these entities are free to share with any interested party, including members, that would be interested in the waiver renewal process this information. Additionally case managers and provider entities and advocacy groups are free to help any of these members in providing questions to the Department on the waiver renewal or the process. Through the HCBS Settings public process the State has provided numerous mail outs that have included all members in the Waiver program. To date there have been few if any members that have provided comments

or participated in that process. The waiver renewal information is posted in the same area of the web site that members have been directed to for information on the HCBS Settings Transition process. To the extent members are utilizing the web site for information; they have been provided the direction on how to access the waiver renewal documents as well.

Comment: The State received one recommendation that the State conduct a waiver program assessment with feedback from consumers, providers and stakeholders, to identify how program structures and policies affect members and their ability to self-direct.

Response: The State continually looks for feedback on how they can improve on and deliver services more effectively. We will take this suggestion into consideration on how to better address self-direction for members.

Comment: One commenter suggested the State consider ways of decreasing the amount of paperwork while meeting reporting standards.

Response: The States agrees that procedures to complete the requirements of the program should be managed through an electronic function whenever possible. Avoiding unnecessary paperwork will be cost effective and save time to focus on delivering quality services to waiver members.

Comment: One commenter supports the State's effort to have members reside in a safe place through the implementation of the State's HCBS Transition Plan.

Response: The State appreciates the support of the efforts to provide members with a safe place to reside. The State will continue to rely on input from stakeholders, members and other interested parties as the State Transition Plan is developed.

Comment: One commenter mentioned the value of the HELP Medicaid Expansion in Montana.

Response: The State agrees that the expansion of Medicaid in Montana through the recently implemented Health and Economic Livelihood Partnership (HELP) Plan is a valuable benefit for thousands of Montanans in need of health care coverage.

HCBS 1915(b)(4) Comments:

Comment: The case management waiver language indicates that this service provides both transitional and ongoing case management. The work around provision of transitional case management remains largely unfunded and continues to increase as a work load for case management. Recommend SLTC look at adding a transitional coordination rate, as done in the Money Follows the Person grant program, or allow adequate billing of the case management per diem rate to reflect the work completed for transitions/admits.

Response: Services provided under case management are only able to bill once a member is Medicaid eligible and enters a waiver placement. While under the Money Follows the Person (MFP) grant there are demonstration services that provide funding for pre-transition activities, at this time there is not enough information available from this grant in order to scope the parameters of this service and determine if this is a valuable services to add to the

waiver. Through the MFP Grant we will have the opportunity to continue to evaluate pre-transition services and assess the reimbursement process to determine if pre-transition services and the regional transition coordinator role can be sustained within the waiver budget. If it is determined that this type of pre-placement service is a necessary and viable service we will evaluate if this can be added through the waiver amendment process, and at that time the State will develop a reimbursement strategy and definition for this service.

Comment: The waiver language, as it predicts case management expenses for the next five years of waiver approval, indicates no provider rate increase for FY18-21. For providers struggling to meet the requirements, cost increases and staffing needs when increased costs are higher than the 1.9% provider rate increase of this last biennium, the prediction for no rate increases is difficult to understand. Why would there be a prediction of no increase?

Response: Funding for the HCBS waiver, and for any Medicaid program offered by the State, is determined by the Montana Legislature who meets every two years. The State has no ability to determine that there will be an automatic provider rate increase that will be appropriated by the Legislature, or an increase in waiver capacity, and as such we will not put into the waiver renewal any expectation that provider rates for any services will be increased and by what percentage these rate increases will be approved.