Intellectual and Developmental Disabilities (I/DD) Alternative Settings

Supplemental Report

Delivered to: Montana Department of Public Health and Human Services (DPHHS)

Prepared for: House Bill 872 Behavioral Health System for Future Generations (BHSFG) Commission

Delivered by: Guidehouse

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Acronym List

ADL	Activities of Daily Living
AMI	Area Median Income
ASD	Autism Spectrum Disorder
BHSFG	Behavioral Health System for Future Generations
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicaid and Medicare Services
CoC	Continuum of Care
CSS	Center for START Services
DDP	Developmental Disabilities Program
DPHHS	Department of Public Health and Human Services
ED	Emergency Department
HB	House Bill
HCBS	Home- and Community- Based Services
HCV	Housing Choice Voucher
HSS	Home Support Services
HUD	Department of Housing and Urban Development
IADL	Instrumental Activities of Daily Living
I/DD	Intellectual and Development Disabilities
IBC	Intensive Behavior Center
ICF	Intermediate Care Facility
LIHTC	Low-Income Housing Tax Credit
MDC	Montana Developmental Center
MHP	Montana State Highway Patrol
MICRS	Management Information and Cost Recovery System Medicaid Management Information System
MMIS	Medicaid Management and Information Systems
MSH	Montana State Hospital
NCSS	National Center for START Services
NED	Non-elderly Disabled
PHA	Public Housing Authority
PRTFs	Psychiatric Residential Treatment Facilities
QAP	Qualified Allocation Plan
SFY	State Fiscal Year
SPV	Special Purpose Voucher
START	Systemic, Therapeutic, Assessment, Resources, and Treatment
TFC	Therapeutic Foster Care

Section 1: Executive Summary

Montana Intellectual and Developmental Disabilities (I/DD) Recommendations

Governor Greg Gianforte signed House Bill (HB) 872 into law on May 2, 2023, to establish the Behavioral Health System for Future Generations (BHSFG) Commission to make recommendations to the Governor. As part of the BHSFG Commission, the Department of Public Health and Human Services (DPHHS) retained Guidehouse ("study team" or "team") to conduct a design study of alternative behavioral and intellectual/developmental disabilities (I/DD) healthcare settings beyond existing state-run facilities. DPHHS charged the I/DD study team to identify and make recommendations to improve access to I/DD services and care provided by appropriate settings based on clinical needs and best practices.

This report summarizes the findings and recommendations of the I/DD Alternative Settings Design Study and is a supplement to the Behavioral Health Alternative Settings Report provided to DPHHS and the BHSFG Commission. This report contains design details for new components of the care continuum to strengthen a "whole continuum" approach. The recommendations also support transitions of care to the least restrictive setting of care possible, reflecting the spirit of the *Olmstead* Rule. Additionally, the report provides considerations for advancing affordable housing through public and private partnerships to maximize home and community-based services (HCBS) and avoid use of clinical settings for housing needs.

These recommendations presented to the BHSFG Commission exist alongside broader recommendations generated via Commission processes, meetings, stakeholder engagement, and public comments. **The recommendations are subject to the review and approval of the Commission and Governor Gianforte and do not guarantee funding or implementation.**

Key Recommendations

Table 1 includes a summary of key recommendations.

Table 1. Key Recommendations

Summary of Recommendations	
1.	**Pilot a Systemic, Therapeutic, Assessment, Resources, and Treatment (START) program** in a targeted geographic area of the State with the intention of expanding statewide. Launching a pilot START program would aid in providing gradual and thoughtful direction for planning and implementation of an expanded START program, upon successful pilot results.
2.	Pursue opportunities to partner with a vendor to **provide intensive on-site provider supports, such as updated diagnostic, medication, and functional behavior assessments, staff coaching, and other wraparound services,** to improve the continuum of care for individuals with I/DD served in the community. These supports are especially important in cases where the family, providers, and/or caregivers are supporting an individual with complex needs or a dual diagnosis.
3.	Transition to a **revised standardized assessment tool** and **consider the feasibility of a rate structure adjusted by individual resource need**, with the policy goal of aligning reimbursement more closely with actual support requirements, and better incentivizing providers to serve individuals with more resource-intensive needs.
4.	Develop a **waitlist management system** that offers the most appropriate waiver type **based on a person's identified need(s)**. Under a restructured waitlist management system, individuals could first be screened using a model to help assess the urgency of need for the individual.
5.	Explore current and future options to **enhance and/or advance State-funded transition grant opportunities** to improve the placement of individuals in community-based services.
6.	**Relocate the Intensive Behavior Center** from Boulder to a new setting located within a proximate, larger population center. Potential population centers for the new location include, but are not limited to Butte and Helena, allowing existing employees the opportunity to continue providing critical services and reducing the State's reliance on contract workers and travelers.
7.	**Restructure reimbursement options for Children's residential services** to improve access and consider additional in-home support services for children with I/DD, like Home Support Services (HSS) and Therapeutic Foster Care.

Section 2: Background

The Need for Enhancements to the I/DD Continuum of Care

Montanans with I/DD service needs currently receive services in both community-based care and institutional settings. While quality improvements have occurred to both sides of what could be seen as a dichotomous continuum of care, limits exist in the current service structure. Institutional settings are traditionally restrictive with less of a focus on community integration and community services and lack the provisions to provide adequate care to individuals with I/DD and acute behavioral health needs. Additionally, individuals with I/DD who receive treatment at Montana State Hospital (MSH), or the Intensive Behavior Center (IBC) are not receiving services and supports in the least restrictive setting. When services are received in a community setting, they sometimes lack a level of care to advance treatment in an appropriate manner, especially during behavioral health crisis events. By engaging in this study, Montana intends to identify where improvements to service provision exist for individuals with I/DD, maintaining focus on least restrictive settings and needed safety and clinical supports within an appropriate geographic and, where possible, community setting.

As of March 2024, individuals with I/DD receive services and supports from the IBC, and a number of individuals diagnosed with I/DD receive treatment at MSH.[1] While DPHHS has a 0208 Comprehensive Waiver that provides extensive behavioral health services, the community-based system has not kept up with behavioral health demands. In turn, MSH and the IBC struggle to arrange for appropriate, community-based service provision that allows for individual care in their respective communities. There are 2,139 individuals on the waitlist for 0208 Comprehensive Waiver services that have Medicaid claims utilization. The eligibility requirements have remained constant but funding limitations for the 0208 Comprehensive Waiver have created challenges for DPHHS moving individuals into waiver services.

There is a need for more flexibility in the I/DD continuum of care to address existing gaps in services for individuals with short and long-term intensive needs. With Montana's commitment to advancing systems that promote high-quality care in the least restrictive settings, it is possible to develop and enhance high-quality, comprehensive services in modern, person-centered settings to support Montanans with I/DD, including those with intensive care needs. These services must exist within a broader care continuum that is committed to promoting community-embedded settings wherever possible.

Throughout the study, the study team engaged DPHHS leadership, and an I/DD Subcommittee comprised of individuals with expertise to confirm the unique challenges facing individuals with I/DD and explore viable solutions. In conjunction with the Behavioral Health Alternative Settings project, and as further outlined in Section 3 of this report, the study team engaged stakeholders and experts across the State to explore solutions to improve the setting of care for individuals with I/DD.

[1] Data obtained from State of Montana's Management Information and Cost Recovery System (MICRS), September 2023.

Guiding Principles

The study team, DPHHS leads, and the I/DD Subcommittee agreed upon a set of guiding principles to direct collaboration and decision-making, and to form recommendations. The continued goal of the guiding principles is to outline the components of a modernized system that offers high quality and comprehensive services and supports for Montanans with I/DD, addresses known gaps in the I/DD continuum of care and reduces dependency on the IBC and other more restrictive settings of care.

The study team used the following guiding principles to frame inputs and recommendations:

- **Improvement of Care:** Improve access and quality of care for individuals with I/DD based on their clinical and functional needs in the least restrictive setting.
- **Modernized System:** Create a system that addresses the Quadruple Aim: improves physical and behavioral health, reduces avoidable cost of care, enhances the individual's experience, and improves provider satisfaction (see Figure 1).
- **Sustainable Model:** Explore viable and successful care models from across the nation through best-practice research that requires collaboration across community leaders, partners, and sponsors considering ease of access for individuals, workforce availability, and resource management.
- **Stakeholder Inclusion:** Inform recommendations with subject matter expert feedback and involvement from providers, parents, individuals with lived experience, organization leaders, and other community leads.
- **Risk Management:** Plan for risks and address immediate challenges within the I/DD system, while considering the future.
- **Data-Driven Decisions:** Use data where available to create recommendations based on fact.

Figure 1. Quadruple Aim of Modernized Acute and Sub-Acute Behavioral Healthcare System

Section 3: Study Approach and Stakeholder Engagement

Study Approach

The study team engaged in three key activities to develop the I/DD Alternative Settings Report: stakeholder engagement, quantitative data analysis, and qualitative research. The study team provided DPHHS material for review, input, and insights through weekly meetings held with DPHHS executive staff.

The culminating objective of these efforts was to gain a strong understanding of the I/DD system in Montana, highlighting current challenges and opportunities. This section outlines the key activities that contributed to the information base for all presented findings and subsequent recommendations for Montana's I/DD service delivery system.

Stakeholder Engagement

The study team conducted extensive stakeholder engagement, from December 2023 through April 2024, see Figure 2. Stakeholder engagement involved two major streams of input: the I/DD Subcommittee and focused stakeholder groups. Stakeholder engagement regularly occurred throughout the study and aligned with key activities of the Alternative Settings project at large.

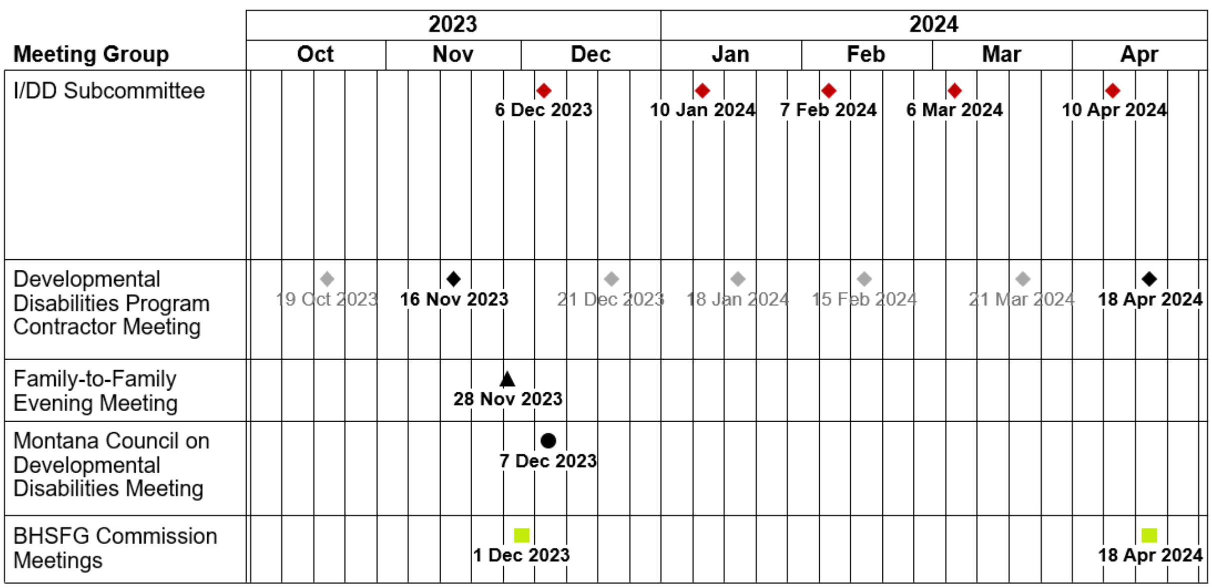


Figure 2. Stakeholder Meeting Timeline

I/DD Subcommittee Engagement

The I/DD Subcommittee consisted of 32 members, representing different experiences, perspectives, organizations, and geographies across Montana, see Table 2. The I/DD Subcommittee membership included multiple providers, advocates, and individuals with lived experience utilizing I/DD services in different Montana communities. The study team also engaged in one-on-one stakeholder interviews with both Subcommittee and non-Subcommittee members to allow for smaller, focused conversations with individuals.

Table 2. I/DD Subcommittee Members

Stakeholder Member	Organization Affiliation (if applicable)
Aaron Atkinson	Arc of Western Montana
Chris Baglio	Alvarez and Marsal
Jenni Bailey	Constituent
Josh Beeman	Billings Public Schools
Cecily Raining Bird	Constituent
Melissa Brock	Intensive Behavior Center
Matt Bugni	AWARE
David Carlson	Disability Rights Montana
Lacey Conzelman	Disability Employment Transition
David Culbertson	Montana State Hospital
Elizabeth Cummings	Constituent
Clayton Eastman	AWARE
Jeff Folsom	University of Montana
Catherine Hafliger	Child Development Center
Shawna Hanson	The Rural Institute for Inclusive Communities
Jeremy Hoscheid	Montana Mental Disabilities Board of Visitors
Lisa Parks Jones	Montana Association of Behavior Analysts
Josh Kendrick	Opportunity Resources, Inc.
Molly Kimmel	Rural Institute for Inclusive Communities
Leighann Knight	AWARE
Patrick Maddison	Montana Association of Community Disability Services/Flathead Industries – 872 Commission
Dr. Michelle McCall	Montana State Hospital
Dan Mendonca	Crisis Intervention Team County Officer
Jean Morgan	Spring Meadow Resources
Dr. Patty Notario	Billings Clinic
Eden Roberts	Child and Family Services Division
Deborah Swingley	Montana Council on Developmental Disabilities
Diana Tavary	Constituent
Anne Titus	Benchmark Human Services

A Subcommittee charter offered clarity and expectations for all members, outlined the project intent, explained member responsibility, and delineated key participation goals. I/DD Subcommittee members were charged to:

- Consider both the needs of children and adults, including those with co-occurring I/DD and behavioral health diagnosis(es),
- Offer insight, share relevant experiences, and develop a set of final recommendations to improve the ability to meet the needs of those in crises and/or with acute needs,
- Contribute to the development of a long-term strategic plan,
- Provide both promising and best practice approaches,
- Collect comments from individuals with I/DD and caretakers on lived experience for improving current programs and settings,
- Envision future treatment setting(s) to better meet the needs of Montanans with I/DD during stakeholder meetings, and
- Use feedback from the Subcommittee to assist Montana in their decision-making authority regarding system improvement recommendations.

I/DD Subcommittee engagement included five monthly meetings, lasting between two and three hours, which took place between December 2023 through April 2024. As public meetings, recordings of these meetings are accessible on the DPHHS website.[2] Table 3 describes each meeting and topic of focus.

Table 3. I/DD Subcommittee Meetings and Focus Topics

Meeting Date	Topic of Discussion
December 6, 2023	Scope, Objectives, and Context of Design Study
January 10, 2024	Environmental Scan of Best Practices and Strategies
February 7, 2024	Continued Best Practices and Strategies
March 6, 2024	Preliminary Data Review and Recommendations
April 10, 2024	Final Report of Recommendations and Next Steps

Stakeholder Group Engagement

Concurrent with monthly I/DD Subcommittee meetings, the study team scheduled meetings with key stakeholder groups to gain focused perspective on specific issues and service areas relevant to enhance understanding of the I/DD care system in Montana.

The study team met with five stakeholder groups for focused topic area feedback:

Developmental Disabilities Program (DDP) Contractor Meeting

As outlined in Figure 2, Montana's DDP holds monthly contractor meetings. The I/DD study team presented and led conversation relevant to the I/DD Alternative Setting Study's goals in November 2023 and April 2024. Discussion with DDP representatives and contractors provided

[2] "Future Generations - Intellectual/Developmental Disabilities," 2023, https://dphhs.mt.gov/FutureGenerations/IDD/Index.

specific insight into current service provisions, targeted case management, and waiver programming available to individuals with I/DD in Montana.

Montana Family to Family (F2F)

In November 2023, the study team attended a Montana F2F call to converse with parents, therapists, and case managers about relevant challenges and priority needs for children and youth with physical, developmental, or behavioral health diagnoses. This conversation provided unique emphasis on the family perspective and lived experience of navigating I/DD services on behalf of a child.

Montana Council on Developmental Disabilities (MCDD)

In December 2023, the study team attended a MCDD meeting to engage directly with key leaders and advocates from across the State on issues related the quality of life of individuals with I/DD in Montana. The meeting provided a valuable perspective on key community-level activities to support individuals with I/DD.

Children's Focus Group

To gather information on children specific I/DD service needs, the study team held a focus group on children's care. Ten leaders and providers across relevant I/DD systems and organizations in Montana participated in the conversation, sharing feedback on the unique experiences and decision-making concerns that arise for children.

Housing Work Groups

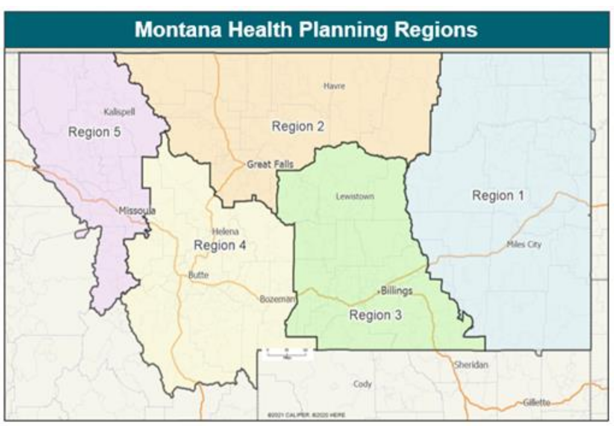
Acknowledging that housing is a unique complexity deeply connected to I/DD service provision across the care continuum, the study team scheduled two workgroups in January 2024 to focus on the key challenges and action areas to address housing needs. One meeting involved a subset of members from the I/DD Subcommittee and DPHHS leaders with experience in housing provision. The second meeting engaged representatives from community leaders. Both meetings produced new insight and consideration as to how housing impacts the I/DD service system at large, and directly informed this Report's recommendations.

Section 4: Study Methodology

Data Analysis

As a concurrent activity with stakeholder engagement, the study team analyzed available Medicaid claims data to provide a quantitative overview of individual utilization of I/DD services for participants enrolled within the 0208 Comprehensive Waiver, those individuals waiting on the waitlist, and participants that present with a primary diagnosis of I/DD within Medicaid claims data. When analyzing data, the study team applied the qualitative data captured from stakeholder engagement and quantitative research to holistically evaluate Montana's I/DD system. Figure 3 shows Montana's planning regions. The quantitative data used includes:

- **Utilization data** provided by DPHHS through their Medicaid Management and Information Systems (MMIS) platform. The study team analyzed MMIS data to assess variations in how Medicaid enrollees utilized behavioral health and/or I/DD services across Montana's health planning regions (shown in below) and to identify gaps in provider volume to understand areas where there is a need for access to services.
- **I/DD diagnosis crosswalk from the Centers for Disease Control and Prevention (CDC)** to identify all individuals with a diagnosis of I/DD based on Medicaid claims data in Montana's Medicaid network engaged with services. The study team and the CDC have both historically leveraged this diagnosis list in academic research.
- **Waitlist roster and list of** individuals enrolled in the Montana's 0208 Comprehensive Waiver. The study team analyzed participants' utilization of healthcare services, including inpatient, emergency department (ED), and crisis services, focusing on total service volumes and reimbursement totals by service type within the I/DD care continuum. Identifying utilization and gaps in provider capacity helped the study team understand the current state of I/DD services in Montana and inform where additional services are needed.



Region	Counties
Region 1	Sheridan, Daniels, Valley, Roosevelt, Richland, McCone, Garfield, Dawson, Prairie, Wibaux, Fallon, Custer, Rosebud, Treasure, Powder River, and Carter
Region 2	Blaine, Hill, Liberty, Toole, Glacier, Phillips, Pondera, Teton, Chouteau, and Cascade
Region 3	Judith Basin, Fergus, Petroleum, Musselshell, Golden Valley, Wheatland, Sweet Grass, Stillwater, Yellowstone, Carbon, and Big Horn
Region 4	Lewis and Clark, Powell, Granite, Deer Lodge, Silver Bow, Jefferson, Broadwater, Meagher, Park, Gallatin, Madison, and Beaverhead
Region 5	Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, and Ravalli

Figure 3. Healthcare Planning Regions of Montana

Data analytics centered on Medicaid enrollees due to available access to relevant data. Therefore, conclusions from this quantitative analysis are limited to individuals enrolled in Medicaid. However, Medicaid data analytics provided foundational understanding of I/DD service utilization and system engagement that directly informed recommendations.

Qualitative Research: Leading Practices and State Models

To develop sound and relevant recommendations, the study team reviewed leading practices and state models for I/DD service provision from across the United States. Qualitative research focused on four key policy areas and relevant state models, as indicated in Table 4.

Table 4. Leading Practice Policy Areas and Comparison States

Policy Area	Relevant State Models
HCBS Payment Innovations	Georgia, Maryland, Missouri
On-Site Provider Support and Capacity	Arkansas
Intermediate Care Facility (ICF) Models	California, Indiana, Oklahoma
Crisis Response Models	Georgia, North Carolina

The purpose of this research was to identify best practice approaches to I/DD service delivery and consider optimal or innovative programmatic strategies when developing recommendations to address the priority challenges for individuals utilizing I/DD services in Montana.

Study Limitations

The study team acknowledges the following limitations:

Data: The I/DD system relies heavily on paper charting and documentation in institutional settings. On-site chart reviews are required to conduct a deeper, informed clinical understanding of the services received and outcomes for individuals with I/DD. However, timing and resource limitations prevented the study team from conducting chart reviews to collect clinical data to help inform recommendations. The study team limited the data analysis to claims data, which provided the most robust and accessible overview of how services are utilized and delivered. Due to limitations in the availability of data, quantitative data was not available to directly support all recommendations in this report. When quantitative data was unavailable, the study team relied upon stakeholder input and qualitative research.

Study Timeline: Study activities were condensed to align with deadlines of the broader Behavioral Health Alternative Settings Report, per the HB 872 legislative requirement[3]. This condensed timeline limited the ability of the study team to evaluate the I/DD system more fully. This report intends to serve as a supplemental study to the Behavioral Health Alternatives Setting Report.

[3] Montana Legislature, HB 872, 2023, https://leg.mt.gov/bills/2023/billpdf/HB0872.pdf.

Section 5: Findings and Recommendations

As Montana considers implementation of the recommendations provided, the strategic use of data and analytics will be necessary to effectively evaluate programs, allocate resources, and measure performance. Successfully implemented, the proposed recommendations have the potential to improve access to services, reduce workforce shortages, decrease dependency on emergent and inpatient care settings, and address the management of waitlists for services.

The section below provides detailed recommendations for Montana. These recommendations intend to improve access to services and help address gaps that exist in the current I/DD care continuum for Montanans. Each recommendation includes a summary of the recommendation, information regarding the rationale supporting the recommendation, a description of potential impacts and considerations, and applicable next steps should the State implement the recommendation. A total of seven recommendations are below, broken down into two categories: **Immediate Programmatic Initiatives** (within two years) and **Long-term Initiatives** (beyond two years).

Overview of Data Findings that Informed Recommendations

Analysis of Montana's Medicaid roster revealed 2,139 individuals with Medicaid claims utilization who were on the waitlist for the 0208 Comprehensive Waiver and 2,727 individuals enrolled in the 0208 Comprehensive Waiver. The combination of the individuals on the 0208 Comprehensive Waiver and the waitlist equate to 4,866 individuals. Of the 4,866 individuals, about 30% (1,486) also had a co-occurring behavioral health diagnosis found within Medicaid claims. Co-occurring I/DD and behavioral health diagnoses have the potential of impacting the variety and complexity of services and providers these individuals require.

As of October 2023, an individual on the waitlist for 0208 Comprehensive Waiver services waited an average of 4.3 years. However, the time at which an individual is placed on the waitlist influences waitlist duration as individuals are typically offered waiver services in chronological order.

In addition to understanding the needs of those diagnosed with I/DD who are either enrolled or waiting for services, the study team analyzed specific services among those with an I/DD diagnosis and a co-occurring behavioral health diagnosis to better understand healthcare utilization patterns in the population. In SFY23, the average Medicaid expenditures for an individual with an I/DD diagnosis is three times higher – even for routine healthcare utilization – than that of a Medicaid participant without an I/DD diagnosis. Inpatient admissions among individuals with both I/DD and behavioral health diagnoses increased 58% from state fiscal year (SFY) 2022 to SFY23, and 86% among those with only an I/DD diagnosis, indicating that acute healthcare needs of the I/DD population might be increasing.[4] The study team did not identify any consistent patterns in healthcare utilization among individuals on the 0208 Comprehensive Waiver waitlist. There was increased crisis and ED utilization year-over-year among those with co-occurring I/DD and behavioral health diagnoses, while inpatient admissions decreased for the same cohort of individuals. Full data analytical outcomes are in Appendix A – Data Overview.

[4] Note that inpatient admissions could have been for any reason and were not directly attributed to an I/DD or behavioral health condition.

Immediate Programmatic Initiatives

The study team recommends Montana pursue three immediate programmatic initiatives aimed at improving flexibility in the I/DD system. Based on discussions with the I/DD Subcommittee members and DPHHS, a common theme discovered was the need for service offering flexibility within the I/DD waiver program that allows for the system to better meet the needs of those individuals served. At its core, flexibility allows for better supports and provides a more personalized Medicaid services program that supports families, providers, and the individual. Added flexibility promotes independence and reduces the risk of institutionalization and reliance on state facilities. The three immediate programmatic initiative recommendations are:

- Pilot the national START model.
- Offer intensive on-site provider supports.
- Transition to a revised standardized assessment tool.

1. Pilot the national START crisis program.

The study team recommends piloting the START model in a targeted area of the State that would create a pathway for expansion of the START Program Certification statewide. Launching a pilot START model would help in providing gradual and thoughtful direction for planning and implementation of an expanded statewide START model, upon successful pilot results.

The START model is a research-based model of community-based crisis prevention and intervention services for individuals aged six and older with I/DD and behavioral health needs. START was first developed in 1988 and was cited as a model program in the 2002 US Surgeon General's report[5] on behavioral health disparities for people with I/DD. The model operates out of the Center for START Services (CSS) at the University of New Hampshire Institute on Disability with experts in the behavioral health aspects of I/DD who develop innovative behavioral health and I/DD training programs, conduct research, and facilitate the development of START programs across the country.

Members of the CSS national team assist START model programs in each location with their START program design, model training and tools, on-going evaluation of outcomes, technical support, and best practices in behavioral health aspects of I/DD. START teams across the country work together as a national community of practice facilitated by the national CSS. 15 states have developed START models with a goal of positive system changes in each location.

Certified START programs offer:

- Expertise in co-occurring I/DD and behavioral health diagnoses,
- Validated assessments, training, interventions, and ongoing dialogue with stakeholders within the context of the START model's guiding principles,
- Therapeutic coaching and clinical evaluation,
- Outreach to the individual, their supports, and service providers to enhance capacity of the service provider,
- Face-to-face and timely crisis prevention and intervention services with a 24 hour / 7-day crisis response,

[5] "START Model," National Center for START Services, January 11, 2024, https://centerforstartservices.org/START-Model.

- Increased knowledge of the dually diagnosed population (behavioral health and I/DD) among professionals through outreach and training, and
- Participation in CSS innovative training and research initiatives.

START programs obtain certification through a rigorous review by the National Center for START Services™ (NCSS) Quality Assurance Department. Throughout the process, NCSS reviewers utilize quality assurance tools to ensure fidelity to START program certification standards, provide guidance, identify training needs, and promote reliability and consistency across the National START Network. There are two certification programs offered through the NCSS certification process:

- **Clinical Team Plus:** A program certified in both clinical team services and therapeutic supports (resource center, therapeutic coaching, or both) to either adults (18+), children (6-21), or lifespan (6+).
- **Clinical Team:** A program certified in clinical team services only, serving adults, children, or lifespan.

START Resource Center

The study team recommends the that the State pursues the Clinical Team Plus Certification as it offers Resource Center services that provide community-based, short-term therapeutic support for people enrolled in START. People use Resource Center services when experiencing acute needs that may be identified as "crisis" or when people live with their families and cannot access traditional community respite options and need additional support. Different from an inpatient behavioral health facility, the intent of the Resource Center is crisis stabilization, assessment, treatment, and identification of interventions to reduce stress for the person and system. The START team accomplishes this by providing a change in environment and a structured, community-based, home-like, therapeutic setting. Individuals served by the Resource Center (known as “guests”) are admitted because they have a recent history of, are at risk for, or are currently experiencing intense crisis events.

The START Resource Center offers planned and emergency admissions. While the day-to-day activities are the same for all guests, the purpose and goals for the visits will vary depending on the type of admission.

The START Resource Center requires clear emergency back-up policies and procedures and a highly trained staff to provide the needed services to guests. The START clinical and resource center team work collaboratively, and all admissions/discharges are facilitated by the assigned START coordinator and center director or designee. START Resource Center services also include evaluations by the medical and clinical directors in addition to ongoing discharge planning facilitated by coordinators.

Pilot Description

The certification process aims for completion in 4 years. Preparation to achieve all START model competency areas begins during the initial program implementation phase. During years 3-4 of operation, demonstrated mastery of START practices occurs and programs typically begin preparing for the program certification application process. Table 5 outlines high level outcomes of the Pilot program during each year of the 4-year process:

Table 5. START Pilot Program 4-Year Outcomes Timeline

Year	Pilot Outcomes
1	• NCSS project facilitator provides technical assistance (in-person and/or virtual visits) based on contractual agreements. • Program staff receives training, coaching, and coordinator certification support from NCSS.
2	• START program director begins program certification preparation with assistance from NCSS project facilitator and Quality Assurance department.
3	• NCSS direct involvement wanes; project facilitators conduct practice certification reviews. • Programs submit Certification Application narrative at least 4 months prior to scheduled on-site review and application attachments 30 days prior to on-site review. • On-site review conducted by one or more members of NCSS Program Certification Review Board. The NCSS Reviewer(s) is accompanied by assigned project facilitator.
4	• Programs receive 2-year certification based on outcome of on-site review. • Initial program on-site review concludes with corrective action recommendations expected to be submitted to NCSS. • The team can expect annual visits by NCSS staff. The visits will either be quality assurance reviews or certification renewal (every two years) visits.

Clinical Team

To meet the requirement, Montana would need to build a clinical team to operate the START Model in the designated pilot area. The Department could choose to hire this clinical team internally or procure staff augmentation services through an outside vendor. This clinical team would be a 10-person team of qualified licensed professionals including:

- Program Director (master's level),
- Clinical Director (PhD psychologist; can be part-time),
- Medical Director (psychiatrist; part-time),
- Clinical Team Leader (master's level), and
- START Coordinators - 4 Full-Time Equivalents (master's preferred).

Additional workforce to consider:

- Therapeutic Coaching Team Leader (master's level), and
- Therapeutic Coaches (bachelor's preferred).

The clinical team would provide support to providers during crisis events and operate the START Resource Center, as described above. Annual estimated costs for the clinical team are approximately $2 million.

Training

Once the clinical team is onboarded, Montana would need to procure contract services from the NCSS to provide required training for the clinical team during year 1 of the pilot. Training from a NCSS project facilitator provides technical assistance (in-person and/or virtual visits) and the clinical team receives training, coaching, and coordinator certification support from NCSS. The

NCSS review team must incorporate quality assurance requirements into the training. Estimated costs for the NCSS training range from $900,000 to $1 million for the 4-year period.[6]

Factors Supporting the Recommendation

- There is currently no ICF operating in the State of Montana. The START program fills a needed gap in addressing acute crisis intervention for those who are living in the community but need a high acute, short term stabilization service historically provided in ICF settings.
- This gap has translated into use of costly and ineffective care, resulting in frequent ED and psychiatric hospital visits,[7,8] decreased quality of life, and earlier age of mortality[9,10] for individuals with I/DD.
- House Bill 691 of the 67th legislature[11] requires DPHHS to establish crisis response services to help individuals with I/DD minimize or avoid instances of crisis. Services must assist providers and families in preventing, deescalating, and intervening in instances in which individuals with I/DD are likely to go into crisis.
- The START Model assists DPHHS in meeting legislative requirements of HB 691, including the requirement that crisis response services consist of three distinct levels of prevention, intervention, and crisis support services.

Findings that Informed the Recommendation

Montana's current I/DD system is a dichotomous care system with HCBS waiver programs and services at one end of that dichotomy and state-run institutional care (e.g., MSH and IBC) on the other. This dichotomy characteristically creates a gap in the I/DD continuum of care, particularly one where crisis services are not available for 1) those who may be in less restrictive settings but in need of crisis stabilization, or 2) those leaving institutional care and in need of higher levels of crisis services as they transition to community placements.

Stakeholders emphasized the importance and need for individuals having a safe and well-equipped care setting to utilize during crisis episodes. The START Resource Center would serve as a place for crisis stabilization services and provide additional support through offering beds for crisis respite and planned respite. Also, because of positive feedback received from stakeholders on the START National Crisis program, stakeholders had additional inquiries surrounding program components, implementation process, workforce requirements, and methodology that Montana could adopt. To inform the recommendation:

- The study team brought in a representative from START's National Crisis Program to expand and provide statistical evidence to demonstrate the measurable efficacy and success behind implementing this program model. The representative also discussed

[6] Estimate provided by NCSS leadership.
[7] Kalb, L. G., Beasley, J., Klein, A., Hinton, J., & Charlot, L. (2016). Psychiatric hospitalization among individuals with intellectual disability referred to the START crisis intervention and prevention program. Journal of Intellectual Disability Research, 60(12), 1153-1164.
[8] Kalb, L., Stuart, E., Freedman, B., Zablotsky, B., & Vasa, R. (2012). Psychiatric-related emergency department visits among children with an autism spectrum disorder. Pediatric Emergency Care, 28(12), 1269-1276.
[9] Lauer, E., & McCallion, P. (2015). Mortality of people with intellectual and developmental disabilities from select US state disability service systems and medical claims data. Journal of Applied Research in Intellectual Disabilities, 28(5), 394-405.
[10] Nota, L., Ferrari, L., Soresi, S., & Wehmeyer, M. (2007). Self-determination, social abilities, and the quality of life of people with intellectual disability. Journal of Intellectual Disability Research, 51(11), 850-865
[11] https://leg.mt.gov/bills/2021/HB0699/HB0691_1.pdf

with stakeholders at-will respite requirements, medication management, and other crisis management protocols. Stakeholders agreed that a dedicated setting specific for crisis intervention services in Montana could lead to favorable outcomes, such as preventing individuals with I/DD from unnecessary inpatient admissions to psychiatric facilities, hospitals, and facing other displacements.

- The study team and DPHHS leaders had an opportunity to discuss the vision for a pilot program by exploring funding options, training requirements, the START model certification process, and outlining the workforce qualifications needed to run a successful program in Montana. To substantiate the need for a pilot, the study team also found that crisis service utilization rose 275% from SFY22 to SFY23 among a small set of individuals on the 0208 Comprehensive Waiver waitlist who received services that in the future could be through the START Resource Center. [12]

Anticipated Impact of the Recommendation

Across the United States, individuals enrolled in START have shown improvements in key outcome measures including:

- **Improved health outcomes**: Crisis services through the START model can lead to earlier intervention, improved adherence to treatment plans, and better physical and behavioral health outcomes for individuals with I/DD and behavioral health needs.
- **High rates of stabilization following crisis events:** 73% of the 3,000 crisis contacts of START programs in SFY19 resulted in individuals remaining in their current community-based setting, avoiding potential ED visits and/or psychiatric inpatient admissions.[13]
- **Reduced psychiatric hospitalization and ED usage:** Individuals enrolled in START programs visit the ED less and have fewer psychiatric hospitalizations than they did in the 12 months prior to receiving START services.[14]
- **Reduced long-term admissions:** Crisis services through the START model offer the potential to reduce the need for admissions to IBC in Montana and to the State hospital as an intermediary crisis services intervention for that occurs within the community and outside an institutional setting.
- **Increased quality of life**: Improving access to crisis services can contribute to increased quality of life through early interventions that can reduce crisis episodes, which in turn promotes improved quality of life for the individual receiving services and their caregivers, informal and formal.

Considerations for the Recommendation

- **Goal alignment**: If Montana implements this recommendation, the State will need to ensure alignment with its long-range goals and the START model. The START model is one of high fidelity in terms of outcomes, methods, and results. This important level of program fidelity comes with strict terms of what the program can and cannot do related to adapting to the specific needs of Montana.

[12] Center for Medicare & Medicaid Services [CMS], "Montana MMIS Medicaid Claims," Data set, 2023.
[13] Joan B. Beasley et al., "Reduced Psychiatric Hospitalization and ED Usage," report, Center for START Services, n.d., https://www.denvergov.org/content/dam/denvergov/Portals/692/documents/i-dd-council/Center%20for%20START%20Services%20at%20the%20UNH-IOD%202019.pdf.
[14] *Ibid.*

- **Funding and sustainability**: The certification of a crisis START model is a multi-year approach and financial investment that requires sustained funding. Planning for sustained funding should occur during the 2025 legislative session.

Recommended Next Steps

- Assess the flexibility and alignment of the START model with DPHHS' goals to capture long range strategy and planning objectives.
- Consider sending DPHHS staff to the 2024 START National Training Institute in May of 2024 for planning and strategy purposes.
- Implement a pilot program in a targeted area of the State to assess the feasibility and effectiveness of a statewide model before broader rollout. Implementation activities would include:
  - Contract with CSS,
  - Build START crisis clinical team, and
  - Identify resource center location.
- Conduct a service system resource analysis. This analysis is a comprehensive, data-driven approach to identify a system's strengths and areas for improvement. It is a critical first step in evaluating a service system's ability to meet the needs of this population and improve overall quality of life for those individuals and their families. It includes two main components:
  - Methods - Data collection through a variety of methods including focus groups, online surveys, and family member interviews.
  - Results - Development of discipline-specific professional development training and professional learning communities.

2. Offer intensive on-site provider supports.

The study team recommends that Montana pursue opportunities to partner with a vendor to provide intensive on-site provider supports to improve the continuum of care for individuals with I/DD served in the community. These supports are especially important in cases where the family, providers, and/or caregivers are caring for an individual with complex needs or a dual diagnosis – individuals who experience a behavioral health condition concurrent with I/DD. On-site provider services offer wraparound supports to enhance programs and services from existing providers. These support services aim to improve outcomes for individuals with complex care needs as well as increase the overall capacity of the existing provider network. These services can include direct training, support, and resources to allow for multiple pathways to stabilization for highly acute cases. The types of services offered through an on-site provider support model are flexible and modifiable to meet the specific needs of existing providers and the individual receiving services. Examples of intensive on-site provider supports include:

- Immediate placement with identified providers,
- Updated diagnostic assessments within a specific, identified period,
- Psychopharmacological reviews within a specified period from admission to the provider,
- Medication adjustments during transition period, as needed,
- Updated functional behavior assessments and behavioral support plans,
- Preventative crisis plan updates,
- Staff coaching and 24-hour crisis support, and
- Treatment responses within a specific period.

Provider on-site supports have the potential to produce better outcomes for individuals with complex needs and can reduce costs and stressors of workforce turnover. A lack of adequate training to manage the demands of the job is an often-cited reason workers pursue other positions.[15]

By using an on-site provider support model, Montana could identify individuals using established eligibility criteria and report these individuals to the vendor who can then deploy supplemental clinical staff, assess, support, and stabilize the individual in need for a specified duration (e.g., 90 days). During this process, the vendor collaborates closely with existing community providers, caregivers, and care coordinators to address needs and capture data to report outcomes back to the State. This allows individuals in services to maintain stability in the community via adequate 0208 Comprehensive Waiver and/or behavioral health supports while allowing immediate access to on-site supports for providers including behavioral supports, therapies, added staff support, and clinical psychopharmacologies reviews. Using an on-site provider support model aims to expedite enrollment with providers and reduces disruption of out of home placement.

Factors Supporting the Recommendation

- **Added flexibility in the 0208 Comprehensive Waiver:** Community-based services for individuals with I/DD are currently rigid, limited, and do not allow for flexibility in the system to care for higher acuity needs in the most appropriate way. This causes an over-reliance on institutional care when HCBS providers are unable to support higher acuity cases successfully in the community. Provider on-site supports can strengthen current providers' ability to appropriately care for individuals with higher acuity and keeps these providers "at the table" and engaged in offering comprehensive services in the community.
- **House Bill 691 Requirements**: House Bill 691 of the 67th legislature requires DPHHS to establish crisis response services to help individuals with I/DD minimize or avoid instances of crisis. Services must assist providers and families in preventing, deescalating, and intervening in instances in which individuals with I/DD are likely to go into crisis. The provider on-site supports model assists DPHHS in meeting legislative requirements of HB 691, including the requirement that crisis response services consist of three distinct levels of prevention, intervention, and crisis support services.

Findings that Informed the Recommendation

Enhancing HCBS

Through the stakeholder engagement process, the study team identified gaps in Montana's current HCBS model for individuals with I/DD:

- Lack of provider training and limited expertise in serving individuals with complex needs,
- Constraints in transitioning individuals from intensive care settings to HCBS,
- Ineffective care coordination, and
- Inadequate access to behavioral healthcare services.

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[15] Renáta Tichá et al., "Interventions Used With Direct Support Workforce of Adults With Disabilities in Home and Community-Based Settings: A Scoping Review," Manuscript Draft, 2023, https://www.aaidd.org/docs/default-source/prepressarticles/interventions-used-with-direct-support-workforce-of-adults-with-disabilities-in-home-and-community-based-settings-a-scoping-review.pdf?sfvrsn=3c0e0221_0.

Stakeholders voiced the need for flexibility in the delivery of services to individuals with I/DD across different care settings.

Due to lack of capacity in current workforce, stakeholders agreed that the intensive on-site provider support model could be beneficial in helping current I/DD providers and caregivers:

- Serve individuals with complex conditions across systems,
- Promote appropriate staffing ratios, and
- Allow for shorter response times, as the on-site provider support model can provide immediate coaching and support.

Flexibility in the intensive on-site provider support model allows for the system to build capacity within the I/DD care continuum while also accommodating flexibility of service and provider type. With this model, stakeholders suggested improvements to the workforce capacity challenge such as: intensive on-site providers can provide support in areas such as rapid treatment responses, behavior support and crisis planning, immediate staff coaching and training, and crisis support.

To support this model, I/DD providers and caregivers need specific resources such as:

- Staff training,
- Clinical needs,
- Functional assessments, and
- Behavioral support plans.

Intermediate Care Facilities (ICF)

Montana does not currently have an ICF in the I/DD continuum of care. As an alternative to and/or in addition to offering intensive on-site provider supports, the study team researched and presented information on the potential of incorporating an ICF into Montana's current I/DD care continuum.

The I/DD Subcommittee members voiced concerns throughout a thorough discussion of the option of re-introducing an ICF. Montana closed the Montana Developmental Center (MDC) in 2018 due to unmet safety regulations and in pursuit of a goal of moving towards less restrictive and more inclusive settings per *Olmstead*.[16]

Feedback and public comments suggest the State move towards a community inclusive model in lieu of the development of an ICF. The study team considered the feedback received, discussed it with DPHHS, and finalized the recommendation for on-site provider supports as the option to pursue to best meet the needs of individuals with I/DD across the State.

Anticipated Impact of the Recommendation

Similar on-site provider support models are currently in pilot and offered in other states. Anticipated outcomes include:

For the individual served:

- Faster stabilization,

[16] "Olmstead: Community Integration for Everyone -- About Us Page," n.d., https://archive.ada.gov/olmstead/olmstead_about.htm.

- Prevention of behavior escalation and psychiatric crises, and
- Improved care coordination / case management.

For the community provider:

- Increased capacity to serve a wider array of individuals,
- Increased staff skill and retention due to the additional on-site support,
- Improved paraprofessional and professional development, and
- Increased access to supports and improved ability to offer higher quality of care services.

For the system:

- Maintained and/or stabilized levels of Medicaid funding, and
- Reduced intensive care needs that require higher levels of care.

Considerations for the Recommendation

Montana can use its procurement process to identify vendors that excel at offering provider on-site supports and similar services. These services could complement the services currently offered by existing Medicaid HCBS providers. For example, on-site support services can enhance service offerings, particularly with crisis and stabilization support for those with co-occurring I/DD and behavioral health diagnosis.

Recommended Next Steps

- Utilize Montana's procurement process to explore partnership opportunities with existing or new organizations to leverage resources and expertise in building the on-site provider support service offering.
- Secure sustainable funding through a combination of state, federal, and private sources, while advocating for policy changes that support additional provider on-site support models.
- Implement a pilot program in targeted areas to assess the feasibility and effectiveness of the model before broader rollout.
- Identify outcomes to evaluate the pilot program to measure its potential success. Examples may include:
    - 30-day readmission for behavioral health,
    - Behavioral health admissions for acute and Psychiatric Residential Treatment Facilities (PRTF),
    - ED admissions, and
    - HCBS initiated within 90 days of referral.

3. Transition to a revised standardized assessment tool.

In 2022, DPHHS completed a comprehensive provider reimbursement rate review of services provided in Adult Behavioral Health, Children's Mental Health, Developmental Disabilities, and Senior and Long-Term Care programs. The focus of the rate study was to address legislative requirements issued in 2021 through HB 632 Section 20 Subsection 2B. Specifically, HB 632 authorized a provider rate study to determine the need for adjusting service rates to address the financial and service delivery impacts of COVID-19.

The resulting rate study report recommended that DPHHS develop a reimbursement methodology for adjusting residential service rates based on an individual's assessed resource need. The feedback received from stakeholders during the rate study, as well as the feedback the study team received from the I/DD Subcommittee, underscored the need for a revised acuity-based reimbursement methodology.

In HCBS waiver programs, including those tailored to I/DD populations, significant variations may exist in the level of support or resources needed for everyone, as individuals can live independently with occasional supports, while others require increased supervision or other frequent and intensive interventions. As such, a single rate for a service may be misaligned with an individual's needs in specific cases, making it too low or too high to meet the need supported by the service. In Montana, according to the rate study report, the need for appropriate calibration is particularly high in consistently delivered residential and day services.

In part, addressing this challenge includes the development of tiered rates that vary reimbursement based on intensity of resource need. DPHHS has established tiered rates in its developmental services programs, especially, to account for substantial differences in individuals' needs.

Both the rate study and the study team recommend these tiered rates can be further "fine-tuned" through the development of a reimbursement adjustment framework that relies on variation in individual scores from an objective assessment tool, with scores aligned to various levels of reimbursement based on the assessed need. This form of "acuity adjustment" is a widespread practice in other state Medicaid programs, especially for residential services, where reimbursement frameworks incorporated the cost of assessment tools, discussed further in this section.

The study team recommends that Montana consider the feasibility of a rate structure by individualizing the reimbursement per unit based on the complexity of an individual's needs. As a first step in the process, Montana will need to adopt the use of a nationally recognized, empirically informed, and validated assessment tool to identify pattern and intensity of supports required to serve a person appropriately through the waiver programs.

The implementation of a new assessment tool would not only immediately address the need for flexibility in the system to give more accurate and structured provider reimbursement rates based on an individual's level of acuity and resource-intensive needs.

Selecting an Assessment Tool

The study team recommends Montana, in consultation with stakeholders, review and select an assessment tool with the following primary objectives in mind:

- **Ability to compile and view reliable assessment data in aggregate to better understand** the needs of individuals served. Ideally, aggregated assessment results will show the range of support needs across individuals. Combined with demographic information, this data will help DPHHS understand the service need across Montana, age groups, and other groupings of people to better describe who needs what services at what time.
- **Inform program innovation** to respond more effectively to support needs over time. The assessment data generated, especially when used with other information (e.g., individual care plans, and behavior support plans and associated data) can inform the design of service innovations currently under consideration, such as a fine-tuned tiered rate reimbursement methodology.

- **Improve equity of supports.** Montana's I/DD system serves individuals with an extremely broad range of needs, from those who live independently with occasional supports to those who require 24 hours a day support. By aggregating and analyzing standardized assessment data across individuals supported by the system, DPHHS can develop support tiers. In the future, the person-centered team can plan individualized supports, but within a fair and reliably determined tier.

Factors Supporting the Recommendation

- **Implementing a new assessment tool is the first step in creating a tiered acuity-based rate structure.** Tiered rates can be further "fine-tuned" through the development of a reimbursement adjustment framework that relies on variation in individualized assessment scores from an objective assessment tool, with scores aligned to distinct levels of reimbursement based on the assessed need. Montana does not currently use a nationally validated assessment tool. Without such a tool, Montana lacks a standardized picture of the range and types of supports required.
- **Long-term system improvement and planning.** A new assessment tool could allow for a more accurate assessment of individual needs, and in turn, lead to optimal service. The state would benefit from having standardized information from a nationally recognized assessment tool to create a reliable composite picture of the people supported by the system.

Findings that Informed the Recommendation

Through the public comment process, the study team identified key gaps in Montana's current HCBS model for individuals with I/DD, notably **unsustainable provider reimbursement.**

The feedback received from stakeholders underscored the need to bolster flexibility of service by providing finer tuned tiered rates. The implementation of a revised assessment tool determines a distinct level of reimbursement for individuals addresses the identified gap in the current model. Stakeholders indicated that current rates are not reflective of the complexity of needs of individuals.

Anticipated Impact of the Recommendation

The assessment tool is a needed first step in developing and implementing tiered reimbursement rates; the goal of which is to provide funding for services based on the complexity of the individual's needs.

A standardized assessment tool has the potential to:

- Distribute funding more effectively by targeting reimbursement where it is most needed,
- Foster more responsive action to individuals' evolving service needs, and
- Minimize 'cherry-picking' of members with less intensive needs and encourages providers to deliver care to members with greater need.

Considerations for the Recommendation

Should the State move forward with the described recommendation, there are key areas to consider regarding the implementation of an assessment tool:

- Use of **person-centered best practices** to create a structure and process for using the tool,

- Gather **sufficient information** to identify individuals and provide base demographic data to analyze trends,
- Assess support needs **across essential life domains** and recognize that these needs change over time,
- The tool should result in **consistent scores** regardless of who is conducting the assessment and constructed in ways to promote easy automation of data entry, aggregation, and scoring,
- Implement a **database software platform** to gather, manage, and apply the information collected, and
- **Range of cost** for using a national standardized assessment and the corresponding cost for training of providers and staff.
- Implementing a revised assessment tool will require both a **waiver amendment** as well as **administrative rule changes** and/or updates to the 0208 Comprehensive Waiver program.

Recommended Next Steps

- Conduct a gap analysis of the State's current assessment policies, procedures, and tools.
- Use Montana's procurement process to screen and assess tool vendors and evaluate proposals.
- Consider Federal funding sources such as grants aimed at improving / revising state assessment instruments and procedures.
- Communicate to providers and stakeholders the State's intention and plan to pursue a revised assessment tool and reimbursement methodology.
    - Ensure opportunities for public feedback and input.
    - Understanding and communicating Montana's long-range plans to use the information from the assessment tool is important.
- Develop new policies, procedures, instructions, and training on the assessment tool for provider network.

Long-term Initiatives

The study team recommends that Montana pursue four long-term initiatives aimed at strengthening the statewide I/DD system. Based on discussions with the I/DD Subcommittee members and DPHHS, a common theme discovered was the desire to bring the system in line with evidence-based best practices and/or promising practices occurring in other parts of the country. These long-term recommendations focus on adding stability to the system from entry point to the delivery of services, and, like the immediate programmatic initiatives, also reduce the risk of institutionalization and reliance on state facilities. The four long-term initiative recommendations are:

- Develop a Revised Waitlist Management Approach,
- Re-evaluate Transition Grant Supports,
- Relocation of the IBC, and
- Evaluate Children's Services.

4. Develop a revised waitlist management approach.

The study team recommends Montana develop a waitlist system that offers the most appropriate waiver services based on an individual's identified need(s) rather than duration on the waitlist. Under a restructured waitlist system, individuals may first be screened using a model to help assess the urgency of need for the individual. The State could consider the following areas to determine the urgency of need for an individual, such as:

- Change in caregiver status,
- Individual needs / circumstances,
- Eligibility status, and
- Other external factors.

Montana could then assign individuals a score to identify the level of need an individual requires. While additional effort will be needed to determine the exact type of changes best suited for Montana, other states have implemented *tiered* waitlist systems to create levels of need / tiers, as highlighted in Table 6 below.

Table 6. Example of a Tiered Waitlist Management System

Example of Levels of Need in a Tiered Waitlist Management System
4 - Emergent: Supports needed in the next 90 days
3 - Urgent: Supports needed in the next 3-12 months
2 - Critical: Supports needed in the next one to two years
1 - Planning: Supports needed in the next three to five years
0 - Currently no unmet needs

Even though individuals may have similar diagnosis, their level of support and urgency of need may be different based on their individual supports and goals. An individual could request a re-evaluation at any time by notifying the State that their needs have changed. Implementation of a revised assessment tool as mentioned in Recommendation 3 above would strengthen the efficacy of this recommendation.

By using a revised system, other states have identified those with the greater urgency of need (i.e., emergent, urgent) and offered waiver services to these prioritized individuals. Legislative bodies developed funding requests to prioritize the individuals on the waitlist with the greatest demonstrated need. For example, it would have cost Louisiana $832 million to offer waiver services to all the individuals on their 0208 Comprehensive Waiver waitlist. However, the Louisiana Department of Health requested and received $43 million from the Legislature to provide I/DD HCBS waiver services to those individuals in emergent and urgent categories.[17] Louisiana still maintains a registry of individuals whose needs are currently met through other services and programs but remains flexible and responsive to individuals on the registry if their needs change.[18] The revised approach to waitlist management allows Louisiana to offer

[17] "New Approach to Home and Community Based Services Ends Wait for Thousands of Citizens With Developmental Disabilities: Priority Now Placed on a Person's Level of Need, Not Their Place on a List," Louisiana Department of Health, July 6, 2018, https://ldh.la.gov/news/4687.

[18] *Ibid*

community-based services in a manner that will provide coverage to a greater number of individuals, provide for more predictable budget requests, and in a manner that will be more sustainable for the long-term.

Approach to Waitlist Assessment

As part of this recommendation, reviewing the electronic capture of screening data for waitlist assessments could improve effectiveness and quality of waitlist management and oversight. Montana could then conduct a comprehensive initial policy review and data inventory, coupled with stakeholder interviews and/or focus groups with relevant stakeholders, to determine current state vs future state of waitlist management. Leveraging this data would inform a strategy to support informed decision-making regarding a revised waitlist management approach. Potential data that can be collected and reviewed is listed in Figure 4. Waitlist Assessment Considerations

Processes and Supporting Systems	Organizational Structure	Data and Other Documentation
• Policies • Standard Operating Procedures • Workflows / process maps including interplay and data sharing • Dashboards and standardized reporting	• Organizational charts • Other materials outlining organizational structure, including roles / responsibilies of each entity	• Performance and outcome data related to the I/DD waivers • Financial data (e.g., from claims or administrative data) • Other assessments performed, formally or informally

Figure 4. Waitlist Assessment Considerations

Other tasks associated with this recommendation could include the following:

- **Integrate and analyze data collected:** Outline and communicate the extent of data available, data elements possessed by each entity, and unique identifiers that could crosswalk the data across the sources identified.
- **Develop a report to outline gaps in information:** Develop a report that outline any data gaps identified through discussions and review of the data elements. These gaps could range from information used to identify needs of people on the waiting lists to discrepancies that will limit the department’s ability to analyze data.
- **Collection and analysis of current and future support needs:** Conduct a comprehensive review and analysis of the current I/DD waiting lists to understand current state. Review the data elements in Table 7, as an example, to gain an overarching understanding of the waiting list population and to identify areas for greater analysis to determine common themes and / or characteristics of individuals on the waiting list:

Table 7. Wait List Characteristics

Population Information	Functional Assessment Information
Ages of individuals on waiting lists	Cognition
Medicaid status	Communication Modality
Length of time on waiting list	Behaviors
Types of other waiver or state plan services accessed while on waiting list, if applicable	Activities of Daily Living (ADLs) / Instrumental Activities of Daily Living (IADLs)
Diagnoses	Environmental

- **Collect and analyze information about individuals at risk for entering services through a crisis or exception:** After completing the initial analysis of those currently on the I/DD waiting list, expand the analysis to look at individuals who have entered the I/DD waiver within the last three to five years due to crisis or exception to determine precursors.
- **Gather and analyze data to forecast service needs and track important trends:** To provide a forecast of the service needs, both at the provider-level and State-level, for the current landscape, and up to five years out, use data on current individuals enrolled in the I/DD waiver to look at current service utilization. Compare person centered support plans and Medicaid encounter data to identify the rate of utilization. Additionally, complete a review to identify highly utilized services and the utilization rate of each provided service within the waiver.

Factors Supporting the Recommendation

- **Ensuring access to Medicaid services**: Ensuring beneficiaries can access covered services is a critical function of the Medicaid program and a top priority of the Centers for Medicare & Medicaid Services (CMS). The proposed rule, *Ensuring Access to Medicaid Services,* advances CMS's efforts to improve access to care, quality, and health outcomes, and better promote health equity for Medicaid beneficiaries across fee-for-service including HCBS provided through those delivery systems. These proposed requirements intend to increase transparency and accountability, standardize data and monitoring, and create opportunities for states to promote active beneficiary engagement in their Medicaid programs. A revised waitlist management system aligns with the goals of the proposed rule and promotes Medicaid as an essential program for people with I/DD.
- **Litigation**: The need to modernize waitlist management can reduce Montana's risk of litigation tied to *Olmstead v. L.C*. Supreme Court Decision which includes an individual's rights to receive adequate services in inclusive settings of the individual's choice.
- **Reduced waitlist count and added flexibility**: The average wait time is 4.3 years. Placement on the 0208 Comprehensive Waiver waitlist currently does not consider individual service needs or service availability. By prioritizing the needs of individuals over when they applied for services, the State could make a fundamental shift to target those most in need.
- **Data-driven funding requests and waiver amendment considerations**: The ability to manage waitlists allows for better and more accurate reporting, which can influence

future waiver amendments including increases in the number of slots for a waiver. States that appropriately manage waiver eligibility can quickly communicate eligibility to the individual when a slot becomes available. In addition, screening can enable agencies to assist individuals with linkages to other services if they are not waiver eligible.

- **Improved tracking and quality outcomes**: A revised waitlist system will allow for the tracking for data by inputs (e.g., services type, location, demographics) to allow for better coordination and planning efforts and to better understand what services individuals are waiting for. Waitlist management can also improve outcomes by centralizing data, reporting, and quality, while managing information across provider agencies.

Findings that Informed the Recommendation

Throughout the study, stakeholders highlighted **waitlist management as a priority area** for reevaluation. Stakeholders suggested having a standardized waitlist management process and a formal procedure for documenting when individuals would move from the 0208 Comprehensive Waiver waitlist into 0208 Comprehensive Waiver services. Stakeholders also suggested a **revised approach** to assess the level of need along with the expected period of when waiver supports may be available.

As of October 2023, **2,139 individuals are currently on the waitlist for 0208 Comprehensive Waiver services with Medicaid claims utilization** and the **average length of time waiting for services is 4.3 years**. Time spent on the waitlist varies with exceptions given to individuals who have experienced crisis or emergency situations or are transitioning from institutional care settings.

Anticipated Impact of the Recommendation

- **Waitlist reduction:** A waitlist management system assists with all aspects of waitlist management, allowing for individuals to receive the needed and appropriate services in a timelier manner.
- **Fiscal management:** Waitlist management allows Montana to better manage costs, provide for more predictable budget requests, and direct resources to where they are most needed.
- **Decreases total cost of care**: A standardized waitlist management approach may decrease total cost of care as receiving lower cost ongoing HCBS services may mitigate the need for emergency and/or acute crisis level care, typically received through more expensive entry points such as urgent care centers, hospitals, and EDs.
- **Client/family satisfaction:** Waitlist management improves access to I/DD waiver services and improving overall satisfaction and relieving stress on family caregivers.

Considerations for the Recommendation

- **Stakeholder engagement:** A strong stakeholder engagement approach is necessary for successful implementation. Further, the study team suggests that the State conduct constituent interviews with DPHHS, and other parties identified in coordination with DPHHS, to gather input and feedback on the waitlist management process. Stakeholder engagement should be ongoing - stakeholders should be a part of all waitlist transformation activities, including conceptualization, design, communication, implementation, and continuous quality improvement.

- **Provider capacity:** Provider capacity is a limit to and impacts a potential revised waitlist management process. Considering a balance of capacity issues with a potential increase in waiver slots might support a successful planning process.
- **Individuals with lower acuity needs**: A revised waitlist management process should consider a plan to be responsive to individuals with lower acuity needs, including the ability to respond timely to any changes that allow for a higher urgent or emergent placement need.

Recommended Next Steps

- Consider engaging with national organizations, such as the National Association of State Directors of Developmental Disabilities Services, to maximize research efforts.
- Engage in targeted interviews with peer states to identify best practices and lessons learned. The State could consider the challenges of HCBS waitlist management identified in peer states as part of the environmental scan found in Table 88.

Table 8. Challenges and Examples in Implementing a Revised Waitlist System

Challenge	Examples
HCBS Workforce	• Current HCBS workforce's ability to support the overall needs of those currently enrolled in the waivers and capacity to support those on the waitlists to access services
Policy Changes	• Current cap on waiver slots and potential of adding additional slots.
Future and Fiscal Impact	• Expected future demand for waiver services and impact on waitlist length. • Provider network readiness for expanding waiver slots and the associated costs. • Impact of longer life expectancy for individuals with I/DD on waitlist length.
Needs Assessments and Redeterminations	• I/DD needs assessments, ADLs, IADLs, the individuals' service needs, co-occurring conditions, age of family caregivers and natural supports, aging out of public school, and other factors impact the length of time spent on a waitlist.
Geographic Variation	• Supply and demand for waiver slots by geography across Montana.

5. Re-evaluate transition grant supports.

HCBS providers play a key role in facilitating transitions to less restrictive settings of care for individuals with I/DD. Transitioning into community settings can be a time of disruption and uncertainty for the individual in services. Montana currently offers two types of grant funding to support HCBS providers who are willing and able to provide appropriate care for those who are transitioning out of institutional settings and into community-based services. The study team recommends Montana explore options to enhance and/or advance these grant opportunities to improve the transition of individuals from institutional care to community-based services. The existing grant funding options described in greater detail are in Table 9.

Table 9. Existing Grant Funding Options

Grant	Description	Examples of Permissible Uses
HCBS Transitional Grants	The intent of this funding is to financially assist with non-recurring expenses for individuals transitioning from an institution to a Developmental Disabilities Program waiver funded HCBS service. Allowable expenses are those necessary to enable a person's health and safety needs and to assist with successful transition into community services. The individual must be served by the provider for at least one year or grant funds need to be returned to the State. Funding amounts are up to $25,000 per individual per transition from an institution (including the IBC, MSH, Central Montana Nursing Home Care Center, Skilled Nursing Facility, PRTF, or other institutional setting) to a community setting.	• Environmental modifications or specialized medical equipment that is not reimbursable through Medicaid State Plan or Waiver. • Staff training prior to transition specific to the person's unique care needs as identified in the care plan as a transition need. • Reimbursement for providers for shadowing staff at the residential facility prior to transition for the purpose of cross training provider staff on the person's specific needs identified in the care plan and necessary for a successful transition.
Community Transition Waiver Services	The intent of this funding is to cover non-recurring expenses for individuals necessary to enable a person to establish a basic household that do not constitute room and board. Funding of up to $3,000 per individual per transition from an institution (including IBC, MSH, Central Montana Nursing Home Care Center, Skilled Nursing Facility, PRTF, or other institutional setting) to a residential setting owned, leased, or rented by the member and must be considered the member's private residence. Community transition services do not include monthly rental or mortgage expense, food, regular utility charges, or items for purely recreational purposes such as television or cable TV access. This service is not available to individual members transitioning into residential settings owned or leased by a Developmental Disabilities Program-funded service provider.	• Security deposits required to obtain a lease on an apartment or home. • Essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bath/bed linens. • Set-up fees or deposits for utility or services access, including telephone, electricity, heating, and water. • Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy. • Moving expenses. • Necessary home accessibility adaptations. • Activities to assess need, arrange for, and procure needed resources.

Approach to enhance and/or advance grant opportunities

- **Grant evaluation:** Montana could explore options to expand these grant opportunities for service providers through a grant evaluation that assesses the effectiveness, efficiency, and impact of the transition support grants. This evaluation would provide an opportunity to assess the current effectiveness of the grants and identify ways to expand the grant criteria and/or modify the criteria to have a broader impact.

- **Explore opportunities to expand permissible use of grant dollars:** Permissible uses of grant funding define allowable programmatic spending. The study team recommends Montana examine opportunities to add permissible uses of spending grant funds. For example, providers in Montana have traveled outside of the State to evaluate placement opportunities for individuals currently served out-of-state. These providers do not receive reimbursement for their travel costs associated with these placement evaluations. Exploration into the possibility of grant funds covering these costs, particularly when the travel is at the request of DPHHS, could be beneficial. Expanding permissible use of grant funds provides opportunities to engage providers and incentivize them to build capacity to provide services to individuals that have more difficult, higher acute cases.

Montana could also expand grant funding to those individuals who are transitioning within the community from one community placement to the next. Current grant funding opportunities only support transitions out of institutions. This could mitigate the need to consider institutional placement when a transition from a current community placement is necessary.

Factors Supporting the Recommendation

- **Flexibility in the overall I/DD system:** Allows providers to receive reimbursement for costs not historically covered to support individuals to transition into the community.
- **Provider capacity building:** Incentivizes providers to discuss, explore, and plan for serving individuals with higher acuity cases without concerns of incurring uncompensated costs associated with the process.
- **Deinstitutionalization:** This recommendation could help to ease reliance on institutional placement at the IBC and/or MSH.

Findings that Informed the Recommendation

Stakeholders strongly encouraged expanding the permissible use criteria for transitional grants due to the benefits of enhanced provider capacity and usefulness in successful transitions into the community. Stakeholders noted that providers play a key role in successful transitions, and therefore funding for non-reimbursed planning efforts is necessary to help ensure successful community transitions. Stakeholders also expressed that individuals with I/DD who are transitioning back into their family homes should have the option to receive transitional support, as there are similar costs associated with transitioning back into a family home as with transitions to other community locations.

Anticipated Impact of the Recommendation

The State may experience the following impacts as it implements new and/or improved transition support services into its care continuum:

- Improved access to services and supports in community-based settings,
- Reduced reliance on institutional care settings, including IBC and MSH, and
- Improved satisfaction and quality of life for the individual receiving services.

Considerations for the Recommendation

- **Prioritize stakeholder feedback:** Involving stakeholders in discussions around modifications to transitional grant funding, particularly community providers, is necessary to find the right balance in permissible uses for these grants.

- **Budget implications:** At the discretion of the State, this recommendation does not organically require increased funding for successful implementation. For example, Montana could choose to keep grant funding at current levels while concurrently expanding permissible uses for the funding to allow for more flexibility for providers. However, if the State were to increase the level of grant funding, a study of the budgetary impact would need to occur.
- **Funding and sustainability**: Maintaining and/or expanding a transitional grant program requires long-term sustained funding and an exploration of options to secure funding at current levels or increase funding for long-term planning.

Recommended Next Steps

- **Hold stakeholder engagement sessions regarding the transition grants**. These forums provide an opportunity for providers to generate questions and ideas, hear individuals who have transitioned with the grant program's perspectives, and incorporate stakeholder insights into the grant policy and process.
- **Consider the use of different marketing channels to promote transition grant awareness**, such as websites, social media, blogs, newsletters, or podcasts, or offline platforms, such as flyers, posters, brochures, events, or media outlets.
- **Implement pilot programs in targeted areas** to evaluate the effectiveness of any policy and programmatic changes needed to expand permissible uses for grants.
- **Identify outcomes to measure the success of transitional grant program changes**, such as placement durations, crisis events, transition times, and difficulties securing housing.
- **Develop robust policies and procedures** for any changes to permissible uses for grant funding.

6. Relocate the Intensive Behavior Center (IBC).

The IBC is an intensive, short-term treatment facility located in Boulder, Montana, providing services for individuals with I/DD. The IBC serves a vulnerable and high-need patient population as the State's intensive, short-term stabilization facility for individuals with I/DD. The intensive 12-bed facility was the result of the legislative decision to close the MDC, the State's I/DD facility. The IBC has challenges beyond the scope of the current setting.

- **Physical plant:** The grounds and the physical plant for the IBC are outdated and require substantial investments to continue functioning properly. Issues include heating, ventilation, and air conditioning along with security issues, including locks and cameras. Equally important are limits in the facility's ability to introduce residents to more traditional community living settings and hampering the ability to prepare individuals for transition back to the community.
- **Small community provides limited access to needed services and workforce**: Boulder is located between Butte and Helena. The small size and rural nature of this town presents challenges to running the IBC. For example, most people who deliver direct care services to individuals with I/DD are not willing to travel long distances to do so. As a result, most direct support professionals (DSPs) hired from neighboring communities lead to staffing challenges at the IBC. The community that surrounds the site of service delivery impacts the access to physical health or specialty. The IBC has had challenges securing willing clinicians to provide services on its grounds, resulting in

the need for residents to travel to larger communities to obtain needed services (e.g., neurology, counseling, physical therapy). The IBC maintains its basic workforce needs by using costly contract staff to fill vacant positions.
- **Proximity to Montana State Highway Patrol (MHP)**: The IBC is located on property behind the MHP. Access to the IBC requires entry and transition through the MHP, which maintains operational management of the property. The proximity to MHP reinforces the perception that the IBC is a forensic or correctional facility. The intended primary purpose of the IBC is to stabilize and then transition each person back into the community.

To address the challenges outlined above, the study team recommends services and the physical plant move from Boulder to a new setting located within a proximate, larger population center. Potential population centers for the new location are Butte and Helena, allowing for existing employees the opportunity to continue providing critical services.

Factors Supporting the Recommendation

- The units lack kitchens and resident laundry rooms, limiting residents' ability to learn key skills needed to successfully integrate back into the community.
- The units, grounds, and other buildings are secure through use of locks and cameras. The residents do not have the ability to move freely out of the units, or around campus without staff.
- Other buildings used by administrative and clinical staff are in disrepair and require substantial maintenance.
- The MHP currently has an agreement with DPHHS to provide maintenance and support for grounds and building needs. Obtaining the needed resources from MHP to continue operating a safe facility has challenged the IBC.
- Residents at the IBC no longer have access to the amenities that were available at MDC, including the pool, the gym, and walking paths.
- The community that surrounds the IBC impacts access to clinical services. Given the small and rural nature of the town of Boulder, the IBC has had challenges securing willing clinicians to provide services on its grounds, resulting in the need for residents to travel to larger cities to obtain those needed services.
- Boulder offers limited access to community services. The IBC has done a commendable job taking residents off-grounds to gain access to community activities of their choosing, including access to ice skating, restaurants, and shopping. These trips typically require transportation to Helena given their limited presence in Boulder. As DPHHS' leadership and care teams work to re-integrate individuals back into the community, it will continue to be important to have ready access to a full array of community activities to provide enhanced opportunities to engage residents and facilitate their full participation.
- The IBC setting limits its ability to provide vocational training and supported employment opportunities to individuals. There is an increasing expectation that individuals with I/DD receive employment opportunities within the community. For employers, this requires an investment in additional training, supervision, and support through use of professionals such as job coaches. By nature of the surrounding community, residents at the IBC do not receive opportunities for vocational services.

Findings that Informed the Recommendation

Stakeholder feedback regarding the care provided at the IBC emphasized a strong need to reevaluate current residents' level of need. The reevaluation would determine if those residing at the IBC could successfully transition to a less restrictive community-based setting, and in turn, reduce current IBC census. Stakeholders also suggested there is a need to evaluate the allocation of resources to plan for an evolved facility with fewer beds that will allow for the recruitment of appropriate workforce, up-to-date infrastructure, and offer a more centralized location where resources are readily accessible.

Anticipated Impact of the Recommendation

- **Expanded access to workforce:** By relocating the IBC within a population center, there would be increased access to a pool of clinical and direct care workers, as well as potential to reduce the State's continued reliance on contract staff/travelers. There may also be an opportunity to establish internships and practicums with local universities, providing an opportunity for new clinicians to be knowledgeable and sensitive to the needs of individuals with I/DD, as well as serving as a pipeline for future clinicians to work at the IBC.
- **Vocational Training:** There is an increasing expectation that individuals with I/DD receive employment opportunities within the community. Moving the IBC to an area with a larger population provides equal opportunities for vocational training and employment opportunities.
- **Community Reintegration:** Relocating the IBC improves access to a full array of community services and activities – providing enhanced opportunities to engage residents and facilitate their full participation and integration back into the community.

Considerations for the Recommendation

- **Staff housing availability:** Identify real estate markets within a larger community, with more housing available for staff.
- **Community integration opportunities**: Provide an opportunity to reduce or eliminate restrictions and increase access to opportunities that support community readiness (e.g., public transportation, cooking, laundry).
- **Reduce stigma:** Focus on a new location/setting that will assist in reducing or eliminate the current stigma that currently is present with the existing location.
- **Food service**: Currently, the IBC has limited food services. Consider cost and consistency of food services, to improve regulatory expectations in the new location.

Recommended Next Steps

- Identify and select a location in the State that best meets the needs of the facility in addressing the following factors:
    - Improvement in the physical plant,
    - Improved access to required and needed services for residents,
    - Improved access to community services,
    - A strong real estate market for workforce capacity, and
    - Reduction of the current location isolation.
- Engage stakeholders to identify an appropriate location and review details around moving the facility.

- Conduct an evaluation of bed count need to identify size and square footage of the new facility.

7. Evaluate children's services.

Out-of-state placements for children continue to be an area of focus for the State, especially for children with I/DD. Montana licenses two types of residential treatment options, PRTF and Therapeutic Group Homes to serve children in need. Although there is a comparable residential service for children with I/DD, there is only a single licensed provider in the state to serve the needs of this population within the group home setting. Thus, there is a lack of residential services for this population. The study team recommends the following changes to better support children with I/DD and their service providers:

- **Develop tiered reimbursement options for Children's Residential Services:** Although Montana offers a range of low-need to intensive-need rate options for its adult residential services, congregate living services for children reimbursement is according to a single hourly rate. Since children's services involve a variety of more and less intensive resource needs, the State should consider developing additional rate tiers for children with higher care needs to overcome potential service barriers due to current reimbursement levels.
- **Replicate Home Supports Services (HSS) for the I/DD population:** The main goal of HSS is to keep the family unit intact. HSS is a service that occurs in the home setting. HSS provide high-quality, in-home behavioral health services for children and youth with serious emotional and behavioral needs. Provided services in multiple settings focus on assisting children and caregivers to develop skills necessary to safely remain in school, in the home, and in their community while focusing on their social, emotional, behavioral, and basic needs. Each family is assigned a Home Support Services Specialist or a Treatment Manager who facilitates at least weekly home visits. Services include:
  - Engagement with the youth and caregivers in initial and continued psychoeducation related to the youth's diagnoses and/or behavioral health needs, as well as applicable intervention strategies.
  - Work with the youth and caregivers to develop adaptive and emotional coping skills across settings, such as emotional regulation, problem solving, communication, conflict management, and decision making.
  - Work with caregivers to help them acquire and use behavior management skills, as indicated by the treatment plan. Examples include consistency and follow through, use of meaningful rewards and consequences, problem solving, praise and positive communication, conflict resolution, and the development of youth supervision and monitoring plans.
  - Work with caregivers to develop supportive and nurturing relationships with the youth that promote resiliency and wellness.
  - Demonstration of competency in cognitive behavioral interventions, including assisting youth and caregivers in identifying underlying emotions and emotional triggers, and in developing cognitive flexibility, emotional regulation, and/or adaptive thinking patterns.
  - Work with the youth and caregivers to identify non-adaptive interactional patterns and develop and implement family system interventions that increase youth and caregiver adaptive responses and functioning.

    - Administration and documentation of the Child and Adolescent Service Intensity Instrument or the Early Childhood Service Intensity Instrument in each individualized treatment plan and 90-day treatment plan review. The treatment plan includes anchor points identified in the Child and Adolescent Service Intensity Instrument or the Early Childhood Service Intensity Instrument as areas of treatment focus.
- While these services are currently available to families of children with behavioral health needs, similar services would also benefit children with I/DD care needs and the State should consider establishing a billable HSS option for children with I/DD.
- **Offer Therapeutic Foster Care Services to children with I/DD:** The Children's Mental Health Bureau currently offers Therapeutic Foster Care (TFC) services to children served in the foster care system. TFC services are services that are in-home therapeutic and family support services for children living in a licensed therapeutic foster home environment. Services focus on the reduction of behaviors that interfere with the youth's ability to function in the family and/or home community, facilitation of the development of skills needed by the youth and family to prevent or minimize the need for more restrictive levels of care, and to support permanency or return to the legal guardian. The provider is available by phone or in-person to assist the youth and foster family during crisis. TFC services include:
    - Functional assessment of the youth and family system,
    - Crisis planning and response,
    - Behavioral coaching and training for the youth, and
    - Behavioral coaching and training for the foster and natural family.
- The study team recommends developing a similar TFC option for children with I/DD based on the services offered for children with behavioral health needs in foster care system.

Factors Supporting the Recommendation

- **Hourly rate structure:** The current hourly rate structure does not incentivize providers to build capacity around serving children with I/DD. Tiered rates could offset costs not currently captured in the hourly rate and incentivize providers to increase capacity for serving more children with I/DD.
- **Keeping children at home with families:** Children with I/DD are best served when they are living at home with care and attention provided by natural supports and immediate family. Replicating HSS and offering them to the I/DD population supports families to care for children with I/DD at home and reduces admission to out of home placements.
- **Offers support for foster care families to care for children with I/DD:** TFC services for children with I/DD could provide stabilizing support for foster parents to provide services to children with I/DD. Foster care parents could be more interested in taking fostering roles if additional supports are available to them.

Findings that Informed the Recommendation

Extensive stakeholder engagement revealed that youth to young adults (ages 6 to 18) with I/DD face gaps in the continuum of care. These gaps include a lack of support services, inadequate workforce to deliver care, ineffective referral management that lead to improper placements, and earlier identification of children with I/DD. These gaps highlight the system challenges leading to children with I/DD displaced to out-of-state settings due to in-state providers' inability or lack of in-state providers to provide adequate care.

Anticipated Impact of the Recommendation

- **Workforce development:** Tiered reimbursement could allow for providers to hire more qualified staff and helps with recruitment, training, and retention efforts.
- **Provider capacity:** Tiered reimbursement could provide an opportunity to bring more service providers into the network to offer appropriate services to children with I/DD.
- **Child/family satisfaction:** Tiered reimbursement could improve overall satisfaction for children and relieve stress on parents/families.
- **An increase in foster parents to work with children with I/DD:** The foster care system for children with I/DD could reduce participation barriers if TFC services were available to foster families.
- **Less reliance on institutional care:** These recommendations can mitigate reliance on institutional care for children with I/DD, particularly with the need for out-of-state placements at PRTFs.

Considerations for the Recommendation

- **Stakeholder involvement:** The State should collaborate closely with stakeholders, including providers, associations, and the foster care network to appropriately implement changes.
- **Interdepartmental collaboration:** Due to the nature of these recommendations, DPHHS internal departments (e.g., DDP, Children's Mental Health Bureau) should collaborate closely on the implementation of these recommendations to offer a seamless and collaborative approach to planning, execution, and implementation.
- **Foster care capacity:** Capacity issues in the foster care system may limit the ability to increase the volume of TFC services provided. It is important to plan for increased capacity needs associated with a potential increase in TFC services.
- **State plan amendment changes:** These changes to the I/DD system will require the state to Pursue a state plan amendment or waiver amendment to add the recommended services.

Recommended Next Steps

- **Identify policy impact** on rules and programmatic variables because of these recommendations.
- **Address organizational realignment** within the children's I/DD system to support a smooth implementation process.
- **Reevaluate DPHHS' reimbursement methodology** to support expanded bed capacity and the development of new specialized facilities to serve larger volumes of youth.
- Implement a **systematic approach to use data** for change management to enable the State to make decisions that optimize care coordination and service delivery to meet the evolving needs of children with I/DD.

Appendix A – Data Overview

As outlined in the Study Methodology section, quantitative data served as a key foundation for the recommendations presented in the report. Appendix A provides information on the data sources and analysis steps for the study.

The study team used Medicaid claims data to understand the volume of multiple participant groups including individuals currently enrolled in the 0208 Comprehensive Waiver, those on the waitlist for the 0208 Comprehensive Waiver, as well as those who are not currently receiving or waiting for services but have an I/DD diagnosis within the Medicaid claims data. By evaluating the three groups of individuals the study team was able to identify the variability in service utilization and inform future planning efforts. The study team also analyzed healthcare utilization among individuals, comparing expected utilization with individuals who are high utilizers of inpatient care, ED care, and crisis services. Finally, the study team compared concentrations of individuals on waitlists relative to provider locations.

The study team analyzed Medicaid claims data to understand the volume of individuals with an I/DD diagnosis based on criteria outlined by the CDC in their chronic conditions warehouse. In addition, the study team evaluated utilization patterns among participants enrolled or waitlisted for the 0208 Comprehensive Waiver, to determine if there were differences in healthcare utilization among eligible individuals.

Eligibility Criteria

An evaluation of Montana's Medicaid data revealed that more individuals with an I/DD diagnosis exist within the Medicaid system than qualify for I/DD services or waitlists (e.g., diagnoses of autism spectrum disorder (ASD) do not meet level of need for I/DD waiver services). This is an important distinction when trying to determine overall need in the I/DD system versus the expected need in the future. DPHHS provided criteria for individuals to qualify for I/DD services, which includes criteria that an I/DD diagnosis alone does not determine an individual's eligibility for waitlist placement and enrollment in the 0208 Comprehensive Waiver. These criteria contained in the State-issued "Determining Eligibility for Services to Persons with Developmental Disabilities in Montana: A Staff Reference Manual (6th Edition-2013)" and outline the evaluation process for individual enrollment in or placement on the waitlist of the 0208 Comprehensive Waiver. A determination of eligibility for the 0208 Comprehensive Waiver does not guarantee services at the time the individual is eligible. If an individual is eligible for the 0208 Comprehensive Waiver, they place on a waiting list and offered services as they become available.

A person must meet all the following eligibility criteria for the receipt of State-sponsored I/DD services:[19]

- IQ approximately 70 or below,
- Adaptive Behavior Composite scores of 70 or below,
- Functional limitations in three or more major life activities:
  - Self-care,
  - Receptive / expressive language,

[19] Montana DPHHS Developmental Disabilities Program Eligibility Training Materials (2023)

- Learning,
- Mobility,
- Self-direction,
- Capacity for independent living, or
- Economic self-sufficiency,

- Documentation that I/DD originated before age 18,
- Statement that disability is expected to continue indefinitely, and
- Person must demonstrate need for treatment required of individuals with I/DD, which is the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other lifelong / extended duration services that are individually planned and / or coordinated.

In addition to the criteria above, individuals with ASD must demonstrate both a significant impairment of intellectual functioning and a DSM-5 severity rating of Level 2 or Level 3 for social communication and restrictive repetitive behaviors that require either substantial or very substantial support. An ASD diagnosis alone does not result in eligibility for I/DD services in Montana.

Analysis

Eligibility Counts

To better understand the potential volume of individuals with I/DD within the State, the study team leveraged the CDC diagnosis list to identify those that may not currently be on the 0208 Comprehensive Waiver or on the waitlist. These individuals could be placed on the 0208 Comprehensive Waiver or waitlist in the future and are therefore important to consider when capacity planning and assessing future demand for services. In addition, the study team evaluated behavioral health diagnoses to understand the volume of co-occurring I/DD and behavioral health diagnoses and inform recommendations related to managing populations with dual diagnoses.

During SFY23, 6,691 individuals with a CDC-determined I/DD diagnosis were in Montana's Medicaid system identified using Medicaid claims data. As described above, the waiver eligibility criteria exclude I/DD diagnoses, therefore there are individuals in the 0208 Comprehensive Waiver or waitlist who do not present an I/DD diagnosis within the Medicaid claims data. There are an additional 1,341 individuals on the 0208 Comprehensive Waiver or waitlist within the claims data who do not have a primary diagnosis of I/DD based on the CDC diagnosis list. This results in a total of 8,032 individual in SFY23 that either have an I/DD diagnosis, are currently on the waitlist, or currently enrolled in the waiver. In total, 4,866 individuals were eligible for 0208 Comprehensive Waiver services. The study team analyzed Medicaid claims utilization data to identify these individuals currently enrolled in the waiver or on the waitlist:[20]

- 2,139 individuals were on the 0208 Comprehensive Waiver waitlist and had Medicaid claims utilization:
  - Of the individuals on the 0208 Comprehensive Waiver waitlist, 1,277 (59.7%) individuals did not present with a primary diagnosis of I/DD in the Medicaid claims data.

[20] Eligibility counts calculated February 2024

 - Of the individuals on the 0208 Comprehensive Waiver waitlist, 620 (29%) individuals have a co-occurring behavioral health diagnosis.
- 2,727 individuals enrolled in 0208 Comprehensive Waiver services and had Medicaid claims utilization:
  - Of the individuals enrolled in the 0208 Comprehensive Waiver, only 64 (2.3%) did not present with a primary diagnosis of I/DD in the Medicaid claims data.
  - Of the individuals enrolled in the 0208 Comprehensive Waiver, 866 (31.8%) individuals have a co-occurring behavioral health diagnosis.

Waitlist Counts

As indicated above, over 2,100 eligible individuals are currently waiting for 0208 Comprehensive Waiver services across Montana at a given time. Selection into waiver services typically relies on an individual's time spent on the waitlist (i.e., enrolled in chronological order), but exceptions are based on crisis or emergency situations as well as transitions from an institutional setting or from state custody. The average length of time a participant is on the waitlist is currently 4.3 years. This is based on an average of the current waitlist and includes those recently added to the waitlist, which can influence the average.

The proportion of individuals on the 0208 Comprehensive Waiver waitlist by region, detailed below in Table 10, typically tracks with the greater distribution of Montana's population, with a higher proportion of individuals in and around the Billings metro area within Region 3 on the waitlist as compared to proportion of the State population.

Table 10. Proportion of Individuals on the 0208 Comprehensive Waiver Waitlist by Region

Region	Count of Medicaid IDs	% of Medicaid IDs	State Pop %
1	204	10%	7%
2	280	13%	14%
3	696	33%	20%
4	426	20%	28%
5	529	25%	31%
Unknown	4	<1%	N/A
Total	**2,139**	**100%**	**100%**

Table Note: *Count of persons on waitlist that have Medicaid claims. Four IDs without an identified Region. Totals may not sum due to rounding.

Enrollment Counts

Counts of individuals diagnosed with I/DD who are receiving services in more intensive settings, including MSH, IBC, and an out-of-state residential treatment facility for children and adolescents in need of care for psychiatric and behavioral disorders listed in Table 11 below.

Table 11. Individual Counts by Care Settings

Care Setting	Individual Count*	Data Source	Report Date
MSH	19**	MICRS	Sept. 2023
IBC	8	MICRS	Sept. 2023
Out-of-state facility	7	Medicaid Claims	March 2024

Table Note: *These figures do not include children who might be eligible for I/DD services but who are receiving out-of-state services funded by Children and Family Services Division and Children's Mental Health Bureau. **Count of individuals with a primary or secondary diagnosis of I/DD within MICRS database admitted to MSH.

Participant Profiles

Using Medicaid claims data for individuals either enrolled or waitlisted for 0208 Comprehensive Waiver services, the study team compared non-outlier and outlier participants to draw contrasts between individuals who received routine services, such as case management and HCBS, against those who utilized more intensive forms of healthcare in inpatient or ED settings. Outlier participants have one of the following identifications:

- Greater than three behavioral health-related ED visits within an SFY,
- Greater than two behavioral health-related inpatient admissions within a SFY,
- One or more crisis services within a SFY as defined on the Montana fee schedules for Crisis Stabilization and Crisis Intervention and Response services.

Using the outlier definitions, the study team analyzed specific participants profiles to understand the individual's interactions with the healthcare system. All healthcare utilization within the participant profiles represents Medicaid claims with a primary behavioral health diagnosis, inclusive of I/DD.

Utilization Analysis

Non-outlier Utilization Analysis

For example, purposes, the study team selected two participant profiles that represented expected utilization of services of a "non-outlier" Medicaid participant. These participants received consistent services and remained out of hospital-based care settings.

Figure 5 represents healthcare utilization from June 2022 to July 2023 for a single participant added to the waitlist for 0208 Comprehensive Waiver services in June 2022. This participant utilized consistent monthly case management services with no high-acuity service utilization.

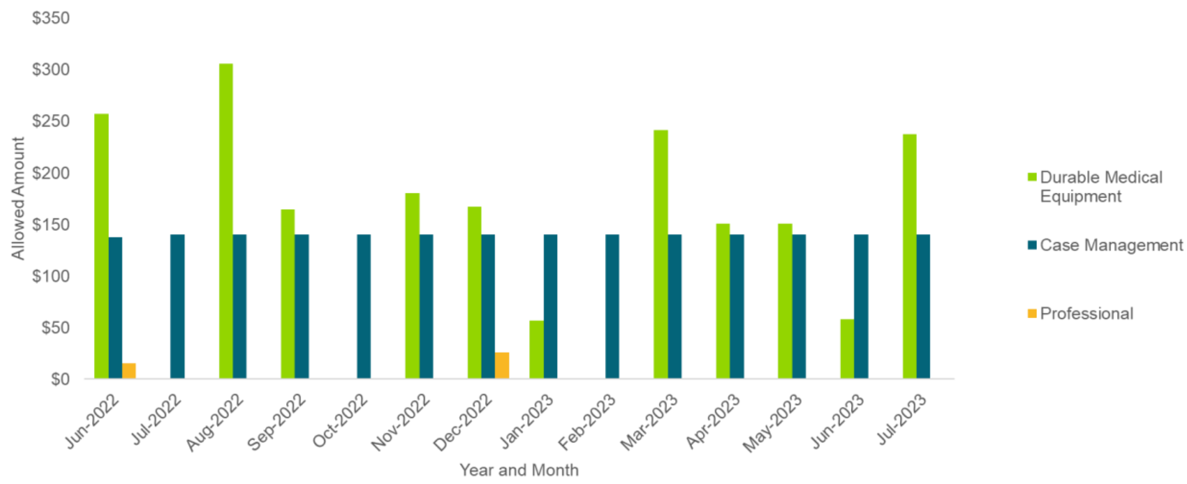

Figure 5. Non-Outlier Profile Example #1

Figure 6 represents healthcare utilization from June 2022 to July 2023 for a single participant added to the waitlist for 0208 Comprehensive Waiver services in June 2015. This participant utilized consistent personal care and case management services with no high-acuity service utilization.

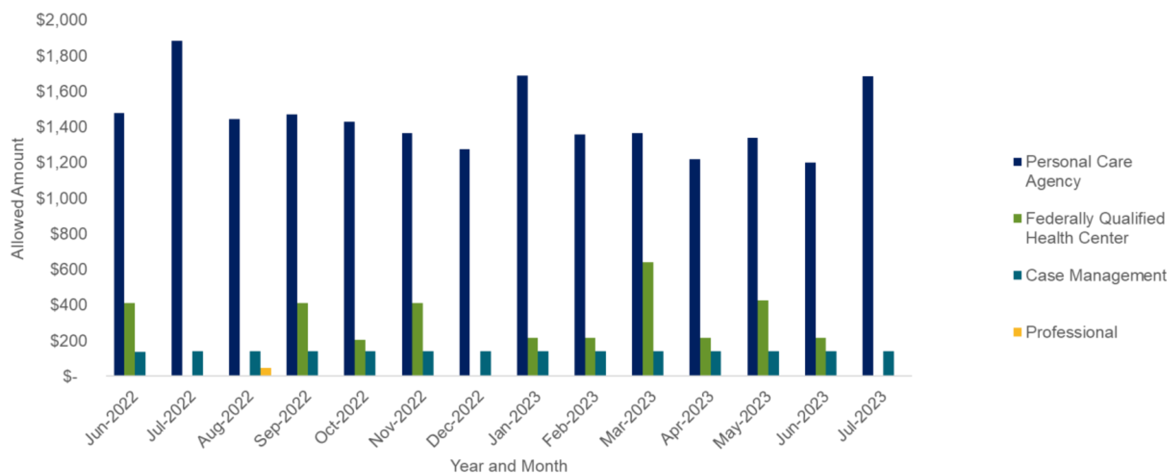

Figure 6. Non-Outlier Profile Example #2

Outlier Utilization Analysis

Figure 7 below represents behavioral health-related healthcare utilization from February 2022 to July 2023 for a single participant added to the waitlist for 0208 Comprehensive Waiver services in January 2020. This participant had three inpatient admissions within a 12-month period related to Attention-Deficit/Hyperactivity Disorder, intellectual disability, and autistic disorder, with four additional behavioral health-related ED visits within the same year.

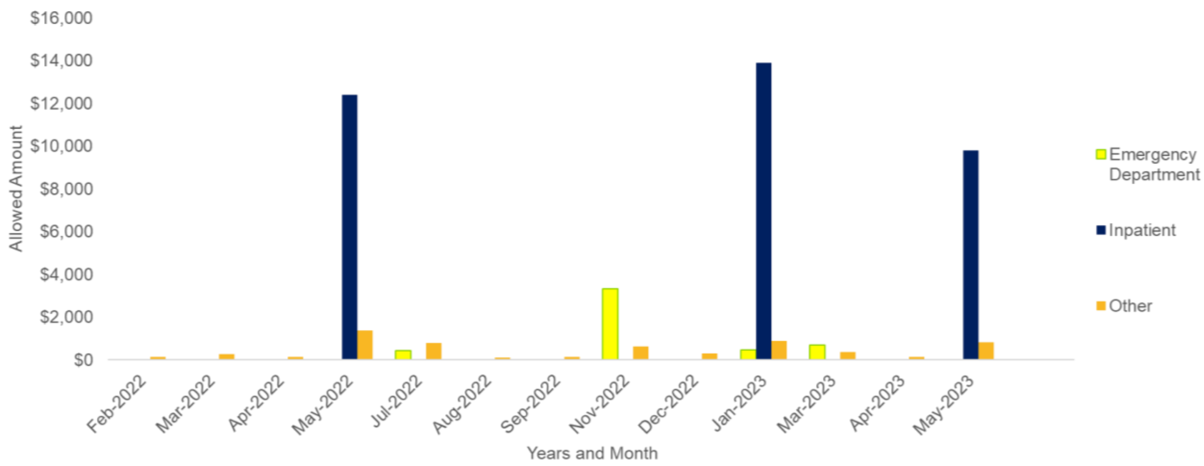

Figure 7. Outlier Profile Example #1

Figure 8 below represents behavioral health-related healthcare utilization from April 2022 to March 2023 for a single participant enrolled in the 0208 Comprehensive Waiver. This participant is currently receiving I/DD residential services but has recurring ED visits with a primary diagnosis of autistic disorder. In August 2022, an ED visit occurred resulting in decreased residential utilization in September and October of 2022. In March 2023 there was a crisis event with a primary diagnosis of autistic disorder.

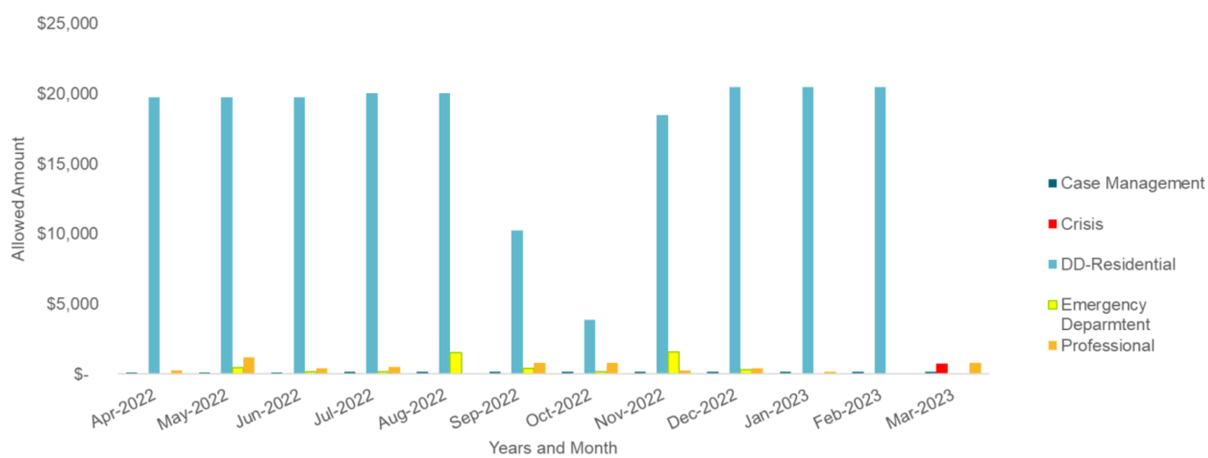

Figure 8. Outlier Profile Example #2

The study team analyzed the above four specific participant profiles to better understand and build person-centered and least-restrictive recommendations. These examples influence recommendations related to waitlist management, provider capacity, and the timing of provider intervention.

Access – Heat Maps

The study team produced heat maps to illustrate the varying distribution and concentration of individuals on the waitlist as well as providers of the top four 0208 Comprehensive Waiver services with the highest expenditures. The heat maps report the count of individuals waitlisted for the 0208 Comprehensive Waiver by participant zip code (e.g., the darker the shading, the higher the concentration of individuals who are currently waiting for 0208 Comprehensive Waiver services in that zip code), relative to the location of a given provider corporate office of the following services with the highest expenditures:

- Day Supports and Activities,
- Residential Habilitation Supported Living,
- Congregate Living, and
- Adult Foster Support.

Table 12 informs where participants may require additional provider capacity as participants move from the 0208 Comprehensive Waiver waitlist onto the waiver and become eligible to receive services. Before effectively providing waiver services, it is critical to ensure adequate provider capacity for the top-utilized services. As noted previously, Region 3 has the largest volume of individuals on the 0208 Comprehensive Waiver waitlist, therefore it is important to evaluate the number of providers currently within the region before moving waitlist participants onto the waiver.

Table 12. Montana Providers by Region

Region	Day Supports and Activities	Residential Habilitation Supported Living	Congregate Living	Adult Foster Support
Region 1	4	6	4	0
Region 2	9	8	7	0
Region 3	6	7	3	4
Region 4	9	12	7	4
Region 5	11	14	7	3
Total Unique Providers: 58*				

Table Note: *Total Provider Count as of SFY23

Figure 9 through Figure 12 depict the interaction between the waitlist density and the location of the different provider types across the State. The study team utilized the combination of waitlist density heat maps to overlay where potential provider quantity misalignment in regions for the top utilized waiver services is a possibility. When comparing the volume of providers within each region, Residential Habilitation Supported Living has more providers in every region in comparison to the top utilized service of Congregate Living. As an example, in Region 5, there are 14 Supported Living providers but seven Congregate Living providers. This could indicate that the provider network needs to grow to support additional Congregate Living sites. Shown below are details of each service relative to waitlist density.

Figure 9 below depicts Day Supports and Activities provider locations across Montana relative to concentrations of individuals who are currently waiting for Comprehensive 0208 Comprehensive Waiver services, organized by zip code. Day Supports and Activities providers are typically located in areas with concentrations of individuals on the waitlist. Providers are not present in portions of Regions 1 and 3 where there are individuals on the waitlist.

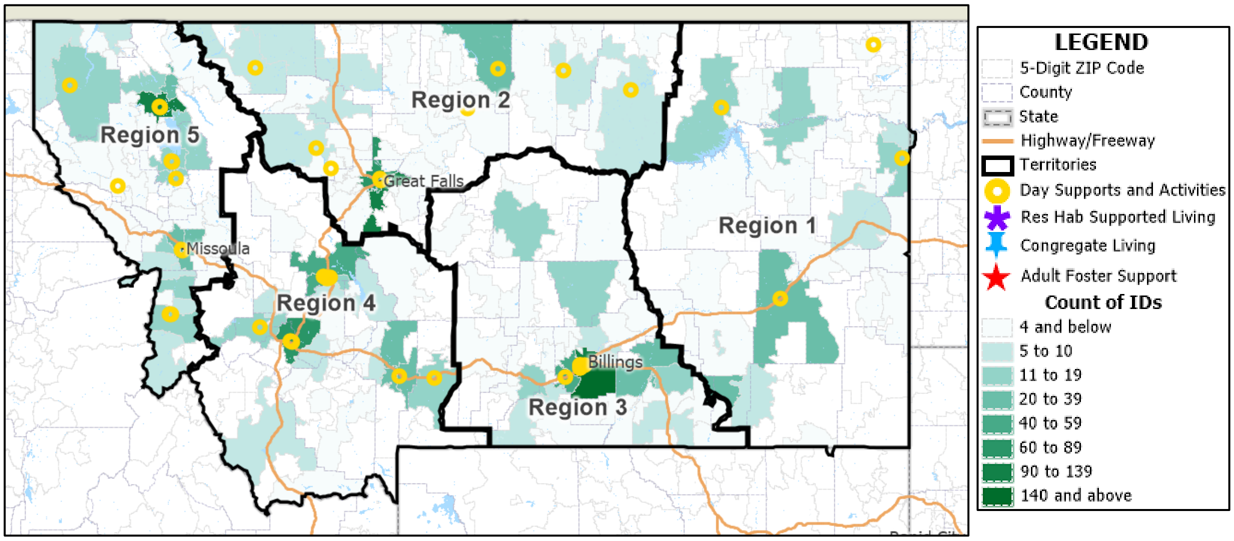

Figure 9. Day Supports and Activities - Heat Map of Individuals and Provider Locations

Figure 10 depicts Residential Habilitation Supported Living provider locations across Montana relative to concentrations of individuals on the waitlist for Comprehensive 0208 Comprehensive Waiver services, organized by zip code. Residential Habilitation Supported Living providers are typically located in areas with concentrations of individuals on the waitlist. Providers are not present in portions of Regions 2 and 3 where there are individuals on the waitlist.

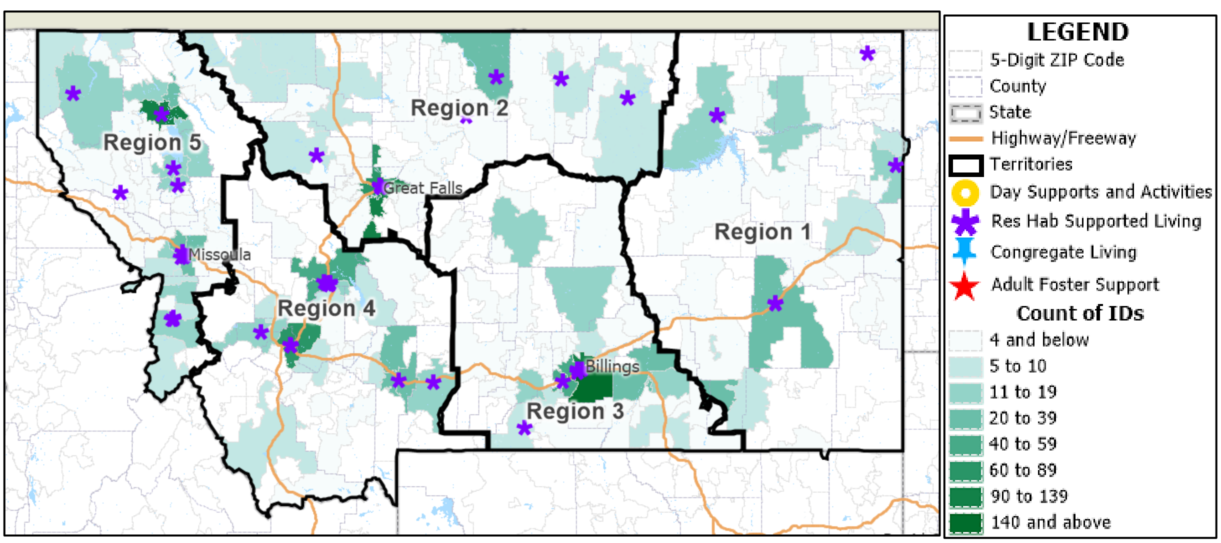

Figure 10. Residential Habilitation Supported Living - Heat Map of Individuals and Provider Locations

Figure 11 below depicts Congregate Living provider locations across Montana relative to concentrations of individuals who are currently waiting for Comprehensive 0208 Comprehensive

Waiver services, organized by zip code. Most providers of Congregate Living are typically located in areas with concentrations of individuals on the waitlist. Providers are not present in portions of Regions 1 and 3 where there are concentrations of individuals on the waitlist.

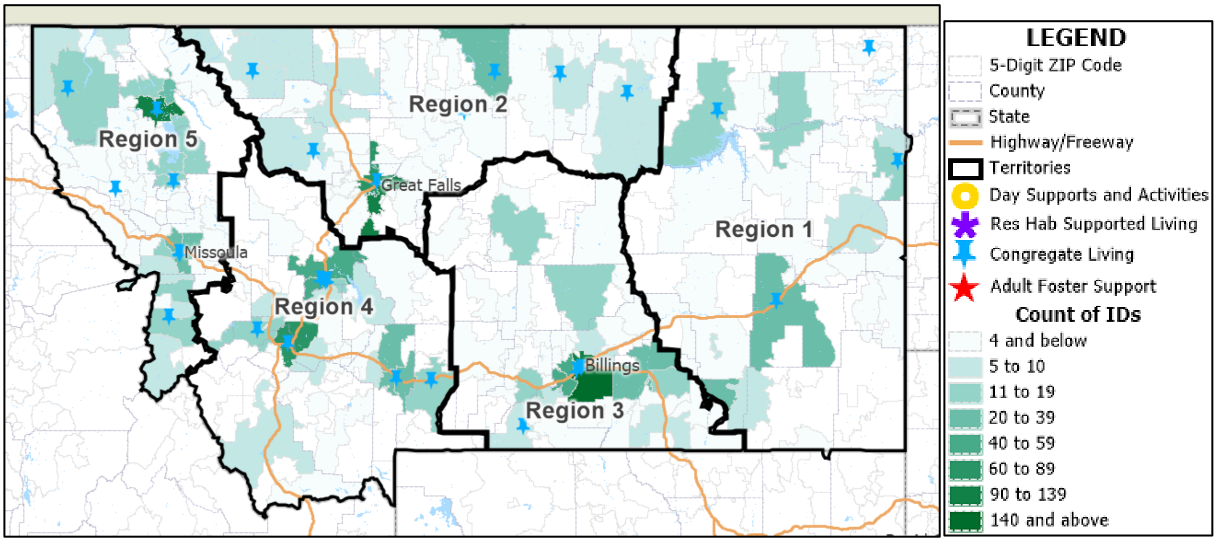

Figure 11. Congregative Living - Heat Map of Individuals on Waitlist and Provider Locations

Figure 12 below depicts Adult Foster Support provider locations across Montana relative to concentrations of individuals who are currently waiting for Comprehensive 0208 Comprehensive Waiver services, organized by zip code. There are less Adult Foster Support providers as compared to other providers and are in the southern and southwestern regions of Montana.

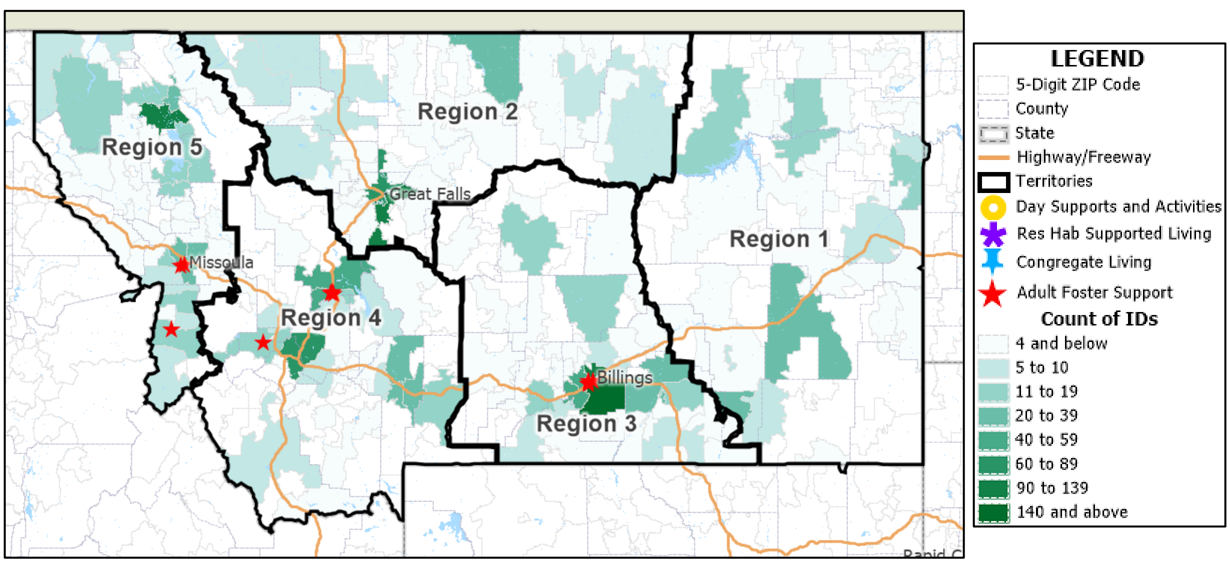

Figure 12. Adult Foster Support - Heat Map of Individuals and Provider Locations

Appendix B – Feedback Themes

Overview of Key Feedback Themes

Across all stakeholder engagement, including advocates, providers, and individuals with lived experience, key themes emerged as priorities for optimizing I/DD service provision in Montana. Table 13 outlines the three key, repeated themes voiced by stakeholders as priority challenges when considering I/DD service delivery in the State.

“Key themes” are reoccurring topics or items, mentioned by multiple stakeholders, representing areas of strength and opportunities to improve care for individuals with I/DD. Reinforced by quantitative analysis and qualitative research, key themes drove study findings and prioritized areas for recommendation.

Table 13. Stakeholder Key Themes

Key Theme	Relevant Considerations
Education and Training	• Provision of level-appropriate training, including video and live simulations for providers and families, • Direct support professional crisis supportive debrief practices, • Training and employment opportunities for individuals, and • Strategic recruitment and retention workforce efforts.
Wraparound Services	• Case management restructuring efforts, • Step-down and transition facility enhancement, • Crisis stabilization and service integration, • Resource communication and related outreach, and • Care coordination across services.
Funding and Reimbursement	• Optimizing staff wages and billing, • Optimizing provider and caregiver reimbursement, • Early identification and diagnosis of children with I/DD service needs, and • Funding housing initiatives.

Contributing Insights to Key Feedback Themes

The following section elaborates on the key themes, including strategic considerations as the study team considered these topics for recommendation development.

Education and Training

Stakeholders suggested a need for the following:

- Provision of level-appropriate training, including video and live simulations for providers and families,
- Direct support professional crisis supportive debrief practices,
- Training and employment opportunities for individuals, and
- Strategic recruitment and retention workforce efforts.

Additional Insight

Stakeholders widely agreed workforce capacity, engagement, training, and retention are significant challenges to adequate I/DD service provision in the State. More specifically, stakeholders expressed that providers at all levels of care have gaps in knowledge of how to care for individuals with I/DD. With consideration of crisis events, stakeholders expressed the need for law enforcement and first responders to receive additional training for responding to needs of the individuals with I/DD. Additionally, stakeholders repeatedly expressed the current system and staffing training infrastructure does not incentivize providing services to individuals with complex needs and/or multiple diagnoses, such as I/DD and behavioral health diagnoses.

Strategic Considerations

Throughout stakeholder engagement, participants expressed the usefulness of innovative training techniques, mediums, and approaches to foster both positive experiences and effectiveness in provider education. For example, stakeholders proposed care level-specific video trainings, live simulations for both providers and families, and the use of training cameras for group home staff. Multiple stakeholders raised the priority of fostering staff retention and advancement in I/DD service positions through appropriate reimbursement, advancement opportunity, and workforce support.

Wraparound Services

Stakeholder feedback included providing the following wraparound services to further enhance and sustain care of individuals with I/DD:

- Case management restructuring efforts,
- Step-down and transition facility enhancement,
- Crisis stabilization and service integration,
- Resource communication and related outreach, and
- Care coordination across services.

Of note, care coordination refers to broad organization of client care activities, related information sharing, and collaboration between interdisciplinary care providers. Case management is more focused treatment planning and management of specific health conditions for an individual.

Additional Insight

I/DD stakeholders expressed the desire to build an I/DD system that is least restrictive, community-oriented, and flexible. To move in this direction, stakeholders expressed the need for restructuring of case management, placement of individuals in various settings, and general service enhancement and integration.

Stakeholders repeatedly highlighted two instances of particular concern in I/DD care provision: transition of services and crisis events. During transitional care and crisis events, individuals are reliant on wraparound services to render appropriate information sharing, resource implementation, and follow-up attentiveness. Stakeholders expressed that the current models of care can lose individuals with I/DD in transitions.

Strategic Considerations

To implement a least restrictive, community-oriented, and flexible I/DD service delivery system, stakeholders raised the necessity of care coordination across all services contributing to the care continuum for an individual. Care coordination must inherently encourage appropriate resource allocation and outreach to support entities.

Stakeholders emphasized the need for step-down policy and transitional facility placement consideration in addition to the creation of crisis stabilization options at the community level. Finally, stakeholders felt strongly that an integrated care approach will ensure the consideration of wraparound service needs at each step of care provision in the I/DD system.

Funding and Reimbursement

Stakeholders suggested a need for the following:

- Optimizing staff wages and billing,
- Optimizing provider and caregiver reimbursement,
- Early identification and diagnosis of children with I/DD service needs, and
- Funding housing initiatives.

Additional Insight

Stakeholders emphasized the current reimbursement for I/DD service provision is reliant on staff hours, which they felt is inadequate for provider reimbursement and impedes staff retention. Stakeholders felt the current reimbursement system oriented to staff hours does not encourage the flexibility necessary for an adaptable, individualized I/DD care approach.

When considering the reimbursement and financial strength of the current I/DD system, stakeholders focused on pediatric population and housing concerns. For children and youth, stakeholders reinforced that early diagnosis and identification of I/DD service needs can ensure optimal service provision and community-based resource allocation. Early identification and diagnosis of children within the system can ensure appropriate measures are in place for the delivery of care and appropriate services across systems. This process will limit the use of more costly settings such as hospitals and ED meant for higher acuity needs, as children can utilize community-based alternatives to care.

The State is also currently facing challenges relating to funding, availability, and resources for housing. Housing-focused feedback reiterated that Montana's housing advocates are seeking to form partnerships with I/DD care providers to better tailor potential housing initiatives to the needs of the I/DD community. More information surrounding the process and resource options are in Appendix D of this report.

Strategic Considerations

In place of current reimbursement structures centered on staff hours, stakeholders expressed interest in bundled rate models. Stakeholders also felt strongly that staff wages, billing practices, and provider/caregiver reimbursement are at the forefront of workforce challenges. As such, stakeholders would like to see appropriate funding and workforce investment prioritized.

Stakeholder Policy Insight and Engagement

In addition to key themes and challenges experienced across the I/DD service system in Montana, stakeholders brought forward policy and initiatives of interest to contribute to an improved care continuum. Table 14 represents focus areas and program initiatives of interest expressed by stakeholders.

Table 14. Feedback Themes Captured from Stakeholder Meeting Series

	DDP Contractor Call	Family-to-Family	MCDD	I/DD Subcommittee
Level-Appropriate Training • Video or live-simulations	✓			✓
Step-down and transition facilities and services restructure/process	✓	✓	✓	✓
Children's Services • Early Identification of diagnoses		✓	✓	✓
Caregiver and Family Support programs		✓	✓	
Transition Career Opportunities/ Employment			✓	✓
Communication and Outreach		✓	✓	✓
Recruitment Process	✓			✓

Additionally, Table 15 outlines key themes raised by stakeholders that translated into specific policies of interest for potential application to Montana's I/DD service system.

Table 15. Policies of Interest and Consideration from Stakeholder Meeting Series

	Crisis Services Expansion	Institutional Model of Care (ICF)	Enhanced HCBS (Provider Capacity)	Other Options
Level-Appropriate Training • Video or live-simulations			✓	
Step-down and transition facilities and services restructure/process	✓		✓	
Children's Services • Early Identification of diagnoses	✓	✓	✓	
Caregiver and Family Support programs			✓	✓
Transition Career Opportunities/ Employment			✓	✓
Communication and Outreach			✓	✓
Effective waitlist management and Service funding			✓	✓
Crisis Stabilization and Integration	✓	✓	✓	✓
Access to medical treatment for complex and co-occurring diagnoses populations		✓	✓	

Appendix C – Leading Practices and Comparable State Research

The study team conducted a comprehensive review and analysis of leading practices implemented across states in four areas:

- HCBS payment innovations,
- On-site provider support and capacity model,
- ICF models, and
- Crisis response models.

The study team also summarized three standardized assessment options. The leading practices review helped to inform feasible options for Montana given Montana's current workforce, landscape, and population of individuals with I/DD.

HCBS Payment Innovations

Across the United States, models of HCBS delivery are evolving to improve quality and coordination of services for individuals with I/DD served in the community. HCBS are types of person-centered care delivered in the home and community for people who have functional limitations and need assistance with everyday activities. These services enable people to stay in their homes and avoid placement in a facility for care. HCBS for individuals with I/DD can include (but are not limited to) home health care, personal care, case management, meals, and durable medical equipment.[21]

The study team identified three states outlined in Table 16 with notable payment innovations that both sustain providers and improve the service complement for individuals with I/DD.

Table 16. HCBS Payment Innovation Examples

State	HCBS Redesign	Payment Innovation
Maryland	Implemented 1) tiered reimbursement based on number of beds in group homes / community living and 2) fee adjustments for individuals with trial experience	Home Size
Georgia	Implemented Additional Staffing reimbursement model based on individual's acuity	Acuity-based
Missouri	Began implementing value-based payments using pay-for-reporting and training, utilizing remote supports	Value-based

Maryland

In 2019, Maryland enhanced their HCBS offerings with person-centered options to support individuals and families, with a focus on self-directed services and supports, as well as revised reimbursement methods to ensure providers' financial sustainability. Maryland deploys a support team, including the individual's friends, advocates, and family members, coupled with a

[21] Home- and community-based services. CMS.gov. (n.d.).

state-appointed coordinator, to develop a Person-Centered Plan (PCP), which includes information on the person's values and goals coupled with screening and assessment information on the individual.[22] The PCP then informs which services the individual will receive within the following waivers, all of which feature elements of both person-centered services and sustainable reimbursement for providers:

- **Community Pathways Waiver:** Notable design and program features serving approximately 16,000 individuals aged 18+ include offering a full array of services, including Career Exploration, Supported Employment, Community Living, Group Homes, and Live-In Caregiver Supports, among others.
- **Community Supports Waiver:** Serving 1,700 individuals aged 18+, these self-directed services target Support Services, Employment, and Day Services.
- **Family Supports Waiver:** Serving 400 individuals aged 0-21, this waiver was created to support families and caregivers of individuals with I/DD with meaningful Day Services, Assistive Technology, Behavior Support, Environmental and Vehicle Modifications, Family and Peer Mentoring Supports, Family Caregiver Training and Empowerment, Individual and Family Directed Goods and Services, Respite Care Services, Remote Support, and Transportation.[23]

In 2024, Maryland amended its Medicaid waiver rates to reflect tiered reimbursement based on size of Group Homes and Community Living arrangements, as well as rates for individuals who have encountered the judicial system across the Community Pathways, Community Supports, and Family Supports waivers. Adjusting rates to a sliding scale of reimbursement, ranging from one to eight beds, allowed providers to receive more reimbursement per individual with fewer occupied beds. This innovation assists providers in meeting their operating costs when there are few individuals requiring care at a given time.[24] The impact of reimbursement adjustments expanded waiver capacity year-over-year.

Georgia

In 2022, Georgia introduced acuity-based staffing rates to its Comprehensive Waiver for individuals requiring extra assistance during a period of crisis or transition from an institutional setting to a home or community-based setting. Georgia increased additional staffing rates by 2% on a quarter-hour billing basis in further efforts to sustain staff compensation and address workforce shortages, as well as maintain health and safety measures for both individuals and providers.[25]

Additional staffing services may be authorized to provide a higher ratio of staff to individual support, additional hours of service on a temporary basis in response to individual or family crisis, or to assist with transition services from institutional or acute care to community settings.[26] Duties of additional staff include (but are not limited to):

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[22] "Pages - Person-Centered Planning," Maryland.gov Enterprise Agency Template, n.d., https://health.maryland.gov/dda/Pages/Person-Centered_Planning.aspx.
[23] Maryland Developmental Disabilities Administration, "Easy-to-Understand Guide to Services," May 2023, https://health.maryland.gov/dda/Documents/Person-Pentered%20Planning/5.19.23/DDA%20Easy%20Read%20Guide%20May%2019%202023.pdf.
[24] "FY2024 (from January 1, 2024) LTSSMaryland Rate Chart," Maryland.gov, n.d., https://health.maryland.gov/dda/Pages/rates.aspx#fy24.
[25] "BE COMPASSIONATE," Georgia Department of Behavioral Health and Developmental Disabilities, December 31, 2022, https://dbhdd.georgia.gov/be-dbhdd/be-compassionate.
[26] *Ibid*.

- Providing direct assistance to the individual in self-help, socialization, and adaptive skills training, retention, and improvement,
- Providing personal care and protective oversight and supervision, and
- Implementing behavioral support plans of individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors.

Acuity-based staffing rates are an innovative payment model intended to reflect that providers deliver additional staffing services for individuals with multiple functional, medical, or behavioral needs and to provide temporarily increased reimbursement to providers when those scenarios occur.

Missouri

Beginning in 2020, Missouri implemented an innovative payment system for HCBS network providers participating in the State's transition to a value-based payment (VBP) model. Missouri has experienced ongoing challenges with its direct support professional workforce, including high turnover rates, most workers being employed only part-time, substantial increases in overtime utilization, as well as salaried staff needing to step-in to provide care to individuals when there are direct service worker shortages.[27] There is also continuing evidence of individuals with I/DD boarding in hospitals waiting for HCBS providers on account of a lack of workers.[28]

Missouri instituted an opt-in approach for the VBP model among its HCBS provider network, with focus on innovation and person-centered results.[29] Components of the model include:

- **Pay-for-reporting:** Incentive payments as Missouri transitions to VBP over the next 5-7 years.
  - Annual and monthly incentive payments for reporting on Staff Stability, Training, and Outcomes data.
- **Remote supports payments:** In lieu of in-person care, the State gives 15% of total savings to providers for transitioning to remote supports every 6 months (i.e., 15% of the cost of employing direct support professional replaced by a remote support system). Remote supports are technology that allows individuals to receive support without the presence of direct support staff. They may include:
  - Sensors in the home that alert remote support staff if someone else tries to enter the home,
  - Telephones or video and web cameras for two-way communication,
  - Sensors that track an individual's movement and health information, such as activity sensors, temperature monitors, bed or chair sensor pads, and seizure monitors.
- **Transition support payments** to providers of individuals transitioning from institutional to community-based care.
  - Services include attending staffing, pre-placement visits, and filing reports.

[27] "2022 HCBS Rate Study | dmh.mo.gov," n.d., https://dmh.mo.gov/media/pdf/2022-hcbs-rate-study.
[28] Rudi Keller, "Missourians With Developmental Disabilities Languish in Hospitals, Jails, Shelters," Missouri Independent, March 22, 2023, https://missouriindependent.com/2023/03/22/missourians-with-developmental-disabilities-languish-in-hospitals-jails-shelters/.
[29] "Value Based Payments (VBP)," dmh.mo.gov, n.d., https://dmh.mo.gov/dev-disabilities/value-based-payments.

Missouri also established Self-Directed Service options within its waiver programs serving individuals with I/DD, in which an individual participates in the drafting of an Individual Support Plan (ISP) and becomes the "employer" of a given Direct Support Professional, if needed.[30]

The individual and his or her ISP and providers receive review annually. The provider evaluation is based on annual surveying and interviewing with state monitoring staff to gauge an individual's satisfaction and attainment of "goals" in living independently and attaining supportive employment, among other factors. Monitoring of ISP evaluation data led to increased referrals for life skills training, Due Process and Rights Resources, ISP revisions, and increased community access and collaboration.[31]

On-Site Provider Support and Capacity Model

On-site provider support includes enhanced stabilization and support systems targeting individuals and providers.

Arkansas

Partnering with Benchmark Human Services, Arkansas implemented an immediate pathway to stabilization aimed at driving down costs and improving the quality of care for individuals with complex needs. The utilization of these services can extend services to existing clients, or their deployment can assist providers connect to and serve new clients. In either scenario, Benchmark deploys supplemental and clinical staff to assess, support, and stabilize individuals for up to 90 days, and considers an individual's Social Determinants of Health (in its aim to enhance service capacity. Built into its immediate pathway to stabilization, the program includes the following services to support both individuals and providers:

- Treatment response within 24 hours,
- Immediate placement with identified providers,
- Psychopharmacological review within hours of admission paired with medication adjustment through StationMD,
- Updated diagnostic assessment within one week,
- Updated functional behavior assessment,
- Updated positive behavior support plan and crisis plan,
- Immediate staff coaching and 24-hour crisis support,
- Weekly psychotherapy,
- Guardianship and legal review,
- Vocational skills assessment, and
- Weekly wrap-around meeting with data review.

Benchmark provided a hypothetical example of cost savings based upon real occurrences of providers utilizing its support services. The example is composed of one month's costs for an individual with complex needs (i.e., a dually diagnosed individual with I/DD and behavioral health needs who was in crisis and requiring intensive behavioral supports). Consulting the provider, or set of providers, to address the client's multiple complex needs could have avoided fees of over $34,000, including a 30-night hotel stay, ED visit, property damage caused by the individual's disruptive behaviors, professional fees, and direct service worker compensation.

[30] "Self-Directed Supports Brochure | dmh.mo.gov," n.d., https://dmh.mo.gov/media/pdf/self-directed-supports-brochure.
[31] "MO Quality Outcomes," dmh.mo.gov, n.d., https://dmh.mo.gov/dev-disabilities/quality-programs/outcomes.

Additionally, the total cost estimate excludes costs of onboarding unfamiliar staff and other training fees due to employee turnover and worker's compensation claims. This amount stands in contrasts to the $2,170 monthly cost to offer intensive on-site provider support and capacity building for one individual through Benchmark, representing a means of financially de-risking care for individuals with complex needs.

The model notably offered benefits to providers, including:

- Increased capacity to serve a wider array of individuals,
- Increased staff skills and retention,
- Increased compliance with state and federal standards,
- Staff and administrative professional development,
- Savings in staff onboarding and workers' compensation, and
- Increased access to support and improvement in quality of care.

Intermediate Care Facility Models

ICFs are residential settings that provide 24/7 monitoring and health and rehab services to individuals with I/DD or related conditions. They offer Medicaid-funded institutional long-term services and support. ICFs may be state operated or privately operated.[32] ICFs provide a more restrictive level of care and intend to only serve individuals who require a higher level of support and supervision. ICF eligibility requires a need for active treatment, which "refers to aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services. Active Treatment does not include services to maintain independent clients who are able to function with little supervision and who do not require a continuous program of habilitation services."[33] ICFs must follow specific licensing requirements and regulations to remain open and compliant. ICFs, unlike HCBS, are not subject to waitlists and are more readily available than other long-term care setting options because states may not limit access to the service.[34]

The study team selected three ICF state models for review based on considerations for individuals of all ages, the feasibility for success, and smooth implementation into Montana's current infrastructure. These ICF models included one in California known as the Epiphany Care Homes that focuses on the ICF home distinctions, another known as ICF Group Home Model in Indiana, and lastly one specific to children known as the Laura Dester Children's Center.

California – Epiphany Care Homes

California has three ICF program types. These licensed settings provide services to Sonoma, Solan, and Napa County individuals of all ages with intellectual/developmental disabilities that meet the eligibility criteria as determined by qualified clinicians. The three program types are:

- **ICF I/DD (Developmentally Disabled).** This program provides a 24-hour setting that provides personal care, habilitation, supportive and developmental health services to

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[32] "Intermediate Care Facilities for Individuals With Intellectual Disabilities (ICFs/IID) | CMS," n.d., https://www.cms.gov/medicare/health-safety-standards/certification-compliance/intermediate-care-facilities-individuals-intellectual-disabilities-icfs/iid.

[33] *Ibid.*

[34] "Intermediate Care Facilities for Individuals With Intellectual Disability | Medicaid," n.d., https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/intermediate-care-facilities-individuals-intellectual-disability/index.html.

individuals whose primary need is for developmental services that have recurring but intermittent need for skilled nursing services.[35]

- **ICF I/DD-H (Habilitative).** This program provides a 24-hour I/DD setting that holds 4 to 15 beds and provides personal care, habilitation, and supportive/developmental health services to 15 or less individuals with I/DD.[23]
- **ICF I/DD-N (Nursing).** This program provides 24-hour I/DD setting that holds 4 to 15 beds and provides nursing supervision to individuals with intermittent recurring needs for skilled nursing care determined by a qualified clinician but not requiring continuous skilled nursing care.[36]

Epiphany Care Homes is an organization that provides all three ICF residential setting types for all ages. Founded in 1999 in Ventura County, this program provides 13 six-bed licensed homes that support children, adults, and seniors with I/DD.[37] Through a "person-first" approach, Epiphany Care Homes works to create a "growth plan" with the individual that ensures their needs are met. As individuals age and mature through the system, the interdisciplinary team creates an Individualize Service Plan and makes modifications and service expansions, as necessary. Epiphany Care Homes offers long-term residential services and provides primary and specialty care to individuals as needed.[38]

Indiana – Group Home Model

The study team reviewed the Indiana group home model as an option for families to consider for placement opportunities. Indiana group homes are licensed ICF group home styles that serve 6 to 8 individuals with 24-hour care and supervision. The group home model is available to both children and adults and delivers specialized services for behavioral management, communication training, helps individuals to develop independent living skills and provides community inclusive activities and recreation.[39] Funding for ICF group homes is through Medicaid. Medicaid also provides full healthcare coverage to individuals with disabilities residing in the facilities.[40]

Oklahoma – Laura Dester Children's Center

The Laura Dester Children's Center, formerly known as the Tulsa Boys Home Dormitories, was used as a shelter in 1988 to house Oklahoma's Department of Human Services children who were neglected and abused.[41] The center closed in 2018 after allegations that children in the state-run foster care were abused, lacked supervision, and that the center presented unsafe living conditions.[42,43] Due to the number of children with I/DD left that lacked appropriate

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[35] CA.gov Department Of Developmental Services. "Intermediate Care Facilities (ICF)," April 29, 2023. https://www.dds.ca.gov/services/icf/#:~:
[36] *Ibid.*
[37] "Residential Intermediate Care Facility | Habilitative Oxnard." Epicare.org, epicare.org/.
[38] *Ibid.*
[39] In-Pact, Inc, "Group Homes - In-Pact, Inc," May 4, 2022, https://www.in-pact.org/service/group-homes/.
[40] The Arc of Indiana, "State & Federal Programs | the Arc of Indiana," May 4, 2022, https://www.arcind.org/supports-services/state-federal-programs/.
[41] "City Council Clears Way for Development at Former Laura Dester Site," Tulsa World, October 19, 2019, https://tulsaworld.com/news/article_28ad7875-1098-519b-938e-eaf5cea94155.html.
[42] Liberty Healthcare Corporation, "Laura Dester Center Provides Short-Term Stabilization for Children With Disabilities - Liberty Healthcare Corporation," January 16, 2020, https://www.libertyhealthcare.com/newsroom/laura-dester-center-provides-short-term-stabilization-for-children-with-disabilities/.
[43] Hugh Sage, "Dester Center Completes First Year as a Short-Term Treatment Program," Liberty Healthcare Corporation, January 24, 2020, https://www.libertyhealthcare.com/newsroom/dester-completes-first-year/.

placement, the center was rebuilt in a new location and currently houses 24 licensed beds that follow the licensing requirements by the State for ICF I/DD settings.[44,45]

Presently, the center is acting as a treatment center for foster children with co-occurring I/DD and populations with mental and behavioral diagnoses who are in crisis to stabilize. The Centers for Medicare and Medicaid Services certifies the center which provides pre-placement training for behavior maintenance practices to families, staff, and caregivers as well as short-term stabilization for children and the youth as young as 9 years of age.[46] The goal is to prepare individuals for least restrictive settings and provide post-placement re-integration and successful community transitions.

Crisis Response Models

Program and support services with effective crisis response systems are an essential component of the care continuum. The study team evaluated two crisis response models based on evidence of program success and the feasibility of implementing the model in Montana:

- Georgia's crisis response model, which has a nationally accredited healthcare call center, crisis center, and a partnership with Benchmark Human Services. Benchmark Human Services has experience in developing and operating crisis management systems specifically for individuals with I/DD who are experiencing a crisis. This program's notable outcomes include:
    - Fewer incidences due to effective time-based protocols to dispatch and respond,
    - Options for acute placements have led to overall reduction in psychiatric admissions, displacements, and failed placements.
- North Carolina's National START crisis program is recognized as an effective system for small- or large-scale systems looking to provide the appropriate setting and support services for individuals with I/DD or co-occurring behavioral health needs that are in or approaching crisis. This program's notable outcomes include:
    - Improved health and wellbeing of persons enrolled and caregivers,
    - Decreased emergency service and system use,
    - Improved ability of community partners to serve/support more people with I/DD and co-occurring behavioral health needs effectively.

Georgia Crisis Response Program

The Georgia Crisis Response Program is a collaborative effort between Benchmark Human Services and the Behavioral Health and Developmental Disabilities (BHDD) department in Georgia. This program is specific to individuals with I/DD and other behavioral health, and co-occurring behavioral health conditions.[47] Georgia's Crisis Response Program has a "someone to respond" and "somewhere to go" motto that allows individuals to get in touch with appropriate qualified personnel and provide short term crisis stabilization or a face-to-face crisis response service to both adults and children 24/7 in a 365 days per year support model.[48] All program

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[44] Liberty Healthcare Corporation, "Laura Dester Center Provides Short-Term Stabilization for Children With Disabilities - Liberty Healthcare Corporation."
[45] "Sage, "Dester Center Completes First Year as a Short-Term Treatment Program."
[46] Liberty Healthcare Corporation, "Laura Dester Center Provides Short-Term Stabilization for Children With Disabilities - Liberty Healthcare Corporation."
[47] "Georgia Crisis and Access Line (GCAL) | Georgia Collaborative," n.d., https://www.georgiacollaborative.com/providers/georgia-crisis-and-access-line-gcal/.
[48] *Ibid*

offerings and incentives are designed to reduce hospitalizations, improper incarcerations, and setting displacement.[49] Georgia's crisis dispatch and response system assess callers and provides support within one hour. Georgia's Crisis Response Program also has crisis centers that provide temporary observation and walk-in options for individuals in need.[50] Crisis homes are also available based on level and complexity of need.

North Carolina START Crisis Program Assessment Tool Highlights

North Carolina's START crisis program is a national program through the Institute on Disability spearheaded by the University of New Hampshire.[51] This program offers a person-centered, multidisciplinary, cost-effective approach for individuals aged six years or older with I/DD and for individuals with behavioral health and behavioral health conditions. START provides an evidence-based and solutions-focused approached to crisis response and treatment.[52] Although meant to be short-term, resource centers are a vital component of this program. Resource centers serve as an alternative to inpatient admissions and can provide assessment and support to an individual in distress.[53] Resource centers can also assist an individual upon discharge from a behavioral health inpatient facility.

Currently, the START Crisis Program centers in North Carolina have three regions. Each region consists of a START clinical team and a resource center.[54] All three resource centers have four beds. This includes two beds for crisis respite and two beds dedicated to planned crisis respite.[55] All START Crisis Programs have a qualified 8-to-10-person clinical team trained to provide appropriate resources, coaching, and consultations to individuals in the program. Through the NCSS, the teams undergo extensive training and re-education as well as certification processes to remain in good standing with program requirements.

Assessment Tool Highlights

There is a myriad of assessment tools that the State could examine. Table 17 lists three relevant example tools (in no specific order). While there are other assessment tools available, these examples are those that have general acceptance and use across the country.

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[49] Georgia Department of Behavioral Health and Developmental Disabilities, "Adult Mental Health Crisis Services," November 15, 2023, https://dbhdd.georgia.gov/be-dbhdd/be-supported/mental-health-adults/adult-mental-health-crisis-services.
[50] *Ibid.*
[51] "National Center for START Services | University of New Hampshire," National Center for START Services | University of New Hampshire, March 15, 2024, https://centerforstartservices.org/.
[52] *Ibid.*
[53] *Ibid.*
[54] "NC START Access," Alliance Health, September 29, 2020, https://www.alliancehealthplan.org/members/services/crisis/nc-start-access/.
[55] "NC START | NCDHHS," n.d., https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-use-services/nc-start.

Table 17. Standardized National Assessment Tools

Assessment Tool	Description
Inventory for Client Assessment and Planning (ICAP)	ICAP is a nationally recognized, statistically validated assessment tool used by other state agencies throughout the country and is one of the most common assessments used for the population to identify resource need. Although states have adopted different scoring techniques for the ICAP tool, its results are most frequently generated on a scale of 1-100, with higher overall scores reflecting lower resource need, and the lower scores reflecting higher need.
InterRAI	The InterRAI instruments are designed to be compatible across health sectors which improves continuity of care, promotes a person-centered approach, and enhances an organization’s capacity to measure clinical outcomes. Instruments are built on a “core” set of items with identical definitions. Additional items are added to address issues unique to the population or setting. The InterRAI is used in other states in diverse ways, as there are separate modules that are used for distinct populations. The Home Care module is used in 21 states for older adults and individuals with physical disabilities. The Intellectual or Developmental Disability module is used by two states, as is the behavioral health module called “Community Mental Health.”
Supports Intensity Scale (SIS)	The SIS is designed to measure the pattern and intensity of supports that a person aged 16 years and older with I/DD requires to succeed in community settings. First launched in 2004, the American Associations on Intellectual and Developmental Disabilities developed this assessment tool over a five-year period (1998 to 2003). Normalization of the SIS occurred with a culturally diverse group of 1,300 people with I/DD aged 16 to 72 in 33 US states and two Canadian provinces. The psychometric properties of the tool are strong: research published in peer-reviewed journals around the world continuously demonstrates the reliability and validity of the SIS-A.

Appendix D – Housing Sub-Study

Housing Sub-Study Objectives

There is a need to increase housing solutions for individuals with I/DD. The sub-housing study aims to examine both short-term and long-term approaches that Montana can leverage with internal and external stakeholders to expand housing options crucial for promoting independence and improving the quality of life for individuals with I/DD. The objectives of the housing study included:

- Equip the State with policy and program recommendations to effectively advocate with housing partners to address housing gaps for individuals with I/DD,
- Identify housing models that provide equitable housing in the least restrictive, community-inclusive setting possible, and
- Identify potential external partnerships to leverage resources that allow for cross collaboration and efficient communication.

Beyond this specific sub-study, it is important to note that the State focuses on identifying and implementing broader solutions to make housing more affordable and attainable for Montanans through the Governor's Housing Task Force, created in July 2022 and will continue through June 2025.[56]

Methodology

The study team collaborated with DPHHS staff to convene stakeholders in the housing system to gather insight on the current housing landscape and gaps in the housing transition planning process for individuals with I/DD. This process involved meeting with the I/DD Subcommittee members in 2023 and 2024 to perform stakeholder interviews to develop housing recommendations.

Housing Sub-study Workgroup

As part of the larger stakeholder engagement process, the study team convened diverse stakeholders in the housing ecosystem with relevant experience and focus across the housing and Health and Human Services sector. Members of the workgroup provided input on housing system issues for targeted populations, barriers to housing, and opportunities to strengthen cross collaboration and communication between public and private sector entities. Stakeholders who participated in the stakeholder interviews came from the Helena Housing Authority, Montana DDP, DPHHS, Family Outreach Inc., and CEO Opportunity Resources, Inc.

Housing and Voucher Inventory Analysis

The study team researched housing stock and housing-related programs in Montana that were specifically associated with supportive housing needs for individuals with I/DD. The study team reviewed key inputs including: the type of housing vouchers throughout the State and their utilization rates and the number of public housing agencies, housing units, and affordable housing units providing both emergency housing vouchers and traditional housing vouchers. The study team analyzed the breakdown of the type of vouchers provided at public housing agencies to understand average costs per unit and overall program administration and attrition.

[56] "Governor's Housing Task Force," Department of Environmental Quality, https://deq.mt.gov/about/Housing-Task-Force.

The study team also researched and summarized the total number of supportive housing units funded through the Low-Income Housing Tax Credit (LIHTC) program to properly identify program distribution of properties and units. Finally, the study team researched leading practices across the country to guide the formulation of supportive housing recommendations for individuals with I/DD.

Findings

Like the rest of the country, Montana continues to grapple with a housing affordability crisis that affects residents. Montana is among the nation's fastest growing states and the surge in housing costs coupled with limited supply of housing has made it difficult for Montanans to find affordable housing. The influx of out-of-state investors along with a pandemic-influenced migration to the State has only exacerbated the situation, leading to increasing rental rates and property values. To afford a two-bedroom rental home in Montana, a resident must earn $19.28 an hour compared to the current $10.30 hourly minimum wage established by the State as of January 2024.[57] As a result, impacted residents burdened with housing costs experience financial strain. Approximately 69% of those extremely low-income renter households earning under $30,000 are cost burdened, which means these renter households are spending more than 30% of their gross annual income on housing costs and utilities.[58]

Developing affordable housing units is a critical need for individuals with I/DD, especially those of low-income. Table 18 below highlights the current state of Montana's rental market based on household income at 30% and below area median income (AMI) along with specific wage and labor statistics.

Table 18. Montana Facts[59]

State Facts	Statistic
Minimum wage	$10.30
Affordable rent for households at 30% of Area Median Income	$684/month
Income level – 30% of Area Median Income (AMI)	$27,345
Number of renter households	135,060
Number of renter households below 30% AMI	31,337
Percent of renters households below 30% AMI	23%
Shortage of rental homes affordable and available for extremely low-income renters	-16,629
Adults with a disability	250,549
Percent of extremely low-Income renter households who are disabled	22%

[57] National Low Income Housing Coalition. "Montana: Out of Reach 2023." NLIHC, https://nlihc.org/oor/state/mt.
[58] National Low Income Housing Coalition. "Montana Housing Needs By State." NLIHC, https://nlihc.org/housing-needs-by-state/montana.
[59] United States Census Bureau, "2022 American Community Survey (ACS) Public Use Microdata Sample (PUMS)."

The Fair Market Rent for a one-bedroom unit in Montana is $785 a month and for a two-bedroom housing unit it is $1,002. A household must earn approximately $31,400 and $40,098 for a one-bedroom and two-bedroom apartment, respectively, in order to afford their housing and not be considered housing cost burdened, spending more than 30% of their income on housing costs.[60] This is assuming an individual is working a normal 40-hour work week throughout the year and earning at least minimum wage.

An individual diagnosed with I/DD often has income below 30% of the AMI and may receive Supplemental Security Income (SSI), a maximum amount of $914 per month or $10,968 annually. The annual income of an individual with I/DD who may solely rely on SSI payments is significantly lower than needed to afford a one-bedroom apartment. In addition to high housing costs, there are fewer housing options given the underproduction of housing units in Montana, which is facing a housing deficit of 16,629 housing units available for low- and extremely low-income renters.[61] A critical source of addressing rental assistance and housing options come in the form of Housing Choice Vouchers.

Current Public Housing Agencies and Vouchers

There are 18 public housing authorities (PHAs) operating in Montana, with seven of those entities operating specifically for tribal populations. PHAs play a critical role in addressing housing needs for low-income families, senior citizens, and individuals with disabilities. These agencies administer various federal housing programs based on funding guidance of the U.S. Department of Housing and Urban Development (HUD). One of the key programs administered by PHAs in Montana includes the Housing Choice Voucher (HCV) Program, which provides rent subsidies to targeted populations to afford decent, safe, and sanitary housing in the private market. HCV eligibility is established by federal statute with guidance from HUD, and eligibility determination for individual households is decided by the PHA; the family's income may not exceed 50% of the median family income. With the HCV Program, residents receiving vouchers pay approximately 30% of their adjusted gross monthly income towards rent and utilities.

There are vouchers that are part of the Housing Choice Voucher Program that specific populations can target; especially those individuals with I/DD. These special purpose voucher programs are often used in the same manner but have differ eligibility criteria. One such voucher program is the Special Purpose Voucher (SPV), which is a type of HCV program administered by PHAs. SPV voucher types include the following:

- Mainstream Non-elderly Disabled (NED) Vouchers
- Family Unification Program (FUP)
- HUD-Veterans Affairs Supportive Housing (HUD-VASH)
- Emergency Housing Voucher (EHV)

Mainstream and NED vouchers have special eligibility criteria to serve non-elderly persons with disabilities (individuals must be at least 18 years old and less than 62 years old) or households with a member with disabilities. These vouchers are unique in that they can help any household that includes a qualifying person lease affordable private housing of their choice. Under the NED Vouchers, the programs also support persons leaving institutional care for community-based housing and services. Vouchers enable individuals with I/DD to secure stable housing

[60] National Low Income Housing Coalition. "Montana: Out of Reach 2023." NLIHC, https://nlihc.org/oor/state/mt.
[61] National Low Income Housing Coalition. Montana Housing Needs By State." NLIHC, https://nlihc.org/housing-needs-by-state/montana.

and prevent homelessness. PHAs can leverage SPVs with Continuum of Care (CoC) programs to target rental assistance resources to specific populations like those individuals with I/DD. Table 19 below provides the current total number of HCVs and SPVs in Montana.

Table 19. Housing Choice Voucher (HCV) and Special Purpose Voucher Programs[62]

Housing Authority	Total HCVs & SPVs (excluding EHV)	Total SPVs	Total SPVs Leased
Great Falls Housing Authority	265	0	0
Helena Housing Authority	401	5	3
Housing Authority of Billings	803	137	121
Missoula Housing Authority	1,008	109	91
Montana Department of Commerce	4,393	452	202
Public Housing Authority of Butte	503	39	18
Richland County Housing Authority	103	0	0
Ronan Housing Authority	39	0	0
Whitefish Housing Authority	19	0	0
Total	**7,614**	**742**	**435**

Based on the data in Table 19, the Montana is facing a low lease rate of 58% for the SPVs and a 75.5% leasing rate for overall HCVs. Underutilization of vouchers means that individuals in need of housing assistance may not receive these vital resources despite the availability of rental vouchers.

Montana Statewide Continuum of Care

While the HCV program addresses housing needs by providing financial rental assistance to low-income families, the CoC Program provides rental assistance with extensive supportive services for homeless persons with disabilities. The CoC Program promotes a community-wide commitment with the following goals:

- Ending homelessness,
- Provide funding for efforts by nonprofit providers, states, Indian Tribes or tribally designated housing entities, and local governments,
- Re-house homeless individuals, families, persons fleeing domestic violence, dating violence, sexual assault, and stalking, and youth while minimizing the trauma and dislocation caused by homelessness,

[62] "Public Housing (PH) Data Dashboard," HUD.gov / U.S. Department of Housing And Urban Development (HUD), n.d., https://www.hud.gov/program_offices/public_indian_housing/programs/ph/PH_Dashboard.

- Promote access to and effective utilization of mainstream programs by homeless individuals and families, and
- Optimize self-sufficiency among those experiencing homelessness.[63]

The CoC Program provides a holistic, comprehensive approach to support individuals with I/DD throughout their life stages.

In 2022, HUD announced $2.8 billion in CoC Competition Awards for thousands of local homeless service and housing programs across the country. Montana received approximately $4,731,872. Table 20 below highlights Montana's FY 2022 Statewide Awards. Prior to the FY 2022 Statewide Awards, the last awards were in 2016.[64]

[63] U.S. Department of Housing and Urban Development. "CoC Program Eligibility Requirements." HUD Exchange, https://www.hudexchange.info/programs/coc/coc-program-eligibility-requirements/.
[64] U.S. Department of Housing and Urban Development. "FY 2022 CoC Competition: Funding Availability." HUD, https://www.hud.gov/program_offices/comm_planning/coc/fy_2022_coc_competition.

Table 20. FY 2022 Montana CoC Statewide Awards[65]

Organization Name	Project or Award Name	FY 2022 Amount
Action Inc.	Action Inc. Rapid Rehousing	$94,277
Action Inc.	Action Inc. YHDP System Navigation & Crises Response	$83,230
Action Inc.	Action Inc. YHDP Transitional Housing	$112,990
Alliance for Youth, Inc.	Alliance for Youth YHDP 2022	$100,000
Browning School District #9	BPS YHDP	$178,645
Dawson Community College	Dawson Promise YHDP Renewal Application FY2022	$40,222
District 7 Human Resources Development Council	YHDP Renewal Project FY2022	$103,150
Friendship Center of Helena Inc	Domestic Violence Housing Assistance	$175,834
Hays/Lodge Pole School District #50	Hays/Lodge Pole System Navigator Project	$102,870
Helena Housing Authority	Helena Housing PSH	$343,656
Human Resource Council District XI	YHDP 2022-2023	$234,376
Human Resource Development Council of District IX, Inc.	HRDC IX PSH	$55,253
Human Resource Development Council of District IX, Inc.	HRDC IX RRH	$122,665
Human Resource Development Council of District IX, Inc.	HRDC IX YHDP Diversion	$60,321
Human Resource Development Council of District IX, Inc.	HRDC IX YHDP Dual Grant TH/RRH	$131,776
Human Resource Development Council of District IX, Inc.	HRDC IX YHDP Rapid Rehousing (RRH)	$36,935
Human Resource Development Council of District IX, Inc.	HRDC IX YHDP Systems Nav	$110,005
Missoula Housing Authority	MHA PSH Renewal 2022	$1,063,971
Montana Continuum of Care Coalition	MT-500 CoC Planning Grant 2022	$137,822
Montana Legal Services Association	YYA Legal Housing Project FY22	$100,000
Northwest Montana Human Resources, Inc.	CAPNM Permanent Supportive Housing	$30,880
Northwest Montana Human Resources, Inc.	CAPNM RRH	$61,078
Northwest Montana Human Resources, Inc.	CAPNM Shelter Plus	$77,404
Northwest Montana Human Resources, Inc.	YHDP CAPNM	$51,617
Pathways Community Network, Inc.	HMIS Renewal FY2022	$157,332
Public Housing Authority of Butte	PHA Butte Permanent Supportive Housing	$116,176
Supporters of Abuse Free Environments (SAFE), Inc.	SAFE FY 22 TH-RRH	$146,952
Tumbleweed	YHDP Renewal (Sept 2022)	$104,685
YWCA Billings	YWCA Billings Rapid Re-Housing	$263,700
YWCA Missoula	YWCA Missoula Rapid Rehousing Program	$334,050

[65] *Ibid.*

The total 2022 CoC Program awarded amount for Montana was $4,731,872 and much of the funding components aimed at permanent supportive housing for individuals with disabilities rapid re-housing. Under the permanent supportive housing component for FY 22, approximately $1,632,087 supported five renewal projects listed in Table 20 above. This vital funding stream to these organizations continues to support a robust continuum of care and service delivery system for individuals with I/DD.

Low-Income Housing Tax Credit

Another essential federal program that benefits individuals with disabilities and fosters the development of affordable, accessible housing is the Low-Income Housing Tax Credit (LIHTC) program. Since 1987, the federal LIHTC program has awarded approximately $827 million in federal tax credits to funding the construction, acquisition, and preservation of over 8,600 units in Montana.[66] Low-Income Housing Tax Credits are tax incentives through the Internal Revenue Code for multifamily rental construction and renovation, requiring projects to maintain affordability for at least 30 years, and frequently longer due to state-layered requirements. The LIHTC program continues to serve vulnerable populations who make up extremely low-income households and can often incentivize private investment in affordable rental housing, often including units designed for disability access. Montana's Qualified Allocation Plan (QAP) sets the criteria for evaluating all projects that apply for a tax credit allocation. Based on the scoring criteria of Montana's 2023 QAP, all development projects with LIHTC funding need to maintain affordability provisions for at least 15 years and will receive additional points for 35 extend use years of affordability.[67]

Currently, Montana has a total of 253 active LIHTC projects across the State, and Table 21 below specifically highlights the locations the select projects.

Table 21. Select FY2023 Montana LIHTC Projects[68]

Location	Number of Projects
Missoula	29
Billings	23
Bozeman	19
Kalispell	17
Helena	16
Great Falls	12
Butte	11

[66] Novogradac & Company LLP. "Montana LIHTC Impact Report." March 2, 2023, https://www.novoco.com/public-media/documents/montana-lihtc-impact-report-03022023.pdf.
[67] Montana Department of Commerce. "2023 Qualified Allocation Plan." Montana Housing, https://housing.mt.gov/_shared/Multfifamily/docs/2023QAP.pdf.
[68] "Low Income Housing Tax Credit (LIHTC) Data Montana - Policy Map," Data set, n.d., https://lihtc.huduser.gov/.

More urban areas such as Billings and Missoula tend to have a greater number of LIHTC units available.

Principles of Supportive Housing

Supportive housing is a combination of affordable housing and specific wrap-around services designed to help those individuals and families facing complex challenges thrive in the local community. The typical characteristics of supportive housing include the following: 1) Affordable, 2) Permanent Tenure, 3) Flexible and Voluntary Services, and 4) Tenant-Driven. The types of supportive housing models can vary widely due to target populations, such as individuals experiencing chronic homelessness, persons facing complex health and behavioral health conditions, veterans facing difficulties transitioning to civilian life and at-risk of homelessness, elderly persons needing supportive services to live independently, and individuals with disabilities requiring accessible living environments and supportive services. Housing models that fall under supportive housing and offer benefits of integrating tenants into diverse communities, such as urban or rural environments, include:

- **Scattered-site**: Housing rented anywhere in a community (urban setting/rural setting),
- **Clustered or integrated**: A limited number of units are set aside for people who need supportive housing within a larger rental development (urban setting/rural setting),
- **Single-site or congregate**: An entire housing development prioritized for people who need supportive housing (urban setting).

The combination of housing shortages, long voucher waitlists, and long-standing policies and programs can create unnecessary challenges for individuals with I/DD.[69]

A national report by the Council on Quality and Leadership and the Arc shared insight on housing needs by those individuals with I/DD. The report found:

- 79% of people with I/DD wanted to live in their own home,
- 55% of people in the survey stated they were able to choose where to live and who they wanted to live with, and
- Inclusion and community-based support services were principal factors.[70]

The 1999 *Olmstead* decision by the United States Supreme Court established that unjustified segregation of individuals with disabilities constitutes discrimination under the Americans with Disabilities Act. This landmark ruling emphasized the importance of integrating individuals with disabilities into the community and providing them with the opportunity to live independently with appropriate support services. Supportive housing aligns with the *Olmstead* decision, in that it offers stable, affordable housing connected with supportive services tailored to the needs of those individuals with disabilities.

Considerations

The housing issue in Montana requires collaborative efforts from policymakers, housing and community organizations, and developers to implement equitable strategies and programs that increase the availability of affordable housing for all residents, including those with I/DD. This section provides considerations for Montana that intend to help solve for gaps in the current

[69] The Arc of the United States. “Position Statements.” The Arc, https://thearc.org/position-statements/.
[70] Council on Quality and Leadership. “There’s No Place Like Home: A National Study on the Housing Crisis for People with Disabilities.” CQL,, https://www.c-q-l.org/resources/projects/theres-no-place-like-home-a-national-housing-study/.

housing development and voucher system for individuals with I/DD. Each consideration includes a summary and a case study.

Advocate for targeted set asides for individuals with I/DD in the LIHTC program. The combination of limited housing supply and continuously rising housing prices places a significant constraint on Montana residents, especially those with I/DD. This consideration aims to increase housing options for individuals with I/DD. By working within the Montana housing system, the State can leverage the Montana QAP to specifically advocate for set asides to help finance the creation or preservation of a specified number or percentage of housing units for individuals with I/DD.

The QAP sets out the State's eligibility priorities and criteria for awarding federal tax credits to housing properties. In most states, this plan establishes the threshold criteria for noncompetitive 4% tax credits and additional state low-income housing tax credits. Although the QAP directs preferences to projects that aim at serving residents with the lowest income for the longest period and located in qualified census tracts, housing finance agencies can leverage these tax credits in targeted ways.

By establishing set-asides through the QAP, the State housing agency can reserve a specific percentage or dollar amount of the given year's tax credit allocation for projects that serve a specified location or population, such as individuals with I/DD. The Montana Board of Housing, housed within the Department of Commerce, is responsible for the allocation of the LIHTC and helps to establish the QAP. HFAs are required to hold public hearings and an open comment period that can allow housing advocates, developers, and disability advocate groups to provide comments on specific set-asides. The State can use this input on potential proposed QAP inclusions to better target tax credits to properties that serve individuals with I/DD, locate projects in priority areas that positively integrate individuals with I/DD into the community, and preserve the existing stock of affordable housing for individuals with I/DD.

Case Study: Under the Florida Housing Finance Corporation, the State's QAP offered priority scoring for tenant populations with special housing needs and reserved 5% of the Allocation Authority funds specifically for affordable housing projects that target persons who have a disabling condition. A development project located in Hillsborough County, Florida leveraged $11 million in LIHTC financing to produce set-asides for individuals with I/DD.[71] Upon completion, the construction of new apartments will include 30 LIHTC units, 15 of which are set aside for individuals with I/DD. This is an example of an innovative approach leveraging LIHTC to produce housing options to allow individuals with I/DD to live independently and receive individualized support services that better integrate them into the local community.

Create a cross-sector advisory group with State agency partners and external stakeholders such as landlords, developers, and service organizations to improve communication and eliminate obstacles faced by individuals with I/DD. The State may also leverage an existing advisory group for this purpose. This consideration aims to bring together various stakeholders (private and public sector housing, health and human services, and service providers) to increase awareness of housing issues experienced by individuals with I/DD and directly address gaps in the housing and support service ecosystem. The use of a working

[71] Affordable Housing Finance. "Development for People with Disabilities Receives LIHTC Financing." AHF, https://www.housingfinance.com/finance/development-for-people-with-disabilities-receives-lihtc-financing_o.

group or committee made up of these stakeholders can inform the development of targeted housing programs and resources that assist individuals with I/DD to identify and secure independent housing. The convening of the working group can facilitate discussions on potential ways to incentivize landlord and developer participation as well as barriers faced by individuals with I/DD, such as rental voucher awareness and education, and security deposit requirements.

Additionally, the State can work with PHAs throughout Montana to increase the uptake or utilization of its HCVs, specifically SPVs. The study team found that Montana has a low lease rate for SPVs, as shown in Table 19. When coordinated strategically through the CoC Program and other partners, PHAs and their partners can perform targeted outreach to improve the utilization and lease rates of SPVs. The State's housing agencies can collaborate with PHAs to advocate for strategies that increase the utilization rate of SPVs.

Case Study: Through the 2020 passing of HB 854 Statewide Housing Study, Virginia created the State Rental Assistance Program funded with State General Funds.[72] The Virginia Department of Behavioral Health and Developmental Services established this subsidy program in collaboration with the PHAs in select locations within the State and aims to help individuals with I/DD afford to live independently. Although like the HCV in that the program is administered by the local public housing agencies, it differs in the overall process flow. With the collaboration with the Department of Behavioral Health and Developmental Services, individuals avoid placement on a PHA waitlist that could take a year or more and instead get direct referrals screened by the Department. To qualify, individuals must be 19 or older, with I/DD as defined in the code of Virginia, and be in one of the following categories:

- Transitioning out of training centers, skilled nursing facilities, IFCs, congregate residential settings and meet level of functioning criteria for a Developmental Services Waiver,
- Receiving Building Independence, Family and Individual Support or Community Living Waiver Services, or
- Determined eligible for or currently on a waitlist for one of the preceding waivers,
- Not receiving additional sources of local, state, or federal rent assistance, or
- Must live or have stated preferences to reside in the County/City of Fairfax, Clifton, Herndon, and Vienna.

As of SFY 2021, the program serves approximately 900 individuals across the State with an average annual rent assistance of $10,213.[73]

[72] Virginia Housing Commission. "HBB854 Full Report." Virginia Housing Commission, https://vhc.virginia.gov/hb854-full-report_FINALE_pdf.
[73] Virginia Department of Housing and Community Development, "Report on the Findings and Recommendations for a Down Payment Assistance Program", https://dmz1.dhcd.virginia.gov/HB854/pdf/dhcd-dpa.pdf.