

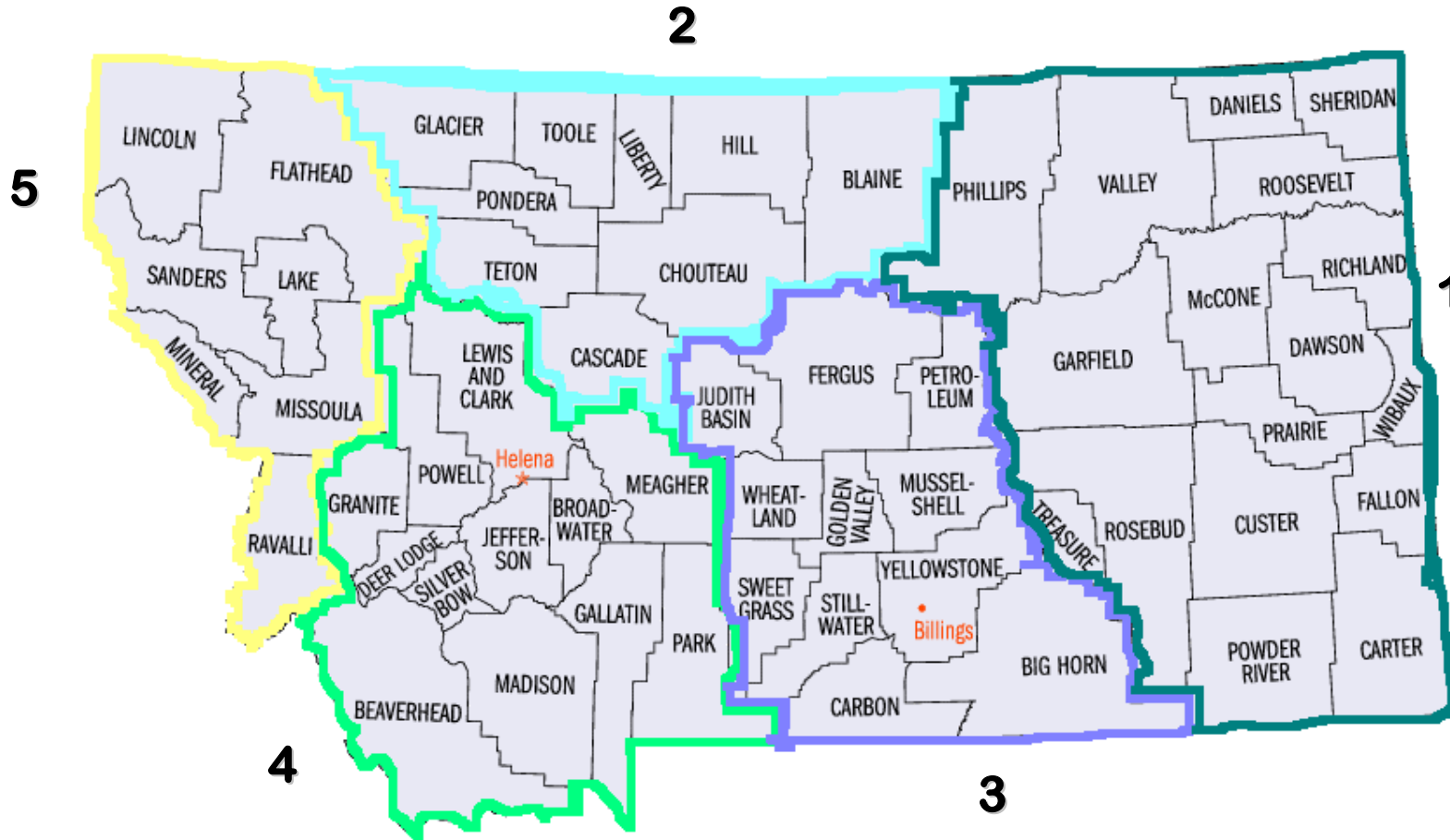
Montana Legislative Mental Health Study Preliminary Findings and Recommendations



August 21, 2008



Regions for Analysis – CMHSB Regions





Preliminary Statewide Prevalence, Penetration and Spending Data

The data on the following pages are preliminary and are intended solely to provide a progress update and to frame the discussion of issues concerning mental health access and spending.

They are not for attribution or quotation until a final report is submitted.



Differences in Prevalence

- There was a 6% difference between the highest and lowest prevalence region for adults, and a 40% difference between the highest and lowest prevalence counties
- There was only a 1% difference between the highest and lowest prevalence region for children, and a 15% difference between the highest and lowest prevalence counties.
- Methods for estimating prevalence for children are less refined than for adults

Adults with SMI and Children with SED as a percentage of 2006 population under 200% of poverty

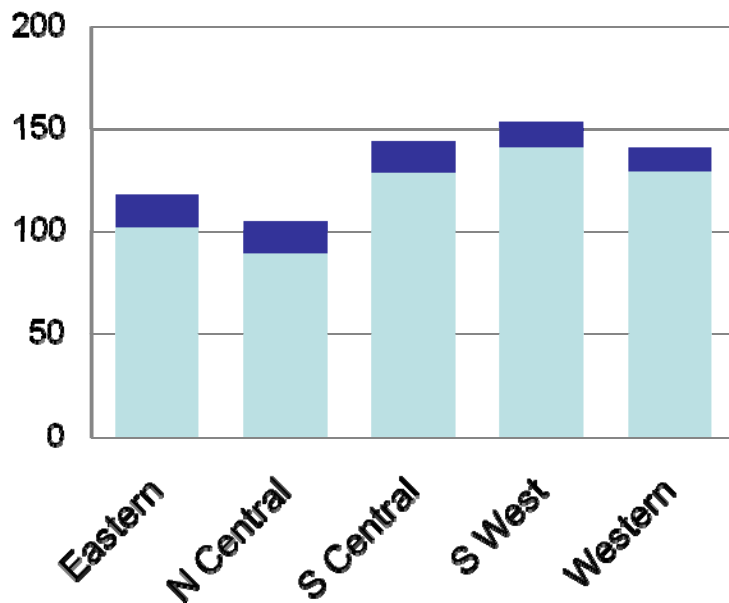
Counties with the highest and lowest estimated prevalence of serious mental health problems			
Adults with SMI		Children with SED	
Lowest prevalence rates			
Sheridan	7.4%	Treasure	8.2%
Prairie	7.6%	Broadwater	8.5%
Treasure	7.8%	Jefferson	8.5%
McCone	7.9%	Stillwater	8.6%
Garfield	8.0%	McCone	8.6%
Highest prevalence rates			
Silver Bow	9.7%	Musselshell	9.2%
Granite	9.7%	Roosevelt	9.3%
Glacier	9.8%	Prairie	9.3%
Big Horn	10.0%	Meagher	9.3%
Roosevelt	10.4%	Petroleum	9.4%

Source: Estimates by Charles Holzer based on CPES and Census Estimates

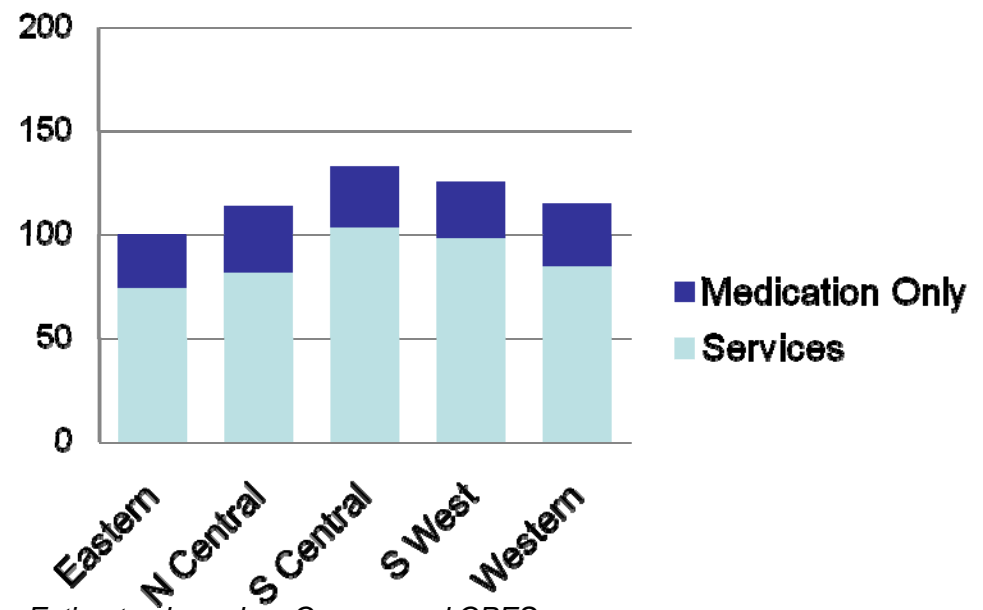


Utilization Rates Vary More Than Prevalence Rates

FY2007 DPHHS Child MH Service and Medication Users Per Thousand Population under 200% of Poverty



FY2007 DPHHS Adult MH Service and Medication Users Per Thousand Population under 200% of Poverty



Sources: DPHHS Special Report and Holzer Estimates based on Census and CPES

- There was a 39% difference between the highest and lowest MH service utilization regions, and more than an 8-fold difference between the highest and lowest prevalence counties
- There was an even greater differential of 59% between the highest and lowest MH service utilization region for children, and almost a 10-fold difference between the highest and lowest prevalence counties.
- Note: exclusion of Medicaid mental health services delivered by Indian Health Service Centers contributes to the degree of variation in utilization rates



FY2007 Utilization of Selected Services by Region: Service Users Per Thousand Population Under 200% of Poverty

	School based services	Case management - child	Case management - adult	Medication management - child	Medication management - adult
Eastern	21	32	33	7	19
N Central	17	22	23	4	2
S Central	6	33	17	16	12
S West	25	55	38	10	18
Western	25	36	27	17	20

- School based services did not vary greatly, except for S Central counties, which had much lower utilization of this service
- Children's case management services were particularly low in North Central and high in South West. Adult case management were lowest in North and South Central.
- Medication management services were more varied between regions than case management services, with North Central showing extremely low rates for both children and adults, and Easter showing very low rates for children, but not for adults. This degree of variation may be affected by the exclusion of any Indian Health Services claims in our data.



Next Steps on Geographic Analysis

- Seeking and testing adequacy of data on IHS mental health services
- Conducting additional analyses to further refine low service areas of the state and their most salient needs
- Data does not allow for analysis of:
 - Ethnicities of service recipients
 - Medicaid enrollment category of recipients
 - Income eligible
 - Disabled
 - Foster child



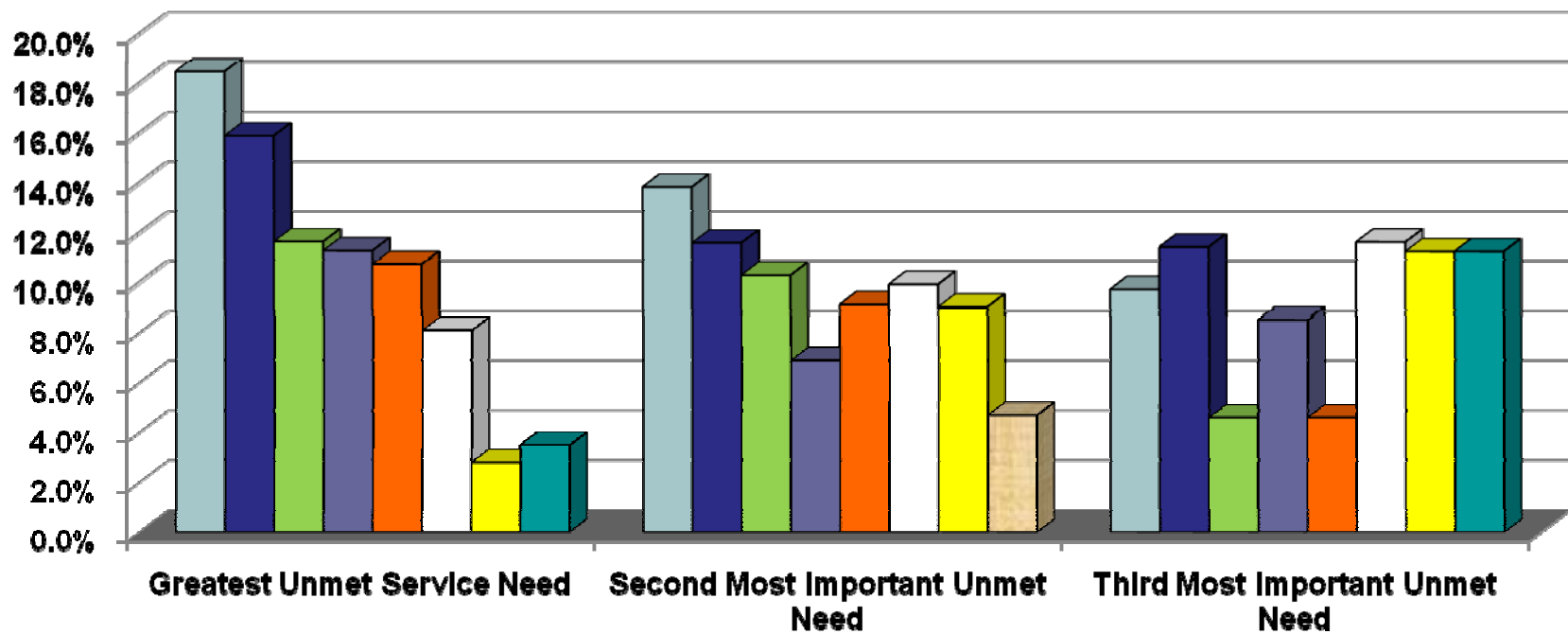
Survey Highlights

- Respondents (n=706)
 - One quarter consumers and families, one quarter providers, 17% advocates
 - Largest response rate from Missoula and Lewis and Clark counties
 - 8 counties not represented
- Greatest strengths of the MT mental health system
 - Skill and supportiveness of mental health workforce
- Populations rated least likely to have all needed services and supports
 - Children who don't meet SED criteria
 - Adults who don't meet SDMI criteria
 - People with co-occurring medical problems
 - Urban Indians
 - People with co-occurring substance abuse problems
- Barriers most often cited
 - Cost of private insurance
 - Insufficient number of providers or services
 - Limits on amount of services



What is the greatest unmet service need for mental health recipients in your part of Montana?

- Crisis Services
- Child psychiatric services
- Adult psychiatric services
- Other community treatment services
- Early Identification and Intervention
- Other
- Transitional and supportive housing
- Other community support services



N = 542 for the Greatest, 536 for the Second and 517 for the Third Most Important Unmet Need



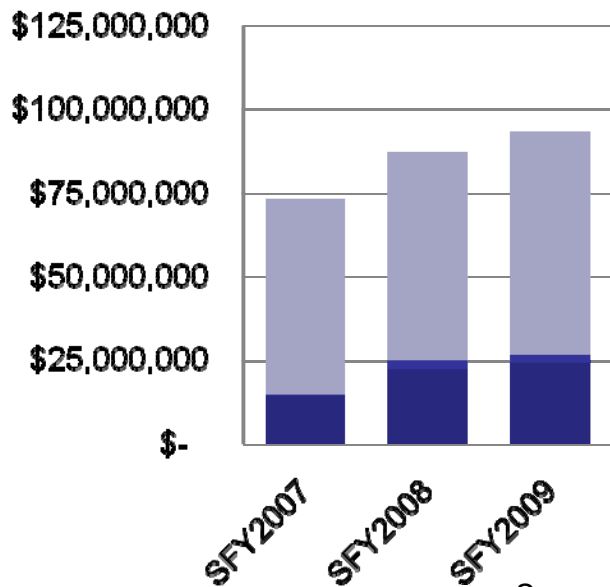
Financial Analysis

- Financial Analysis
 - Extensive review of service utilization by service and funding source
 - Review of DPHHS budgetary and expenditure data over a 3 year period
 - Identification of major federal and state funding sources for DPHHS MH services
 - Profiling of expenditures by service type
- Preliminary Conclusions
 - Medicaid is being well utilized
 - Most services that can be covered by Medicaid are in your Medicaid benefit
 - The HIFA waiver, should it be granted, would be a very significant benefit to MT
 - Marginal improvements can be made in a few places
 - SAMHSA and Foundation grants addressing the mental health and the corrections system provide opportunities to fund pilots and system development

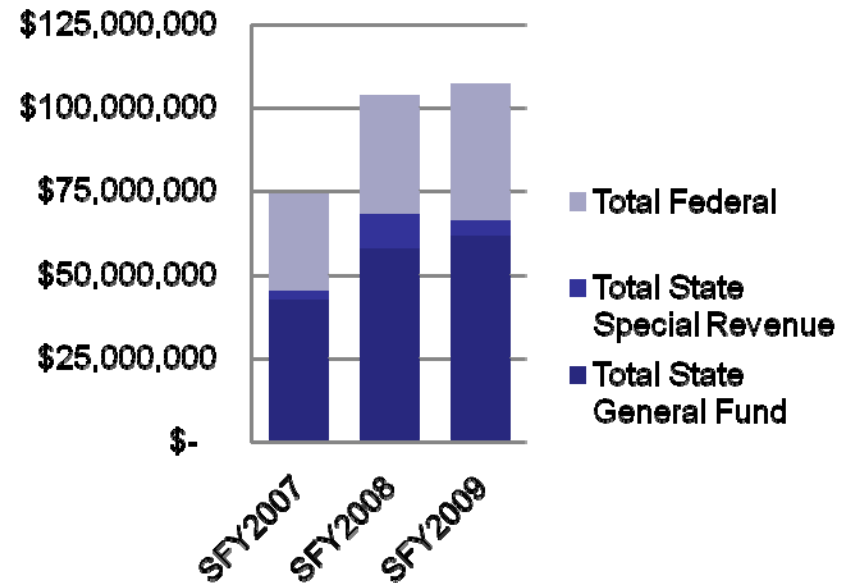


Recent Budgetary Trends

Total Appropriations for CMHSB and School Mental Health Services



Total Appropriations for AMDD Mental Health Services



Source: FY07 and FY09 Biennium
Legislative Fiscal Reports

- Children's services are funded primarily from federal funds, while the state finances the majority of adult mental health services.
- Both state and federal estimated expenditures have risen substantially over the 3 budget years.



Completing the Financial Analysis

- Additional Investigation of different Medicaid funding opportunities
 - 1915 b waiver for managed care
 - 1915 I waiver or state plan options for rehabilitation services
 - Further discussion of HCBS waiver enrollment
- Cutting back on state institutions
 - What would it really take to close beds?
- Identify specific grant opportunities matched to Montana priorities
- Discussion of different organizational options – e.g. developing a public mental health authority, managed care and consolidating adult and child services.



The Issues

- **Crisis Capacity**
- **Limited Eligibility**
- **Inpatient Capacity**
- **Coordination at case and agency levels**
- **Rate Setting**
- **Accountability and Performance Management**
- **Mental Health in the Criminal Justice System**



Crisis Capacity: Findings

- **Limited crisis and acute treatment capacity in many Montana communities**
 - Survey respondents overwhelmingly identified crisis care as the most needed or second most needed service in the state
 - Crisis service billing is somewhat limited and may not fully reimburse all needed services (Medicaid and MHSP)
- **Unexpected barriers**
 - Presumptive eligibility expansion required significant planning and implementation time
 - Hospitals slow to use new presumptive eligibility option
 - Liability for non-reimbursable medical costs limits expansion of crisis capacity
 - Crisis services may not be financially feasible in the current system
 - Many users of crisis services are not insured, Medicaid eligible, or meet requirements for presumptive eligibility
 - Community Crisis Center in Billings has not been able to bill for over 80% of visits
 - So far, only 3-10% of visits meet criteria for 72 Hour Presumptive Eligibility
 - Their problems include chronic alcoholism as well as mental health conditions
- **Effects**
 - Police and emergency rooms deal with mental health crises
 - Limited capacity of needed MH services to divert certain individuals from jail
 - Overreliance on Montana State Hospital



Crisis Capacity: Recommendations

- **Build telemedicine capacity at Montana State Hospital to support local crisis management**
 - Implement more aggressive recruiting of new psychiatrists at MSH or reissue an RFI/RFP with more market research
 - Pilot and implement linkage to hospital emergency rooms
 - Add clinicians trained in forensic psychology and offer psychiatric consultation to police and sheriffs similar to Billings Crisis Center's tele-health consultation to jails
- **Strengthen financing for crisis services**
 - DPHHS should review Medicaid and MHSP funding mechanisms for crisis services to ensure that they can appropriately reimburse real costs of the service
 - Simplify rate structure; consider grant or deficit funding mechanisms to purchase capacity
 - Legislature should request a formal one year review of implementation and utilization of crisis and stabilization services under presumptive eligibility including a review of populations not served (substance abuse or co-occurring?)
 - Expand resource currently available for next biennium and allow crisis providers to bill Medicaid for substance abuse or dual diagnosis crises.
 - Explore options for developing local partnerships like Billing Crisis Clinic
 - Hospitals benefit from reduced costs for detoxification of uninsured individuals and may need to contribute to crisis service costs
 - Consider limiting providers to one designated organization per geographic area



Eligibility is Limited: Findings

- Children over 5 can get Medicaid coverage up to 100% of poverty, and children of any age can get CHIP coverage up to 175% of poverty (up from 150%)
 - But many services are limited to children with SED
 - Montana Medicaid excludes most poor adults without dependent children, high medical expenses or disabilities
 - Medicaid parents - 40% of Poverty Level
 - Medically needy - individual 73% of Poverty Level
 - Pregnant women - 133% of Poverty Level
 - Montana ranks 38th in eligibility levels for non-working parents
 - Among Western states only Nevada and Idaho rank lower
- Seventy percent of survey respondents indicated that Medicaid eligibility requirements were a barrier affecting many or most people seeking services
- Survey respondents rated children with mental health problems not meeting SED criteria and adults with mental health problems not meeting SDMI criteria as least likely to get the mental health services and supports they need.



Eligibility is Limited: Findings, cont.

- 72 Hour presumptive eligibility criteria are more flexible about income, but still exclude quite a few people with MH problems
 - Not implemented statewide
 - Exclude a number of people who are served by crisis programs
 - People experiencing domestic violence crises, severe alcoholism, or severe co-occurring mental health and addiction problems may not be covered
 - Two-year appropriation
- Uninsured adults cannot get preventive care or early treatment. There is no payer if they need crisis services.
- Montana State Hospital becomes the “facility of first resort” for many who have no insurance and experience a mental health crisis.



Eligibility: Recommendations

- **Increase Medicaid application rates**
 - Require MHSP eligibles to apply for Medicaid disability
 - Assist incarcerated individuals to apply for Medicaid so it will be in effect immediately upon release
- **Reduce gaps in Medicaid eligibility**
 - Keep disabled and others on a suspended enrollment basis while incarcerated
 - Simplify and/or provide assistance with applications
- **Targeted eligibility expansion**
 - Continue to pursue HIFA waiver to cover MHSP eligibles under Medicaid
- **General eligibility expansion**
 - Review SED and SMDI definitions for Medicaid and/or MHSP
 - Could consider raising income eligibility levels
 - Routinely match MHSP and Medicaid eligibility files to ensure MHSP is not covering Medicaid eligible consumers
- **Legislature should commit to continuing 72 Hour Presumptive Eligibility**
 - AMDD should review implementation and make needed adjustments in policy and practice



Inpatient Capacity: Findings

- **Inpatient capacity is limited** - only 1 facility in Eastern Montana; no children's inpatient units
 - Need for additional psychiatric hospital capacity was a theme running through our survey results
- **Overreliance on Montana State Hospital**
 - Census has been over 200 in 9 of the past 12 months, though it has been lower in the most recent 3 months, reaching a low of 172 in July as a result of Project 189 efforts
 - Distance of MSH from Eastern and Northern Montana is excessive
 - Makes transportation (county responsibility) expensive
 - Distance is a hardship for patients and their families
 - Difficulties in discharge planning and community follow-up for MSH
 - Distance limits ability to have case managers present for discharge planning
 - Both state hospital staff and community providers reported lack of communication and collaboration in discharge planning with MSH, despite reported efforts by both
- **The Legislative initiative to support development of Behavioral Health Inpatient facilities encountered unexpected barriers**
 - CMS required billing on a 15 minute basis
 - Providers feared liability for medical care for uninsured individuals
 - One-time project funding created uncertainty
- **Financial burden on state**
 - No federal match for MSH as a result of the CMS IMD exclusion



Inpatient Capacity: Recommendations

- Address barriers to creation of behavioral health inpatient facilities
 - Consider developing legislation limiting medical liability for non-Medicaid consumers.
 - Identify available general hospital beds (e.g. Billings Clinic)
 - Further investigate behavioral inpatient models used by other rural states who currently provide this as a Medicaid reimbursable service and develop a strategy to propose this again to the new federal administration.
- Reduce Unnecessary Use of MSH
 - Develop legislation that enables MSH to refuse admission for individuals that can be safely and appropriately served elsewhere
 - Monitor MSH denials and how people who are denied MSH admission are served elsewhere
 - Strengthen MSH discharge planning process
 - Utilize video-conferencing capacity for discharge planning that includes providers and family members
 - Compensate providers for travel time to MSH to attend discharge planning meetings
 - Measure MSH and provider performance in participation in discharge planning and outcomes for discharged clients



Care Coordination: Findings

- Multiple state agencies are involved in delivering services to adults and children with mental health problems
- Effort to expand recovery through the collection of data on recovery markers by case managers is a national best practice. Support further expansion of this.
- Poor service coordination was identified as a problem in surveys and interviews
- DPHSS' multi-agency extraordinary case review process is a promising approach to managing high cost cases. It needs further expansion and dedicated staff support
- Children's Medicaid and the CHIP Basic and Expanded benefits are administered through separate processes and personnel
- KMAs are developing family leadership and trying to implement wrap around planning
 - Funding for flexible services is very limited
 - Funds to sustain KMA infrastructure are not secured
- The expanding network for MHSP services will likely require additional attention to case coordination between providers
- Both MSH and community providers have noted that discharge planning for MSH is problematic and often uncoordinated. They cite different reasons for this.
- Police, jails, courts and mental health providers are establishing innovative working relationships in a number of areas, but these are not system-wide



Care Coordination: Recommendations

- **Support current innovations through public recognition**
- **Consider opportunities to coordinate and unify management of CHIP and Medicaid mental health at least from a reporting perspective**
- **Consider how to develop increased financial support for the KMA service planning process**
 - DPHHS should find methods to cover KMA case service planning activities as administrative expenses under Medicaid
 - Continue training in systems of care and measuring fidelity to systems of care principles
 - Provide state flex funding for non-Medicaid wraparound services to replace federal grant funds when the grant terminates
- **Focus provider accountability on interagency coordination and client outcomes**
- **Expand use of peer services for outreach, care coordination and support**
 - Peer services can compensate for some of the gap in the frontier workforce
- **Strengthen linkages between police, jails, prisons and crisis centers**
- **Expand DPHHS Extraordinary Case Review initiative and consider whether a more extensive chronic disease management approach should be implemented**



Rate Setting: Findings

- **Montana rates for a number of mental health services and codes are lower than those in other neighboring states.**
 - Medication management
 - Psychiatry was one of the services most frequently identified as a high priority need by survey respondents.
 - Twenty-two thousand Montanans received psychotropic medications through Medicaid or MHSP, but less than 5000 received medication management from a psychiatrist. Primary care physicians are probably managing psychotropics for most people.
 - Targeted case management rates for children are lower than other states and much lower than for MT adult TCM services. TCM services also need to be restructured to be compliant with new CMS rules
 - Family and Group therapies
 - Family and group therapies are a core component of children's MH services.
- **Low rates affect availability of services and salary levels over the long term however increases are costly**
 - At FY2007 utilization levels, rates for medication management, case management and family and group therapy could be increased to the average of other Western states for an estimated total of approximately \$3 million. However, if utilization of these services increases as desired, the eventual cost would exceed this amount.
- **CFSD pays higher rates than Medicaid to get MH assessments and treatment for some of its most complex cases**



Rate Setting: Recommendations

- **For certain services, adopt reimbursement methodologies that more adequately reflect providers' costs:**
 - Use program based budgeting for program services such as crisis services
 - Use proxy rates from other states that use costs to establish rates
 - Set separate rates by level of practitioner rendering a service (e.g. day treatment, PSR, etc.)
- **Ensure that rates establish desirable incentives**
 - Promote case management and other services in home and other community settings versus clinic setting
 - Allow reimbursement for teaming functions for youth with significant SED
 - Establish incentives for programs that meet outcomes established by the state
 - Develop a Medicaid procedure with a rate that adequately reimburses the assessment and treatment of certain complex CFSD cases increasing access to providers and to timely availability of services.
 - CFSD paid approximately \$1 million for these services in FY07, primarily from state general funds. Paying through Medicaid would garner federal match for these amounts.
- **Consider expanding the scope of the current Rate Commission or request similar studies by DPHHS to address the adequacy of rates in selected services**



Accountability and Performance Management: Findings

- **System priorities suggested by survey respondents included:**
 - Improving quality
 - Measuring and monitoring client outcomes and
 - Implementing evidence based practices
- **Regulations governing the Medicaid fee for service system allow for no direct incentives for accountability and performance**
- **Montana's limited provider network reduces competition that could foster performance and quality improvement**
- **Quality improvement and innovation is occurring, but depends on priorities of individual providers and certain specific state initiatives**
- **State has limited ability to drive changes on important aspects of provider performance like:**
 - Discharge planning for MSH
 - Consumer direction
 - Wraparound planning
 - Evidence Based Practices



Accountability and Performance Management: Recommendations

- **Use state funds strategically by establishing incentives for performance and/or tying them to attaining desirable client outcomes.**
 - Designate a small pool of funds to be used for a pilot of performance contracting
 - Review and develop plans for pay for performance options in Medicaid and implement.
 - Implement quality improvement efforts that facilitate actions on important performance improvement areas. These should be voluntary and intended to promote professional development as well as performance improvement
 - Develop provider reporting that includes client outcomes and can inform Quality Improvement with specific and frequent measures.
- **Develop more specific contract and licensing service standards and performance requirements and monitor provider performance more closely**



Mental Health in the Criminal Justice System: Findings

- **Prevalence**
 - An estimated 6% of incarcerated men and 16% of incarcerated women have a severe mental illness (national research studies)
 - A University of Montana study of people entering a Montana pre-release center found that almost 70% of women and 41% of men had a current emotional condition or had experienced an overnight stay in a mental hospital
- **Montana has developed a number of important and innovative mental health resources in its criminal justice system, including:**
 - Behavioral Health Program Facilitator
 - Police Crisis Intervention Team Initiatives and Community Crisis Center in Billings
 - Missoula Mental Health Court
 - DOC Assessment and Sanctions Units at Billings and Missoula
 - Gap Funding for medications and community services upon discharge



Mental Health in the Criminal Justice System: Findings

- **Gaps in Pre-booking diversions**
 - Police CIT Teams are helpful, but not sufficient
 - Crisis stabilization centers or hospital ERs are also needed to allow police to divert
- **Gaps in Post-booking diversions**
 - Only one mental health courts
 - Greater organization and collaboration needed in many communities to allow release on bond with referral to community services
- **Gaps in institutional services**
 - Capacity for screening and treatment in jails is limited
 - Integrated dual diagnosis treatment is not consistently available
 - Trauma informed treatment identification and care coordination for veterans can be strengthened
 - Suicide rates and factors contributing to suicide are not routinely monitored
 - Secure Forensic Treatment Unit for Guilty by Mental Illness and Hospital Level of Care is needed
- **Gaps in post-release services**
 - Limited transition planning and limited involvement of community providers
 - Case management services
 - Difficulty accessing case management and ACT for people post-release
 - Lack of forensic informed case management
 - Wait lists and delays for Medicaid and MHSP services
 - Need additional resources to fund psychiatric medication upon release



Mental Health in the Criminal Justice System: Recommendations

- **Overall Recommendations**
 - Standardize data collection on MH services throughout the criminal justice system
 - Step 1: fund pilot sites in police CIT programs or the largest jails to serve as learning sites for other communities
 - Step 2: based on what has been learned, implement data collection throughout the system
 - Involve the veterans system in planning activities at all levels
- **Fill gaps in diversionary services**
 - Expand crisis stabilization capacity
 - Video conference links between jails and crisis centers is promising and has been done in Kentucky
- **Expand post-booking diversionary options**
 - Expand MH courts
 - Direct local planning councils to plan for jail diversion programs
- **Expand jail based treatment capacity**
 - Move toward state-wide jail standards that address identification and treatment of mental health problems
 - Develop integrated dual diagnosis and trauma informed treatment programs
 - Use transition to state staffing to review and refine mental health staffing and programming at Montana State Prison
- **Enhance post-release community services**
 - Develop specialized forensic case management and include forensic expertise in PACT teams
 - Train the community mental health workforce about the criminal justice system and forensic mental health issues
 - Explore use of peer services in transition planning and community services



Potential Legislative Actions

- **Crisis Capability**
 - Request review of implementation and utilization of 72 hour presumptive eligibility, including eligibility criteria and rates; Expand the resources available in next biennium; Ensure broad geographic coverage for crisis services.
- **Eligibility**
 - Commit to continuing 72 Hour Presumptive Eligibility and develop strategies for voluntary “commitment”
- **Inpatient Capacity**
 - Consider developing legislation limiting medical liability for non-Medicaid consumers
 - Develop legislation that enables MSH to refuse admission for individuals that can be safely and appropriately served elsewhere
- **Care Coordination**
 - Ensure continued local system of care planning and provide state flex funding for non-Medicaid wraparound services to replace federal grant funds when the grant terminates
 - Expand support for peer services for outreach, care coordination and support



Potential Legislative Actions

- **Rate Setting**
 - Consider expanding the scope of the current Rate Commission or request similar studies by DPHHS to address rate adequacy in key services like medication and case management
- **Accountability and Performance Management**
 - Authorize a small pool of funds to be used for a pilot of performance contracting
- **Mental Health and Criminal Justice**
 - Authorize pilot data collection and research sites in police CIT programs or the largest jails to serve as learning sites for other communities
 - Based on what has been learned, authorize expanded data collection throughout the system
 - Direct local planning councils to plan for jail diversion programs
 - Request a study and recommendations for state-wide jail standards that address identification and treatment of mental health problems



Questions?