Montana Centers for Independent Living
MTCIL

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Medicaid Home and Community-Based Services Waiver Program

The Montana Big Sky Home and Community Based Services Program (also known as HCBS or the Medicaid Waiver program) is an enhancement of the basic personal assistance programs and covers services that are necessary for individuals to remain living in the community but are not otherwise covered under the state plan Personal Assistance or Community First Choice programs. The purpose of this program is to enable people, who would otherwise be institutionalized, to more fully access services that greatly increase their ability to move into or remain living in their own home and community rather than in a nursing home. The services are made available through the Department of Public Health & Human Services (DPHHS) and the Senior and Long Term Care Division (SLTC).

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Case Management Teams (CMT) consist of a nurse and social worker who provide a holistic approach to care planning. They look at each individual's medical and psychosocial needs and then develop a plan of care based on the person's needs and choices. Each CMT has a fixed number of individuals they can serve per year based on the budget they are allocated by the State.

The following are examples of services that may be available through HCBS:

- Adult Residential Living
- Adult Day Health
- Case Management
- Chemical Dependency Counseling
- Dietician
- Environmental Adaptations
- Habilitation Services
- Health & Wellness
- Homemaker Services
- Nutrition
- Pain & Symptom Management
- Personal Assistance
- Personal Emergency Response Systems (PERS)
- Private Duty Nursing
- Respiratory Therapy
- Respite Care
- Special Child Care
- Transportation
- Therapies (OT, PT, Speech)
- Specially Trained Attendant
- Specialized medical equipment and supplies
- Services for Individuals with Traumatic Brain Injury

The Waiver program allows states the flexibility to develop creative alternatives to institutionalizing Medicaid-eligible individuals. The program recognizes that with assistance, many individuals at risk of institutionalization can remain in their homes and communities, at a fraction of the cost of institutional care. These services are in addition to traditional home health services, such as Personal Assistance and Community First Choice services, that have been covered by Medicaid for many years.

Currently, there are a total of 2084 Waiver slots in the state of Montana. The funding amount used to define a slot has typically been $18,000 for a Basic Slot and $26,500 for an Assisted Living Slot.

Eligibility for Home and Community Based Services
To qualify for the HCBS Waiver Program, a recipient must be financially eligible for Medicaid and meet the minimum level of care requirements for nursing facility placement. Individuals must also have an unmet need that can only be addressed through a home & community based service in order to qualify for the program.

Since the Waiver program is not an entitlement program, it utilizes a specified number of slots to serve individuals. The Waiver Program is limited in the number of people it can serve based on how many slots are available. As a result, there is, and has always been, a lengthy waiting list to receive services through the Waiver program. As of July 19, 2016, there are 495 people on the waiting list. The average length of time someone is on the waiting list is approximately 200 days. The Waiver waiting list has continued to increase across the last biennium as a result of no waiver expansion from the last legislative session.

Impediments to Waiver Service Delivery
The overall budget for the waiver program is projected to be underspent by a little over $1 million. There are several factors that may contribute to this, which include:

- Waiver services allocated cannot always be utilized due to caregiver shortages and provider inability to recruit and staff for waiver hours authorized.

- Issues related to the Office of Public Assistance Medicaid eligibility system, which continually removes individuals from being Medicaid eligible when it should not be doing so.

- The length of time it takes to enroll new providers through Xerox and get approval from Central Office to add necessary procedure codes to current providers' charge files.

- The lack of an adequate provider rate.

The lack of an adequate provider rate also contributes to the caregiver shortage as, without an adequate provider rate, providers are unable to pay caregivers a competitive wage and often have to pay a lower wage for Waiver services than they do for services under the Community First Choice or Personal Assistance Services programs. Hence, potential caregivers look for employment elsewhere with higher wages.

Other impediments to waiver service delivery include:

- Additional time and travel requirements for HCBS case management are prohibitive within the rate provided. Coordination of visits has proven difficult in some areas and meetings are often too long for the consumer to be able to effectively participate.

- HCBS Case Management authorizing CFC Personal Emergency Response System (PERS) services is cumbersome and inefficient for teams as well as providers.

- The denial, by Central Office, of some durable medical equipment and other items which have been deemed medically necessary by a member's health care professional as well as the elimination of some Waiver services which were previously covered such as shipping and handling costs on durable medical equipment and vehicle modifications that already exist in a vehicle, such as in a lowered floor minivan.

- It can take OPA six months or more to finalize a member's eligibility and return the eligibility form (form MA-55) to the CMT so that the member can begin receiving Waiver services.

Community First Choice & Personal Assistance Services

Community First Choice and Personal Assistance Services are attendant care services that support people who need hands-on assistance in order to perform important daily life activities. These programs are designed to provide long-

term supports in the home setting for people with disabilities, as well as older adults, who have long-term care needs and have full coverage under Montana Medicaid.

Eligibility requirements for both AB-CFC/PAS and SD-CFC/PAS include:

1) Member has a health condition that limits their ability to perform activities of daily living,
2) Member must participate in the screening process, and
3) The Member must be eligible for Medicaid.

In order to qualify for the CFC program, a member must also meet nursing facility or ICF/MR level of care requirements. The nursing facility or ICF/MR level of care requirements do not apply to the Personal Assistance Services program. These programs enable older and disabled citizens to remain in their homes rather than needing to move into a nursing home or other institutional setting to get the assistance with activities of daily living they need.

Services available through the CFC/PAS programs include tasks such as:

- Bathing
- Toileting
- Dressing
- Ambulation/exercising
- Personal hygiene
- Meal preparation and eating
- Transferring
- Positioning
- Laundry
- Light house-keeping
- Limited shopping
- Medication assistance
- Medical escort
- Correspondence assistance (CFC Only)
- Yard hazard removal (CFC Only)
- Community integration (CFC Only)
- Skill acquisition (CFC Only)
- Emergency back-up devices (CFC Only)

The Community First Choice program incorporates all of the services available under the State Plan Personal Assistance program but also allows for some additional "permissible" services that previously were available only under the Waiver program. The enhanced services that Montana has chosen to include in its CFC program are community integration, correspondence assistance, yard hazard removal (e.g. shoveling snow off of a sidewalk so members can safely leave their home), skill acquisition, and emergency backup systems. Other service enhancements that are "permissible" under the CFC program but have yet to be implemented include things such as covering expenditures for transition costs for persons who move into community-based service settings from an institutional setting, services that increase a member's independence or substitute for human assistance, and others. These enhancements allow the State to provide a more holistic, well-rounded package of services that provide members a better opportunity to remain living in their own communities.

There two options under which CFC/PAS eligible individuals can choose to receive their services: Agency Based CFC/PAS (AB-CFC/PAS) or Self-Direct CFC/PAS (SD-CFC/PAS). The SD-CFC program, in existence since 2014, and the SD-PAS program, in existence since 1995, are for consumers who wish and have the capacity to direct their own care. The member, or their personal representative, is responsible for hiring, training, and managing their personal care assistants (PCA). Under the SD-CFC/PAS programs only, individuals can be authorized by their health care professional to receive the above mentioned care provided by their PCA(s) as well as any of the following four health maintenance activities: bowel program, catheter care, medication assistance, or wound care. Anytime a member chooses Self-Direct CFC/PAS, they must obtain authorization from their health care professional. The consumer or their personal representative must also meet capacity…that is, demonstrate a thorough understanding of the program and an ability to be able to direct their own care in accordance with the regulations that define and govern the program. Under the AB-CFC/PAS option for service delivery, members still have a voice in how their services are delivered, however, they are not responsible for hiring, training, or managing their personal care assistants. The responsibility of hiring, training, managing, and scheduling of personal care assistants under the AB-CFC/PAS option falls to the provider agency through which the

member has chosen to receive their services. The health maintenance activities previously mentioned, which are available under the SD-CFC/PAS option, are not available to members under the AB-CFC/PAS option.

Another crucial benefit to the State's CFC program is that there is an ongoing financial incentive associated with CFC – a six percent increase in the federal match rate for Medicaid's cost of delivering CFC services (aka the FMAP Rate). The FMAP increase for CFC is ongoing and does not have an end date.

As is the case with most other services on the Medicaid State Plan, any eligible individual who is eligible for Medicaid and has a documented need for CFC/PAS services is permitted to receive them.

To deliver Community First Choice and Personal Assistance Services, provider agencies throughout the state sign up as Medicaid providers of these services and serve as the conduit through which members receive these services. Some provider agencies provide both agency-based and self-directed services and others only provide one or the other. Provider agencies who provide AB-CFC/PAS services are reimbursed at a rate of $22.16 per hour and provider agencies who provide self-directed SD-CFC/PAS services are reimbursed at a rate of $17.92 per hour.

Impediments to CFC/PAS Service Delivery

When the Community First Choice program was implemented in Montana, the amount of requirements placed on provider agencies as well as on CMT's also increased. These increases in responsibilities did not come with sufficient additional funding in the way of provider rates or other mechanisms that would have allowed provider agencies to hire adequate additional staff to meet the increase in administrative responsibilities. Additionally, especially on the AB-CFC/PAS side of these programs, a lack of available caregivers to provide these services has left provider agencies with no alternative but to turn members who qualify for these services away. A key contributing factor to this shortage of available caregiving staff is a lack of a livable wage and inadequate provider rates.