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DRAFT

Children, Families, Health, and Human Services Interim Committee
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FINAL REPORT TO THE 66TH MONTANA LEGISLATURE

HJR 24:
DD SERVICES FOR ADULTS

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Summary

This report is a summary of the work of the Children, Families, Health, and Human Services Interim Committee, specific to the Committee's 2017-2018 House Joint Resolution 24 study of community services for people with developmental disabilities as outlined in the Committee's 2017-18 work plan and in HJR 24. Members received additional information and public testimony on the subject. This report is an effort to highlight key information and the processes followed by the Children, Families, Health, and Human Services Interim Committee in reaching its conclusions. To review additional information, including audio minutes, and exhibits, visit the Children, Families, Health, and Human Services Interim Committee website: www.leg.mt.gov/cfhhs. Reports specific to the study can be found on the HJR 24 study page on the committee's website.[1]

Language in italics throughout this draft report indicates text that will be updated for the final report published in September 2018.

[1] The URL for the HJR 24 Study web page is http://leg.mt.gov/css/Committees/Interim/2017-2018/Children-Family/Committee-Topics/hjr24/hjr24.asp.

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OVERVIEW

Starting in the 1970s, Montana began building a system of community services for people with developmental disabilities. Creation of the community system allowed people to move out of existing state institutions or to avoid placement in an institution at all. Over time, the community system has come to serve about 2,800 Montanans.

However, the system has faced increasing challenges in recent years. Pressure points include changes in the rate methodology and other funding practices in the past decade, the ongoing closure of the Montana Developmental Center and the facility's changed mission of housing a limited number of individuals with intensive behavioral needs, and the increased difficulty community providers are experiencing in hiring and keeping staff — a trend experienced not just in Montana but across the country.

These pressures led to introduction of House Joint Resolution 24 in the 2017 Legislature. HJR 24 asked for a study of community services for adults with developmental disabilities to see if improvements could be made to the way services are provided and paid for.

The study ranked 10th out of the 20 successful study resolutions in a poll of legislators conducted after the 2017 Legislature adjourned. The Legislative Council assigned the study to the Children, Families, Health, and Human Services Interim Committee.

The resolution suggested that the study look at:

- the number of developmentally disabled adults who are receiving services in the community and the number who are waiting for services, overall and by category of service;
- the length of time individuals spend on the waiting list for services and how the amount of time varies by category of service;
- the factors used to determine the so-called "cost plan," or the amount of money the state will pay for services provided to a developmentally disabled person in the community;
- the limitations placed on the use of funds in the cost plan and how the limitations affect the ability of community providers to offer services;
- the transition of developmentally disabled youth from school-based services to community-based services as they move into the adult service system, including the sharing of information among service providers;

The committee reviewed information from Montana and other states for the study.

- service delivery models used in other states; and
- barriers to reducing the waiting list or providing community services in a more timely manner.

HJR 24 also asked that the study determine what steps could be taken to:

- update or revise the way in which the cost plan is determined;
- provide more flexibility in the use of funding to increase the availability of community services; and
- reduce the amount of time people are on the waiting list.

In carrying out the study, the committee heard from DPHHS officials and Montana service providers; learned about rate methodologies, direct-care worker wage increases, and crisis service programs in other states; toured programs offered by a Helena provider; and listened to education officials and parents.

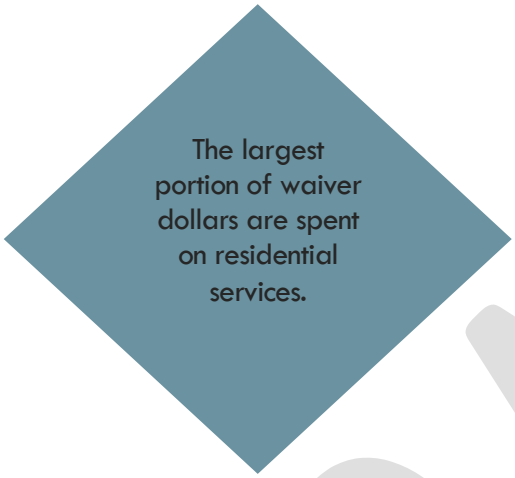
At the end of the interim, the committee recommended the following bills to the 2019 Legislature:

(List of final bills will be included here, along with any findings or other recommendations the committee may want to make.)

Community Services in Montana

About 2,800 Montanans with developmental disabilities receive Medicaid-funded services to help them live in their homes and communities, rather than an institutional setting. The services are covered under a Medicaid waiver that pays for a wide range of nonmedical services to prevent a person from being admitted to an institution, hospital, or nursing home.

About 1,600 other developmentally disabled Montanans are waiting to receive services under the waiver. About 500 of those individuals are adults.



Because the amount of money spent on the waiver is capped, the waiver can only serve a specified number of people. That means people who have been assessed as in need of services must wait for a slot to open in the waiver — unless money is added to the program to increase the number of people served or the number of services is decreased to allow the available money to be spread to more people.

Montana's Menu of Waiver Services

Montana pays for up to 34 different types of services that are grouped into three general categories: residential services, work and day services, and other services, such as behavior support services and transportation. The state spent at least $105.5 million on waiver services for 2,722 in Fiscal Year 2016.

The largest portion of waiver dollars were spent on residential services, such as group homes or other living arrangements in which a person receives support.

Of the money spent on work and day services, slightly more than half was used for day supports and activities. Those services focus on behavioral, socialization, educational, and adaptive skills for living in the community.

Building an Individual Cost Plan

The Department of Public Health and Human Services (DPHHS) uses a tool known as the Montana Resource Allocation Protocol, or MONA, as the starting point for determining an individual's cost plan. Individual cost plans can range from $1,500 a year for a person who is able to live fairly independently and

who has family supports in place to $450,000 a year for an individual with intensive needs. The average cost plan is about $48,000.[2]

Case managers work with individuals to fill out the MONA, which looks at:

- where and in what setting a person currently lives and would like to live;
- the level of paid, personal support a person will need because of behavioral issues or limitations on their ability to live independently or care for themselves; and
- whether and to what degree a person can engage in employment.

The MONA scores the responses to 39 different statements to reflect the level of paid support that a person will need to live safely in the community. The statements cover topics that include the person's ability to shop for food and clothes, prepare meals, arrange social opportunities, manage financial affairs, take medications, and undertake activities of daily living, such as bathing and dressing.

The score for each response is entered into a database that calculates the dollar amount of services the person will need. The person's care team then agrees on a plan of care that outlines the specific type and amount of services the person should receive.

The total annual cost plan is based on the reimbursement rate for each service the person is eligible to receive and the number of units of each service that is determined to be necessary.

Using the Available Funds

Providers can bill for each unit of service they provide. Under Montana's waiver, most services are reimbursed at an hourly rate.

Providers generally may bill for the service only if the person is present for the service and the service is provided by a qualified employee; some limited exceptions exist to these requirements. If the person doesn't show up for a scheduled service or if a direct-care employee isn't available to provide the service, the provider may not bill for the service even if it's included in the cost plan. For example, if two staff members are to be present for services and only one staff member is available for a shift, the provider may only bill for the hours that the one staff member provided.

As a result, it's possible a provider may not receive all of the reimbursement identified in a cost plan — a situation that was discussed in depth by providers, the committee, and DPHHS during the study process.

[2] DPHHS Developmental Services Division Administrator Rebecca de Camara, presentation to the Children, Families, Health, and Human Services Interim Committee, Sept. 11, 2017.

Where the Money Has Gone

The table below shows the services provided in FY 2016, the amount spent on each service, and the number of people receiving the service.

Residential Services	Amount	% of Total	# Served
Residential Habilitation	$65,777,412	62%	1,904
Respite	$2,498,415	2%	417
Adult Companion	$2,110,566	2%	317
Adult Foster Support	$963,542	1%	47
Personal Supports	$852,386	1%	46
Assisted Living	$315,995	<0.5%	7
Caregiver Training/Supports	$284,714	<0.5%	269
Residential Training/Supports	$253,616	<0.5%	24
Remote Monitoring	$205,814	<0.5%	16
Homemaker	$107,374	<0.5%	92
Personal Care	$38,654	<0.5%	2
Meals	$25,622	<0.5%	17
Work and Day Services	**Amount**	**% of Total**	**# Served**
Day Supports and Activities	$14,182,670	13%	1,055
Job Discovery/Job Preparation	$7,299,937	7%	844
Retirement Services	$2,035,923	2%	116
Supported Employment-Follow Along	$1,753,389	2%	381
Supported Employment-Small Group	$355,261	<0.5%	96
Supported Employment-Individual Support	$7,770	<0.5%	7
Supported Employment-Coworker Supports	$1,520	<0.5%	2
Other Services	**Amount**	**% of Total**	**# Served**
Transportation	$2,917,777	3%	2,316
Waiver Children's Case Management	$1,089,627	1%	2,903
Private Duty Nursing	$1,081,520	1%	133
Individual Goods and Services	$605,555	1%	923
Environmental Modifications/Adaptive Equipment	$334,185	<0.5%	183
Behavioral Support Services	$167,861	<0.5%	114
Psychological Services	$161,880	<0.5%	57
Personal Emergency Response System	$71,677	<0.5%	199
Supports Brokerage	$6,932	<0.5%	15
Physical Therapy	$0	0%	1
Speech Therapy	$0	0%	1

CHALLENGES FACING THE COMMUNITY SYSTEM

As the committee proceeded with the HJR 24 study, members delved into the topics outlined in the resolution and other concerns raised by stakeholders during the study process. Often, the issues were intertwined. For instance, providers discussed their struggles with hiring and keeping staff at a time of low unemployment statewide and a move towards higher wages in other sectors of the economy. Without enough direct-care workers, providers sometimes cannot bill for services because the required number of staff aren't on hand. And state budget cuts led to lower reimbursement rates, creating additional pressures for providers.

Staff Recruitment and Retention

The committee learned that staffing issues are not unique to Montana. States across the country are struggling with workforce shortages — so much so that a national report by the President's Committee for People with Intellectual Disabilities said the ongoing staffing challenges have reached "crisis levels."[3] The first of the committee's 10 recommendations focused on wages for direct-care workers. The panel said the federal government should make sure that the methods the states use to set Medicaid reimbursement rates include sufficient wages and benefits for direct-care workers.

A national presidential commission says workforce challenges are at "crisis levels."

Little comprehensive data has been gathered, however, on whether increasing wages will reduce staff turnover. The National Core Indicators project has been collecting workforce stability data from providers in participating states for the past three years. The initial data is hard to compare because of disparities in survey methods among the states. However, the NCI 2016 report on staff stability showed that in 10 jurisdictions where data had an error rate of plus or minus 5%, the three areas with the lowest turnover rate — the District of Columbia, New York, and Vermont — had the highest average wages. Providers in all three areas paid their direct-care staff $13 or more per hour.[4]

As part of the HJR 24 study, the National Conference of State Legislatures contacted state legislative staff to see if any states had recently increased direct-care worker wages and if they had looked at whether pay raises resulted in reduced turnover. A number of states reported that the legislatures had increased wages, but only Utah and South Dakota had required reporting of the results.

[3] "America's Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy," *President's Committee for People with Intellectual Disabilities*, 2017, p. 8.
[4] "2016 Staff Stability Survey Report," *National Core Indicators Project*, a collaboration of The National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute, January 2018.

Utah

The Utah Legislature increased funding for direct-care worker wages by $1.25 million in FY 2015, $5 million in FY 2016, $5 million in FY 2017, and $2 million in the current fiscal year. An August 2017 report said the FY 2016 appropriation resulted in a 30% increase in wages for the 10 largest providers in the state. The average starting wage for employees of those providers increased from $8.11 to $10.53 an hour, while the overall average wage increased from $10.17 to $13.20 an hour. Turnover decreased from 80% in 2014 to 69% in 2016.[5]

Clay Hiatt, the finance director for the Utah Division of Services for People with Disabilities, told the committee in March that turnover has since declined to 57%. He attributed the change to the pay increases.

South Dakota

The South Dakota Legislature provided one-time-only appropriations of $7.1 million in state and federal funds in 2015 and $4.1 million in 2018 for targeted retention and recruitment of direct-care staff across all provider types. The appropriations did not continue into the next year's base budget, the way general provider rate increases did.[6]

Providers were required to report on the use of the FY 2015 appropriation, and about 53% did so. Of those, about 55% said the payments increased longevity or retention. About 31% said the funds had a positive effect on recruitment of staff.

Montana's 2017 Effort

The Montana Legislature approved a bill in 2017 to increase wages for workers who provide direct care to developmentally disabled people and to elderly and physically disabled individuals. However, the effort was put on hold when state revenues failed to reach target levels.

House Bill 638 would have increased DD direct-care worker wages by 75 cents an hour every six months during the two-year budget period, for a total increase of $3 an hour.

Meanwhile, Senate Bill 261 called for the increase to be delayed if FY 2017 revenues didn't reach a certain level. When revenues missed the target level, the increase did not go into effect as scheduled. *If revenues are higher in FY 2018, half of the increase will go into effect, resulting in a pay raise of $1.50 an hour by the end of FY 2019.*

[5] "Direct Care Staff Increase Report," *Division of Services for People with Disabilities*, Utah Department of Human Services, Aug. 21, 2017.
[6] E-mail correspondence with Jason Simmons, Principal Fiscal Analyst, South Dakota Legislative Research Council, April 24, 2018.

Billing and Reimbursement Issues

Montana's reimbursement system for community services takes a number of factors into consideration and was developed through a rate restructuring process undertaken by a consultant in the mid-2000s. Before that time, DPHHS generally reimbursed providers on a monthly basis. Essentially, providers received one-twelfth of the total amount allocated for services for each client they were serving. However, the Centers for Medicare and Medicaid Services (CMS) raised questions about that approach during visits in 2000 and 2002,[7] leading to the rate restructuring process and subsequent changes.

Hourly rates are a rarity; most states use daily rates and varying tiers to account for acute needs.

The current reimbursement rates and rate-setting methods are outlined in the *Montana Developmental Disabilities Program Manual of Service Rates and Procedures for Reimbursement*. The rates are developed using four "cost centers:" direct-care staff pay, the benefit package offered to employees, general and administrative expenses related to management and operating costs, and program supervision and indirect costs such as training and transportation costs.

Rates also take geography and economies of scale into account, with larger providers receiving slightly lower reimbursement rates for some services.

Rates also are adjusted based on the appropriations made by the Legislature every two years.

Throughout the study, providers stressed that the current rate system has made it more difficult for them to draw down all of the funds allocated in a client's cost plan. They pointed in particular to the requirement to bill for most services at an hourly rate and to the prohibition on shifting funds among cost plans.

Hourly vs. Daily Rates

Montana requires providers to bill in one-hour increments for most waiver services, and providers consistently said that requirement creates problems when direct-care staff miss a scheduled shift or a client isn't present for services because of illness, vacations, or other reasons. Providers either can't bill for the time or must pay staff overtime to fill in for missing employees while being reimbursed at a regular rate that doesn't reflect the overtime costs.

A survey of waivers in 42 other states shows that Montana is unique in using an hourly rate for most of its services. Nearly all of the other states used daily rates for residential services, such as group homes, and often for day services as well. Many of the states also have started to use tiered rates that account for the level of

[7] "DD Rates Information," *Department of Public Health and Human Services*, handout provided to the Montana Developmental Center Transition Planning Committee, July 23, 2015, p. 1.

needs of the people being served. Services provided to people with more complicated medical or behavioral conditions are reimbursed at a higher level than services for people with lower-level needs.

States that use tiered rates usually use one of two nationally recognized assessment tools to determine a person's level of needs — either the Supports Intensity Scale (SIS) or the Inventory for Client and Agency Planning (ICAP).

Other Funding Issues

As the committee reviewed funding concerns for the developmental disabilities systems, providers and others discussed past funding practices that are no longer in use.

Those practices include:

- allowing providers to shift unused funds from one client's cost plans to services for another client who needs more services; and

- reallocating to providers any unused appropriations, based on decisions made by regional councils.

State officials say those practices generally occurred in the earlier years of system development, when most of the funding for the system came from state general fund dollars or federal social services block grants that had few strings attached. However, the waiver services are funded by Medicaid dollars. Those funds are subject to tighter federal requirements and closer federal scrutiny.

Virginia's Tiered System: Four Tiers/Seven Levels

Reimbursement Tier 1	1 LEVEL	**Mild Support Needs** Individuals have some need for support, including little to no support need for medical and behavioral challenges. They can manage many aspects of their lives independently or with little assistance.
Reimbursement Tier 2	2 LEVEL	**Moderate Support Needs** Individuals have modest or moderate support needs, but little to no need for medical and behavioral supports. They need more support than those in Level 1, but may have minimal needs in some life areas.
Reimbursement Tier 3	3 LEVEL	**Mild/Moderate Support Needs with Some Behavioral Support Needs** Individuals have little to moderate support needs as in Levels 1 and 2. They also have an increased, but not significant, support needed due to behavioral challenges.
	4 LEVEL	**Moderate to High Support Needs** Individuals have moderate to high need for support. They may have behavioral support needs that are not significant but range from none to above average.
Reimbursement Tier 4	5 LEVEL	**Maximum Support Needs** Individuals have high to maximum personal care and/or medical support needs. They may have behavioral support needs that are not significant but range from none to above average.
	6 LEVEL	**Intensive Medical Support Needs** Individuals have intensive need for medical support but also may have similar support needs to individuals in Level 5. They may have some need for support due to behavior that is not significant.
	7 LEVEL	**Intensive Behavioral Support Needs** Individuals have intensive behavioral challenges, regardless of their support needs to complete daily activities or for medical conditions. These adults typically need significantly enhanced supports due to behavior.

Source: Virginia Department of Behavioral Health and Developmental Services

DPHHS does have a process that allows funding from a person's cost plan to be reallocated to different types of services if the person needs more support in one area and less in another. In addition, the state has a process for increasing a person's cost plan if an urgent need arises.

Crisis Services

During the study, providers discussed the need for services to address individuals with behavioral health needs who are experiencing a crisis in their community placement and may be at risk of losing the placement. They also discussed the additional pressures that closure of the Montana Developmental Center has placed on providers, who are being asked to take individuals with more difficult behaviors without necessarily having the resources to meet their needs.

The committee heard about the crisis response systems in Montana, Georgia, and New Mexico as they considered potential solutions for the provider concerns.

Montana's Behavior Consultation Team

DPHHS has a Behavior Consultation Team that is available to assist developmentally disabled individuals, their families, and community providers when a person's behaviors are not responding to interventions or therapies that have worked in the past and the behaviors have led to hospitalization, interaction with law enforcement, or the risk of losing a community placement.

The team typically meets by conference call with people familiar with the individual, develops an action plan, makes formal recommendations, and follows up with the referring team two weeks later to see if the recommendations have been followed and been effective. The formal recommendations could include training for the staff or in-person mentoring by a Behavior Consultation Team member or may be limited to pointing the referring team to available resources.

DPHHS clearly states in its materials that it is unable to provide crisis intervention services because of its limited resources.

Georgia

As part of the settlement of an Americans with Disabilities Act complaint brought by the U.S. Department of Justice in 2010, Georgia has developed a crisis response system that includes:

- on-call mobile crisis response teams that must respond to a site within 90 minutes;
- supports for the individual in crisis, optimally in the person's home setting; and
- four-bed crisis respite homes throughout the state for individuals who can't safely remain in their current placements.

The state has contracted separately for crisis response for people with developmental disabilities and for people with behavioral health issues. However, the state is in the process of combining the two systems.

An independent reviewer for the settlement agreement noted that "very challenging" barriers exist to discharging people from the crisis respite homes, including behavioral management issues and a lack of providers with the skills and resources to provide services in an alternative setting. The report noted that 30 of the 39 people in crisis respite homes at the time of the review had been there for more than 30 days; three of them had been there since 2014.

New Mexico

The committee heard about the development of a crisis response system in New Mexico that focuses on a tiered response, depending on the needs of the person involved. That system developed as a response to settlement of a lawsuit.

Tier I services focus on crisis prevention. State employees train direct-care staff in ways to detect potential crisis situations and prevent them from escalating. Tier II services add on-site support and mentoring for the direct-care workers who are responsible for providing a person's care. Those services are provided by state employees or specially trained direct-care workers. Tier III response involves services from a provider who has been certified as a crisis provider agency and can provide services either in the individual's home or an alternative setting.

Tier III providers are able to bill for their services at an enhanced rate.

Transitioning from Youth to Adult Services

HJR 24 suggested that the study look at the transition of youth from school-based services to community-based services as they move into the adult service system, including the sharing of information among service providers.

The committee heard from a panel of speakers about this topic. An Office of Public Instruction representative discussed the requirements of the Individuals with Disabilities Education Act (IDEA) requirements, under which schools must have a plan in place by a child's 16th birthday for transition to post-school activities. Montana requires that the plan be written into a child's Individual Education Plan at age 15. The remainder of the high school activities are to be geared towards the post-graduation goals.

Because of waiting lists for community and vocational-rehabilitation services, many youth are unable to obtain services upon graduation. Sometimes, the gap between completion of high school and acceptance into community or vocational-rehabilitation services can last several years. A parent whose two sons both experienced that gap in services discussed the effects the lack of services had on her sons and on their family.

CONCLUSIONS AND RECOMMENDATIONS

Based on the information received throughout the study, the committee decided to focus on:

- improving direct-care worker wages;
- providing more flexibility in the funding of community services; and
- creating a more comprehensive system of crisis response.

Members were encouraged by the weekly conversations that DPHHS began to have with community providers in the spring of 2018. However, members also felt the Legislature could play a role in resolving some concerns. *Toward that end, the committee proposed the following bills for consideration by the 2019 Legislature:*

The committee also made the following findings and recommendations:

List any additional committee conclusions here