

Report to the State of Montana: Legislative Mental Health Study



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Prepared by

DMA Health Strategies



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EXECUTIVE SUMMARY

Purpose and Scope of the Report

In commissioning this study of the Montana mental health system, the Montana Legislature has taken another major step forward in the State's process of mental health systems transformation. Montana faces significant access challenges that include its primarily rural and frontier character, a limited mental health workforce, a large population in poverty and numbers of under- and un-insured. The state's system transformation requires intensive coordination of services, funding and information; creative approaches to expanding eligibility; and the development of new and expanded services for children and adults that also meet the needs of special populations such as Native American Tribes, veterans and those in the corrections system. The change process also requires the input and support of local advisory groups – those best qualified to describe the needs of their communities.

This report addresses community needs, additional services needed, the extent to which Montana is fully using existing state and federal resources, and additional opportunities or resources that may exist. Financial and organizational options for the state and their costs are described, with analysis of recommendations for system improvement. The report centers on the concerns and feedback of the Montana State Legislature and a broad range of consumer and provider stakeholders, and is designed to contribute to an achievable and measurable state mental health systems transformation plan.

Key Findings

Montana is a progressive state that has been creative and proactive in piecing together multiple state, federal and local sources of funding to serve as many of its citizens as possible, wherever they live. Montana has been able to build its children's mental health system on Medicaid and SCHIP, creating a comprehensive mental health system with relatively generous eligibility standards. As with many other states, however, Montana has had to patch together funding streams and services that do not consistently provide equal access or types of service across populations and payer systems. While state officials have developed a waiver and other plans to make improvements, this study is an opportunity to make more comprehensive improvements. Key findings of this study are nested in five broad categories:

- 1) Coordination of services, payments, funding streams and data;
- 2) Eligibility, access and underlying funding mechanisms;
- 3) Improvements in the community based system of care;
- 4) Services for special populations; and
- 5) Support for local planning.

Coordination. Over time Montana has seized multiple opportunities to implement new initiatives with different configurations of service, funding streams and reporting requirements, under the auspices of different state agencies. This challenges management oversight and interagency communication, and often leaves consumers in a quandary about how to navigate the system. The system needs an

overarching structure to coordinate service programs, make and track reimbursements by funding stream, and provide regular data reports that are consistent across state agencies.

Eligibility, access and underlying funding mechanisms. Inequities in service access and reimbursement exist between the child and adult systems; levels of severity of mental illness; income levels; Medicaid vs. state payer systems; and across urban, rural and frontier areas. Limitations in Medicaid eligibility, especially for adults, compromise access, can result in the exacerbation of symptoms and hence need for more intensive and costly services, and shift costs from potential federal matches to state funds. There is potential for making better use of federal funds through Medicaid Waivers and expanded eligibility.

Community based system of care. Although both adult and child mental health service systems are relatively comprehensive in the State's Medicaid plan compared to other states, some services need expansion, with attention to specific regions of the state, rural areas in particular. Over-utilization of Montana State Hospital, despite constructive steps to control admissions, is clearly stressing hospital capacity and resulting in unnecessarily high costs to the State. Utilization data suggest that many adults with Serious and Disabling Mental Illness (SDMI) are not receiving the services they need. Crisis services as well as psychiatry are key target areas for both adults and children. Residential placements for children, while reduced through recent initiatives, can be further controlled through expansion and enhancement of intensive community based family services and supports.

Services for special populations. *Native Americans* – The Indian Health Service (IHS) and two independent tribal facilities provide basic mental health and social services on all reservations. They face challenges in maintaining mental health staff and too often see people when their problems have reached a crisis. This system needs more resources, potentially through expansion of its third party revenues. *Adult and Juvenile Corrections* – There are well documented increases in the criminal justice system of mental illness, substance abuse and co-occurring disorders, yet mental health expenditures represent a very small portion of the Corrections budget. The standard of mental health care in Corrections needs improvement; expansion of case management for those who are diverted or released is critical; and there is potential for maximizing Medicaid and other third party payments to improve mental health care in community corrections. *Veterans* - Montana's National Guard has made improvements in identification and referral of guardsmen with mental health needs, and the VA has expanded its mental health treatment and trauma training for eligible veterans. Capacity for outreach is limited, however, and children of discharging veterans are often not immediately eligible for Medicaid and may lack other forms of health insurance.

Support of local planning. The development of responsive community based systems of care depends on the input and effectiveness of local advisory groups. While Montana has been quite progressive in its development of Local Advisory Councils (LAC), Service Area Authorities (SAA) and Kids Management Authorities (KMA), the advisory process suffers from confusion regarding the definition of their respective roles, memberships and relationships with state entities, inconsistent dissemination of needed systems information, and limited resources for statewide development.

Key Recommendations

The following major recommendations are highlights of detailed recommendations that follow and are organized in tandem with the five key findings, as follows:

Coordination. The state should take action to improve coordination in administering the mental health system through co-location, improved coordination and consistent leadership of the Addictive and Mental Disorders Division (AMDD) and the Children’s Mental Health Bureau (CMHB), with more effective financing rules and other changes. In addition the Department of Public Health and Human Services (DPHHS) should consider a more ambitious restructuring of the mental health system. It should develop a plan for a quasi-public Care Coordination Organization (CCO) to manage mental health services for children and adults under a 1915(b) or 1115 waiver. This CCO, in essence a Managed Care Organization, would coordinate services currently overseen by different state agencies, and make reimbursements for state funded services as well as Medicaid fee for service. The CCO would track expenditures by funding stream and disseminate standard reports across state agencies. An 1115 Research and Demonstration waiver would allow the state to consolidate its Health Insurance Flexibility and Accountability (HIFA) waiver terms into the managed care approach. The state should consider whether to include substance abuse services also.

Eligibility, access and underlying funding mechanisms. Montana’s proposed Health Insurance Flexibility and Accountability (HIFA) waiver is targeted to expand Medicaid eligibility to SDMI adults and certain other specific groups. It would allow most current Mental Health Services Plan (MHSP) enrollees access to the comprehensive services provided through Medicaid, and would garner federal match for these services. In addition to active follow-up of the HIFA waiver, Montana should consider the following Medicaid eligibility expansion efforts:

- 1) Appropriate funds for and adapt 72 Hour Presumptive Eligibility (crisis response and stabilization services) as needed to create a strong and accessible crisis service that can effectively divert many clients from hospitalization;
- 2) Ensure maximum possible enrollment of adults into Medicaid by rolling Medicaid application into the MHSP re-application process, assisting those who are incarcerated in making Medicaid applications and keeping them on suspended enrollment so that that they will qualify for services immediately upon release; and
- 3) If the HIFA Waiver is not approved, consider raising income eligibility levels for adults and revising SDMI levels for Medicaid and/or MHSP as funds may allow.

Community based system of care. For adults, further and more consistent control of state hospital utilization is needed. Key community services to support hospital diversion and step-down include more accessible crisis services, expanded psychiatry services supported by more attractive rates and telepsychiatry, and the deployment of trained Peer Recovery Support Specialists in the community. The DPHHS Extraordinary Case Review initiative should be expanded and a more extensive chronic disease management approach considered. Further efforts to expand community based acute inpatient capacity as alternatives to reliance on Montana State Hospital should be considered (in the context of an overall reduction in Montana State Hospital beds). This would be aided by efforts to increase housing options for the chronically mentally ill as well as by expansion of Montana’s telemedicine initiatives.

For children, access to child psychiatry must be improved through aggressive recruitment and the consideration of higher rates for psychiatry services. Wraparound service planning with intensive care coordination should provide more coordinated access to a broadened range of intensive community based services and supports that should include paraprofessional family support, respite, and flexible funds to purchase needed goods and services that fall outside of definitions of Medicaid Medical Necessity. The child system will benefit from improved utilization and outcome reporting that holds providers responsible for maintaining children in the community rather than in out-of-home placements. Both the adult and child systems will benefit from improved integration of behavioral and primary care.

Services for special populations. *Native Americans* will benefit from a long-term strategy to enhance DPHHS collaborations with IHS and independent tribes to better understand their needs, enhance cultural competency, and make best use of combined mental health resources. A joint approach to developing accurate DPHHS and IHS data on services will support a collaborative planning process for improving access for Indians. Continued cooperation to maximize Medicaid enrollment and Medicaid billing can further extend IHS resources. *Corrections* will benefit from the development of data sharing systems by DPHHS/DOC to support the monitoring and oversight of youth in or at risk of residential treatment as well as methods to minimize any gap in Medicaid enrollment upon release for those who are Medicaid eligible. DPHHS and DOC should periodically review DOC's mental health expenditures to evaluate braided funding mechanisms for the treatment of incarcerated adults. For *Veterans* CMHB should closely coordinate with the Division of Military Affairs to provide information on CHIP eligibility that can be communicated to veterans and their families during the process of transition. The National Guard's plans for continuing post-discharge assessments in the 2 years following discharge should be supported by state funds if federal funds are not appropriated. Screening, outreach and community based service access should be supported by enhanced collaboration between AMDD, the National Guard and the VA.

Coordinated support of local planning. Consumers will benefit from broader consensus on the vision, mission and goals of LAC, SAA and KMA community oversight. Better definition is needed regarding responsibilities and relationships between these groups and state authorities such as DPHHS, AMDD, CMHB and the Mental Health Oversight Advisory Council. Membership should be reviewed for greater inclusiveness, beginning with law enforcement. Similar planning areas should be agreed upon between adult and child systems. Standard reports on prevalence, service access, utilization and outcomes data should be shared with advisory groups, providing county-level data with regional and state comparisons. To become truly effective across the state, the collaborative advisory process is likely to require a greater investment of resources.

Conclusion

In this six-month study by the DMA Health Strategies team, Montana has demonstrated that the state, in response to significant geographic, economic and cultural challenges, has seized many key opportunities to make system improvements, a recent one being application for a HIFA 1115 Medicaid waiver. Study findings have led to five key recommendation areas, the most ambitious of which is the first – the development of a Care Coordination Organization to address fragmentation in the state's systems of service delivery, financial reimbursement and tracking, and data reporting. This major systems change will support efforts to expand Medicaid eligibility and develop and coordinate a more comprehensive array of community based services for adults, children and special populations such as Indians, veterans, and youth and adults in Montana's corrections system, thus ultimately reducing utilization of high cost residential, hospital and corrections facility services. Critical to the success and sustainability of these efforts is the greater refinement of and support for local advisory groups and processes, through improved membership, role definition, data sharing and resources for statewide development. With its strong foundation and track record, the state of Montana shows great potential for being a leader amongst frontier states in mental health system of care transformation.

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ADDENDUM:

SUMMARY OF CHANGES MADE IN FINAL REPORT

DMA Health Strategies presented its draft Legislative Mental Health Study report to the Children, Families, Health, and Human Services Interim Committee on October 14, 2008. At that meeting, Department of Public Health and Human Services Director Joan Miles noted the agency had some concerns about the data presented in the report, but emphasized that the concerns had no effect on any of the report's recommendations.

After that meeting, DMA reviewed and discussed data concerns with DPHHS staff to consider their perspectives and review the additional analysis they had undertaken. Based on those discussions, the final report concludes that available data does not provide enough information to determine with sufficient clarity how well the state is serving adults with severe disabling mental illness (SDMI). The changes are reflected on Page 42 of Section III. DMA also adopted a more conservative estimate of the number of children with SED receiving DPHHS services, as reflected on Page 17 of Section III.

To help address these data issues, DMA has added recommendations for reporting that should allow for more detailed analysis of how well the system is serving Montanans with the most serious mental health needs. Those recommendations are on Page 6 of the Summary of Recommendations and Page 89 of Section V.

The report does provide considerable data on access to specific services on a statewide, regional and county basis that provides additional perspective on the relative sufficiency of services in different parts of the state. See Section III and Appendices B and C for specific information on the number of Montanans per thousand receiving various types of mental health services in each county on a statewide and a regional basis.

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SUMMARY OF RECOMMENDATIONS

Service Needs and Gaps

Child Mental Health Services

- ▶ Strengthen crisis services for children
 - CMHB should work with LACs and KMAs to more systematically assess the needs for children's crisis intervention and how capacity can best be created.
 - Develop a plan for funding crisis response and stabilization services that is consistent with and aligned with AMDD's 72 hour presumptive eligibility services.
- ▶ Make plans to further develop family support and peer providers to conduct outreach, facilitate service planning, coordinate care and deliver support services. Work with KMAs and LACs to develop peer service models that can compensate for some of the gaps in the frontier workforce.
- ▶ Conduct marketing and recruitment efforts for child psychiatrists
- ▶ Develop a strategy for increasing training in treatment of very young children.
- ▶ Define 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.
- ▶ Work with LACs and tribes to identify priorities for local service development and develop plans for expanding those services. Pay particular attention to North Central Montana and other remote locations. Find or fund small grants that can finance collaborative approaches with primary care and family support programs.
- ▶ Continue to provide a financing vehicle for flexible fund support to CMHB in order to reduce the use of residential care and maintain youth with SED in their homes and communities.

Adult Mental Health Services

- ▶ Continue to seek federal authorization for targeted eligibility expansion in Montana. The Health Insurance Flexibility and Accountability (HIFA) (Section 1115) waiver is targeted to expand Medicaid eligibility to adults with SDMI and certain other specific groups. The state should continue to pursue the HIFA waiver, assessing its chances of approval by a new administration.
- ▶ Modify 72 Hour Presumptive Eligibility as needed to support an effective crisis intervention service. The Legislature should expect this program to need adjustment and modification as it matures. They should require AMDD to review implementation and make needed adjustments in policy and practice.
- ▶ Increase Medicaid application rates through requiring Medicaid application upon MHSP renewal.
- ▶ Reduce gaps in Medicaid eligibility. Keep Medicaid eligibles on a suspended enrollment basis while incarcerated so that they qualify for services immediately upon release.
- ▶ Consider a general eligibility expansion. If the HIFA waiver is not likely to be approved, the Legislature can consider expanding Medicaid income eligibility or SED/SDMI criteria.

- ▶ AMDD should work with LACs, SAAs and tribes to identify priorities for service development and develop peer service models suitable for frontier areas.
 - The needs of Eastern Montana and other frontier areas should be prioritized.
 - Pursue small grant sources that can finance creative and collaborative approaches to filling local service gaps. The Pharmacy project developed in Eastern Montana which is utilizing pharmacists to provide active telephone follow-up for individuals on certain psychotropic medications is an excellent example of creatively using local resources and a small amount of funding to better meet local needs.

Services for Special Populations

Native Americans.

- ▶ Develop a long-term strategy to enhance collaborations with IHS and independent tribes to better understand their needs, enhance cultural competency, and make best use of combined mental health resources.
- ▶ Collaborate with IHS if they wish to assess why billings do not consistently identify mental health visits.
- ▶ Work with IHS and the independent tribal health facilities to assess the mental health needs of the tribes.

Veterans.

- ▶ The Health Resources Division (HRD) should closely coordinate with the Division of Military Affairs to provide information on CHIP eligibility that can be communicated to veterans and their families during the process of transition.
- ▶ The Legislature should consider funding:
 - The National Guard's plans for continuing post-discharge assessments in the 2 years following discharge if federal funds are not appropriated.
 - Training for community providers on veteran's mental health issues.
- ▶ AMDD, the National Guard and the VA should:
 - Develop outreach and referral strategies to reach troubled veterans and get access to VA resources.
 - Monitor the need for services and identify training needs and capacity needs as they arise, and develop collaborative plans to address them.
 - Work with the police and the court system to screen for veteran status and promote access to military services and supports.

Other Services

Crisis Services.

- ▶ Strengthen and expand financing for crisis services
 - Expand resources for next biennium and allow crisis providers to bill Medicaid for substance abuse interventions.
 - DPHHS should review Medicaid and MHSP funding mechanisms for crisis services to ensure that they can appropriately reimburse the full costs of the service. Consider:
 - ~ Simplifying the rate structure;
 - ~ Grant or deficit funding mechanisms to purchase capacity
 - ~ To maximize resources, consider ways to limit providers to one designated organization per geographic area as the service expands further across the state

- Explore options for developing local partnerships like the Community Crisis Center in Billings
- Hospitals benefit from reduced costs for detoxification of uninsured individuals and may need to contribute to crisis service costs
- ▶ Build telemedicine capacity at MSH to support local crisis management, both in hospital emergency rooms and for law enforcement officers
 - Implement more aggressive recruiting of new psychiatrists at MSH or reissue an RFI/RFP based on 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 the Community Crisis Center’s tele-health consultation to jails.
- ▶ The 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 denied presumptive eligibility or referred elsewhere

Montana State Hospital (MSH) and Other Inpatient Care

- ▶ Reconsider legislation that enables MSH to refuse admission for individuals that can be safely and appropriately served elsewhere as crisis capacity is developed. 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, particularly for consumers who have been hospitalized for long periods of time where face to face meetings may be particularly important.
 - Measure MSH and provider performance in participation in discharge planning and outcomes for discharged clients
 - Commit to ongoing appropriations to fund flexible services and supports in the community to facilitate timely discharge.
- ▶ Address barriers to the creation of additional community behavioral health inpatient facilities
 - The state should clearly commit to providing this service for its population on an ongoing basis.
 - Consider developing legislation limiting facilities’ medical liability for non-Medicaid consumers.
 - Identify available general hospital beds (e.g. Billings Clinic)
 - Further investigate behavioral health inpatient financing models used by other rural states that currently provide this as a Medicaid reimbursable service and develop a strategy to propose this again to the new federal administration.

Cross Cutting Issues

Workforce Limitations

- ▶ Conduct a more comprehensive review of telemedicine service capacity and utilization among providers and consider using enhanced rates under Medicaid to cover reimbursement for operating costs if that would enhance its utilization.

- ▶ Use more comprehensive and systematic recruiting efforts for psychiatry and other professions, including participation in conferences and recruiting fairs, incentives for relocation and retention policies and practices.
- ▶ Expand funding for Montana’s Advanced Practice Registered Nurse (APRN) program or develop recruiting affiliations with other programs to train more practitioners qualified to prescribe psychotropic medications.

Primary Care and Mental Health Integration

- ▶ Continue current efforts in screening of young children to identify mental health problems as early as possible.
- ▶ Continue current efforts to expand disease management (DM) initiatives to include mental health conditions. As an example, DM efforts could identify and follow up on individuals receiving psychotropic medications but not receiving treatment to better understand the care they are receiving and how it can be improved through providing support to and better coordinating with their primary care clinicians and prescribers.

Local Planning

- ▶ Develop broader consensus on the vision, mission and goals of LAC and SAA community oversight. Clarify relationships between planning groups, councils and authorities.
- ▶ Modify LAC membership to include law enforcement representatives from local authorities and state offices.
- ▶ Make the geographic boundaries for planning areas consistent for the adult and youth systems so that resources can be consolidated to work more closely with communities.
- ▶ Improve flow of information to LACs and SAAs needed for their planning and monitoring functions. Develop standard reports that provide prevalence, program access, utilization and outcomes data for LAC and SAA areas and regions in formats that allow comparison to the region and state average. Consider building on the reporting framework laid out in this report for utilization and costs data by funding stream, service and county.

Financing Opportunities

Financing of Children’s Mental Health Programs

- ▶ *Co-Payments:* Montana should establish reasonable and fair co-pays that are consistent across both children’s and adult mental health services as allowed by Medicaid, CHIP and DRA regulations. The principle should be to create equity and consistency within and across programs and age groups. The financial benefits will be minor.
- ▶ *Strategic Rate Increases:* Review Medicaid rates in comparison to nearby states with similar workforce issues and raise Montana rates to a more competitive level. Rates for the following three services could be increased to the average of other Western states for a total of \$3.6M.
 - Ensure a competitive rate for psychiatry.
 - Set rates for children’s case management in the context of any changes necessary in the service to comply with new DRA requirements. Revise adult rates if necessary.
 - Increase rates for individual and group therapy for children to be competitive for the region.

- ▶ *Child and Family Service Division (CFSD) Services.* Develop a Medicaid procedure with a rate that adequately reimburses the assessment and treatment of certain complex CFSD cases so that these services can be accessed through Medicaid.

Financing of Adult Mental Health Programs

- ▶ *Co-Payments:* Implement co-payment and cost-sharing arrangements to ensure that Medicaid clients are not charged co-payments that are greater than MHSP members.

Targeted Case Management and Rehabilitation Option

- ▶ Review claiming and rate setting methods for AMDD and CMHB services to determine specific services being claimed under these two rules. This review should identify the overall volume and number of people served, and should also provide a sample of detailed claims by provider, to provide a basis for review of a sample of provider records for these claims.
- ▶ Assess exposure and the risk of lost revenue in each of these services and identify actions that will mitigate this risk. The state should also work with provider leadership to develop an action plan for those items that should be implemented now and those that will need to occur once the direction of the new administration is clear.
- ▶ Actively monitor changes in federal rules and seek support from SAMHSA and NASMHPD on best practices to minimize Medicaid revenue risk.
- ▶ Under the current administration and until the policies of the incoming administration are clearer, AMDD should not take any steps that would open up the state plan for federal review of the definition of rehabilitation services.

Home and Community Based Services Waiver - 1915(c).

- ▶ AMDD should review its enrollment experience to identify whether there are any impediments that need to be addressed with waiver modifications or through parallel provider participation.
- ▶ Consider whether HCBS services could be used for some individuals currently served at the Montana Nursing Care Center that might allow that program to be downsized.

Maximize Medicaid revenues for IHS Facilities

- ▶ Continue joint efforts with IHS to increase Indian enrollment in Medicaid to maximize Medicaid reimbursement for IHS services and free IHS federal appropriations to serve more people.
- ▶ Collaborate with IHS, if it wishes, to investigate whether additional services are eligible to be billed to Medicaid.

Peer Services.

- ▶ Build on the peer certification program in Great Falls and extend this to several additional sites in frontier areas to help address provider shortages.
- ▶ Based on what is learned from pilots of peer service models in rural and frontier areas, study the use and adequacy of Medicaid to support these services.
- ▶ Review and modify, as necessary, the state plan to allow Medicaid billing for peer specialists once the new administration's approach to State Plan Amendments is clear.

HIFA waiver.

- ▶ Montana should continue to pursue its HIFA waiver request, with the new administration, if necessary.

Section 1915i.

- ▶ Monitor the use of the 1915i by other states and make a decision in a year or more. One area many states are considering is services to developmentally disabled people (particularly youth) who also have mental illness.

Other Federal Revenue Opportunities

- ▶ Continue excellent work in applying for and winning federal grants.
- ▶ Consider retaining a grant writer on staff or retainer as grant opportunities arise.

Potential for Research, Foundation, Philanthropic Support

- ▶ Review the identified grant program requirements and consider whether they are a good fit for Montana's goals, priorities, and resources.
- ▶ Regularly review the Catalog of Federal Domestic Assistance and refer to the Federal agency websites for additional information on mental health granting opportunities

Organizational Issues

Approaches to Improving Mental Health Service Delivery

Sharing Data & Information

- ▶ Develop standard reporting formats to review mental health service provision and expenditures across all DPHHS divisions on a periodic basis – at least every two years to inform the budget and planning process.
- ▶ CMHB should develop a report that counts the unduplicated number of children receiving services that are restricted to children with SED so it can better assess this group's access to services statewide, and on a regional and local basis.
- ▶ DPHHS and AMDD should further analyze patterns of service use in AMDD Medicaid and other State Plan Medicaid to better understand the range of mental health needs being met by AMDD's network of specialty services for SDMI, and those being met within the broader medical system. Based on what is learned, DPHHS and AMDD should periodically generate reports that measure access and utilization by individuals with SDMI, as well as reports that measure access and utilization for adults with less serious mental health needs. These data can inform efforts to improve access for adults with SDMI, better integrate primary and mental health care, and design disease management approaches.
- ▶ Design standard reports on CHIP services that adequately cover the utilization and funding of mental health services. Add this to the vendors' reporting requirements. Develop parallel routines for state data on the Enhanced CHIP SED benefit.
- ▶ Review laws governing information sharing by CMHCs, police, jails and the judicial system, and ensure that they are written to allow sharing of relevant information about the mental health needs of an individual in police or judicial custody.
- ▶ Develop and authorize routine data sharing protocols between DPHHS Divisions if needed and between DPHHS and DOC that meet HIPAA and other legal requirements. This may require legislation.
- ▶ Train CMHCs, police, jails and staff of the judicial system on legal protocols for information sharing.
- ▶ Develop plans over the next five years to move toward a more integrated and comprehensive information system that not only tracks consumers, utilization and costs but that also allows for reporting on clinical outcomes and other quality measures.

Care Coordination

- ▶ Strengthen linkages between police, jails, prisons and crisis centers.
 - Develop a pilot for mental health screening for individuals entering jails or prison and develop processes for collecting and sharing results across the treatment and judicial system. Use the data as the basis for a needs assessment of individuals who need services while in custody and ensure that pre-release planning incorporates referral to and monitors access to services where needed. A small seed grant may be all that is needed to spark this effort with prison officials and pre-release staff.
- ▶ Consider opportunities to coordinate and unify management of CHIP and Medicaid mental health.
- ▶ Expand the scope and improve the efficiency and effectiveness of KMAs or related entities:
 - Make the current KMA process more efficient by increasing support staffing and other resources.
 - Implement a scaled back KMA system on a statewide basis, particularly for rural areas. Consider a clinical home approach with strong family supports and a regional pool of flex funds that are accessed by approved clinical home providers.
 - DPHHS should find methods to cover KMA case service planning activities as administrative expenses under Medicaid. This can be accomplished through the 1115 or 1915(b) waivers.
 - Finance continued training in systems of care and measuring fidelity to systems of care principles.
 - Provide state flex funding through the System of Care account authorized by HB 98 to replace federal grant funds when the grant terminates. Allocate a meaningful set of funds for each KMA's use. A statewide total of at least \$250,000 may be sufficient to create meaningful regional pools of flex funds.
- ▶ Expand the DPHHS Extraordinary Case Review initiative and consider whether a more extensive chronic disease management approach should be implemented that focuses on mental illness. Review evidence on available models to identify those most likely to be both effective and efficient.
 - Provide pharmacy consultation and outreach for certain diagnostic groups.
 - Implement statewide telephonic support for individuals not receiving case management but needing education, support, referral and follow up.
 - Ensure that existing case managers coordinate closely with the primary care providers of their clients

Opportunities for Improving Accountability

- ▶ Develop a strategy for a pilot in Medicaid pay for performance. Incorporate this into the CCO scope or begin a planning process to implement it. This process will need to include key purchaser, consumer and ultimately provider stakeholders, and content experts in performance measurement and improvement.
- ▶ Designate a small pool of state general funds to be used for a pilot of performance contracting. Establish incentives for performance and/or tie them to attaining desirable client outcomes. Implement, measure (monthly or quarterly) and revise as needed over the next two or more years.
- ▶ Implement other quality improvement projects to create action on important performance improvement areas. These should be voluntary and intended to promote professional development as well as performance improvement. They should follow the

QI models proposed by the Network for Improvement of Addiction Treatment or the Institute for Healthcare Improvement.

- ▶ Develop provider reporting that includes key performance measures of client outcomes and can inform quality improvement with specific and periodic measures.
- ▶ Develop more specific contract and licensing standards and performance requirements, and monitor provider performance more closely, with regular measures such as length of stay, re-admission rates, etc.

Options for Major System Reorganization

Consolidation of Functions Option

- ▶ The state can achieve improvements by reorganizing administration of its mental health agencies to consolidate certain functions
 - Give CMHB more authority over the mental health benefit and the coordination of care within CHIP and for the CHIP extended benefit.
 - Co-locate AMDD and CMHB management staff and share certain administrative functions. These shared functions should include purchasing, network management, revenue and TPL functions, among other functions. This should not be a merger.

Medicaid Waiver Option

- ▶ Develop a formal proposal with stakeholder input for a public Care Coordination Organization (CCO) to manage mental health services to children and adults under a 1915(b) or 1115 waiver.
- ▶ Develop a detailed implementation plan for approval.

Criminal Justice Recommendations

- ▶ Improve Data management
 - Build upon jail screening pilots to develop a system for standardized collection of mental health data across intercepts to improve planning.
 - Develop procedures to ensure flow of clinical information for continuity of care. Attention should be given to building capacity to match justice system data with mental health databases to improve screening and information for police, jails, and prisons.
 - Match mental health and criminal justice databases to identify persons with past or current treatment histories who are incarcerated.
- ▶ Expand Crisis Stabilization Capacity as called for in prior recommendations
- ▶ Expand Post Booking Options including expanding drug courts and diversion options earlier in the justice process
- ▶ Expand jail-based treatment capacity
- ▶ Consider expanding gap funding to jails and diversion programs for transition planning
- ▶ Develop specialized Forensic Case Management and Transition Case Management Teams and increase forensic expertise on PACT teams.
- ▶ Train the community mental health workforce on successfully working with justice-involved persons with mental illness by providing an overview of the criminal justice system and specific characteristics of the justice-involved population.

- ▶ Facilitate partnership building at the community level by including police and court membership on LACs and SAAs as called for in prior recommendations.
- ▶ Review mental health staffing and programming at Montana State Prison.
- ▶ Explore the use of telemedicine in the correctional system for assessment and discharge planning.
- ▶ Explore use of peer services for re-entry planning and as part of forensic multi-disciplinary teams.
- ▶ Develop trauma informed systems and implement trauma specific services in jails, prisons and community corrections.
- ▶ Involve veterans groups in planning for their constituents who become involved with police or courts.

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Report to the State of Montana: Legislative Mental Health Study

I. Introduction

DMA Health Strategies is pleased to present the State of Montana with this Final Report on the Legislative Mental Health Study. Over the past six months DMA and our contractors for this project, Policy Research Associates, Leslie Schwalbe and John O'Brien, have conducted site visits to Montana; interviewed individuals, primarily in person but also by telephone when necessary or appropriate; and made presentations to Montana legislators. In addition we disseminated a survey both on-line and on paper to a wide variety of stakeholders. DMA also requested and analyzed data on mental health service utilization and costs from a variety of sources. Based on this effort, we have developed answers to the twelve study questions with which we began.

A. Goals of the Project

The goal of the Montana Legislature in initiating this project was for its contractor to assess mental health needs, identify gaps in services, recommend a best-practices model of services, and identify potential new funding sources in the state of Montana. More specifically, the goal of this study was to evaluate mental health services in the state to determine the extent to which Montana's publicly funded system is fully using existing state and federal resources and whether additional services are needed and/or new resources may be found. The availability of resources relates directly to the adequacy of the mental health service array and the capacity of the mental health providers in the state to provide the necessary services in a timely manner to all residents, regardless of where they live.

B. Purpose of this Report

This report summarizes key findings, options for improvement, and recommendations for short, medium and long term activities for system change and improvement. It builds on and follows our presentations to Montana legislators and other stakeholders, incorporating feedback from them and from state agency staff. We describe financial and organizational options for the state, including opportunities for new revenue and the costs and benefits of new organizational approaches. Our recommendations are consistent with the opportunities for additional funding, and the Legislature's preferences for system development overall, including within the criminal justice system. The recommendations build upon and strengthen Montana's current system and its current initiatives and outline a process for improvement and transformation that is systematic, achievable, and that allows measurement of progress.

The report addresses the public mental health system for children and for adults. It also includes a chapter specific to the mental health needs in the criminal justice system. Our analysis and recommendations are in keeping with the goals of the President's New Freedom Commission on Mental Health's recommendations for a consumer- and family-driven system of care and the further development of a comprehensive, statewide public mental health system.

C. Study Questions

To guide our investigation and analysis, DMA worked with the Montana Legislature's, Children, Families, Health, and Human Services Interim Committee (the Committee) and the Department of Public Health and Human Services (DPHHS) staff to formulate twelve study questions. They are:

1. How many people need mental health services and where are they located?
2. What services does Montana have in place?
3. Where are services being delivered? And by whom?
4. How can the system be organized differently to deliver services more efficiently?
5. What services do the citizens of Montana need that currently do not exist?
6. How are services funded?
7. Have Montana's funding streams changed significantly over the past few years? If so, which ones and why?
8. How does the consumer pay? Should consumers pay more?
9. How can Montana make better use of current funding streams and funding levels? What is needed in order to blend or braid funds to improve efficiency?
10. What funding sources are not being accessed by Montana and why?
11. What funding streams will support needed new services, and which of them are potentially available or unavailable to Montana?
12. How can the sequential intercept model be used to improve services to persons in the criminal justice system?

II. Methodology

To complete this study, numerous individuals and organizations cooperated to meet with our consultant team in Montana. We also gathered, reviewed and analyzed large quantities of qualitative and quantitative data.

A. Site Visits and Interviews

Richard H. Dougherty, Ph.D., Leslie Schwalbe, Wendy Holt, Dan Abreu and Henry Steadman visited Montana a total of six times. They conducted interviews with representatives of state agencies, consumer organizations, members of Montana's local and regional planning groups, and other stakeholders; made presentations to the Committee and one to the Mental Health Oversight Advisory Council (MHOAC). In addition, we disseminated a survey using a Web application and on paper that yielded over 700 responses from stakeholders in the state.

B. Quantitative Data on Need for and Utilization of Services

This project required that we estimate the need for mental health services in Montana, and inventory the services available to meet that need, in order to identify the strengths of Montana's mental health system, the gaps in that system and the barriers affecting access to care and optimal functionality of the service system. To meet this requirement we collected and worked with state staff to develop, and subsequently analyze, four types of information about Montana's mental health system:

- Data on prevalence of mental health problems;
- Data on service and utilization;
- Information about eligibility standards and other relevant state agency policies that affect access to and use of mental health services; and
- Information about the experiences and concerns of Montana's mental health service providers and the perceptions and experiences of Montana's consumers of mental health services and other mental health system stakeholders.

To provide a context for our analysis we also sought data from other Western states with significant rural populations.

1. County Based Prevalence Estimates

DMA purchased prevalence estimates developed by Dr. Charles Holzer of the University of Texas Medical Branch based on 2006 Census data. Dr. Holzer uses the National Institute of Mental Health's Collaborative Psychiatric Epidemiology Surveys (CPES) as the basis for his estimates. CPES provides data on the distributions, correlates, and risk factors of mental disorders among the general population, with special emphasis on minority groups. This project joins together three nationally representative surveys: the National Comorbidity Survey Replication (NCS-R), the National Survey of American Life (NSAL), and the National Latino and Asian American Study (NLAAS). While the estimates have some limitations in terms of poverty data (only reporting for 200% of federal poverty), this data set is the most widely accepted and most comprehensive prevalence data available in the US; it builds on the foundation laid by all the major national studies of prevalence. Dr. Holzer develops estimates for specified sectors of the population, and extrapolates to develop estimates for sectors for which robust prevalence studies have not yet

been conducted. These data are stratified by county, which enabled us to account for differences in prevalence that stem from race, ethnic, age and economic differences in county adult populations.¹ See Appendix A for more detailed notes on prevalence estimates, and county and regional data.

2. DPHHS Data

Montana's Department of Public Health and Human Services (DPHHS) completed a comprehensive utilization and spending matrix (spreadsheet) that summarized Medicaid and all other mental health service utilization and spending data (by service type) and by county across multiple funding streams. With these data, DMA was able to compare service use to need, measured by the prevalence data, and identify geographically, by age, whether some groups have a relatively greater unmet need than others. In our experience, few, if any, other states have the capacity to generate a report with this scope of data. Appendices B, C and D provide more detailed information on these data and county and regional rates of service use in comparison to population under 200% of poverty.

DMA sought data on Medicaid mental health services for Medicaid eligible American Indians provided by Indian Health Service (IHS) Facilities from DPHHS and data on all mental health services provided directly from IHS. We received a report from DPHHS on claims filed with the mental health revenue code 915 and from IHS on total mental health visits to Montana facilities. DPHHS believes the report it provided to be incomplete, and our analysis of the data suggests this to be the case. This report provides information about the nature of the problems with the data and analyzes how its absence may affect the understanding of service gaps in the regions served by IHS facilities.

An Important Note about the Limitations of Our Data

Our data request captured an extensive menu of mental health services, including those that are only used as mental health treatment or rehabilitation, and other medical services, like personal care services, labs, medications, and physician evaluation, that may be provided in connection with assessing or treating a mental health diagnosis or for other health problems. A high proportion of individuals in Medicaid, 9095 adults - virtually half of those served by AMDD, and 4695 children, over half of those served by CMHB, receive what we have reported as "miscellaneous" services. This broad definition of mental health services, combined with our inclusion of individuals receiving psychotropic medications gives Montana an indication of the extent and cost of the treatment of mental health conditions both through traditional mental health services, and by other practitioners. However, this broad definition also contributes to the high rates we have found for Medicaid recipients to get mental health services. The definition may in fact overstate the rates at which individuals receive mental health treatment. For example, because we included psychotropic medications we may be reporting on individuals who are using these medications to treat non-mental health conditions. Our figures also may have included tests or physician examinations that ruled out a mental health condition as the cause of a presenting problem that was eventually determined to be a physical health condition. It may be helpful for Montana to further evaluate both the numbers of individuals served and the types of services they receive in order to establish a working definition for receiving mental health services that may be somewhat more helpful in setting policy and monitoring program performance.

3. Utilization Data from Other States

DMA sought data from other western states and received data from Alaska, New Mexico and Arizona. We also used published data from Minnesota. To better match the rural and frontier

¹ Note: In 2006, Montana commissioned a report from the Western Interstate Commission for Higher Education (WICHE) entitled *The Status of Mental Health in Montana: Prevalence, Service Utilization, Penetration Rates and Unmet Need*. This study also used estimates developed by Dr. Holzer using similar methodologies but based solely on the National Comorbidity Survey Replication (NCS-R).

nature of Montana, we selected data only from Minnesota counties that are considered frontier or had population densities no higher than those of Montana's most densely populated county. Arizona provided use with data that excluded its most urbanized county, Maricopa County which includes the city of Phoenix. Appendix E provides detailed information on these data and how we used them.

C. Department of Labor and Industry: Health Care Licensing Bureau

DMA requested data from Montana's Health Care Licensing Bureau on licensed mental health practitioners in order to analyze their distribution across the state. Detailed lists of these providers by region and city are provided in Appendix F.

D. Juvenile and Adult Justice System

Policy Research Associates (PRA) operates the National GAINS Center, which has served since 1995 as a locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system. Two representatives of PRA and the GAINS Center conducted a Needs Assessment of mental health services in the adult and juvenile criminal justice systems, including institutional justice facilities and facilities that transition individuals from prisons to community services. Dr. Henry J. Steadman, President of Policy Research Associates (PRA) and Director of the National GAINS Center, and Dan Abreu, M.S. CRC, LMHC, Associate Director of the National GAINS Center, visited seven facilities, interviewed individuals who could provide relevant information and reviewed a variety of state documents in preparation of this report.

Dr. Steadman and Mr. Abreu visited the following facilities:

- May 12, 2008 – Passages Assessment and Sanction Center
- May 13, 2008 – Yellowstone County Detention Center
- May 13, 2008 – Montana State Women's Prison
- May 13, 2008 – Pine Hills Youth Correctional Facility
- May 15, 2008 – Lewis and Clark County Detention Center
- May 15, 2008 – Montana State Hospital Forensic Unit
- May 15, 2008 – Montana State Prison

On May 14, 2008, the PRA team met with key criminal justice and mental health stakeholders and on May 15, 2008, they held a dinner meeting with the Missoula Mental Health Court Team.

In addition to conducting site visits and interviews, PRA reviewed several reports and audits, including:

- Mental Health Oversight Advisory Council letter relating to mental health care in the justice system (August 21, 2006)
- Technical Assistance Collaborative Report Recommendations Progress/Updates (November, 2007)
- Strategic Plan Collaboration of DOC/DPHSS (December 1, 2006)
- Criminal Justice/Mental Health Intercept Model Adult Offenders (February 28, 2008)
- Predicting and Reducing Recidivism: Factors Contributing to Recidivism in the State of Montana Pre-Release Center Population & the Issue of Measurement. University of Montana. (2006).

PRA's recommendations for Montana reference a number of relevant resources. A list of these resources is provided in Appendix G, and they can be obtained upon request from the Legislative Services Division.

E. Survey

DMA used a web application, Survey Monkey, to distribute and administer a survey to Montana stakeholders. The survey was developed in consultation with Committee staff and distributed to the contact lists of the CFHHS and the Law and Justice Interim Committee, as well as through Montana advocacy groups and state agencies. This method does not result in a sample that is statistically representative of state stakeholders; however it did allow us to generate significantly broader input to our work. The survey generated 706 responses. Twenty-five percent were consumers and families, 25% were providers, and 17% were advocates. The remaining one-third of responses were from "other" categories. Geographically, Missoula and Lewis and Clark counties had the highest response rates, and there were no respondents from the following eight counties: Blaine, Carter, Glacier, Judith Basin, Liberty, Prairie, Wheatland and Wibaux.

Appendix H contains a summary of survey responses.

F. Glossary

Appendix I contains a glossary of terms and definitions.

III. Findings on the DPHHS Mental Health System

A. Child Mental Health Services

DMA has gathered data from a number of sources in order to develop a clear understanding of the number of adults and children in Montana who need and receive mental health services and where they live within the state.

1. How many children need mental health services and where are they located?

Approximately 30,000 children in Montana between the ages of 9 and 17 are estimated to have a diagnosable mental health condition during the year. An estimated 16,500 children of all ages were estimated to have a Serious Emotional Disturbance (SED) in 2006. Of that group, 8,900 were estimated to be in households whose incomes were under 200% of poverty. The estimated rate of SED among children in households with incomes under 200% of poverty, the group most likely to be eligible for and in need of public mental health services varies relatively little across the regions of the state, but varies as much as 15% between the highest and lowest prevalence counties. This is primarily due to economic and ethnic differences in county populations.

a) Estimates of Children in Need of Mental Health Services

There are different levels of need for mental health services. The most expansive definition of need for mental health services is children who experience a mental health problem that meets the criteria for a mental health diagnosis. This group will include children who may experience a one-time problem, such as depression after a major loss, as well as those who have complex and on-going mental health problems that are serious enough to interfere with their functioning at home or school.

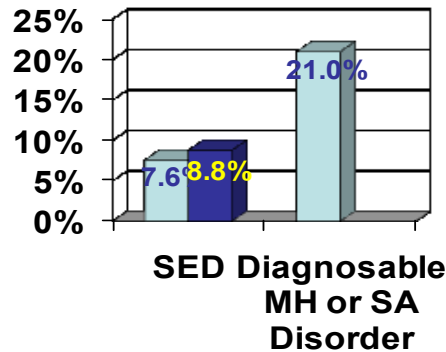
The major epidemiological studies of children have found rates of mental disorders of 20% among a rural sample of 9 to 13 year olds² and of 18.9% in a sample of 9 to 17 year olds.³ We will use a rate of 19% as a benchmark for children with a mental disorder associated with at least a minimum effect on their ability to function. However, it is important to remember that this rate may be somewhat high for children ages 0 to 17, since younger children have a lower prevalence. If that rate is applied to estimates of Montana's population in 2006, this amounts to somewhat less than 30,000 children. In our survey of stakeholders, survey respondents rated children with less serious mental health needs, those with mental health problems not meeting SED criteria, as among those with the most unmet service needs.

² Costello, A.J., Angold, A., Burns, B.J., Stangl, D.K., Tweed, D.L., Erkanli, A., Worthman, C.M. The Great Smoky Mountains Study of Youth. Goals, design, methods, and the prevalence of DSM-III-R disorders. *Archives of General Psychiatry*. Vol. 53 No12, December 1996. Access 10/6/2008 <http://archpsyc.ama-assn.org/>

³ Shaffer, D., Fisher, P., Dulcan, M.K., Davies, M., Piacentini, J., Schwab-Stone, M.E., Lahey, B.B., Bourdon, K., Jensen, P.S., Bird, H.R., Canino, G., & Regier, D.A. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA Study. *Methods for the Epidemiology of Child and Adolescent Mental Disorders Study*. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 865-877.

The most common standard used to identify children with more serious forms of mental illness is serious emotional disturbance (SED). To meet criteria for SED, children must not only have a mental health diagnosis, but the problem must substantially impair their functioning at home, at school, or in the community, and must have persisted, or be likely to persist for 6 months or more. Montana has established a legal definition for SED (see below) which is used as an eligibility criterion for getting certain more intensive mental health services.

**Figure III-1
Estimated 2006 Prevalence of
Children's Mental Health Needs
by Family Income**



Legend: ■ Total* Population ■ Under 200% Poverty**

* Population includes children in households, institutions and group settings

** Population includes only children in households

Source: Estimates by Holzer based on CPES and Census Estimates

The most reliable prevalence studies of children found that in any given year, 5% to 9% of children aged 9 to 17 have an SED.⁴ Dr Charles Holzer has developed estimates of SED prevalence based on these national epidemiological surveys and studies, and taking into account the family income demographics of each Montana county. He estimates that in 2006 7.6% of Montana children (16,500 individuals) had SED. Of that number, 8,900 children were from households with incomes under 200% of poverty. Poverty is a factor that tends to increase risk for mental health disorders. Therefore, we find that the prevalence rate for children with household incomes under 200% of poverty is somewhat higher than for children as a whole, 8.8% (see figure III-1). Throughout our analysis, we will use the SED prevalence rates for children under 200% of poverty as our standard because it provides an indicator that is closest to the population that the state has targeted for provision of public mental health services. Unfortunately, the prevalence estimates are not available for income levels lower than 200% of poverty.

Montana's SED Definition

Under administrative rule, a child aged 6 to 17 meets the SED criteria if the child:

- 1) has a moderate to severe presentation of any one of 20 mood, psychotic, or personality disorders; and
- 2) as a result of the diagnosis, has consistently and persistently demonstrated a significant degree of behavioral abnormality in any two of the following areas:
 - ▶ Failure to establish or maintain relationships with adult caregivers or authority figures;
 - ▶ Failure to demonstrate or maintain appropriate peer relationships;
 - ▶ Failure to demonstrate appropriate range and expression of emotion or mood;
 - ▶ Disruptive behavior that leads to isolation in or from school, home, therapeutic, or recreational settings;
 - ▶ Behavior harmful to the child's growth, safety, or welfare or the welfare or safety of others;
 - ▶ Behavior that results in substantial documented disruption to the family.

A child under the age of 6 meets the SED criteria if the child exhibits one of six behavioral abnormalities that cannot be attributed to intellectual, sensory, or health factors and that results in a substantial impairment in functioning for at least six months and is likely to continue for at least six months.

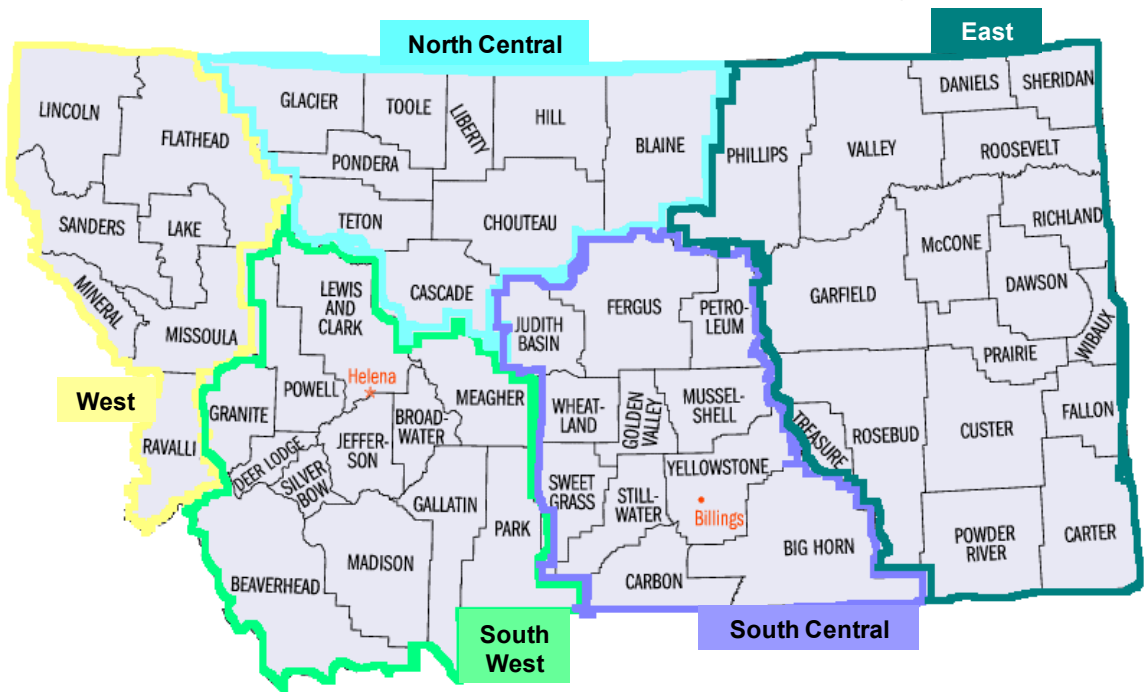
⁴ Ibid.

As we compare the number of children Montana reaches through its mental health programs to these numbers and percentages, it will be important to remember that – because its income standards for publicly funded healthcare do not reach 200% of poverty, Montana should not be expected to match that standard.

b) Estimates of SED prevalence under 200% of poverty by region and county

We collected prevalence, utilization and expenditure data by county across Montana. The county data, because of the small population in many Montana counties, showed wide disparities. In addition, statistical estimates for small populations are not as accurate as those for larger populations. As a result, it was important to group the counties into regions for our analysis. After consultation with Legislative Services Division staff, DMA used five regional breakdowns to analyze the variation within the state. These regions correspond to those used by the Children’s Mental Health Bureau.

**Figure III-2
Children’s Mental Health Service Bureau Regions**



Prevalence rates for SED in children from households under 200% or poverty vary relatively little between regions. Table III-1 shows that rates of SED for poor children vary by from 8.7% to 8.9% between the highest and lowest prevalence regions. County rates show significantly greater variation. Table III-2 presents differences in prevalence of SED by county for children. Rates for children range from a low of 8.2% in Treasure County to a high of 9.4% in Petroleum County. That is, there was a 15% difference between the highest and lowest prevalence counties for children.

Table III-1
Estimated 2006 Prevalence of Children with Serious Mental Health Problems in Households under 200% of Poverty In Montana by Region

Region	SED
Eastern	8.9%
North Central	8.8%
South Central	8.8%
South West	8.7%
Western	8.8%
State	8.8%

Source: Estimates by Holzer based on CPES and Census Estimates

Table III-2
Counties with the Highest and Lowest Estimated Prevalence of Children with Serious Mental Health Problems in Households Under 200% of Poverty

Lowest prevalence rates		Highest prevalence rates	
Treasure	8.2%	Musselshell	9.2%
Broadwater	8.5%	Roosevelt	9.3%
Jefferson	8.5%	Prairie	9.3%
Stillwater	8.6%	Meagher	9.3%
McCone	8.6%	Petroleum	9.4%

Source: Estimates by Holzer based on CPES and Census Estimates

c) Children in Need of Public Mental Health Services

Another dimension of relevance to Montana is how many children in need of mental health services must rely on public programs to get them. In Montana, poor children up to 175% of poverty have access to mental health services through either Medicaid or CHIP. Montana children have eligibility for Medicaid at the federal statutory minimum, which is 133% of poverty for children under 6 and 100% of poverty for children ages 6 and older. In addition, children in the custody of the state are enrolled into Medicaid, and children who are found to be disabled can be enrolled into Medicaid. Table III-3 shows income levels for a family of four as an indication of where these income limits fall at the current time, as well as where 200% of poverty is.

Table III-3
2008 Federal Poverty Guidelines Relevant to Children’s Programs

% of 2008 Federal Poverty Guidelines	Family of 4
100%	\$21,200
133%	\$28,300
175%	\$37,100
200%	\$42,400

Source: <http://aspe.hhs.gov/poverty/08Poverty.shtml> and <http://aspe.hhs.gov/poverty/faq.shtml#chart>

Under Medicaid, basic mental health outpatient services, such as a mental health assessment, outpatient therapy and psychotropic medications, are available to any Medicaid eligible child with a diagnosable mental health problem. Children who meet criteria for serious emotional disturbance (SED) have access to a set of more intensive services under Medicaid.

Montana’s Children’s Health Insurance Program (CHIP) offers insurance coverage for children up to 175% of poverty and covers basic outpatient mental health services for any diagnosable mental health problem. There is also an extended CHIP benefit for children with SED. Children with SED and incomes up to 160% of poverty who are not eligible for Medicaid or CHIP can access some intensive mental health services through the Children’s Mental Health Services Plan to the extent that funds are available. Details of benefits provided are described in the following section.

In FY2007, almost 55,000 children were enrolled in Medicaid for some part of the year, over 19,000 were enrolled in CHIP, and 59 received services through the Children’s Mental Health Services Plan. Together, the enrollment in these programs is similar to the Current Population

Survey estimates of children below 175% of poverty in 2006, suggesting that most children eligible for these programs are enrolled in them.

Children who exceed the income standards for Medicaid and CHIP must rely on private insurance for mental health coverage. In Montana, according to 2004/2005 Current Population Survey data and prior to raising the income limits for CHIP, 17% of children across all income groups were uninsured. Since the rate of uninsurance falls with income, it is likely that fewer than 17% of children above 175% of poverty are uninsured. For those who are insured, private insurance policies generally cover some degree of mental health services, but there may be limits on the amount of services covered and the providers included in the plan's network. Private insurance benefits are often not sufficient to cover the full expenses or the specialized services that a child with SED might need.

2. What children's services does Montana have in place?

To answer this question in the context of Montana's public mental health system, we considered the services provided in its three children's mental health programs: Medicaid, the Children's Health Insurance Program (CHIP) and the Children's Mental Health Services Plan (CMHSP) for uninsured children whose families have incomes up to 160% of poverty. Medicaid and CHIP cover basic mental health services for children who have a diagnosable mental health condition, and an extensive set of services that constitute a comprehensive continuum of care for children with SED. A Medicaid demonstration allows even broader services for up to 100 children annually who are at risk of admission to residential placements. CMHSP provides more limited benefits for children under 160% of poverty who have SED and are not enrolled in Medicaid or CHIP. A comprehensive school and community based services program administered by the Office of Public Instruction is a Medicaid benefit and has grown significantly in recent years. The Youth Services Division of the Department of Corrections also provides some community based and residential services for youth under its supervision.

An effective mental health system includes a comprehensive continuum of services and supports that offer individuals care as close to home as possible. Table III-4 below lists the services covered by Montana's public mental health programs. As the table shows, Montana Medicaid covers a generally comprehensive set of mental health services.

Table III-4 Montana Covered Mental Health Services by Plan Type				
	Medicaid - Child	SCHIP		Children's Mental Health Services Plan (SED only)
		Basic	Extended	
Outpatient Services				
Basic outpatient services	24 visits	20* visits		24 visits
Intensive Outpatient			Visits 21-50	
Evaluation & Mgmt. (physicians, PA, and Nurse Practitioners)	Y	Y		
Psychiatry/Medication				
Medication Management	Y			
Psychotropic Drugs	Y	Y		

Table III-4, cont.				
Montana Covered Mental Health Services by Plan Type				
	Medicaid - Child	SCHIP		Children's Mental Health Services Plan (SED only)
		Basic	Extended	
Crisis Intervention				
Hospital or MHC Crisis Management	Y			
23 HR Observ. - Hosp.	Y			
Intensive Community Services and Supports				
Targeted Case Management	Y			
Comprehensive school & community treatment	Y			
Com-based psych rehab. & support (CBPRS) Psych. Aide	Y		120 hrs	
Behavior Mgmt Skills Dev Scvs	Y			
Day Treatment Services	Y		120 hrs	
Partial Hospitalization	28 Acute or sub-acute days	42* days		
Respite Care Services (State only funds)	12 hrs/mo		144 hrs	12 hrs/mo
Community Residential				
Group Home	3 levels of Therapeutic	Therapeutic*		
Therapeutic Foster Care	Y	Y	+ 30 days	
Inpatient and Residential				
Psychiatric Residential Treat. Fac.	Y	Y		
Acute Inpatient	Y	21* days		
*No limits apply to children with schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder and autism. Sources: Medicaid Mental Health Manual, CHIP Benefit Plan, Presumptive Eligibility Rate Sheet, Billings Indian Health Service Website				

a) Services important for all children with mental health problems

Outpatient mental health services, medication management, and psychotropic medications are available to any child with a diagnosable mental health problem in Medicaid and CHIP. These children may also receive evaluation and management services for mental health problems from a primary care or other health practitioner. These services are often sufficient to treat children with less serious mental health problems, but are also important as a basic service for many children with SED. The remaining Medicaid and CHIP services, including intensive outpatient, are authorized for children with SED.

b) Services important for children with SED

- ▶ Only Medicaid covers targeted case management, a service that assists people with complex service needs to coordinate and manage them. As such, it is of particular importance for children with SED. CMHB reports that there has been considerable growth in the use of this service. As a result, starting in January 2008, limitations were put on the amount of this service available to each child without prior authorization. After study, they were somewhat relaxed, but a higher limit for prior authorization remains in place. Center for Medicare and Medicaid Services (CMS) regulations modified by the DRA have tightened the definition of allowable case management activities and specifically prohibit the direct delivery of an underlying medical, educational, social, or foster care service. This may require the state to review the practice of this service to ensure it complies with the regulations.

- ▶ School and community based mental health services is a behavior management service provided in schools to children with Serious Emotional Disturbance. It is helpful in assisting schools and families to work with children's behaviors in consistent and proven ways. The Office of Public Instruction has been instrumental in encouraging the expansion of this service, which has been well accepted in the schools where it is provided.
- ▶ Other community based services for children with SED covered by Medicaid, CHIP or extended CHIP include: community-based psychiatric rehabilitation and support (CBPRS) which provides the services of a trained psychiatric aide to assist a child and family to address the functional problems caused by a mental health condition in order to assist the child to participate in school and community activities; Behavior Management Skills Development services focus specifically on behavior management techniques. Day treatment services provide a group treatment milieu afterschool. Partial hospitalization provides hospital level of care for relatively short periods of time for children who are able to be at home for the rest of the day and overnight. It can be used as a transition from residential care. Respite Care Services are available only to Medicaid eligibles, but are paid for by state funds. These services provide care for a child with SED so that caregivers can take a break or care for their other children.
- ▶ Crisis intervention services are available in both Medicaid and CHIP. They can be provided by a hospital emergency room or a mental health clinic. They assist families to manage a child's psychiatric crisis. When a child requires more intensive services to address the problems, crisis intervention services can keep the child safe while a respite or residential placement is located. Many of Medicaid's covered services, like outpatient mental health, medication management, etc. can be provided as crisis interventions. Only one service, 23 hour observation, is provided strictly as a crisis service.

c) Out- of-home children services

- ▶ Group homes and foster care provide home settings that are usually based in the community (though some group homes are out of state). They may be needed to provide a level of care that parents cannot provide, or they may be needed when a child with mental health needs does not have a safe home. Medicaid pays for only the clinical portion of such programs. Other state and federal funds cover room and board if the child is in state custody. Parents may bear the cost of room and board if they retain custody and their child needs this level of care.
- ▶ Psychiatric residential treatment facilities (PRTFs) are a more intensive level of care and active clinical treatment near to that provided by inpatient facilities. Medicaid pays the full cost of both PRTFs and inpatient care. A very small proportion of children need this level of care.

d) Psychiatric Residential Treatment Facility (PRTF) Demonstration - Child

CMHB has secured a federal grant from CMS that will allow it to use Medicaid resources flexibly for up to 100 Medicaid children and youth annually who are in or at risk of PRTF level of care and have family incomes up to 150% of poverty. Targeted on the five communities with the highest admission rates, this five year grant and state match provides administrative support to implement and evaluate the project. It will focus on using a system-of-care planning process to develop a plan of community based services that will support a child to return from a PRTF or prevent a PRTF admission. In addition to the administrative support, the state is able to use Medicaid for services that would not otherwise be allowed. These include the provision of respite services (currently available only through state funds); non-medical transportation; a special blood test that provides information about the efficacy of psychotropic medications; and

flexible funding that can be spent for other non-medical needs that are critical to help a child and family cope with the demands of a serious mental health problem. At the end of the five year grant, the state hopes to submit a 1915i waiver application that would allow it to operate such a program on an ongoing basis.

We identified only four mental health services that are not currently covered under children's regular Medicaid benefits. They are respite services, homemaker services, personal care services, and peer support services. Respite services are available to Medicaid beneficiaries, but are fully funded by the state and are not a true Medicaid service. Homemaker and personal care services are most relevant for Medicaid enrollees with physical limitations and disabilities, but are generally not significant for the majority of children with serious mental health problems. Peer services such as support services delivered by peers who are parents of children with SED can assist individuals to recover, manage their illnesses, develop community support systems and build a satisfying and stable life in the community.

e) Children's Mental Health Services Plan.

CMHSP currently covers only outpatient services and respite. Until recently, it also covered day treatment and community based rehabilitation and support. These services were removed to manage within a reduced appropriation.

f) Child and Family Services Division.

CFSD provides assessments and outpatient therapy from providers with specialized qualifications who are not willing or able to participate in the Medicaid program when the complexity or urgency of a child's condition requires this level of expertise.

g) Youth Division, Department of Corrections.

The Youth Division provides mental health residential services for youth in their custody who need that level of care when Medicaid cannot be accessed. The Division also provides certain community based services. However, these services are not a benefit plan, so are not included in the table.

3. Where are children's services being delivered? And by whom? Is additional outreach needed?

Where are children services being delivered, and by whom?

In Medicaid, a high proportion of children are receiving services outside of CMHB's well developed continuum of services provided by mental health specialists. These are services provided by primary care practitioners and advanced practice registered nurses (APRNs) and services in the schools. With only 17 child psychiatrists in the state, and none located in the North Central or Eastern regions, the significance of general health providers in providing mental health services is clear.

Many children are receiving services through Medicaid in schools, but this service is unevenly distributed across the state. Twenty one counties have no such services, with the South Central region having the lowest penetration rate. Intensive community services and supports, which have the potential to successfully maintain children with SED in their homes and communities, are not evenly available across the state. North Central has the lowest penetration and South West has almost twice the penetration of the other regions.

Is additional outreach needed?

In general, Montana seems to be doing a good job of providing access to services for eligible children. Statewide, Montana delivers mental health services to children largely through its Department of Public Health and Human Services (DPHHS), and through a DPHHS collaboration with the Office of Public Instruction. In FY2007, the DPHHS Children's Mental Health Bureau administered Medicaid mental health services for 8,760 children and Children's Mental Health Services Plan services for 59 children. Data on the number of children receiving services through the CHIP program were not available; 19,000 were enrolled. The Child and Family Services Division provided mental health services for 1,152 children in its custody who had the most complex needs. School mental health services, administered by the Office of Public Instruction and billed through DPHHS, served 1,802 children. A total of 5,676 children enrolled in Medicaid and six enrolled in CMHSP received psychotropic medications, most of them in combination with other mental health services. The Department of Corrections provided residential mental health treatment for 26 youth, half of whom are counted by Medicaid since it paid for all or part of the cost. DOC provided community services to an undetermined number.

Our analysis of Medicaid penetration showed that Montana Medicaid is coming close to reaching the number of enrollees estimated to need basic mental health services. Addition of accurate IHS services data is also important to provide a more complete picture of unmet needs in Medicaid. It is also important for the state to better understand how well CHIP is serving Montana children with mental health needs and with SED enrolled in that program.

Based on consultation with DPHHS, DMA used a conservative method to estimate the number of children with SED served through DPHHS programs. This method, based on the number of children receiving targeted case management services, results in a minimum estimate of at least 3,285 SED children receiving DPHHS services, or 6% of those enrolled. While this estimate understates the number of SED children getting services, it does suggest that additional outreach may be needed for this group. Utilization data for specific services of importance to this group at a state and regional level also suggest gaps in access and availability.

This section will address the utilization of services by children at a state level, describing the state divisions involved in delivering public mental health services and evaluating how well they are meeting the need on an overall basis. Then it will address the question in more detail, analyzing use of different service modalities and the relative access in different regions of the state. (Please note the data limitations that are outlined in Section II, page 4)

a) Department of Public Health and Human Services Children's Mental Health Programs

Montana's Department of Public Health and Human Services (DPHHS) is largely responsible for the delivery of public mental health services. In response to a data request, DPHHS compiled a data matrix for this project that summarized all the mental health services provided by the agency and eliminated any duplication of clients served by more than one division. Because data for the CHIP program is administered by a subcontractor, children receiving only CHIP services were not included, and due to incomplete data, people receiving mental health services only through Indian Health Services (IHS) facilities were not included.

DPHHS served an unduplicated total of 11,591 children through four major program areas depicted in Figure III-3, Medicaid, the Children's Mental Health Services Plan and the Child and

Family services Division (CFSD). This figure excludes the CHIP program, a significant fifth source of children's mental health services, for which FY 2007 service data was not available.

- ▶ Children's Mental Health Bureau (CMHB) administers the children's Medicaid mental health benefit, which served 8,760 children or 78% of the unduplicated DPHHS total in 2007.

- ▶ CMHB also administers the Children's Mental Health Services Program.

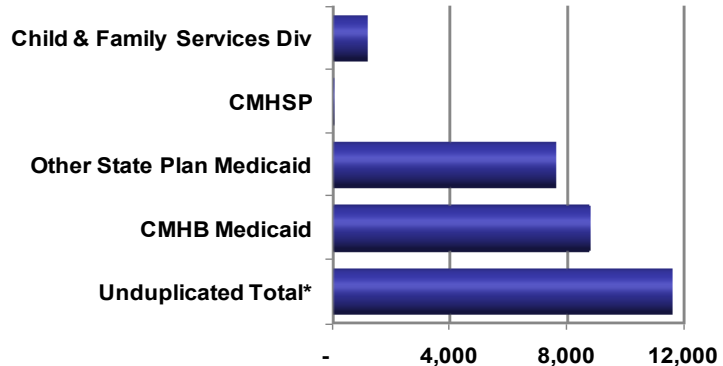
CMHS served 59 children enrolled in the program in FY2007.

- ▶ Seven thousand children, two-thirds of the DPHHS total, are served through several components of Montana's Medicaid program for children that are administered by the Health Resources Division (HRD) or the Office of Public Instruction (OPI). These include the pharmacy benefit and the school mental health services program. OPI has an important role in the administration and expansion of school mental health services, for which local school systems contribute the state match portion. The claims are paid through HRD's Medicaid claims payment system as a part of Other Medicaid. From here on, we refer to this as Other Medicaid, or Other State Plan Medicaid.

- ▶ The Child and Family Services Division (CFSD), Montana's child welfare agency, purchases specialized assessment and outpatient treatment for children who have complex mental health problems and who are not able to receive this service through a Medicaid provider. Over a thousand children, or about 10% of the DPHHS unduplicated total, receive mental health services purchased by CFSD. Foster children get the remainder of their mental health services through Medicaid.

- ▶ Many children - close to 40% - receive services through more than one of these four programs. This is a positive sign that outreach is occurring by each of the programs. Children in CFSD custody are Medicaid eligible and get most of their services through CMHB Medicaid. Children getting mental health services and psychotropic medication will be counted in both CMHB and Other Medicaid. Children eligible for services in schools because of serious emotional disturbance may be in CFSD custody and may be getting CMHB services. In addition, children in the community may lose or gain Medicaid eligibility during the year. If it were possible to include data on children receiving CHIP services, we would undoubtedly find that children move between Medicaid and CHIP, and perhaps between CHIP and other programs.

**Figure III-3
Children Receiving DPHHS MH Services
and/or Medications in FY07**



* Excludes CHIP recipients and recipients receiving mental health services only from IHS facilities

Sources: DPHHS Special Report Montana Mental Health Study

b) Meeting Children's Mental Health Needs - Statewide

To evaluate how well Montana is meeting the needs of its children with mental health problems, we compared the number of children served to the estimate of need. We used two approaches to understanding need; the estimated 2006 8.8% statewide prevalence for children

with SED in households under 200% of poverty and 19% as the estimated prevalence for children with a mental health problem during the year. It is important to remember that both benchmarks include children that are not eligible and could not be served by Montana's public mental health programs under their current eligibility rules. Both benchmarks are rough standards, since they exclude children under 9. While these benchmarks aren't an exact match for Montana's programs, they are a helpful marker in evaluating Montana's success in reaching children who need mental health services at different levels. They are the best available and the most widely accepted estimates of needs.

Penetration in Medicaid. The proportion of children in the population who have received at least one health service during a specified period of time is called penetration, and is a general indicator of access to healthcare. The most robust measure of penetration we can calculate from available data is for Medicaid. We have compared the number of Medicaid enrollees who access mental health services to those who were enrolled in Medicaid at some point during the year. Our data shows that 11,341 unduplicated children were served through HRD Medicaid and CMHSP. Penetration for Medicaid enrolled children was 21%, exceeding the 19% benchmark, the prevalence rate expected for children over 9 with a mental health or substance abuse problem during the year. This calculation suggests that Montana has done very well in reaching children enrolled in Medicaid with some kind of mental health treatment. We remind the reader that our data exclude recipients receiving mental health services from Indian Health Service (IHS) or tribal facilities. These data were excluded because DPHHS staff decided that they were incomplete.

Montana's Medicaid penetration rate compared favorably to that of Alaska, whose penetration rate for children's mental health services (not psychotropic medications) was only 8%. Other comparison states did not submit data in a form that allowed for calculation of Medicaid penetration.

Service Access for Children with SED.

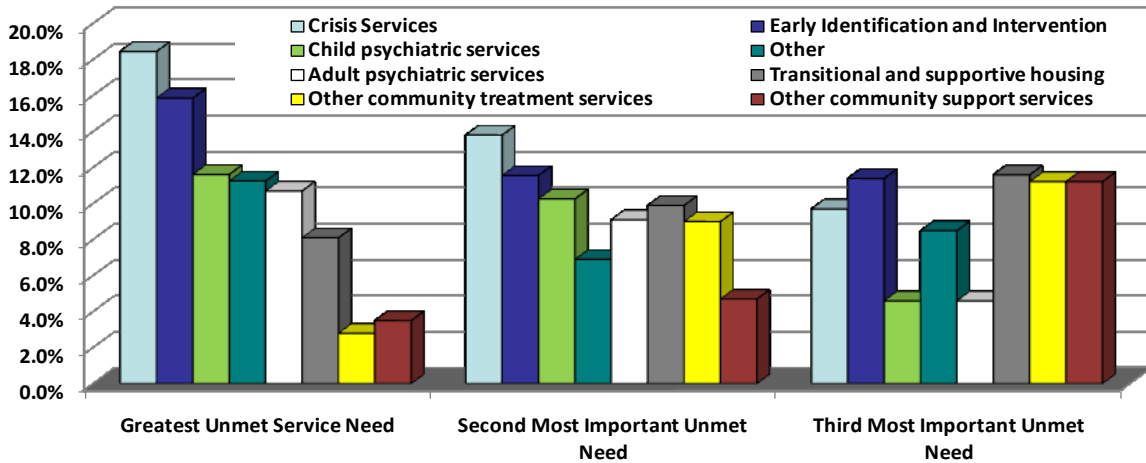
We would have liked to make an estimate of the children receiving services primarily directed towards those with SED. However, to do so, we would have needed to identify those children who used the CMHB Medicaid services that are restricted to children with SED, and remove any duplications. The data that we requested and received did not allow us to perform this type of calculation. Instead, we looked at the SED service with the largest number of users, targeted case management. A total of 3,285 children, or 6.0% of children enrolled in Medicaid, received targeted case management. This is less than the 8.8% of children estimated to have SED. However, since there are likely additional children receiving other SED services, but not using targeted case management, we know that the true penetration rate for SED services would be higher than 6%; the exact amount cannot be determined from our data set. DPHHS's claims system is capable of developing reports that calculate the unduplicated number of children receiving SED-only services. We urge the department to periodically calculate this measure in order to allow it to evaluate the level of access for this group of children.

CHIP is administered by a subcontractor whose reporting differs from Montana's Medicaid system, and we were unable to receive data on the number of children receiving mental health services. However, it is important for the state to get the utilization data for CHIP needed to assess how well the mental health needs of the 19,000 children enrolled in this program are being met.

c) Statewide Availability of Specific Service Modalities

DMA used a variety of methods to measure the availability of services in Montana. In addition to DPHHS’ detailed report, DMA disseminated a comprehensive survey to Montanans interested in commenting on the availability of services and unmet service needs of persons with mental health conditions. Out of 706 respondents, more than 500 respondents to the survey rated the three most needed types of services in the state (see Figure III-4). The most frequently identified services needed were crisis intervention, early identification and treatment, psychiatry for both children and adults, and housing.

**Figure III-4
Survey Responses: What is the greatest service need in Montana?**



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

In addition, we analyzed the number of children receiving key services as an indication of the relative frequency of service use. We have not attempted to show every service type that Montana delivers because the detail would be overwhelming and hard to interpret. However, by excluding some services, the reader may get the impression that fewer people are being reached for services. To evaluate overall access, please consider our analysis in the prior section which did include all the children who are reached by the DPHHS programs.

Figure III-5 (next page) shows the number of children getting certain specific Medicaid services, those receiving CMHSP services, and those served in CFSD.

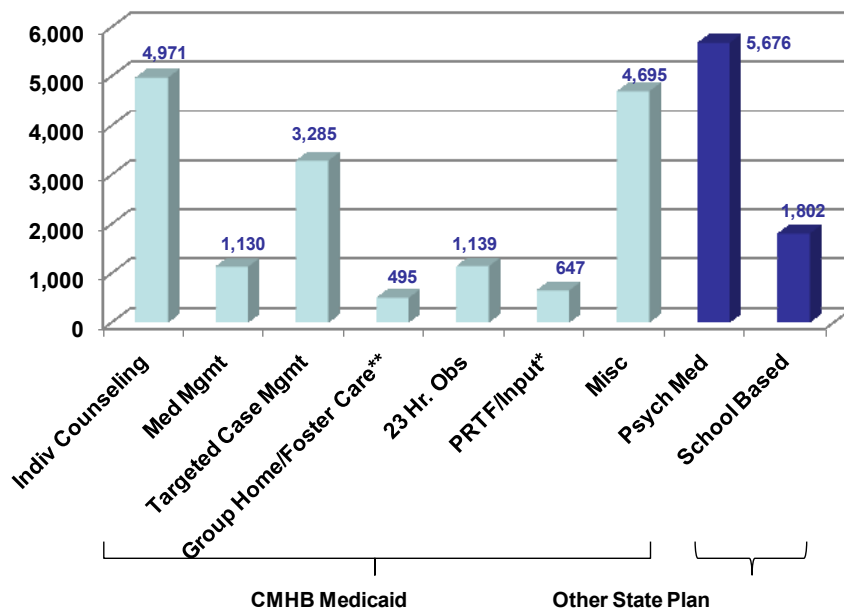
Medicaid services important for all children with mental health problems

- ▶ Outpatient counseling is available for both children with SED and those with much less severe conditions. The modality of individual counseling is most frequently used, accessed by almost 5,000 children, 9% of Medicaid enrollees.
- ▶ Almost as many children as those receiving outpatient counseling, 4,695 or 8.6%, receive miscellaneous services. Miscellaneous services are all those services provided for a mental health diagnosis that are not included in CMHB’s menu of specialized mental health services. As such, they can cover a broad spectrum from very limited services, such as a lab test for medication levels, to ongoing medication management from a primary care physician. The state may wish to better understand who is being served in this

category, and what kinds of services they are getting to better evaluate the significance of the services included in this broad category.

- ▶ Psychotropic medications were prescribed for 5676 Medicaid children, 10% of enrollees, most often in combination with mental health services of other kinds.
- ▶ Only 1,166 Medicaid enrolled children get medication management provided by psychiatric specialists. These are the 1,130 who receive it under CMHB Medicaid, and 36 who receive it under Other State Plan Medicaid (not shown on the chart). These children represent only about 20% of the 5,676 children who used psychotropic medications.
- ▶ The discrepancy between use of psychotropic medications and medication management services suggests that primary care physicians and mid-level practitioners (e.g., APRNs) are prescribing and managing these medications. This likelihood points to the significance of primary care providers as an important part of the mental health service delivery network.

**Figure III-5
SFY 2007 Unduplicated Medicaid Enrolled
Children Receiving Selected Service Types**



Misc includes services for MH diagnoses provided by non-MH providers, including Personal Care Agencies, FQHCs, physicians and labs. Also includes certain psychiatry services not included in standard MH procedure codes.

* Excludes people receiving services in IHS facilities

** May double count children receiving both types of service in the year

Source: DPHHS Special Report

Medicaid services important for children with SED

- ▶ Targeted case management is a service that assists people with complex service needs to coordinate and manage them. As such, it is of particular importance for children with SED. This service is provided to 3,285 children enrolled in Medicaid. CMHB reports that there has been considerable growth in the use of this service. As a result, starting in January 2008, limitations were put on the amount of the service available to each child without prior authorization. After study, the limitations were somewhat relaxed, but a higher limit for prior authorization remains in place. CMS regulations modified by the Deficit

Reduction Act (DRA) have tightened the definition of allowable case management activities and specifically prohibit the direct delivery of an underlying medical, educational, social, or foster care service. This may require the state to review the practice of this service to ensure it complies with these regulations.

- ▶ School based mental health services, behavior management provided in schools to children with Serious Emotional Disturbance, is another fast growing service as it becomes available in more schools. The Office of Public Instruction has been instrumental in encouraging the expansion of this service, which has been well accepted in the schools where it is provided. In FY 2007 it reached approximately 1,802 children and youth.
- ▶ CMHB's menu of other community services targeted towards supporting children with and their families in living a full life in the community are used at much lower rates than targeted case management. Community based rehabilitation and support is used by 1,346, close to the number receiving school based services. Less than 1,000 children use the other intensive community based services.
- ▶ Crisis intervention services are represented only by 23 Hour Observation, a hospital service, which was used by 1,139 Medicaid children. The rate of use for this service exceeds that of Inpatient and PRTFs and is fairly close to the number of children served in group and foster care. This service may perform an important function in preventing longer residential stays. Unfortunately, this is only one crisis modality. We are unable to see crisis services provided on an outpatient basis or through other program types because services provided on a crisis basis are not distinguished from routine service provision.

Medicaid out of home services for children

- ▶ Services like therapeutic foster care, group homes, and psychiatric residential facilities or inpatient care are needed and used by far fewer children. Foster care is the most used residential modality, for 793 children, while 495 are in group homes at some point during the year. PRTF care is used by 635 and only 12 were served in an inpatient hospital.

Cross State Comparisons. One way to compare Montana's relative use of services of different intensities to other states is to compare the utilization rates per thousand population for different levels of care. The table below shows these rates for inpatient and residential services as compared to non-residential community based services. State mental health systems differ in how they organize their services, what services they cover, and who is eligible for services. While all of these issues make such comparisons inexact, the comparisons can be helpful in identifying whether one is an outlier in comparison to other states.

We were able to get comparison data from four other states:

- ▶ Alaska contributed data on its Medicaid mental health services.
- ▶ Arizona contributed data from its managed mental health programs, excluding Maricopa County, the county including Phoenix, its largest city.
- ▶ New Mexico contributed data from its Mental Health purchasing collaborative.
- ▶ From public mental health data reported by Minnesota, we selected only those counties who were frontier or had a population density that did not exceed Montana's most densely populated county.

Table III-5 shows that Montana ranks toward the top in terms of overall mental health utilization rates per thousand, with rates close to Minnesota and New Mexico and exceeding Alaska's rates for Medicaid services substantially.

Table III-5 Children's Services Penetration Rates in Montana and Other States (Utilizers per Thousand Population)					
	MT Medicaid and CMHSP*	AK Medicaid	AZ (excl. Maricopa Cty)	NM*	MN R/F Counties*+
Children's Penetration					
Inpatient and Residential	3.0			5.9	9.8
Group Home and Foster Care	5.9			3.4	
Residential Subtotal	8.9	9.7	2.2	9.3	9.8
Community Only	39.3	30.3	44.3	43.7	43.0^
Total	48.2	40.0	46.4	52.9	52.8
Source: DPHHS Special Report, 2000 Census and submissions from other states – see Appendix E					
*May include some duplications of children served at both inpatient and residential in the same year.					
** May show duplication of children served in more than one county in the same year.					
^May overstate community only utilization rate because group home and foster care use not separately reported.					

Montana's use of inpatient and residential services is much lower than that of New Mexico, and Minnesota. Montana and New Mexico are almost opposite in their relative use of the more restrictive forms of residential care and group home and foster care, which are more likely to be community based. This is a favorable indication that Montana is able to serve children closer to home. In comparing residential use overall, Montana has similar, but slightly lower rates as 3 of the other 4 states. However, Arizona's lower rates for residential and inpatient care may demonstrate that additional reductions in use of this level of care can be achieved.

d) Regional Service Availability

One of the important barriers identified by survey respondents was an insufficient number of providers or services. This section describes the availability of programs and providers, and explains what our analysis of DPHHS and other service data suggests about the availability of services across the major regions of the state.

Service Location and Capacity. As of May 2008, only 17 Montana licensed physicians were board certified as Child and Adolescent Psychiatrists. They were located in only 5 cities, and none were located in the North Central or Eastern regions. The number is low to meet the need, and the limited locations create a transportation burden or barrier for those living at a distance from them.

Other mental health professionals are also less available in the Eastern and to some degree, the Northern parts of the state. (See our analysis in the adult section.) There is no indicator in the data we received that would allow us to distinguish those specializing in adults or children.

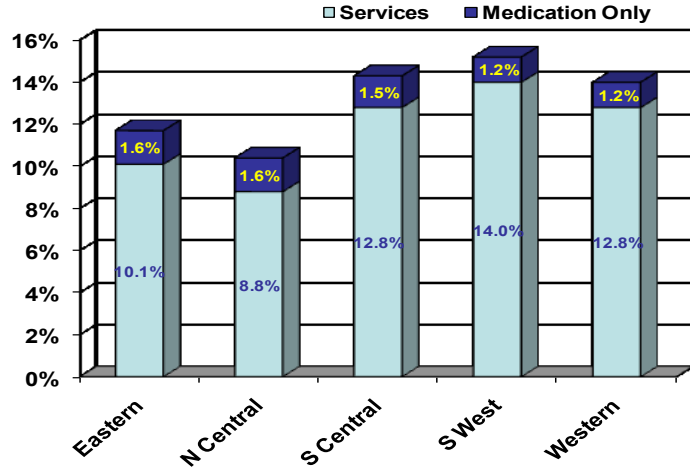
Table III-6 Board Certified Child and Adolescent Psychiatrists in Montana as of 5/2008 by Residence	
City of Residence	# of MDs
Billings	6
Bozeman	4
Helena/Clancy	4
Kalispell/Marion	2
Missoula	1
Grand Total	17

We also looked at the distribution of specialized programs across regions. There are no children's inpatient psychiatric units in the state of Montana, though children are sometimes admitted to pediatric units with a primary mental health diagnosis.

Children's Utilization By Region.

Figure III-6 provides an overall picture of access to services for children across the regions, showing the unduplicated number of DPHHS mental health service recipients by region. There was a 59% difference between regions on mental health service utilization rates for children, and almost a 10-fold difference between the counties with the highest and lowest penetration. The North Central Region had the lowest penetration rate, followed by the Eastern. The remaining three regions were higher, and both Western regions had somewhat lower proportions of children receiving only psychotropic medications. These differentials did not correspond to differences in need as measured by estimates of the rate of SED among children in households under 200% of poverty. In fact, the South West had the lowest SED prevalence, but the highest service penetration.

**Figure III-6
FY2007 DPHHS Child MH Service & Medication Users* as a Percent of Population Under 200% of Poverty**



* Excludes recipients receiving CHIP services and those receiving mental health services only from IHS facilities

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

Table III-7 shows weighted averages for each region of major service categories for children. In our calculations, we weighted each county by its number of service users, so that small counties were not rated equally with larger counties. Because the numbers involved are so small, we have transitioned to using a calculation of users per thousand population. (This essentially is equivalent to multiplying a percentage by 10.) We have provided the same calculations for

	Misc	Medication	Outpatient Services [^] *	Medication Mgmt. [^]	School	Crisis	Intensive Community Services. & Supports [^] *	Community Residential [*]	PRTF/ Inpatient [*]
Eastern	33	51	24	7	21	13	10	7	4
North Central	33	52	23	4	17	6	7	4	3
South Central	73	71	33	16	6	25	12	8	4
South West	56	68	39	10	25	22	21	12	4
Western	32	56	34	17	25	12	11	6	3
Percent difference highest to lowest	227%	138%	170%	402%	404%	400%	300%	297%	137%

+ May include duplications of children receiving services in the same category in more than one county during the year.
[^]May include duplications of children served in both Medicaid and CMHSP during the year.
* Average of more than one service modality. Excludes multiple family therapy, a little used modality.
Source: DPHHS Special Report and Census Estimates

each county in Appendix B. We also calculated the difference between the highest and lowest utilization regions. By this measure, there is considerable variation in the utilization of most service types. Medication and Inpatient/PRTF services are the most evenly distributed, with all other service categories varying two-fold or more between the highest and lowest region. Medication management, school and crisis services were the most variable, with a four-fold difference between the lowest and highest rates.

- ▶ North Central had the lowest utilization for medication management and crisis services and fell at the bottom or was lowest for all other services except school services, where it was not dramatically different from higher counties. This suggests that school services may substitute to some degree for other community based services in North Central.
- ▶ South Central showed more reliance on outpatient than on school services. It had the lowest utilization in school services, falling considerably below all other regions, but had the highest rate for miscellaneous services and medication, and was close to the highest in outpatient services and psychiatry.
- ▶ The Western region was relatively high on outpatient services, psychiatry and school services, but was relatively low on the more intensive levels of care, both community and residential.
- ▶ The South West region stood out in having intensive community supports that are considerably better developed than any of the other regions. Further developing this level of care in the rest of the state represents an opportunity to develop more services and possibly prevent disruptive out-of-home placements.

Our data do not allow us to easily distinguish inpatient services from services in Psychiatric Residential Treatment Facilities (PRTF), so we have combined these two most intensive and restrictive types of psychiatric treatment. During 2007, 2,264 youth were placed in out of home services at some point during the year.

Service type	Total Out of State	Total Instate	Percent Out of State
Inpatient/PRTF	142	801	18%
Therapeutic Foster Care	0	804	100%
Group Homes	60	457	12%
Total	202	2,062	10%
<i>Source: DPHHS Special Report and HRD Medicaid SED Youths Receiving Out of State Placements Services (2/29/08)</i>			

It is important to note that children’s lengths of stay in this level of care is highly varied, ranging from a matter of weeks to considerably longer.

Approximately 10% of children in 24 hour placements were placed out of state. Almost a fifth (18%) of children in the PRTF level of care were sent out of state in FY 2007. A lesser, but still significant 12 % of children placed in group homes were out of state in the same year. Using out of state facilities can allow Montana to better meet a child’s need for a specialized service. However, sending a child far from family, friends and community makes it more difficult to engage those adults in supporting and participating in the child’s treatment, and to plan for discharge and arrange for community based services. Distances are so great within Montana that some of these difficulties can also apply regarding in-state placements, and if out-of- state placements are closer to the child’s home than within-state placements, they may be preferable to the latter. However, scrutiny reveals that a number of children are sent as far as Texas, creating a significant transportation barrier.

CMHB has been focusing considerable attention on bringing children back to Montana from out-of-state and strengthening community services for high need children in order to prevent residential placements. In addition to its initiation of the PRTF waiver demonstration, these efforts include the implementation of Children's System of Care and the use of a flexible System of Care account for services.

4. Children's System of Care

a) Background

Montana has been moving toward systems of care planning for children with complex needs since 2001, creating a multi-agency planning committee in 2001, a System of Care planning committee in 2003, and receiving a SAMHSA system of care grant in 2004, which is now beginning its fifth year. The grant helped the state to carry out the Legislature's directive to develop a system of care.

Systems of care is a way of planning and delivering services that enhances each family's role in identifying the services their child needs and developing and continuously adapting a service plan. System of care is targeted toward children with the most serious mental health problems, and those whose complex needs require services from more than one state agency. In addition to identifying and planning for a comprehensive set of state services, system of care focuses on identifying and further developing natural community resources that can be an ongoing source of support for the youth and family, and enhance their participation in community activities. In general, system of care projects include some limited form of flexible funding which is not required to meet standard reimbursement requirements, like those for Medicaid and Title IVE. This allows it to be used for non-traditional services that can complete service plans or allow a family to make best use of services. For example, funding a car repair may be the least expensive way to support a family's access to services. Paying for a swim program may allow a child access to a form of exercise and community participation that would not otherwise be available. Systems of care have been extensively researched and have often generated cost savings, reductions in out of home placements, and improved outcomes for youth and families.

b) SAMHSA Grant

Montana's system of care grant has involved five sites where local staff have been hired to develop local advisory committees, known as Kids Management Agencies (KMAs), and develop system of care planning processes. To date, 120 youth have been enrolled and approximately 70 meet the requirements for the federal evaluation. Although, flexible funds are quite limited, there has been considerable training of system of care staff, parents, and providers in the principles and practices of system of care, providing a necessary foundation for further implementation. However, Montana's current system of care delivery model is not well financed, and it will be challenging to find ways to sustain it in its current form.

In 2007, the Legislature established a System of Care account that allows state agencies to deposit the state share of any excess Medicaid match or other general fund dollars into the account. These funds can be used to purchase services on a flexible basis on behalf of high risk seriously emotionally disturbed children who have multi-agency service needs. Spending authority for the current biennium is set at a maximum of \$500,000. In FY 2008, \$46,000 was channeled through the account on behalf of 11 children. Nine of them would have required PRTF level of care without the ability to make these flexible expenditures. Another child was at risk of a disrupted adoption, and one would have been sent to an out of state group home.

Overall, the State's efforts have reduced the number of children in residential care in FY 2008 considerably. In May of 2008, there were only 48 children in inpatient and residential treatment facilities. While this is a point in time count that is not strictly comparable to the FY 2007 count of children in treatment at some point during the year, it does appear that there has been a decrease in use of this level of care. In addition, as of July 2008, there were only 42 youth served out of state, 17 of whom were in PRTFs and 22 of whom were in group homes. Again, though comparing full year utilization to a point in time, it does appear that meaningful progress has been made in serving youth in state.

5. What services do the children of Montana need that currently do not exist?

Priority needs in Montana's children's mental health system include: expansion of services for children in the North Central region; expanding systems of care which will assist in encouraging further development of community based services for children with SED; and the continued expansion of school based services.

- ▶ Overall, the North Central region needs improved access for most service types.
- ▶ While school based services are expanding quickly, they do not yet cover the state. Twenty one counties showed no utilization of school based services in FY 2007. In the North Central region, relatively higher utilization of school services may be compensating for lower utilization of standard outpatient services.
- ▶ A severe shortage of trained child psychiatrists, with none located in the North Central or Eastern regions puts children with more serious conditions at risk of being inaccurately diagnosed and not treated optimally. Primary care physicians and mid-level practitioners (for example, physician assistants and APRNs) play an important role in the children's mental health system as providers of mental health prescribing services.
- ▶ Systems of care and local planning efforts can play an important role in encouraging the further development and use of intensive community services. The primary challenge for the state will be to find ways to finance the creative and non-traditional approaches likely to come out of these efforts.
- ▶ CFSD has addressed the needs of its more complex cases to get a specialized assessment and treatment on a timely basis by paying for services outside of Medicaid.
- ▶ CMHB, through the PRTF demonstration grant and the use of flexible funds has some powerful tools for encouraging care of children with the most intensive needs within their communities and use of residential care and out-of-state residential services has begun to show a decline.

Recommendations

- ▶ Conduct more aggressive recruitment efforts for child psychiatrists in accordance with methods suggested in our discussion of workforce issues at the end of this chapter and rate increases recommended in Chapter IV.
- ▶ Develop a strategy for increasing training in the treatment of very young children and continue efforts to identify problems through primary care screening.
- ▶ Strengthen crisis services for children
 - CMHB should work with LACs and SAAs to more systematically assess the needs for children's crisis intervention and how capacity can best be created.
 - Develop a plan for funding crisis response and stabilization services that is consistent with and aligned with AMDD's 72 hour presumptive eligibility services.

- ▶ Make plans to further develop family support and peer providers to conduct outreach, facilitate service planning, coordinate care and deliver support services. Work with KMAs and LACs to develop peer service models that can compensate for some of the gaps in the frontier workforce.
- ▶ Define a Medicaid procedure with a rate that adequately reimburses the assessment and treatment of certain complex CFSD cases which will increase access to providers and to timely services while drawing down federal match.
- ▶ Work with LACs and tribes to identify priorities for local service development and develop plans for expanding those services. Pay particular attention to North Central Montana and frontier locations. Find or fund small grants that can finance collaborative approaches with primary care and family support programs.
- ▶ Continue to provide flexible fund support to CMHB in order to reduce the use of residential care and maintain youth with SED in their homes and communities.

B. Adult Mental Health Services

This section addresses questions related to Montana’s adult mental health services.

1. How many adults need mental health services and where are they located?

In 2006, over 121,000 adults in Montana were estimated to have a mental health condition that caused them to lose at least a week of work. An estimated 38,500 adults met the criteria for serious mental illness that are similar to, but not quite as strict as, Montana’s standard for severe disabling mental illness (SDMI). Of that group, about 22,000 are from households with incomes below 200% of poverty. The prevalence rate for adults in households under 200% of poverty is 9.2%. Prevalence rates across Montana’s regions range from a low of 8.8% to a high of 9.4% for adults in poor households. County rates show significantly greater variation, with a 40% difference between the highest and lowest prevalence counties.

In FY 2007, almost 66,000 adults were enrolled in Montana’s adult public mental health programs. Eligibility for adult mental health services is complex, and varies for individuals with different family statuses, disabilities and presence or absence of SDMI. These eligibility criteria leave significant numbers of poor uninsured adults without access to mental health services.

Special populations with unique needs include Indians, whose estimated rate of serious mental illness of 10.9% among households under 200% of poverty exceeds the statewide estimate. IHS and other tribal facilities provide basic mental health services but lack the capacity to provide services for people with SDMI. Veterans returning from combat are at elevated risk for post-traumatic stress and related conditions. While enlisted, they have access to military health and employee assistance services, but they may encounter gaps in coverage when they leave the military, from delays either in establishing eligibility for Veterans Administration services or in establishing private health insurance.

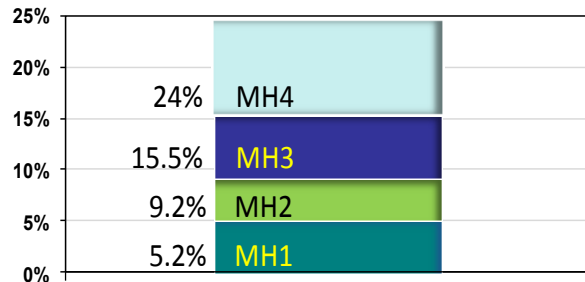
a) Estimates of Adults in Need of Mental Health Services

As with children, adults’ mental health needs cover a considerable span of intensity. The National Institute of Mental Health’s Collaborative Psychiatric Epidemiology Surveys (CPES) provide highly detailed information about the prevalence and severity of adult mental health problems. Dr. Holzer has used this survey data as the basis for developing estimates of four levels of mental health problems in adults. Figure III-7 illustrates the four levels of need defined by Holzer as they are estimated to occur among Montana’s 238,263 adults in households with incomes below 200% of poverty. Need level is defined by:

- ▶ Diagnosis,
- ▶ Days off work and
- ▶ Impairment.

Impairment is defined by the Sheehan Disability Scale which measures the extent a mental disorder interferes with home management (like cleaning, shopping and taking care of the house), a person's ability to work, a person's ability to form or maintain close relationships with other people, and a person's social life. This self-rating scale ranges from zero to ten, and it is scored by taking the average of the four areas assessed.

Figure III-7
Percent of Montana Adult Population
In Households Under 200% of Poverty
by Level of Mental Health Need



Source: Estimates by Holzer based on CPES and Census Estimates

MH1 represents the most impaired individuals and MH4 the least impaired. MH1 is comparable to Serious and Persistent Mental Illness (SPMI), a standard representing the most severe forms of mental illness. The criteria for MH1 are a chronic major mental health diagnosis; average impairment ≥ 7 on a scale of 10, where 10 is most impaired; and more than 4 months off work due to the mental health problem. Criteria for MH2 require a chronic mental health diagnosis; average impairment ≥ 7 ; and more than 4 months off work. Individuals, who meet criteria for MH1, are included in the percentages for MH2, and so on up the scale.

Criteria for MH3 involve a current mental health diagnosis; average impairment ≥ 5 and more than 1 month off work. Criteria for MH4 require any current mental health need, average impairment ≥ 3 and more than 1 week off work. Since many people who benefit from mental health treatment do not miss work because of their condition, this lowest standard still represents a significant level of need. We will be using MH4 as our standard for people needing less intensive mental health services. A larger number of people have a need for services but have not missed work; however, we do not have data for that group. Our standard includes the individuals captured by the more severe standards in MH1 through MH3, but also incorporates the additional individuals who meet the criteria for the lesser level of severity defined by MH4.

Montana sets a standard of Severe Disabling Mental Illness (SDMI) for access to most of its public mental health services. SDMI is generally considered to fall between the more commonly used standards of SPMI and SMI. We compared Montana’s definition of SDMI to Holzer’s levels, acknowledging that this is imperfect since they are based on different criteria. We have chosen to use MH2, a conservative definition of SMI, believing it to provide the closest estimate to Montana’s SDMI eligibility standard. By using MH2, our estimates of need will slightly exceed the number of Montanans who would qualify for SDMI. When we are referring to Holzer’s

utilization, we will refer to SDMI, the standard used to set eligibility for many of Montana’s adult mental health services.

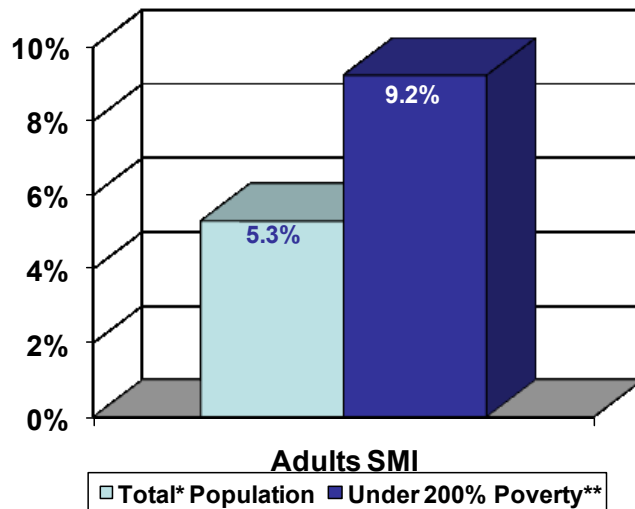
Montana’s SDMI Definition

Under Montana administrative rules, a person has a severe disabling mental illness if he or she:

- has been involuntarily hospitalized for at least 30 consecutive days at Montana State Hospital at least once OR
- has a moderate to severe mood, psychotic, or personality disorder; AND
- has an ongoing functional impairment. A person meeting at least two of the following criteria is considered to have an ongoing functional impairment:
 - ▶ Must be on medication to control the symptoms of mental illness;
 - ▶ Is unable to work in a full-time competitive situation because of the mental illness;
 - ▶ Is determined by the Social Security Administration to be disabled because of mental illness;
 - ▶ Is able to maintain a living arrangement only with ongoing supervision or is homeless or at risk of homelessness because of the mental illness; or
 - ▶ Has had or will predictably have repeated episodes in which the mental illness worsens.

In Montana, Holzer estimates that in 2006 approximately 5.3% of the total adult population, or 38,500 individuals met the criteria for MH2. Among the 238,263 Montana adults in households with incomes under 200% of poverty, the rate is considerably higher, 9.2%, resulting in an estimate of 22,000 adults in this group meeting criteria for MH2. As with children, we will use the rate for adults from households under 200% of poverty as our standard. While it considerably exceeds the income levels at which most adults become eligible for services in Montana, this type of estimate, taking into account Montana’s specific demographic makeup, is not available for income levels lower than 200% of poverty. (See Figure III-8.)

**Figure III-8
Estimated 2006 Prevalence of
Adult Mental Health Needs
by Family Income**



Source: Estimates by Holzer based on CPES and Census Estimates
 *Population includes households, institutions and group settings
 **Includes households only

b) Special Populations - Adults

Dually diagnosed. Adults who have both SMI and a substance abuse problem are said to have “dual diagnosis.” According to Dr. Holzer’s estimates, about 12% of all Montana adults meeting MH2 criteria are estimated to have experienced a substance abuse problem during the past 12 months. Other studies and Montana stakeholder feedback suggest that higher rates are present. For example, the Epidemiological Catchment Area study found a life-time prevalence of abuse of alcohol or drugs of 29% among people with mental illness.⁵ Similarly, the 2007 National Survey on Drug Use and Health (NSDUH) reported that past year illicit drug use in 2007 was 28% among adults with Serious Psychological Distress (SPD), considerably higher than use

⁵ Office of Applied Studies (2008) Results from the 2007 National Survey on Drug Use and Health: National Findings. DHHS, SAMHSA, September 2008, p. 70. <http://www.oas.samhsa.gov/NSDUH/2k7NSDUH/2k7results.cfm#TOC>. Accessed 9/18/08.

among adults without SPD (12.2 percent). SPD is yet another standard for mental illness. It identifies people who would be considered to have a mental health diagnosis.

American Indians. American Indians constitute about 6.4% of Montana's population or more than 60,000 individuals. Holzer's estimates found that Native American adults from households under 200% of poverty had a higher rate of MH2, 10.9%, than all Montana adults under 200% of poverty. Data from a national study found that Indian male and female adults and adolescents are significantly more likely to commit suicide than non-Hispanic Whites (percentages vary by age and gender); and that Indian adults are less likely to receive mental health treatment (12.7% versus 14%) or prescription medications (10.7% versus 11.8%) than Whites.⁶

Veterans. As of 2004, Montana had the highest per capita rate of enlistment in the armed forces among the states. In addition to its armed forces members, it also has close to 4000 active full-time members of the National Guard. Several studies have documented the mental health needs of veterans returning from combat duty. A 1983 study found that approximately 30% of men and 27% of women had PTSD at some point in their life following service in Vietnam. Studies examining the mental health of Persian Gulf War veterans found that rates of PTSD stemming from the war range from almost 9% to about 24%. Because the conflicts in Iraq and Afghanistan are ongoing, their full impact on the mental health of soldiers is not yet known. One study looked at members of four United States combat infantry units who had served in Iraq and Afghanistan. After deployment, approximately 12.5% had PTSD, a greater rate than had been found among these soldiers before deployment.⁷

c) Estimates of MH2 Prevalence by Region and County

We conducted the same kind of regional analysis for adults as for children, using the five children's regions because they provided more detail than the three adult regions.

Prevalence rates vary relatively little among regions. Table III-9 shows that rates of SMI vary by from a low of 8.8% to a high of 9.4% between the highest and lowest prevalence regions in Montana. County rates show significantly greater variation (Table III-10). County prevalence rates for adults range from a low of 7.4% in Sheridan County to a high of 10.4% in Roosevelt County, a 40% difference. However, we caution that small area estimates are statistically less robust than are those for larger populations. Estimates of dual mental health and substance abuse disorders also vary by region. The Eastern region of the state has a lower incidence of co-occurring disorders than the average, and the Southwest had the highest incidence. Appendix A contains prevalence estimates for each county.

⁶ U.S. DHHS, The Office of Minority Health, "Mental Health and American Indians/Alaska Natives," <http://www.omhrc.gov/templates/content.aspx?vl=3&vlID=9&ID=6475>

⁷ Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R.L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351, 13-22. (from: <http://ptsd.about.com/od/prevalence/a/MilitaryPTSD.htm>)

Table III-9
Estimated 2006 Prevalence of Adults with Serious Mental Health Problems in Households under 200% of Poverty In Montana by Region

Region	SMI
Eastern	8.8%
North Central	9.2%
South Central	9.4%
South West	9.1%
Western	9.3%
State	9.2%

Source: Estimates by Holzer based on CPES and Census Estimates

Table III-10
Counties with the Highest and Lowest Estimated Prevalence of Adults with Serious Mental Health Problems in Households under 200% of Poverty

Lowest prevalence rates		Highest prevalence rates	
Sheridan	7.4%	Silver Bow	9.7%
Prairie	7.6%	Granite	9.7%
Treasure	7.8%	Glacier	9.8%
McCone	7.9%	Big Horn	10.0%
Garfield	8.0%	Roosevelt	10.4%

Source: Estimates by Holzer based on CPES and Census Estimates

d) Adults in Need of Public Mental Health Services

Another dimension of relevance to this discussion is how many adults in need of mental health services must rely on Montana’s public programs. Low income adults in Montana have much less access to mental health services than low income children and adolescents, as a result of the lower income cap on Medicaid eligibility. Montana Medicaid excludes the majority of poor adults who are without dependent children, high medical expenses or disabilities. While pregnant women are eligible for Medicaid to 133% of poverty, other adults with dependent children are eligible only to 40% of the poverty level, and in 2001, medically needy adults were eligible to 73% of poverty.

This coverage is lower than many states provide for adults. According to the Kaiser Family Foundation’s “Medicaid Program at a Glance”⁸:

- ▶ In 2006 Montana ranked 38th in eligibility levels for non-working parents.
- ▶ Among Western states only Nevada and Idaho ranked lower. More than half of states set the limit at 100% of poverty or above.
- ▶ According to the Kaiser Family Foundation Health Facts, in 2005, 12% of Montanans were enrolled in Medicaid, a lower percentage than in 38 other states.

Adults who are disabled, whether by reason of mental illness or other conditions, can also get eligibility for Medicaid up to 74% of poverty. Most states use this or a similar income standard; there is little variation in the income eligibility standard across the states, or in their rates of enrollment in the disability category. We have provided a table showing the relevant income levels and how they compare to 200% of poverty.

Montana’s adult Medicaid mental health benefit is commonly described as being restricted to people with SDMI. In fact, there is a set of mental health services available to any adult with a diagnosable mental illness. They may receive basic mental health services from providers that don’t specialize in mental health, such as primary care physicians, mid-level practitioners, and Federally Qualified Health Centers or hospital outpatient departments. They can also receive psychotropic medications. However, most specialized mental health services, including those

⁸ Kaiser Family Foundation’s “Medicaid Program at a Glance”, <http://www.kff.org/medicaid/7235.cfm> accessed 9/10/2008.

provided by Community Mental Health Centers and independent practitioners such as psychologists, social workers and psychiatric counselors, are restricted to serving adults who meet criteria for SDMI.

% of 2008 Federal Poverty Guidelines	Family of 1	Family of 4
40%	\$4,160	\$8,480
73%	\$7,488	\$15,300
74%	\$7,696	\$15,700
150%	\$15,600	\$31,800
200%	\$20,800	\$42,400

Source: <http://aspe.hhs.gov/poverty/08Poverty.shtml> and <http://aspe.hhs.gov/poverty/faq.shtml#chart>

Mental Health Services Plan (MHSP) Eligibility.

The state offers a Mental Health Services Plan (MHSP) with a more limited benefit than Medicaid to provide coverage for adults with SDMI whose incomes exceed the Medicaid poverty level. Currently this benefit is offered up to 150% of poverty, but AMDD has statutory authorization to raise the rate to 160% subject to the availability of funds. Initial eligibility for this program is coordinated with Medicaid to maximize enrollment into Medicaid and ensure that Medicaid resources are used whenever they are available, since the state is fully responsible for MHSP.

Indian Health Service Eligibility.

The Indian Health Service is a federal agency providing a range of prevention, health and behavioral health services to Indian people. Two of Montana’s tribal reservations, Rocky Boy and Flathead, operate their own health facilities. A total of 11 facilities, ranging from clinics to hospitals, operate on seven reservations. In addition, six Urban Indian clinics operate in five communities. The facilities bill the state for services provided to Medicaid eligible Indians, and the state is then fully reimbursed by the Federal government; no state match is required. The facilities can also bill private insurance and Medicare. Indians without health insurance are served from IHS resources. IHS reported that reservation based health facilities delivered 58,000 outpatient mental health visits in FY 2007; however, we do not know how many individuals were served.

72 Hour Presumptive Eligibility.

Recently, the state created a new eligibility category, 72 hour presumptive eligibility, which provides eligibility for all uninsured Montana citizens for crisis assessment and intervention services for up to 72 hours. Begun on a pilot basis in specified communities, services under this eligibility status have now become available from any qualified provider willing to contract with the state to provide them.

State Institution Eligibility.

The state provides hospital and nursing home care for psychiatric illnesses through the Montana State Hospital (MSH) and the Montana Mental Health Nursing Care Center (MMHNCC). According to Montana State Statute, a commitment (or admission) to MSH can accomplish the goal of care and treatment suited to the needs of a person suffering from a mental disorder only when a less restrictive alternative is unavailable or inadequate. The MMHNCC primarily serves individuals who have both mental illness and chronic medical needs that make them particularly complex to care for.

There are ten commitment and detention statuses that govern admission to MSH; five are considered civil commitments for individuals committed by the courts because of need for hospital level treatment, four are considered forensic commitments for individuals involved with the correctional system and in need of hospital level services, and one is administrative - an inter-departmental offender transfer from the Department of Corrections for individuals who need services offered by the State Hospital (also considered forensic for purposes of census

management). One of the forensic commitment statuses, “Not Guilty by Reason of Mental Illness”, is no longer used, yet there remain a number of patients at MSH who were originally committed under this status.

Involuntary admissions are almost two-thirds of all MSH admissions, with court ordered detentions accounting for an additional 19% of admissions but a dramatically lower number of bed days. Reducing the length of stay of these involuntary admissions is probably the area on which to focus attention in order to reduce MSH bed utilization.

Table III-12											
FY 2007 Montana State Hospital Census Totals by Commitment Status											
FY 2007 Commitment Status →	ED (CC)	COD (CC)	INVOL (CC)	I H S (CC)	VOL (CC)	ITT (FC)	COE (FC)	UTP (FC)	GBMI (FC)	NGMI (FC)	Total
Number of Discharges	21	131	447	15	10	1	11	22	20	3	681
Avg. Length of Stay in days	3	5	110	37	573	7	92	152	481	775	n/a
Median Length of Stay in days	3	4	57	38	105	7	85	172	487	996	n/a
Patients Hospitalized for 365 days or more	n/a	n/a	22	0	3	0	0	0	0	9	61
Legend:											
CC – Civil Commitment						FC – Forensic Commitment					
ED – Emergency Detention						ITT - Inter-Institutional Transfer					
COD – Court Ordered Detention						COE – Competency to Stand Trial Evaluation					
I H S – Tribal Court Commitment						UTP – Unfit to Proceed					
VOL – Voluntary Commitment						GBMI – Guilty but Mentally Ill					
INVOL – Civil Involuntary Commitment						NGMI – Not Guilty by Reason of Mental Illness (no longer a commitment type)					
<i>Source: Montana State Hospital Reports</i>											

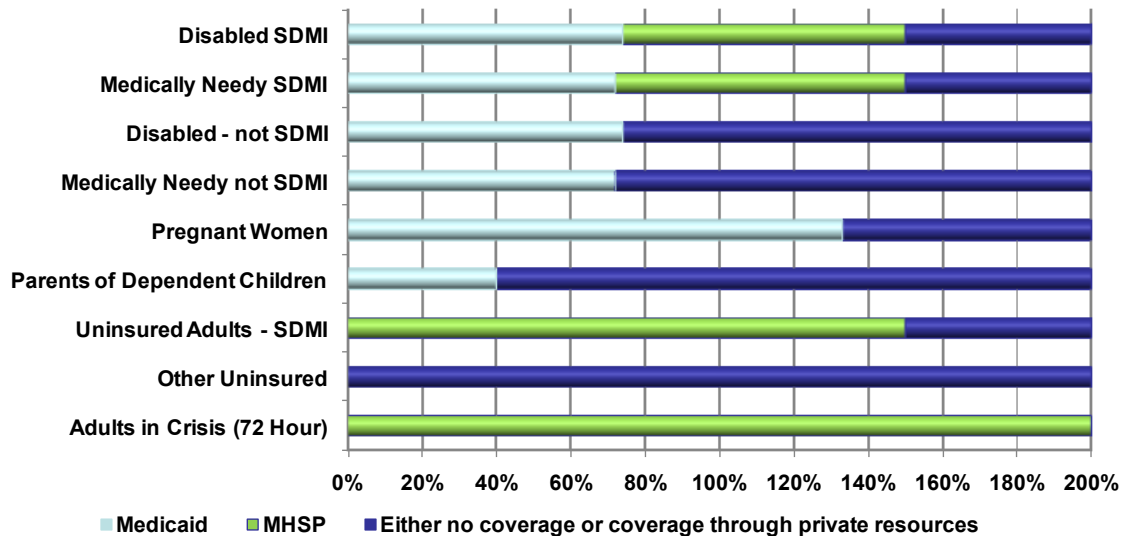
Veterans’ Services. Responsibility for serving military Veterans is shared between the Montana National Guard and the Veterans Administration. The Montana National Guard, which is jointly funded by the state and federal government, oversees the almost 4000 Air and Army guard troops in Montana. National Guard members are eligible for armed forces health insurance and Employee Assistance Services. The Veterans Administration (VA) is a federal service for which military and national guard who meet certain eligibility criteria are eligible post-discharge. Both the armed forces and the Montana National Guard have strengthened their procedures for timely application for VA services for those likely to qualify for them.

Discussion. Consistent with Montana’s relatively low Medicaid income eligibility standards, the 65,691 adults enrolled in Medicaid or receiving MHSP services constituted approximately 74% of adults under 100% of poverty and 43% of adults under 150% of poverty. The other forms of coverage Montana offers are specific to either crisis or institutional care, and do not indicate access to full mental health coverage.

Montana has constructed its adult mental health benefits to meet priority needs within the available resources of the state but the result is a complex system that differs for adults with different family status, disabilities and presence or absence of SDMI. The covered mental health services are comprehensive for Medicaid eligible adults with SDMI, but mental health service coverage is incomplete for non-SDMI Medicaid eligibles and also incomplete in different ways for MHSP eligibles. This patchwork of adult programs leaves important groups of poor

uninsured adults without access to mental health services. Figure III-9 shows the categories of adults that have full or partial mental health coverage by income level. It is challenging for children with ongoing mental health problems to make the transition from the more comprehensive benefits of the children’s system to the more complex and limited benefits of the adult system as they turn 18.

**Figure III-9
Coverage for Montana Medicaid and MHSP MH Services
of Adults Under 200% of Poverty by Selected Eligibility Category**



Since most Medicaid and MHSP mental health services are limited to the category of adults with SDMI, many adults with significant, but less serious, mental health problems are not able to get mental health services unless they have a mental health crisis and can access presumptive eligibility services or are committed to the state hospital. Many such problems co-occur with substance abuse, which exacerbates their effects for individuals, their families and their communities. Many of these individuals behave in ways that involve them with the police or lead to incarceration.

The significance of eligibility limitations is recognized by many stakeholders in the state.

- ▶ Seventy percent of survey respondents indicated that Medicaid eligibility requirements were a barrier affecting many or most people seeking services.
- ▶ Survey respondents rated adults with mental health problems not meeting SDMI criteria as least likely to get the mental health services and supports they need.

e) Health Insurance Flexibility and Accountability (HIFA) Waiver

In 2006, DPHHS submitted an 1115 Medicaid waiver application to the Centers for Medicare and Medicaid Services (CMS) for approval. Submitted as a Health Insurance Flexibility and Accountability (HIFA) Waiver, it would allow Montana to provide health-care coverage to several thousand uninsured low-income Montanans not currently eligible for Medicaid. This would allow DPHHS to enroll current MHSP participants into a Medicaid financed mental health services program. In addition, the proposal would cover a number of young adults, ages 18-22 with SED, who are no longer eligible for Medicaid though they continue to struggle with

significant mental health problems. The waiver also includes provisions to support a small business insurance pool and could cover children eligible for CHIP if a wait list develops. The target date for implementing the waiver was July 2007, but the proposal has been stalled at CMS and has neither been approved nor denied.

Recommendations

- ▶ Continue to seek federal authorization for targeted eligibility expansion in Medicaid. The HIFA (Section 1115) waiver is targeted to expand Medicaid eligibility to adults with SDMI and certain other specific groups. The state should continue to pursue the HIFA waiver, assessing its chances of approval by a new administration.
- ▶ Modify 72 Hour Presumptive Eligibility as needed to support an effective crisis intervention service. The Legislature should expect this program to need adjustment and modification as it matures. They should require AMDD to review implementation and make needed adjustments in policy and practice.
- ▶ Increase Medicaid application rates by requiring Medicaid application upon MHSP renewal.
- ▶ Reduce gaps in Medicaid eligibility. Keep Medicaid eligibles on a suspended enrollment basis while incarcerated so that they qualify for services immediately upon release.
- ▶ Consider a general eligibility expansion. If the HIFA waiver is not likely to be approved, the Legislature can consider expanding Medicaid eligibility in other ways.

2. What adult services does Montana have in place?

To answer this question in the context of Montana's public mental health system, we considered the services provided in Medicaid, the Mental Health Services Plan for adults through 150% of poverty, and 72 Hour Presumptive Eligibility. We also considered services that could be available through an IHS facility. While adults with SDMI who qualify for Medicaid have access to a comprehensive continuum of mental health services, Medicaid eligible adults with less severe mental health problems are restricted with regard to the providers and services they can access, and adults with SDMI who do not qualify for Medicaid have access solely to community based services, with some significant limitations. This coverage - which offers only limited services for problems before they become serious - contributes to the pattern of individuals coming into public mental health services through admission to Montana State Hospital. Continued development of the resources to provide crisis intervention and stabilization services for individuals under 72 hour presumptive eligibility status will help to address this problem, but still requires individuals to reach a crisis state before they qualify for services.

An effective mental health system includes a comprehensive continuum of services and supports that offer individuals care as close to home as possible. Table III-13 below lists the services covered by Montana's public mental health programs. It indicates that Montana Medicaid covers a generally comprehensive set of mental health services. MHSP covers most of the continuum of community based services, while presumptive eligibility covers only crisis services. Indian Health Services are not provided by the state of Montana, but are available to Montana Indians through Urban Indian Health Clinics and IHS or tribal facilities on each reservation. They provide psychiatry, mental health counseling and social services to the degree allowed by their funding and ability to fill staff positions.

Table III-13 Montana Covered Mental Health Services by Plan Type				
	Medicaid - Adult	Mental Health Services Plan (SDMI Only)	72 Hour Presumptive Eligibility	Indian Health Service (IHS)
Outpatient Services				
Basic outpatient services	24 visits for SDMI	24 visits	Y	Y
Evaluation & Management (physicians, PA, & Nurse Practitioners)	Y for all (Not restricted to SDMI)		1/ day per service type	Y
Comprehensive school and community treatment	For 18-22 with SED	N/A	N/A	N/A
Psychiatry/Medication				Y
Medication Management	Y for all (Not restricted to SDMI)			
Psychotropic Drugs	Y for all (Not restricted to SDMI)	\$425/mo		Y
Other Miscellaneous Services**	Y for all (Not restricted to SDMI)			Y
Crisis Intervention				Y
Care Coordination			Y	
Crisis Intervention Facility	Y for SDMI		Y	
Hospital or MHC Crisis Management	Y for all (Not restricted to SDMI)		Y	
23 HR Observ. - Hosp.	Y for all (Not restricted to SDMI)			
Intensive Community Services and Supports				
Targeted Case Management	Y for SDMI	4 hr/mo		
Com-based psych rehab. & support (CBPRS) Psych. Aide	Y for SDMI	Y	Y	
Behavior Mgmt Skills Dev Services	Y for SDMI			
Dialectical Behavioral Therapy – Skill Development (Intensive Outpatient)	Y for SDMI	Y		
Day Treatment Services	Y for SDMI	Y		
Partial Hospitalization	28 days for SDMI			
Program in Assertive Com. Treat.	Y for SDMI	Y		
Respite Care Services (State only funds)	Y for SDMI			
Community Residential				
Group Home	Y for SDMI	Y		
Adult Foster Care	Y for SDMI			
Intensive Community Based Rehabilitation (residential)	Y for SDMI			
Inpatient and Residential				
Psychiatric Residential Treat. Fac.	Y for SDMI Ages 18-20			
Acute Inpatient	Y for all (Not restricted to SDMI)			

a) Services Important for all Adults with Mental Health Problems

Basic mental health services are available for all Medicaid recipients through Evaluation and Management services provided by non-mental health providers. They are also able to get hospital services, not only outpatient and emergency services, but also observation and inpatient care. A broad range of miscellaneous services that can include lab testing and personal care services when provided for mental health diagnoses are also available to all

Medicaid eligibles. Psychotropic medications are also available to all Medicaid enrollees, as well as psychiatric medication management. However, individuals without SDMI who are covered by Medicaid are limited to these services and the providers that offer them, and do not have access to the broader range of intensive community based service available to SDMI Medicaid recipients.

b) Outpatient Services for Adults

Individuals with SDMI have access to outpatient counseling from Mental Health Centers that specialize in services for the most seriously ill, as well as from mental health specialists in independent practice.

c) Crisis Intervention for Adults

Adults have a number of service types that provide crisis intervention services. In addition to 23 hour observation, Mental Health Centers (MHCs) can provide crisis services and specialized crisis facilities can do so also.

d) Community Services important for Adults with SDMI

Targeted case management to assist individuals to develop a service plan that meets their needs and coordinate them is also offered by MHCs. A number of other services are specialized to meet a variety of needs. These include psychiatric aides who can provide one to one support in participating in community activities and undertaking daily living activities, behavioral management services to address behavior problems that interfere with functioning, and an intensive evidence based outpatient service, dialectical behavioral therapy (which is effective in teaching skills related to regulation of emotions, and tolerance of distress for people with certain diagnoses). Day treatment provides day-time rehabilitative services, mostly in a group setting. Partial hospitalization provides hospital level of care which can allow some individuals to prevent a full hospitalization or serve as a transition after a hospital stay. The Program of Assertive Community Treatment (PACT) is an intensive service provided by a multi-disciplinary team for a small number of individuals in the community who need a very intensive level of treatment and support. Respite care services, provided primarily through state funds, allow the caregiver of an adult with SDMI to be freed from care giving duties for a specified period to have a break or handle other responsibilities.

e) Out-of-Home Services - Adults

Group Homes and adult foster care offer community residential settings where there is a considerable degree of supervision and support. Acute inpatient care is available from community hospitals and Montana State Hospital. Only the state hospital provides long term hospital care.

f) Home and Community Based Services Waiver- Adults

Montana has a Home and Community Based Services Waiver that allows it to provide a very flexible mix of community services for individuals with mental illness who are in or at risk of nursing home care. This mix includes services not otherwise covered under Montana's state plan, including respite services, and personal care services (which assist individuals with tasks such as bathing if they are not able to do them safely alone). Of the services not otherwise covered under the state plan, respite services are available to all Medicaid beneficiaries, but are fully funded by the state and are not a true Medicaid service. Homemaker services and personal care services are most relevant for Medicaid enrollees with physical limitations and disabilities. However, they are generally not a significant need for the majority of individuals with SDMI.

g) Peer Services - Adults

Montana has a rapidly developing set of peer services, though they are not financed through Medicaid. These services are available to individuals with SDMI in Medicaid and MHSP. Peer services known as Consumer Operated Service Programs (COSP) include drop-in centers and club houses where consumers have a considerable say in governing and operating the services and activities. The environment that is created fosters growth, leadership and peer support. Peer services can also include support services delivered by trained consumers employed by either a COSP or a traditional provider. Adults who have lived with SDMI can offer important supports that assist individuals to recover, manage their illnesses, develop community support systems and build a satisfying and stable life in the community. This year the state funded four drop-in centers which offer peer support, vocational services and opportunities for socializing, and a virtual drop-in center on-line. AMDD has also funded five half-time community liaison positions to be filled by mental health consumers. They are located in Butte, Helena and Missoula to assist individuals as they transition from the state hospital back to the community. AMDD providers are able and encouraged to hire consumers, who meet education and training requirements, into positions as psychiatric aides.

h) Services for Veterans

The National Guard has an important role in conducting post-discharge assessments, in outreach to Guard members who are not keeping in touch, and in assisting members and their families to access needed services. In response to a task force on the needs of guard members returning from overseas combat deployments, the Guard has greatly strengthened the mental health component of its assessment program and initiated outreach to members who fail to attend required events. As of October 2007, 98% of returning Guardsmen had completed their initial post-discharge assessment, including screening for mental health problems. The Guard has sought funds to support its new standard of conducting additional assessments every six months for the first two years post-deployment. It has also developed two multi-disciplinary crisis response teams to take immediate action when a guardsman experiences a crisis. Though the team does not include a mental health professional, it is trained in the signs of PTSD and traumatic brain injury and is able to consult with a mental health professional when needed. The Guard has also developed information about resources available to guardsmen and their families that include several avenues for seeking mental health services. It has sponsored trainings by mental health professionals on meeting the mental health needs of returning soldiers. The Guard identified additional resources needed to fully implement these changes, indicating that they would be sought from federal sources, and – if that was not sufficient – from the state.

The VA also has geared up to meet the increasing mental health needs of returning veterans. They do outreach by appearing during pre-discharge events to explain benefits and how to access them. In addition, a new position of Transition Coordinator is responsible for facilitating transitions of new vets who are in active treatment in out-of-state facilities and need to continue treatment upon their return to Montana. Once enrolled in the VA, service members are screened for mental health problems and traumatic brain injury during their initial primary care visits, and can be evaluated by an expanded cadre of mental health clinicians if a possible problem is identified. The VA has increased the number of mental health clinicians at its 11 service sites around the state; it also has contracts with the four Community Mental Health Centers in the state, and can pay independent clinicians when those resources are not sufficient. An Access to Care Unit is responsible for making linkages to mental health services within whatever timeframe is appropriate given the veteran's level of acuity.

While mental health clinicians are posted at each VA facility, the VA's three full-time psychiatrists are all located at Fort Harrison in Helena. When veterans need inpatient mental health treatment, they may go to Sheridan Hospital in Wyoming or the VA may pay for service from one of Montana's psychiatric inpatient facilities. On occasion, but relatively infrequently, a veteran may be referred to the Montana State Hospital, in which case the state pays for the care. The VA has received permission to create its own psychiatric inpatient facility at Fort Harrison, and this is expected to be completed within about four years.

The VA would like more veterans to be aware of the services available to them, and how to receive them. They feel that they are well organized and have sufficient resources to effectively address veterans' needs once they access the system. One gap identified is mental health treatment for the families of veterans. Couples counseling is available when it is focused on the problems of the veteran, but no children's counseling is available at all. Unfortunately, many military families cannot immediately meet criteria for Medicaid upon discharge because their last six months of military pay puts them over the income limit. The VA will explore whether such families might qualify for CHIP, which would at least cover their children.

Another opportunity for improvement lies in the area of training. VA health care personnel and clinicians are getting training in the mental health problems most frequently experienced by returning veterans, but the contracted and independent mental health clinicians that serve some veterans are not able to participate in the specialized two week training programs offered by the military. Though the military would cover the training costs, they are not able to pay for travel out of state and two weeks of per diem costs.

Discussion

Montana's adult public mental health programs are considerably more fragmented than are those for children, with limits on available providers, amount of service, and dollar values of medications that affect different groups. While some basic mental health services are available to all adult Medicaid enrollees with a diagnosable mental health problem, they are only available from physicians, mid-level practitioners (e.g., physician assistants or advanced practice registered nurses (APRNs)), health centers and hospitals, and not from Community Mental Health Centers or independent mental health professionals. The scope of our study did not identify how well the options for adults to receive mental health services from non-specialty providers are understood or utilized. In fact, in our conversations, mental health benefits were commonly discussed as being limited to SDMI.

Since early intervention in mental health problems is optimal in terms of enhancing outcomes, lessening the negative impact of mental health problems, preventing crises, and making use of less intensive and lower cost services, it is important for Montana Medicaid recipients and Medicaid providers to ensure that these mental health services are well used. To achieve this goal, enrollees and providers must be made aware that mental health services from a primary care physician, a Federally Qualified Health Center or a hospital outpatient department are available to all Medicaid recipients with a diagnosable mental health problem. Given the significance of these service providers in helping to provide early attention to mental health problems, it is important to support them in providing mental health services. While a number of physicians prescribe psychotropic medications and have developed some expertise in treating mental health conditions, physicians have limited training in mental health. With the limited pool of psychiatrists in Montana, most physicians will not have easy access to psychiatric

consultation to support them in diagnosing and treating mental health conditions. Further support could strengthen the quality and capacity of these providers to deliver mental health services.

Medicaid enrollees with SDMI are able to access the comprehensive continuum of mental health services covered by Montana, with the option to use both mental health specialty providers and general health providers who offer mental health treatment. Adults with SDMI and incomes under 150% of poverty, who don't qualify for Medicaid, have access to a broad range of community based and crisis services funded by MHSP. However, their coverage has some limits not present in Medicaid on case management and medications. The medication benefit, in particular, can be insufficient to cover certain needed medications or combinations of medications. Residential and inpatient care are also excluded in the MHSP benefit. Exclusion of or limitations to these significant services makes it more likely that persons eligible for MHSP services will end up in Montana State Hospital (MSH) if they experience a crisis. Presumptive eligibility for crisis services is beginning to fill one gap in the continuum, but it has not yet been fully implemented. Its limitation of services to 72 hours may not be sufficient to truly stabilize all crises and prevent problems from worsening, particularly for individuals who have significant mental health and/or co-occurring mental health and substance abuse problems, but do not meet criteria for SDMI or income that would qualify them for ongoing community care.

Findings

Montana has developed a comprehensive Medicaid mental health benefit which covers multiple forms of treatment, rehabilitation and support for adults with SDMI. Peer services is one service not currently covered which would be a significant addition to Montana's continuum of care. While adults with SDMI who qualify for Medicaid have a comprehensive continuum of services, Medicaid adults with less severe mental health problems are restricted in the providers and services they can access, and adults with SDMI who do not qualify for Medicaid have access solely to community based services, with some significant limitations. This coverage - which offers only limited services for problems before they become serious - contributes to the pattern of individuals entering public mental health services through admission to Montana State Hospital. Continued development of the resources to provide crisis intervention and stabilization services for individuals under 72 hour presumptive eligibility status will help to address this problem, but still requires individuals to reach a crisis state before qualifying for services. The HIFA Waiver continues to offer the most attractive means of better addressing the needs of adults with SDMI, but its likelihood of being approved is uncertain.

3. What adult services are being provided and by whom? Is additional outreach needed?

What adult services are being provided and by whom?

The Eastern region falls behind the others in penetration for many categories of SDMI mental health services, though North Central has the lowest penetration for medication management. The Southwest has the highest penetration rates for many SDMI service categories. Non-mental health specialists and certain specialists providing services under "miscellaneous" are a significant source of care for many Medicaid eligibles. There appears to be potential for increasing access to intensive community services and supports, which may help reduce use of crisis and hospital care.

Is Additional Outreach Needed?

AMDD served 13,209 people through Medicaid and 5,041 adults with SDMI through MHSP. Almost 15,000 were served through other state plan Medicaid, and 2,148 received vocational services from the Disabilities Division. The Department of Corrections provides mental health services for an undetermined number of people in its correctional facilities and also through its community corrections programs.

Within Medicaid, penetration rates are high for individuals receiving any mental health service or medication. However, because relatively few adults are enrolled in Medicaid, they represent a small percentage of the estimated number of poor adults likely to need mental health services. These poor adults are not likely to have other forms of health insurance.

MHSP services are restricted to adults with SDMI, and reach 3.3% of the population in households under 150% of poverty, equivalent to about a third of the 9.2% of poor adults estimated to meet MH2 criteria. Based on consultation with DPHHS and their additional analysis of the database, we developed two estimation methods for the number of Medicaid eligibles with SDMI receiving Medicaid services. Our minimum estimate showed that AMDD mental health services for SDMI are reaching many, but not all, of Medicaid enrollees likely to need them, while our maximum method indicated that DPHHS is reaching a group that considerably exceeds the number of enrollees estimated to meet MH2 and MH3 criteria. Additional work to understand service patterns and reporting conventions are needed to test assumptions underlying each estimate and develop a robust methodology for making a more meaningful estimate of adults receiving SDMI services and to determine the degree to which additional outreach is needed for this group.

We lack specific data on need and access to services for veterans and Indians. However, the National Guard has improved its capacity for identification of mental health problems, outreach, and crisis intervention, while the Veteran's Administration has expanded its mental health resources and is facilitating linkage to services. Coordination and outreach to veterans and their families can help ensure that they have access to the services for which they qualify. IHS reports difficulties in recruiting and maintaining mental health staff and there appears to be considerable room for strengthening communication and collaboration with IHS, which would help to improve Indians' access to the specialized services the state provides for SDMI.

To address questions regarding services and outreach, we compared people receiving services with those estimated to be in need at the state level. We then looked in more detail at providers delivering different modalities, and the relative access to services in different regions of the state. (Please note the data limitations that are outlined in Section II, page 4)

a) Department of Public Health and Human Services - Adults

DPHHS serves almost 25,500 unduplicated adults annually through Medicaid, the Mental Health Services Plan and the Disabilities Services Division (DSD). Only people served solely by IHS facilities are excluded from this count.

We note that the Department of Corrections also provides mental health services. An indication of some of the numbers served is provided in Chapter VI.

Adult Serving Divisions

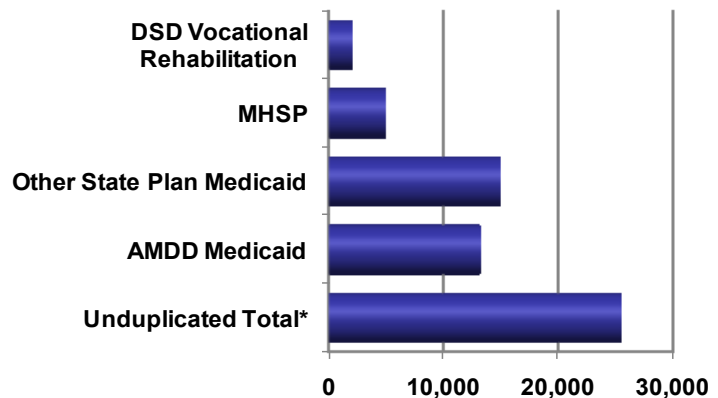
- ▶ The Addictive and Mental Disorders Division (AMDD) administers adult Medicaid mental health services for over 13,000 adults, representing 52% of DPHHS’ unduplicated total.
- ▶ AMDD also administers the Mental Health Services Plan which served over 5000 people, representing 20% of DPHHS’ unduplicated total.
- ▶ HRD serves almost 15,000 adults through the Other State Plan Medicaid, which primarily covers the costs of psychotropic medications. This means that almost 60% of the unduplicated adults served were getting psychotropic medications. There were also at least 1,100 who received some form of mental health services through HRD.
- ▶ The Disability Services Division (DSD) provides vocational services for over a thousand individuals with mental illness, or about 5% of the unduplicated total.
- ▶ Adding together the numbers served by each distinct program and comparing them to the unduplicated total indicates that over half of adults served by DPHHS receive services through more than one of these four programs. It is likely that most adults getting vocational services through DSD are also eligible for services through Medicaid or MHSP. As mentioned above, use of medication often overlaps with use of some form of AMDD mental health services. As with children, adults may gain or lose Medicaid eligibility and move between MHSP and Medicaid during the year. The remaining 50% of adults are receiving services from just one of the four programs.

b) Meeting Adult Service Needs – Statewide

Penetration in Medicaid.

The total number of adults eligible for Medicaid for all or part of FY2007 was 60,650. The data we requested did not allow us to determine the actual number of unduplicated Medicaid recipients. As a result, we have developed an estimate. We do know that the unduplicated total of individuals receiving Medicaid or MHSP services is 23,672. If we subtract the 5,041 unduplicated MHSP recipients from this amount, we can be sure that at least 18,631 individuals received mental health services or medications under Medicaid. If some MHSP recipients were enrolled in Medicaid during that year and received mental health services, then the number could be higher. These 18,631 individuals constituted 31% of total Medicaid enrollees. This penetration rate considerably exceeds the 24% prevalence estimate for people who have a mental health diagnosis sufficient to cause them to lose days of work (MH4).⁹

**Figure III-10
Adults Receiving DPHHS MH Services
and/or Medications in FY07**



* Excludes Montana State Hospital and Montana Nursing Care Center recipients, and recipients receiving mental health services only from IHS facilities

Sources: DPHHS Special Report Montana Mental Health Study

⁹ We note that these rates are not directly comparable to the rates reported by other states because few of those states include psychotropic medications in their utilization figures.

Service Access for Poor Adults. The 25,446 unduplicated individuals¹⁰ receiving DPHHS mental health services constitute 16.6% of the estimated 153,525 adults below 150% of poverty in 2006. This is well below the 24% rate of individuals experiencing a mental health problem serious enough to cause them to lose days of work. Thus, while individuals who have Medicaid have healthy rates of access to services, Medicaid mental health services reach a much smaller proportion of likely need among adults under 150% of poverty. Many of these individuals would not have access to private coverage; Montanans under 100% of poverty experienced an almost 40% rate of uninsurance in 2004/2005, and those between 100 and 150% of poverty had a 33% rate of uninsurance¹¹.

Service Access for Individuals with SDMI.

Individuals with SDMI are served in MHSP and Medicaid. MHSP services are restricted to adults with SDMI, and reach 3.3% of the population in households under 150% of poverty, equivalent to about a third of the 9.2% of poor adults estimated to meet MH2 criteria.

We developed two estimates of the SDMI individuals receiving Medicaid mental health services that represent the minimum and maximum possibilities. The minimum estimate was based on looking at the number of individuals served in the most frequently used service restricted to people with SDMI, outpatient therapy. Between AMDD and Other State Plan Medicaid, a (possibly duplicated) total of 6585 or 10.9% of Medicaid enrolled adults received this service, somewhat more than the 9.2% MH2 prevalence rate. The maximum estimate assumed that all the unduplicated 13,209 adults served by AMDD had SDMI. This constituted 21.8% of the 60,650 adults enrolled in Medicaid in FY2007. This maximum estimate far exceeds the 9.2% prevalence rate for MH2, and even the 15.5% prevalence rate for the more expansive definition of MH3.

We also analyzed how these two estimates would affect our calculation of the numbers of adults under 150% of poverty receiving services for SDMI. Adding our minimum Medicaid estimate to MHSP, we find that Montana is reaching at least 7.6% of the population in households under 150% of poverty, less than the expected 9.2% prevalence for MH2. According to our maximum estimate, it is reaching 11.9%, exceeding the MH2 prevalence rate.

Obviously, there is a considerable variation between the two estimates, leading to very different assessments of the need for additional outreach. The method for developing the minimum estimate is simple and robust, though we know that it is not a complete count since it excludes individuals with SDMI who receive SDMI services other than individual counseling. A number of ambiguities in adult Medicaid mental health claims make it difficult to construct a more solid maximum estimate of adults with SDMI. Though Montana's adult Medicaid benefit is commonly described as restricted to individuals with SDMI, certain mental health services, such as those provided by physicians and federally qualified health centers, do not carry this restriction, and are likely used by individuals with less intensive needs. To develop an estimate of individuals with SDMI it would be necessary to identify and exclude individuals with lower level needs.

The reports we received identified some of these lower need individuals, but likely not all of them. They showed 6233 adult Medicaid recipients who received only psychotropic medications, and had no service claim with a mental health diagnosis. It is likely these

¹⁰ This figure includes individuals receiving vocational rehabilitation services from the Disabilities Services Division that were not included in the unduplicated count of Medicaid and MHSP cited above.

¹¹ 2004/2005 Current Population Survey – Annual Social and Economic Supplement.

individuals are served in primary care settings¹². They constitute 10% of the total adult Medicaid enrollment and a quarter of all adults receiving Medicaid mental health services or medications.

Claims for mental health services provided in primary care settings are reported in the “miscellaneous” service category in AMDD Medicaid. Miscellaneous services can also include personal care services, a lab test for medication levels, or psychiatry services not covered by AMDD’s service menu. Though the dollar value of miscellaneous services is not great, it is the category of service with the greatest number of unduplicated service users, over 9,000, constituting almost 70% of the AMDD Medicaid unduplicated total, and exceeding the over 5,000 adults receiving the next most common service type, outpatient services. This would be consistent with a significant number of individuals with less serious conditions receiving services through primary care or Federally Qualified Health Centers. However, a DPHHS analysis of individuals receiving a miscellaneous service found that virtually all also received a service that is restricted to individuals with SDMI, suggesting the opposite conclusion, that virtually all had more serious conditions.

Another aspect of the data on adult mental health services that was hard to interpret was that data on Other State Plan Medicaid services reported almost 1,000 individuals to be receiving one or more mental health services that were not adjudicated to AMDD. These services ranged from outpatient to inpatient care and all are normally reserved for people with SDMI. The degree of overlap between individuals included in AMDD Medicaid and those reported in Other State Plan Medicaid is unknown. DPHHS should review these kinds of claims in future years to determine whether they are being reported properly.

Given the unanswered questions about the level of need of adults being served and the broad range of possible SDMI estimates, we encourage DPHHS to review its Other State Medicaid and Miscellaneous claims to better understand the individuals being served, their level of access to services and their patterns of care.

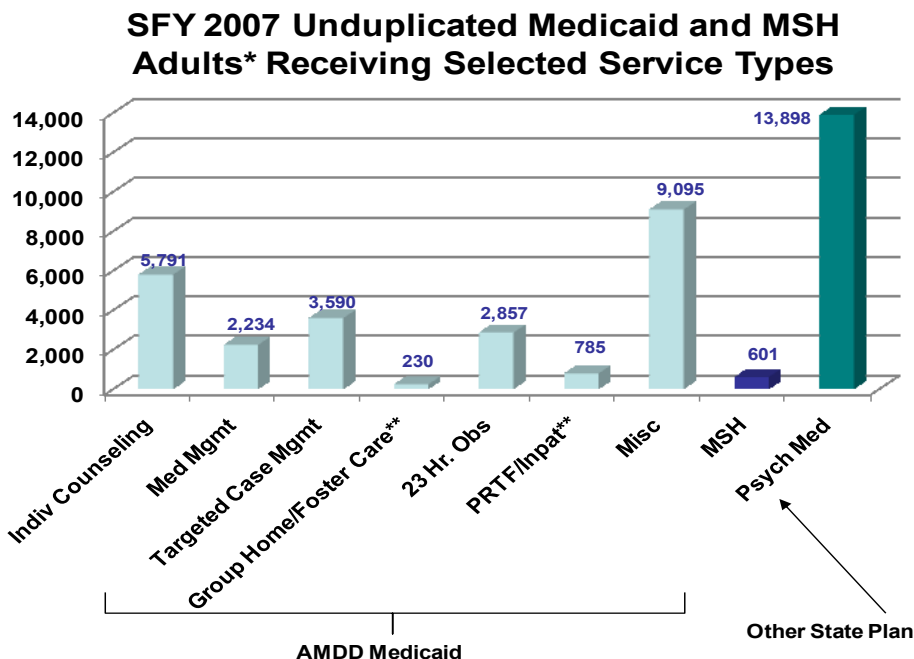
Though our estimates of the overall level of service to individuals with SDMI are inconclusive, our findings on the utilization rates of specific services on a statewide and a regional basis which follow, provide evidence on the relative access to specific services for adults with SDMI that allow for additional consideration of service availability.

c) Statewide Availability of Specific Service Modalities - Adults

We analyzed the penetration rates for some of the most used adult services to provide further indication of service need, summarized in Figure III-11.

¹² According to Surgeon General, “The general medical sector has long been identified as the initial point of contact for many adults with mental disorders; for some, these providers may be their only source of mental health services.” The National Institute of Mental Health Epidemiologic Catchment Area Program found that, in a 12 month period, “More than 6 percent of the adult U.S. population use the general medical sector for mental health care...” They represented 40% of all adults who sought mental health services from any possible provider. (U.S. Department of Health and Human Services, 2001)

Figure III-11



Misc includes services for MH diagnoses provided by non-MH providers, including Personal Care Agencies, FQHCs, physicians and labs. Also includes certain psychiatry services not included in standard MH procedure codes.

* Excludes people receiving services in IHS facilities

** May double count adults receiving both types of service in the year

Source: DPHHS Special Report

Services important for adults with less serious mental health problems. For adults, miscellaneous services and psychotropic medications have the highest penetration rates. Medications and miscellaneous services are not restricted to adults with SDMI, but both are used by adults with SDMI. Over 50% of unduplicated adults receiving DPHHS mental health services or medications used a psychotropic medication. Most use medications in conjunction with some other service; twenty-four percent of adults receiving psychotropic medications receive them without any other public mental health service. Only 16% of adults using psychotropic medications saw a psychiatric practitioner during the year. It is possible that a number of adults are having their medications managed by a primary care physician or mid-level practitioner.

Medicaid Services Important for Adults with SDMI

- ▶ Individual counseling from a Mental Health Center or mental health specialist is the most frequently used modality, used by 5,791 Medicaid enrolled adults. Not shown in the chart are another 794 enrollees (possibly duplicated) who receive this service under Other State Medicaid.
- ▶ Targeted case management was used by 3,590 AMDD Medicaid enrollees, and another 424 received this service under Other State Plan Medicaid.

Medicaid Crisis Services

These data are incomplete in their counts of crisis services, but we see that 2,857 individuals experienced observation stays, and another 350 (not shown) received crisis intervention services.

Medicaid Out of Home Services

- ▶ Relatively few adults are accessing supported housing programs through DPHHS; 230 were in group homes and 113 were in an adult form of foster care.
- ▶ Provision of inpatient and residential levels of care is almost equally split between Montana State Hospital, which served 601 unduplicated clients; inpatient, which served 238; and PRTFs, which served 547. This suggests that there is room to develop more community based capacity and allow adults to be treated closer to home.

Cross State Comparisons. One way to put Montana’s relative use of services of different intensities in context with other states is to compare the proportion of adults served at different levels of care. The Table III-14 below shows the percentage of total adults served who received inpatient and residential services as compared to non-residential community based services.

Table III-14					
Adult Penetration Rates – Montana Compared to Other States					
(Utilizers per Thousand Population)					
	MT Medicaid and MHSP*^	AK Medicaid	AZ (excl. Maricopa Cty)	NM*	MN R/F Counties*+
Adult Penetration					
Inpatient and Residential	1.7			1.5	3.6
Group Home and Foster Care	0.6			.05	
Subtotal Residential	2.3	0.2	6.1	1.55	3.6
Community Only	24.1	10.9	34.6	20.45	33.3
Total	26.4	11.1	40.7	22.0	36.9
*May include some duplications of adults served at more than one residential modality in one year.					
^May show duplication of adults served in more than one plan (AMDD Medicaid, Other State Plan Medicaid, MHSP or DSD) in the same service category.					
+May show duplication of children served in more than one county in the same year					
Source: DPHHS Special Report, 2000 US Census, and submissions from other states – see Appendix E					

Montana’s overall adult penetration rate falls in the middle of a broad range of rates, with the least urbanized states at the low end, and the more urbanized states (even though their most densely populated counties were excluded) at the top end. Montana’s overall residential utilization also falls in the middle of a broad range with the less urbanized states showing the lower rates, and the more urbanized states showing higher rates. Overall this analysis suggests that Montana can improve access to community services. A more qualitative and detailed analysis would be needed to determine whether Montana’s mid-range use of residential services is at the most appropriate level.

d) Regional Service Availability - Adults

One of the important barriers to access identified by survey respondents was an insufficient number of providers or services. This section describes the availability of programs and providers, and explains what our analysis of DPHHS and other service data suggests about the availability of services across the major regions of the state.

Service Location and Capacity.

The 83 psychiatrists who are not Board Certified as Child and Adolescent Psychiatrists and who presumably serve primarily adults, are unevenly distributed. (See Table III-15) The South West region has the highest penetration of psychiatry, while the Eastern region has no resident psychiatrist. Since this is the workforce that serves the entire state, we have calculated their penetration based on the whole population rather than just those under 200% of poverty. A listing of psychiatrists by city is available in Appendix F.

Region	Adult Psychiatrists	Per Thousand
Eastern	0	0
North Central	7	7
South Central	21	14
South West	31	17
Western	24	11
Statewide	83	11

**Excludes those licensed as child and adolescent psychiatrists
Source: Department of Labor and Industry: Health Care Licensing Bureau as of 5/5/08. Census 2006 Total Population estimates.*

Other mental health professionals are also less available in the Eastern and to some degree, the Northern parts of the state. There is no indicator on the data we received that would allow us to distinguish those specializing in adults or children. The Eastern region has the lowest

	Psychologists per 10,000	Social Workers/ Professional Counselors per 10,000	Licensed Alcohol Counselors per 10,000
Eastern	1.1	7.5	5.1
North Central	2.1	14.5	7.6
South Central	1.6	18.2	8.1
South West	3.1	21.9	8.5
Western	3.8	18.2	6.6

Source: Department of Labor and Industry: Health Care Licensing Bureau as of 5/5/08. Census 2006 Total Population estimates

rate of psychologists, social workers/professional counselors and licensed alcohol counselors per population. The two western regions tend to be on the high side, particularly for the mental health professions. South Central is mixed, low on psychologists, but high on social workers. City listings are available in the Appendix F.

The following table shows AMDD’s listing of the services available for adults. Of the services listed in the table below, only group home beds are present in every region. The distribution of remaining programs is similar to that of adult psychiatrists; the four psychiatric units are in the central and western part of the state, as are most of the crisis stabilization programs and PACT teams. The Eastern region is particularly lacking in services, with no psychiatric unit, Dialectical Behavior Therapy (DBT) team, Program of Assertive Community Treatment (PACT) team, or access to Home and Community Based Services (HCBS) waiver services.

	Dialectical Behavioral Therapy Team	Adult Foster Care Beds	Adult Group Home Beds	Crisis Stabilization	Intensive Community Based Rehabilitation Beds	Program of Assertive Community Treatment Teams	Acute Psych Unit	Home and Community Based Services Waiver	72-Hour Presumptive Eligibility Program
Eastern	No	8	8	0	8	0	0	No	Yes
N Central	Yes	19	18	0	8	1	0	Yes	Yes
S Central	Yes	0	12	14	6	1	1	Yes	Yes
S West	Yes	14	7	15	8	2	1	Yes	Yes
Western	Yes	8	18	17	0	2	2	No	Yes

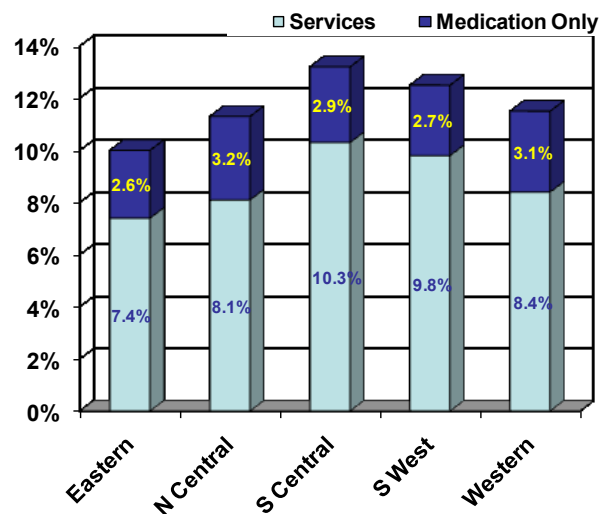
Source: AMDD Report, Service Capacity by County

Telemedicine. Montana providers have been active in building and using telemedicine, and Montana has a widespread telemedicine infrastructure. It is covered by three telehealth networks and one which will be built by 2010. Together they cover most of the state. Our data does not provide any indication of whether services were provided through telemedicine or conventionally. Therefore, we were unable to evaluate how it is being used across the state.

Regional Penetration Rates.

Figure III-12 shows penetration calculated for unduplicated AMDD mental health service users as a percent of population in households under 200% of poverty by region. We found a 39% difference between the highest and lowest mental health service penetration regions, and more than an eight-fold difference between the highest and lowest penetration counties. These differentials considerably exceed those for prevalence. However, the direction of the differences does correspond to variation in prevalence. The Eastern region had the lowest prevalence rate for SMI for adults in households under 200% of poverty and also had the lowest penetration rate. South Central had the highest prevalence rate for SMI for adults in households under 200% of poverty and also has the highest penetration rate for mental health services and medications.

**Figure III-12
FY2007 DPHHS Adult MH Service & Medication Users* as a Percent of Population in Households Under 200% of Poverty**



* Excludes recipients receiving only state hospital or nursing home services and those receiving mental health services only from IHS facilities

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

Table III-18 presents our analysis of penetration for service categories, measuring number of service users per thousand population in households under 200% of poverty. The modality

closest to being evenly distributed was medication, followed by outpatient services and intensive community services and supports. The Eastern region fell at the bottom for medication and outpatient, though South Central was lowest in penetration of intensive community services and supports.

	Misc.	Medication	Outpatient Services ^{^*}	Medication Management [^]	Crisis ^{^**}	Intensive Community Services and Supports ^{^*}	Community Residential ^{^*}	PRTF/ Inpatient ^{^*}
Eastern	29	59	11	19	6	6	0.9	1.2
North Central	35	72	15	2	4	6	0.8	2.4
South Central	65	81	15	12	10	4	0.8	3.7
South West	42	73	18	18	10	8	1.6	1.2
Western	40	73	14	20	8	6	0.7	1.5
Percent difference highest to lowest	219%	137%	165%	990%	245%	170%	248%	299%

+ May include duplications of adults receiving services in the same category in more than one county during the year.
[^]May include duplications of adults served in more than one of the following categories: AMDD Medicaid, Other State Plan Medicaid, MHSP or DSD during the year.
^{*} Average of more than one service modality
^{**}Report predates implementation of Presumptive Eligibility
Source: DPHHS Special Report and Census estimates of 2006 household population in poverty

The largest variation was found in medication management penetration rates, where there was a dramatic 10-fold difference between North Central and the rates in virtually all other regions. However, this disparity doesn't seem to affect use of medications in North Central, which is similar to two other regions. The other services had differentials of between two-fold and three-fold across the regions.

- ▶ The Eastern region, containing the 17 eastern-most counties, had relatively low penetration across the board, with the exception of psychiatry (where penetration was high) and intensive community services and supports and community residential (where it fell in the middle). It was similar to South West in its relatively low penetration of inpatient/PRTF services.
- ▶ North Central is low in psychiatry and crisis services, but relatively high in psychotropic medication penetration. It was second lowest in access to miscellaneous services, but relatively high in use of inpatient care.
- ▶ South Central was highest in its use of the less intensive forms of care, miscellaneous and medication, as well as in use of crisis and inpatient services to meet acute mental health needs. It was low in penetration of intensive community services and supports, and somewhat low in psychiatry.
- ▶ South West was relatively high in most service categories, and had the highest penetration of intensive community services and supports and community based residential services. It shared the low hospitalization rate of Eastern Montana.
- ▶ Western had relatively high penetration rates for most services, with the highest psychiatry penetration. However, it had the lowest penetration of community residential. Its inpatient/PRTF rates were toward the low side.

The Role of the Indian Health Service in Mental Health. We added the counts we received from our special report on IHS facility services¹³ to the miscellaneous category, where services of IHS facilities are categorized, and compared the results to the same category excluding IHS. "Miscellaneous services" includes services for mental health diagnoses provided by non-MH providers, including Personal Care Agencies, FQHCs, physicians and labs. It also includes certain psychiatry services not included in standard mental health procedure codes. These services do not require that the client meet criteria for SDMI, but are available to any individual with a diagnosable mental health problem.

Table III-19 shows how these services are distributed across the regions. We have provided the same calculations for each county in Appendix C. The Eastern and North Central Regions have the lowest penetration of this type of service, with South Central considerably higher, and the two western regions close to the statewide average. Addition of our IHS data, which is likely partial, considerably raises the rates for the two lowest regions. Despite a 30% increase, the Eastern region still remains the lowest, but is

considerably closer to the next lowest regions. North Central actually exceeds the Western region in this calculation. However, in the Salish/Kootenai facility on the Flathead reservation, whose reservation in the 2000 census included over 40% of Montana's total reservation population, showed only 79 Medicaid members served. This appears likely to be a significant undercount of actual mental health services provided. Should actual level of services provided from that service center be correctly identified, it is likely that the relative ranking would look different.

While accurate accounting for IHS facility services may reduce the disparity between regions in access to mental health services provided for individuals with a diagnosable mental health disorder, IHS facilities do not provide the kinds of specialized mental health services targeted toward meeting the special needs of individuals with SED or SDMI. Therefore, our conclusions about access to these targeted services would not be affected, and the regional disparities in these services would be expected to apply equally to Indians with SDMI as to any other resident of the region.

According to the IHS consultant responsible for managing the mental health services in the IHS operated facilities, IHS faces the same challenges as the rest of the State in recruiting mental health professionals to provide services in its more remote locations. They pay a premium when it is necessary to fly a psychiatrist to an IHS site to provide services, and also utilize telemedicine when on-site personnel can't be found. However, they also have some Indian professionals who represent an important, culturally competent resource for serving their communities. Because of limited resources and staff vacancies, IHS reports that they must too often work to resolve

Region	Misc.	Misc. including Partial IHS	Percent Difference
Eastern	29	38	30%
North Central	35	42	20%
South Central	65	66	2%
South West	42	42	0%
Western	40	40	1%
State Total	43	46	5%

Source: DPHHS Special Report and DPHHS Report on Revenue Code 915 Visits to IHS Facilities, 2006 Census Estimates

¹³ This discussion concerns IHS and tribal health facilities operating on reservations. Any mental health services provided by Urban Indian Health Centers were included in the DPHHS Special Report.

immediate crises, rather than being able to provide the proactive and preventive services they would like to emphasize.

4. What services do the adults of Montana need that currently do not exist?

The Eastern region stands out with lower rates of service utilization, programs and mental health professionals than the other regions. While inclusion of IHS mental health services available in the region significantly raised the penetration rates for miscellaneous mental health services, the rates remained low relative to other regions. In addition, the IHS does not deliver the specialized services needed by individuals with SDMI, so would not change the penetration rates for other service types.

Psychiatry is notable for its poor distribution across the state, with no psychiatrists in the Eastern region, and most clustering in only a few cities. While the availability of Psychiatric APRNs and of telemedicine may extend the range of psychiatric prescribers, the overall resource is quite low.

With only five hospital sites (including MSH), inpatient level of care is not readily accessible for many Montanans. The regions with the most hospital resources, South West and South Central, have the highest rates of hospital use. Inpatient care stands out as a service not readily accessible in the Eastern part of the state.

Our data do not reflect the implementation of presumptive eligibility and the expansion of crisis intervention services. Full implementation of this capacity across the state will meet a need emphasized by Montana stakeholders and recognized as a factor in preventing the criminalization of people experiencing mental health crises.

We also note that intensive community services and supports tend to be used by fewer people than other service categories. There appears to be room to expand the capacity of community services to meet the needs of individuals with more serious conditions within their own communities, and potentially reduce the use of out-of-home levels of care.

Recommendations

- ▶ AMDD should work with LACs, SAAs and tribes to identify priorities for service development and develop peer service models suitable for frontier areas.
 - The needs of Eastern Montana and other frontier areas should be prioritized.
 - Pursue small grant sources that can finance creative and collaborative approaches to filling local service gaps. The Pharmacy project developed in Eastern Montana, which is utilizing pharmacists to provide active telephone follow-up for individuals on certain psychotropic medications, is an excellent example of creatively using local resources and a small amount of funding to better meet local needs.

Native Americans.

- ▶ Develop a long-term strategy to enhance collaborations with IHS and independent tribes to better understand their needs, enhance cultural competency, and make best use of combined mental health resources.
- ▶ Work with IHS to assess reasons why bills don't consistently identify mental health visits and collaborate to assess service needs of Indian tribes.

- ▶ Continue joint efforts with IHS to increase Indian enrollment in Medicaid to maximize Medicaid reimbursement for IHS services and free IHS appropriations to serve more of the uninsured.

Veterans.

- ▶ HRD should closely coordinate with the Division of Military Affairs to provide information on CHIP eligibility that can be communicated to veterans and their families during the process of transition.
- ▶ The Legislature should consider funding:
 - The National Guard’s plans for continuing post-discharge assessments in the two years following discharge if federal funds are not appropriated.
 - Training for community providers on veteran’s mental health issues.
- ▶ AMDD, the National Guard and the VA should:
 - Develop outreach and referral strategies to reach troubled veterans and get access to VA resources.
 - Monitor need for services and identify training needs and capacity needs as they arise, and develop collaborative plans to address them.
 - Work with the police and the court system to screen for veteran status and promote access to military services and supports.

5. Presumptive Eligibility and Crisis Services for Adults

This and following sections address high priority issues in the adult service system in more detail.

Crisis intervention is considered a necessary component of any comprehensive mental health system. Without this capacity, individuals in crisis are more likely to end up in police or court custody or in MSH. Montana’s recent creation of presumptive eligibility is a targeted effort to fill one of the significant gaps in Montana’s adult coverage. However, there is currently 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; there are only 2 crisis programs in the state. The presumptive eligibility status creates a broad range of services that will be reimbursed when rendered on a crisis basis to eligible individuals. This does create a funding stream that has the potential to support the existing crisis services and perhaps allow other providers to expand their crisis intervention capacity. However, it is not clear that this is sufficient to ensure a robust crisis intervention capacity for the state.

- ▶ Presumptive eligibility expansion rolled out slowly because it required significant planning and implementation time.
- ▶ Hospitals have been slow to use the new presumptive eligibility option, and may need psychiatric back-up to be willing to participate.
- ▶ Existing crisis services serve a high proportion of dually diagnosed (mental health and substance abuse) clients. Their assessments and mental health interventions are covered, but any addiction treatment they need is not. Crisis providers need to be able to intervene with either or both conditions.

Recommendations

- ▶ Build telemedicine capacity at MSH to support local crisis management.

- Implement more aggressive recruitment of new psychiatrists at MSH. This might involve reissuing a procurement document based on 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.
- ▶ The Legislature should request a formal one year review of implementation and utilization of crisis stabilization services under presumptive eligibility including a review of populations denied presumptive eligibility or referred elsewhere
- ▶ Strengthen and expand financing for crisis services
 - Expand resources available for the next biennium in order to allow crisis providers to bill Medicaid for substance abuse interventions.
 - DPHHS should review Medicaid and MHSP funding mechanisms for crisis services to ensure that they can appropriately reimburse the full costs of the service. Consider:
 - ~ Simplifying the rate structure;
 - ~ Grant or deficit funding mechanisms to purchase capacity
 - ~ To maximize resources, consider ways to limit providers to one designated organization per geographic area as the service expands further across the state
 - Explore options for developing local partnerships like Billings Crisis Clinic
 - Hospitals benefit from reduced costs for detoxification of uninsured individuals and may need to contribute to crisis service costs

6. Montana State Hospital and Other Inpatient Care - Adults

The census at Montana State Hospital (MSH) is felt by many to be the barometer for the well-being of the adult mental health system. Census management at MSH is a daily challenge for hospital administrators. When the census is high, it increases state costs and removes people from both their communities and opportunities for recovery. Exceeding licensed capacity places the Hospital in jeopardy of losing federal reimbursement for Medicaid¹⁴ and Medicare eligible patients and non-compliance with licensing regulations. The current licensed capacity at MSH is 189 and includes 174 hospital beds and 15 adult group home beds. The volatility in the census is demonstrated by the following statistics:

- ▶ In the 36 months that made up FY 2006 - FY 2008, the Hospital exceeded its licensed bed capacity 26 times (72%);
- ▶ The average census for the first month of FY 2009 was 177, well within the hospital’s licensed capacity;
- ▶ On September 25, 2008, MSH census was 185, within the licensed capacity.

There have been close to 700 admissions to the MSH per year for each of the past three years, with the projection that there will be 720 admissions in the current fiscal year. Most admissions are a result of a referral from other psychiatric hospitals, residential treatment facilities, general hospitals and the criminal justice system. Very few people admitted to the state hospital are there because a family member, friend, mental health or primary care provider made a referral. With the five civil and five forensic commitment statuses, the hospital must care for individuals with widely varying needs, including those with lengths of stay between a few days and two weeks and those who remain for years. For example, among those committed as not guilty but

¹⁴ The state is prohibited from billing Medicaid for State Hospital Services for adults between 18 and 64, but there are often a few patients that are younger or older and can be billed.

mentally ill, nine have been hospitalized a year or more, contributing to an average length of stay for this status in 2007 of 775 days.

In FY 2008, emergency detentions accounted for 45% of admissions and were responsible for the greatest number of admissions each month. Emergency detention at the hospital is used when there is no bed available for psychiatric use in the county where the detention took place. These admissions often result in a status change to involuntary commitment.

From discussions with State Hospital staff and other research, we concluded that the hospital lacks the requisite authority to exercise a gate-keeping function to control admissions, and only has limited ability to take proactive steps to prevent overcrowding and a breach of hospital licensed capacity. Instead, court decisions regarding civil and forensic commitment status determine who gets admitted to MSH.

Table III-20 shows data pertaining to inpatient levels of care. Most admissions to MSH come from the South West, where MSH is located, and Western regions. We added MSH total admissions per thousand to PRTF¹⁵ and Other Inpatient clients per thousand to get a sense of total penetration for this intensive level of care. The table is titled a “duplicated” total because it includes an unknown number of users who are counted twice, either because they had multiple admissions to MSH, or because they had admissions to more than one of the three kinds of services. With all inpatient level services considered, South Central stood out with the highest inpatient penetration, but its greater use of PRTFs was paired with lowest reliance on MSH. The South West had the second highest overall rate of inpatient utilization, seeming to rely heavily on MSH, and to make less use than most other regions of other facilities. The Eastern region stood out as having the lowest combined penetration rate at this intensive level of care, with relatively low penetration for all options. North Central and Western used overall inpatient at close to the state average with North Central relying more on community options and Western relying more on MSH. These regional differences suggest that patterns of use that rely less on MSH are possible. The challenge will be to site facilities not only where they are needed, but also where there is sufficient volume for them to be viable. Other considerations may also play into these patterns, including preferences and common practices of different courts.

Region	MSH Admissions		PRTF	Other Inpatient	Duplicated Total
	#	Per Thousand < 200% Poverty	Clients Per Thousand < 200% Poverty		
Eastern	32	1.5	1.6	0.8	4.0
North Central	71	1.9	2.8	2.0	6.6
South Central	62	1.4	6.8	0.6	8.8
South West	286	5.1	1.2	1.2	7.5
Western	231	3	2.1	1.0	6.1
Total	682	2.9	2.9	1.1	6.9

Source: MT 2007 MSH Admissions and DPHHS Special Report, 2006 Census estimates for households

¹⁵ For adults, PRTF is a billing designation used by some psychiatric inpatient facilities. It is not a separate level of care.

a) Legislative and Executive Efforts to Reduce MSH Census

Over the past 18 months, Montana has invested significant resources in mental health services, including:

- ▶ At the hospital, to ensure adequate staffing and support of the licensed capacity (supplemental appropriation for staff and operations);
- ▶ In the community, funding for services that could have a direct impact on hospital admissions (i.e., 72-hour crisis stabilization);
- ▶ In the community, funding to improve the amount of support services in the community that have a negligible impact on hospital admissions (mental health drop in-centers); and
- ▶ In the community, flexible funding for housing, medication, and other services and supports to overcome barriers for a person ready for discharge to return to the community.

While the average daily census at the state hospital has been below capacity for the past three months, the current initiatives at their currently funded level may not have a long-term impact on ensuring that the hospital's census remains within its licensed capacity. Some of the funding, such as that available to be used flexibly, relies on one-time resources which are not necessarily available in the long run.

b) Other States' Practices for Managing State Hospital Census

Other states have put in place measures that statutorily or administratively help manage their state hospitals' census. They fall into two general categories: controlling admissions and managing discharges.

Strategies for Controlling Admissions

- ▶ Limited (or no) emergency admissions
- ▶ The establishment of community crisis services including crisis line, mobile teams, and other intervention services in areas that have high state hospital admission rates
- ▶ Require that local treatment options be exhausted prior to admission to the state hospital. This mandatory local treatment could occur in a general or psychiatric hospital.
- ▶ Some states have given statutory authority to the state hospital CEO. The CEO establishes the annual capacity for each program (forensic, civil, geriatric, adolescent), and notifies State and County political leadership of the bed capacity. When the capacity has been reached or there is a potential for the capacity to be breached, the CEO is required to notify referring agencies (local hospitals, managed care agencies, courts, etc.) Patients are then admitted based on the date of their court order.
- ▶ Some states have further refined admission policy by region. In Arizona, each geographic service area, managed by a regional behavioral health authority, is given a bed allocation for the counties they serve. One of the largest counties in Arizona, Maricopa, has an established bed capacity of 55 civil beds for a population base of more than 3.7 million people. This procedure is established by agreement between the hospital the regional behavioral health authority.
- ▶ In managed care states, the managed care organizations (MCOs) assume the risk for the cost of their members' care in the state hospital.

Strategies for Managing the Discharges

- ▶ Require joint patient discharge planning by hospital and community.

- ▶ Require community providers to actively participate in developing their clients' hospital treatment plans and discharge plans.
- ▶ Establish community liaison positions to the regions with highest admission rates.

Montana's efforts to reduce MSH census have been effective so far. However, there are likely to be continued challenges in controlling census at MSH because Montana relies heavily on the law to regulate admissions to the Montana State Hospital. There is not equal weight given to the medical necessity of the placement when determining admission. When courts, other hospitals, and community providers know that MSH cannot say no to an admission, they have less incentive to work out alternative arrangements. While there is certainly a continued need for a facility of last resort, MSH needs to be able to establish a balance that maintains appropriate admission criteria and controls its census. Additional community psychiatric inpatient capacity can help relieve the stress on MSH and treat many Montanans closer to home. In siting additional units, it may be helpful to better understand causes of regional variation in overall inpatient penetration and reliance on MSH.

Recommendations

Until recent efforts, MSH census was rising significantly. In addition to continuing its successful efforts, and strengthening crisis capacity, the following steps would support census management.

- Reconsider 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, particularly for consumers who have been hospitalized for long periods of time where face to face meetings may be particularly important.
 - ~ Measure MSH and provider performance in participation in discharge planning and outcomes for discharged clients.
 - ~ Commit to ongoing appropriations to fund flexible services and supports in the community to facilitate timely discharge.
- ▶ Address barriers to the creation of additional community behavioral health inpatient facilities
 - The state should clearly commit to providing community inpatient care for its population on an ongoing basis.
 - Consider developing legislation limiting facilities' medical liability for non-Medicaid consumers.
 - Identify available general hospital beds (e.g., Billings Clinic)
 - Further investigate behavioral health inpatient financing models used by other rural states that currently provide inpatient care as a Medicaid reimbursable service and develop a strategy to propose this again to the new federal administration.

C. Cross Cutting Issues

1. Workforce Limitations

Workforce limitations affect both children's and adults' services, and have the biggest impact on the rural and frontier parts of the state, including Indian reservations. The least well served areas are North Central for children and Eastern for adults, suggesting that it is possible to serve each area better. The state has a number of options that can be used to help address the need for a better trained and deployed workforce. In addition, setting attractive rates is necessary. Our analysis of Montana's rates appears in Chapter V.

a) Telemedicine.

While Montana providers have been effective in getting grants to establish infrastructure, there can still be operating challenges. Montana Medicaid will pay for services provided by telemedicine at the same rate as a service provided face to face, but these payments do not necessarily cover operating costs for telemedicine capacity. Providers have actively sought assistance from the Rural Utilities Service of the United States Department of Agriculture (USDA), which can provide assistance for operating costs of the communication services. Even with that support, costs can still be high for a small provider.

Medicaid does allow payment for line charges, use of equipment, and technical support, but many states do not reimburse these expenses. Where telemedicine can enhance local resources in a responsible and efficient way, Montana may wish to consider funding a portion of operating costs. Doing so on a pilot basis and assessing the potential for reducing Medicaid transportation may demonstrate that additional costs are at least partially offset by savings.

b) Recruiting professionals.

The time to recruit a psychiatrist to rural practice averages 32 months across the nation and the cost may be \$20,000-\$30,000.¹⁶ The reasons are common to rural and frontier areas: the geographical area covered is vast, the number of colleagues low, the reimbursement rate generally low and the responsibility to provide on-call coverage unsustainable for an individual practitioner.¹⁷ The strategies employed to respond to the challenge, from Alaska to Vermont, involve collaborative approaches, usually with educational, legislative and healthcare partners, of three types - none of which has been found to be sufficient on its own:

- ▶ *Support trainees.* Grow-your-own strategies include identifying and supporting native residents in obtaining training, with financial support throughout training and financial incentives to remain in or return to the home area.
- ▶ *Increase retention.* Develop strategies to retain existing psychiatrists (e.g., creating support networks, ensuring effective and supportive supervision). Those actions that help with Retention also help with Recruitment, as they make the package more attractive.
- ▶ *Improve recruitment.* Recruit new psychiatrists by using financial incentives and incentives related to quality of professional life. Loan repayment programs in particular are a common incentive, used for example in Kentucky, Minnesota, North Carolina, North Dakota, New York, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah and Washington.

¹⁶Rural Behavioral Health Workforce Development, Presentation by Dennis Mohatt
http://www.nasmhpd.org/general_files/meeting_presentations/07%20Hospital%20Summit/DennisMohatt.pdf

¹⁷"Stress of Practicing in Rural Area Takes Toll on Psychiatrist" Aaron Levin, Psychiatric News May 5, 2006
Volume 41, Number 9, page 4© 2006 American Psychiatric Association.

According to a December 2006 summit in Nebraska¹⁸, New Mexico has one of the most extensive sets of behavioral health recruiting strategies, including the following additional techniques:

- ▶ Financial Incentives - NM provides the following financial incentives:
 - Different Medicaid reimbursement for providers in rural areas
 - Tax incentives for establishing and maintaining practices in specific areas
 - Low/no cost capital financing for new practices
 - Loans for service, loan repayment and stipend programs made available for multiple professions, including psychiatrists.
- ▶ Professional Support and Recruiting Center: The Rural and Community Psychiatric Network of New Mexico provides a professional support network and a recruitment center. This is a collaborative project of the Psychiatric Medical Association of New Mexico, the NM Behavioral Health Purchasing Collaborative, the NM Department of Health/Behavioral Health Services Division, and the UNM Psychiatry Department.

Although Montana does not have a medical school to help meet its needs for physicians and psychiatrists, it does participate in the WWAMI Medical Education Program¹⁹, a partnership among Washington, Wyoming, Alaska, Montana, Idaho, which sends students from Western states without medical schools to the University of Washington. This could be an ideal source from which to recruit. In addition, Montana does train Advanced Practice Registered Nurses. APRNs in Montana are already providing psychiatric services, and expansion of the program could further address the gap in psychiatry. Consider creating a University Collaboration even if not with a Medical School; examples include New Hampshire, Virginia, Oregon and Louisiana. For all mental health professions, it is important to tie into general workforce marketing efforts in the state, such as economic development commissions. The North Dakota Health Workforce summit in December 2006²⁰ included this step, as have most other behavioral workforce development efforts.

A strongly recommended general resource is The Western Interstate Commission for Higher Education Mental Health Program²¹ which among other activities served as the expert source on Rural Substance Abuse Behavioral Workforce issues for the Annapolis Coalition²² on the Behavioral Health Workforce.

c) Peer services.

Montana has made a strong beginning in developing peer services. The State should assess its current models and seek consumer and provider feedback on how such services can be built in the frontier and remote parts of the state. Careful focus will be needed on training, defining roles and responsibilities, and providing supervision and support. Further attention is given to this recommendation in Section V.

¹⁸ Health Care Workforce Pipeline: A Matrix of selected Workforce Strategies from States Across the Nation. December 5, 2006. http://ruralhealth.und.edu/projects/workforcesummit/pdf/HCWS_pipeline.pdf. See generally, the Center for Rural Health <http://medicine.nodak.edu/crh>

¹⁹ <http://www.montana.edu/wwwami/>

²⁰ <http://ruralhealth.und.edu/projects/workforcesummit/>

²¹ <http://www.wiche.edu/mentalhealth/>

²² An Action Plan for Behavioral Health Workforce Development, 2007, prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by The Annapolis Coalition on the Behavioral Health Workforce (Cincinnati, Ohio) under Contract Number 280-02-0302 with SAMHSA, US Department of Health and Human Services DHHS)

Recommendations

- ▶ Evaluate use of telemedicine services and consider using Medicaid to cover reimbursement for operating costs if that would enhance its utilization.
- ▶ Conduct a more comprehensive and systematic recruiting effort for psychiatry and other professions including participation in conferences and recruiting fairs, incentives for relocation and retention policies and practices.
- ▶ Expand funding for Montana's Advance Practice Nurse Practitioners (APRN) program to train more practitioners qualified to prescribe psychotropic medications.
- ▶ Work with LACs and SAAs to pilot peer service models that are appropriate for frontier and rural areas.

2. Primary Care and Mental Health Integration

Strategies to improve the long term health of persons with serious mental illness are often dependent upon practitioners' efforts to collaboratively identify, assess and treat both physical and psychological impairments. Studies show that people with serious mental illness die 25 years earlier on average than the general population, and that 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary, and infectious diseases.

Montana has not targeted the SDMI population as one that could benefit from collaboration between primary care and the mental health system. DPHHS has, however, piloted a screening tool for children ages 0-3, and is considering expanding the DPHHS Medicaid disease management program to cover mental health conditions.

a) Current DPHHS Efforts

Montana has recognized the potential of primary care providers to serve an important role in improving early identification of children's mental health problems. Research has conclusively demonstrated that very young children can show signs of social and emotional problems that can be effectively addressed to prevent or minimize additional problems. As part of a national study, DPHHS implemented a pilot project directed at primary care and pediatric physicians for the screening and identification of developmental concerns in young children from birth to 3 years old. Known as the Ages and Stages Questionnaire, or ASQ, this parent-report screening tool helps physicians, caregivers and parents identify children who should be referred to specialty providers for further evaluation. The DPHHS pilot included 1,230 children who were screened using the ASQ tool; 4.39% of these children were referred for additional evaluation. The challenge with this age group is to develop the needed services. Relatively few practitioners are trained to treat mental health problems in very young children, which generally involves teaching parents and other caregivers how to address these problems in the child's day to day life.

For adult Medicaid enrollees, DPHHS does have a disease management (DM) program that targets people with chronic pain, heart failure, and asthma, among other diseases. DPHHS is considering expanding the program to all chronic illnesses, which would include mental illness. Risk stratification, predictive modeling, and other analysis techniques would be used to identify individual Medicaid enrollees to be enrolled in the Montana Medicaid Health Improvement Plan.

Recommendations

We encourage DPHHS to continue its current efforts in screening of young children and in the expansion of disease management initiatives to include mental health conditions. As an example, DM efforts could identify and follow up on individuals receiving psychotropic medications but not receiving treatment to better understand the care they are receiving and to provide support to their primary care clinicians and prescribers.

3. Issue: Local Planning

Local Advisory Councils, Service Area Authorities and the Mental Health Oversight and Advisory Council have made progress in involving a broad group of consumers, family members and other stakeholders in planning, but further definition and development are needed. KMAs add another layer of organization in the community, planning for services at the individual case level. Often these are the same people who are serving on LACs and SAAs, and the boundary confusion is likely to be significant. In addition, boundaries are geographically inconsistent between adult and youth regions.

The Montana Legislature created Local Advisory Councils (or Committees) (LACs), Service Area Authorities (SAAs), and the Mental Health Oversight Advisory Council (MHOAC) to work with AMDD and CMHB. The majority of the members of MHOAC and the majority of the board of directors of the SAAs must be consumers or family members. People in each county are encouraged to participate in or form these councils to determine needs and suggest solutions to their SAA. In turn the SAA is to provide input to MHOAC. The process is cumbersome and the communication difficult. As a result there are many questions about roles and responsibilities.

Relatively few survey respondents identified LACs or SAAs as one of the strong features of Montana's mental health system. Approximately 3% to 6% ranked Local Advisory Councils an important strength, and 2% to 4% rated Service Area Authorities an important strength. Our interviews found that LACs and SAAs are still figuring out what they should do and how they should work together and with other entities.

The local planning functions are truly central to building responsive local systems of care for children and adults. Communities must take ownership of developing solutions to help and support their citizens. To achieve this, the LAC and SAA structures need more support and more emphasis on communities. It would help if child and adult regions were aligned; the different regional boundaries dilute the resources available to work with specific towns. Local officials need information to help them plan. This report and the detailed appendices should help them better understand the service utilization of their counties; more information should be developed annually to support them. Furthermore, regional staff from AMDD and CMHB need to learn effective organizing skills to empower these councils and facilitate their planning and problem solving.

According to stakeholders, the areas to be further defined include:

- ▶ The role of the state agency representatives who attend meetings.
- ▶ Support when co-leaders of LACs or SAAs have disagreements about agendas.
- ▶ Methods for consumer participants to engage effectively.
- ▶ The ability of the LAC and SAA to speak out publicly. Can they take public positions and advocate for them outside of the LAC/SAA process?

LACs don't explicitly include members of local courts and law enforcement. Their input would benefit planning for the mental health needs of individuals involved with the criminal justice system.

To reach their full promise, Local Advisory Councils need to be able to combine their experiential perspective with relevant data on service needs and service utilization in their area. Regular reporting can help them plan and evaluate the effectiveness of additions to the service network.

Recommendations

- ▶ Develop broader consensus on the vision, mission and goals of LAC and SAA community oversight. Clarify relationships and responsibilities between planning groups, councils and authorities – Do they operate on parallel but independent tracks? Do they review the same priorities? What is their relationship to DPHHS/AMDD? To the MHOAC?
- ▶ Make the geographic boundaries for planning areas consistent for adults and youth system so that resources can be consolidated to work more closely with communities.
- ▶ Modify LAC membership to include law enforcement representatives from local authorities and state offices.
- ▶ Improve flow of information to LACs and SAAs needed for their planning and monitoring functions. Develop standard reports that provide prevalence, program access, utilization and outcomes data for LACs and SAA areas and region in formats that allow comparison to regional and state averages. Consider building on the reporting framework laid out in this report for utilization and costs data by funding stream, service and county.

IV. Montana Financing Opportunities

A. Introduction

Our analysis of the funding sources for Montana's public mental health services is based on information provided by DPHHS on service expenditures for fiscal years 2005 through 2007 (the last available year with full claims). These data include service expenditures from the various Divisions within DPHHS: the Health Resources Division; Disability Services Division; Addictive and Mental Disorders Division; and the Child and Family Service Division. We are able to provide data on FY 2008 CHIP expenditures. Mental health expenditures for services provided by Indian Health Service facilities were not available. Data on IHS mental health expenditures are excluded because they were incomplete. In addition, these data do not include administrative costs for DPHHS divisions or expenditures under certain special federal grants received by the state.

In this section, we describe our findings regarding the financing of services for adults and children with mental health needs, in the course of which we will suggest potential sources of new funding and recommend strategies the State might want to pursue to access those sources. We provide an overview of total funding sources in DPHHS, followed by a more detailed analysis of children's services and adult services with specific recommendations for each. Finally, we look at the funding sources used by Montana across both child and adult and identify opportunities for additional funding.

1. Overview of Service Expenditures

Table IV-1 provides an overview of expenditures for mental health services in Montana by fund source and fiscal year. The cost of DPHHS's mental health services are shared by the state and federal governments. Over the three years, 2005 to 2007, the state share for state-only programs increased from 22% to 25%, while the share for programs with some federal contribution has decreased from 78% to 75%. The federal share comes primarily from Medicaid, which accounts for all but 1% of federal programs. Medicaid requires a state matching effort, and the state's funding is included in the total Medicaid expenditures. The Federal Medicaid Assistance Percentage (FMAP) is declining as a result of increases in Montana's per capita income relative to the national level. The remaining federal contribution comes from two grant programs: Vocational Rehab for the States and the Mental Health Block Grant. State General Funds account for an increasing share of the state-only funding, increasing from 19% to 22% of the total. State special revenues accounted for a constant 3% share.

In FY 2007, DPHHS expended \$176.3 million on mental health services inclusive of all federal and state funding sources. This is an increase of \$4.2 million (2%) from FY 2005 expenditures of \$172.1 M. The most significant changes in expenditures by fund source were:

- ▶ \$5.5 million increase in State General Fund expenditures
- ▶ \$1.2 million decrease in overall Medicaid expenditures
- ▶ \$395,000 decrease in federal funds for the State Hospital
- ▶ \$270,000 increase in MHSP expenditures (state-only)

FY 2007 expenditures were 2% less than FY 2006 (\$180 M), with the majority of this decrease being in Medicaid expenditures. Much of the decrease was due to the implementation of Medicare Part D, which picked up the cost of medication for Medicaid/Medicare dual eligibles.

The state share for mental health services is likely to continue to increase because the state's Medicaid percentage match is due to increase to 32%.

DPHHS Fund Sources	2005	2006	2007
State General Fund Appropriations	\$29,708,799	\$32,774,571	\$35,224,309
Mental Health Service Plan (MHSP)	\$2,727,836	\$3,422,532	\$3,000,365
Children's Mental Health Service Plan	\$9,841	\$7,838	\$6,553
TANF Maintenance of Effort (State General Fund)	\$335,222	\$377,346	\$395,013
MHSP (SSR) Tobacco / I149 initiative	\$2,931,799	\$3,047,434	\$2,700,077
State Hospital - (SSR) Debt Service Bonds	\$1,785,072	\$1,775,375	\$1,792,631
State Hospital - (SSR) State Special Rev. (DOC & Alcohol tax)	\$432,275	\$427,062	\$476,557
Subtotal State-Only Programs	\$37,930,844	\$41,832,158	\$43,595,505
SSI (Federal Funds)	\$12,813	\$26,363	\$40,670
MHSP Block Grant - Federal Funds	\$953,841	\$1,228,489	\$1,220,387
State Hospital - Federal	\$395,910	-	-
MT Mental Health Nursing Care Center - Federal	\$111,090	-	-
Medicaid	\$129,828,424	\$134,113,480	\$128,588,428
Rehab Services: Voc Rehab to the States – Fed. Funds	\$2,873,000	\$2,920,968	\$2,862,460
Subtotal Federal and Federal/State Programs	\$134,175,078	\$138,289,300	\$132,711,945
Total	\$172,105,922	\$180,121,458	\$176,307,450
<i>Source: DPHHS Special Report, rev. 9/15.</i>			

2. Department of Corrections Mental Health Expenditures

Relative to DPHHS and as a percentage of its own overall budget, Department of Corrections (DOC) spending on mental health is relatively small. DOC provides mental health services in its adult correctional facilities, adult community corrections, youth services, and the mental health liaison position. Total spending of \$3.9M in FY 2007 was equivalent to 3% of the mental health services spending for DPHHS. Virtually all DOC funding is from the state.

B. Financing of Children's Mental Health Programs

1. How are children's mental health services funded?

Montana's mental health services for children are primarily funded through Medicaid and CHIP; each has a substantial federal match. A very small portion is solely state financed. Less than 6% of the Juvenile Corrections budget is expended on mental health.

a) DPHHS

Figure IV-1 shows Montana FY 2007 service expenditures for DPHHS children’s mental health services by program. These expenditures totaled \$77.5M excluding CHIP program mental health expenditures. In FY 2008, CHIP mental health expenditures totaled \$1.4 million, equivalent to 1.8% of the \$77.5 M spent on the other three programs in FY 2007.

Children’s services are funded almost exclusively by the Medicaid program. The Medicaid services provided through the Children’s Mental Health Bureau (CMHB), with a budget of \$57.4 million, accounted for almost 75% of the total children’s mental health expenditures. “Other Medicaid”

(which covers school based services administered by the Office of Public Instruction, as well as psychotropic pharmacy services), accounts for a quarter of expenditures. State funded mental health services provided by the Child and Family Services Division (CFSD) account for only 1% of the total, and the Children’s Mental Health Services Plan accounted for even less.

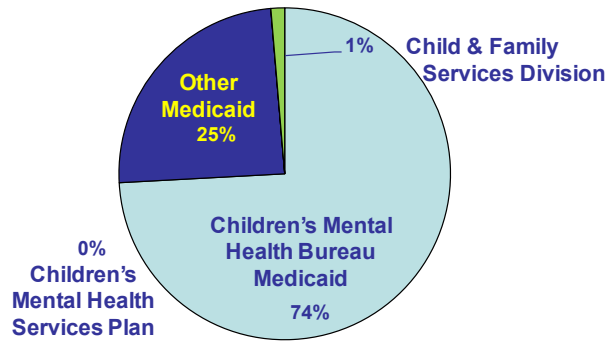
In addition to the above service expenditures, DPHHS has received two grants supporting children’s mental health services. The SAMHSA System of Care Grant totals approximately \$500K per year for the last four years, and provides infrastructure and training support to create and operate children’s system of care. The state is in the last year of this grant. The CMS Psychiatric Residential Treatment Facility (PRTF) Demonstration provides from \$430K to \$980K in potentially new federal support. Approximately two-thirds of this is for services; the balance for administrative support.

b) Juvenile Corrections

Expenditures on mental health services in Juvenile Corrections are growing, and most of these funds are spent on residential placements for a relatively small number of youth. A relatively small proportion of the Youth Service Division budget is spent on mental health services.

Almost \$1.2M (under 6%) of the FY 2008 budget for Juvenile Corrections was expended on mental health services. The vast majority of this was for contracted residential treatment services. The Youth Services Division accounts for 25% of total DOC spending on mental health and it grew at the same rate as other mental health expenditures for youth. Youth Services

**Figure IV-1
SFY2007 DPHHS Child MH
Expenditures* by Source**



Total = \$77.5 Million

Other State Plan includes MH procedures and psychotropic medications not billed to AMDD or CMHB

* Excludes CHIP MH Services and IHS MH Services

Source: DPHHS Special Report

**Table IV-2
FY 2007 and FY 2008
Youth Services Division Mental Health Expenditures**

	FY 2007	FY 2008	% change 07 to 08
Total Mental Health Expenditures	1,006,670	1,154,861	15%
Type of Expenditure	Contracts	Personnel	Medication
Percent of FY 2008 Total Mental Health Expenditures	72%	19%	8%

Source: Department of Corrections Mental Health Costs Fiscal Years 2007/2008, 10-Jul-08

spends a full 72% of its expenditures for contracted services for youth in residential treatment. Mental Health personnel account for only 19% and medications for 8%.

DOC's expenditures for youth residential are a fairly small part of the total spent by the State on residential mental health services for youth. The \$772,180 spent on residential services for DOC youth in FY2007 was equivalent to only 4% of DPHHS expenditures on PRTF level of care in the same period. However the issue has generated a considerable amount of attention.

Medicaid pays for all or some of the cost of mental health services for certain DOC youth in residential facilities who have mental health problems. Almost 20% of the 26 youth with mental health problems in residential facilities under DOC auspices were fully paid for by Medicaid. Another 30% were partially paid by Medicaid, and half were fully paid by DOC state general fund dollars. The amounts included in the Table IV-2 above are the DOC share of mental health spending for those youth.

2. Have Montana's children's mental health funding streams changed significantly over the past few years? If so, which ones and why?

DPHHS expenditures for children's mental health services increased by 16% between FY2005 and FY2007, with most of the increase in Medicaid because of expanding eligibility to children without SED. CMHSP decreased, likely because fewer children needed it. However, the relative state and federal shares remained constant. Montana has effectively leveraged resources through its Medicaid and CHIP programs. The state is spending small amounts for non-Medicaid services for children, but may be spending more than is necessary on complex foster care cases that are likely to have Medicaid coverage.

Expenditures for children's mental health services increased by \$11M (16.5%) between FY 2005 and 2007, from \$66.5 million to \$77.5 million. There were no changes in state and federal shares. Tables IV-3 and IV-4 provide an overview of expenditures for children mental health services by year and funding source.

Several factors were directly related to the increase seen in expenditures for children's Medicaid mental health services over the three year period:

- ▶ The state removed the restriction that only children with Serious Emotional Disturbance could receive Medicaid children's mental health services.

Table IV-3			
DPHHS Children's Mental Health Service Expenditures*			
by Fund Source and Fiscal Year			
DPHHS Fund Sources	2005	2006	2007
State General Fund Appropriations	\$542,443	\$717,211	\$599,970
State GF (TANF of maintenance of effort)	\$335,222	\$377,346	\$395,013
CMHSP	\$9,841	\$7,838	\$6,553
Medicaid	\$65,623,315	\$74,107,513	\$76,458,709
SSI (Federal Funds)	\$12,813	\$26,363	\$40,670
Total	\$66,523,634	\$75,236,272	\$77,500,914
<i>*Excludes CHIP mental health service expenditures</i>			
<i>Source: DPHHS Special Report, rev. 9/15</i>			

Table IV-4				
Changes in DPHHS Children's Mental Health Service Expenditures*				
by Fund Source and Fiscal Year				
DPHHS Fund Sources	\$ Change from 2005-2006	\$ Change from 2005-2007	% Change from 2005-2006	% Change from 2005-2007
State General Fund Appropriations	\$174,768	\$57,527	32.22%	10.61%
State GF (TANF maintenance of effort)	\$42,124	\$59,791	12.57%	17.84%
CMHSP	(\$2,003)	(\$3,288)	(20.35%)	(33.41%)
Medicaid	\$8,484,198	\$10,835,394	12.93%	16.51%
SSI (Federal Funds)	\$13,550	\$27,857	105.75%	217.41%
Child Total	\$8,712,637	\$10,977,281	13.10%	16.50%
<i>*Excludes CHIP mental health service expenditures</i>				
<i>Source: DPHHS Special Report, rev. 9/15</i>				

- ▶ Funds from the Tobacco tax were designated to raise Medicaid mental health reimbursement rates.
- ▶ There was an increase in the utilization of targeted case management. Specifically, the number of units per child increased during this three year period (the state has subsequently placed additional cost controls on this service).
- ▶ School-based health services grew during this period as the number of participating schools increased.

There was a slight decrease in CMHSP expenditures for the three year period. This may have been directly related to changes in eligibility for the state's CHIP program, which was raised from 150% to 175% of the federal poverty level during the three year period. Less revenue for the CMHSP program was needed as additional children qualified for Medicaid or CHIP. In FY 2008, the \$1.4 million in CHIP mental health expenditures were spent almost equally on inpatient services and outpatient services, showing a similar pattern to that seen for the other DPHHS mental health expenditures.

a) Expenditures by Type

Table IV-5 shows children's mental health expenditures by service type. This table includes DPHHS' total expenditures for children's mental health services and psychotropic medications. As is true for our service data, these expenditures include a broad range of service needs. Some services, like PRTF, and targeted case management are used by children with SED, while others are used by children whose needs can be met by a few counseling sessions or a medication. Over half of total expenditures supported residential treatment options, with slightly more than a

Table IV-5		
SFY2007 DPHHS Children's Mental Health Expenditures by Service Type		
<i>(Excluding CHIP and IHS MH Services)</i>		
Group Homes and Therapeutic Foster Care	\$20,918,122	27%
Inpatient/PRTF	\$19,042,567	25%
School Based Services	\$10,000,899	13%
Medication	\$ 8,806,414	11%
Outpatient	\$ 5,617,624	7%
Targeted Case Mgmt	\$ 5,140,369	7%
Rehabilitation and Support	\$ 3,042,231	4%
Day/Intensive OP	\$ 2,429,740	3%
Misc. Services*	\$ 2,122,380	3%
Crisis	\$ 380,569	0%
Total	\$77,500,914	
* Misc includes services for MH diagnoses provided by non-MH providers, including Personal Care Agencies, FQHCs, physicians, labs, and certain psychiatry services not included in standard MH procedure codes.		
<i>Source: DPHHS Special Report</i>		

quarter of total expenditures paid for group homes and therapeutic foster care (which can often, but not always, serve children in their communities). Another 25% of total expenditures supported inpatient and psychiatric residential treatment programs, (a number, but not all of which, are located out of state). These expenditures also included payments for those times when a child with a primary psychiatric diagnosis was served in a non-psychiatric bed. The two next largest expenditure groups were school based services for children with emotional disabilities, and medications plus medication management services. Together they accounted for another quarter of children's mental health expenditures. The remaining service types, of which the main components are outpatient and targeted case management, comprised the final 25%.

The Child and Family Service Division pays for \$1M in outpatient services, primarily from state funds. These services include assessments and individual and family therapy. Since most of these children are in state custody, they qualify for Medicaid. However, the Division has found that the specialized providers needed to assess children with complex needs are not always participating in Medicaid, or are not available as quickly as their services are needed. In these cases, the Division pays a higher rate to obtain services outside of the Medicaid system.

b) Flexible Funds

CMHB has some sources of flexible funding that can be used to pay for additional services needed by a child with serious emotional disturbance when those services are not covered by Medicaid or CMHSP. One source is the almost \$400,000 spent in FY 2007 that the state is required to spend to demonstrate that it has maintained its contributions to the Temporary Assistance for Needy Families program (TANF). These funds can only be provided to children who are Medicaid or CHIP eligible, are under 150% of the Federal Poverty level, and are not receiving cash assistance. However, for those that do qualify, funds can be used very flexibly, such as for transport or lodging that allows a family to visit a child in residential treatment, for a wilderness camp, or for room and board for a group home when a family can't afford it. CMHB is gathering data on the outcomes of the flexible services they purchase to determine which of these services that fall outside the standard benefit are effective.

A second source is a new System of Care Account created by the Legislature. In the current biennium, state agencies are allowed to deposit up to \$500,000 of unmatched or other general fund into the account to be used, flexibly, for children with multi-agency needs. No additional funds are appropriated for this account. In the first year, FY 2008, \$40,000 of the System of Care Account was channeled through the account for 11 children, mostly to avoid residential placements.

The third source is part of Montana's PRTF demonstration grant. This grant is using a system of care approach to enroll 100 children annually and provide them with community based services intended to prevent or minimize their stays in a PRTF level of care. If the number of children using PRTFs is reduced, those who continue to need this level of care are more likely to be able to be served in-state. The grant provides five years of federal funding matched with state funding for the administration of the demonstration, and allows Medicaid to reimburse services not otherwise covered. These include: respite services (currently available only through 100% state funding); a new form of lab testing relevant to children on complex medication regimens; non-medical transportation; and flexible funding for other needs. If the demonstration is successful, Montana may request a waiver that would allow this program to continue.

Findings

- ▶ Montana has effectively leveraged federal resources through its Medicaid and CHIP programs. Very little funding is required from the state outside of these programs. Winning a PRTF grant from CMS is allowing Montana to use Medicaid funding much more flexibly to reduce use of one of its highest cost treatment modalities.
- ▶ The spending level for non-Medicaid services to children is very small. For middle class families with incomes above Medicaid or CHIP eligibility, the costs of caring for a child with mental illness are significant; coverage by commercial insurance plans is limited.
- ▶ Montana is paying from state CFSD funds for some outpatient services for complex cases that could be reimbursed by Medicaid. Since most children receiving these services are enrolled in Medicaid, the state could develop a method for paying the higher rates needed to procure these services through Medicaid, thereby garnering federal match for \$1M.
- ▶ CMHB has a number of sources of flexible funding, which are very important to be able to meet a child's needs that fall outside of the covered services. The System of Care Account provides an important source of flexible funding not limited by the restrictions applicable to TANF maintenance of effort and PRTF waiver services.

3. How does a child/family pay? Should families pay more?

Families of child consumers currently have no co-pays. Co-Pays should be implemented for outpatient services to make the system equitable with that for adults.

Children's Medicaid is prohibited by federal regulation from assessing co-payments. CHIP does have co-payments for certain mental health services for some enrollees; those with incomes under 100% of poverty and Native Americans are exempt. The adult section of this chapter provides additional detail on principles for assessing co-payments. These call for co-payments to be consistent across Montana's programs to the degree allowed by regulation, and to be set at levels that appropriately and consistently consider families' financial resources.

Recommendation

Montana should establish reasonable and fair co-pays that are consistent across both children's and adult's mental health services as allowed by Medicaid, CHIP and DRA regulations. The principle should be to create equity and consistency within and across programs and age groups. The financial benefits will be minor.

4. How can Montana make better use of current children's mental health funding streams and funding levels?

Montana's comprehensive mental health benefit makes good use of Medicaid and CHIP, but its rates for psychiatry, case management and individual and group therapies for children are low compared to other states. Raising them should improve use of Medicaid funds and community based service utilization.

Montana has made good use of Medicaid and CHIP to provide a comprehensive mental health benefit to children within the income eligibility limits. By winning a system of care grant and following it with the PRTF demonstration grant, the state has laid a good foundation for eventually becoming able to administer Medicaid community services flexibly for children at

highest risk. The PRTF grant provides a funding stream that can encourage the further development of community based services and foster creativity in making best use of community resources. Active evaluation of this effort will provide valuable information to inform the design of an ongoing waiver, and lessons learned may be able to be translated to CHIP, CMHSP, and other levels of care.

a) Strategic Rate Increases

Adequate rates that provide for attractive salaries and working conditions are a necessary component of a strategy to increase the capacity of Montana’s mental health workforce. We compared Medicaid/MHSP rates for certain Montana mental health services to rates paid by other, primarily Western, states and found that the rates for the following services were considerably lower than those of the comparison states. (See Table IV-6)

- ▶ Montana’s medication management rate was lower than for other states. Given the state’s difficulties in recruiting psychiatrists, ensuring that rates are competitive may be a necessary part of a workforce development strategy.
- ▶ Targeted case management (TCM) rates for children are lower than other states and much lower than for Montana adult TCM services. In addition, these services may need to be restructured to be compliant with new CMS rules. This would provide an opportunity to modify the service and reset the rates. However, as one of the services that has grown the fastest and is used by a high proportion of Medicaid children, it behooves the state to address rates as part of a comprehensive management plan for this service.
- ▶ Family and Group therapies are a core component of children’s mental health services. Low rates may affect the availability of services as well as the attractiveness of counseling positions.

Code	90862	90806	90847	90853	H2014, H2015, H2017	H2012	H2015, T1016
Description	Medication Mgmt.*	Individual Counseling	Family Psychotherapy	Group Psychotherapy	Psychosocial Rehabilitation	Day Treatment	Case Mgmt.
Min	\$39.80	\$55.91	\$33.54	\$11.74	\$1.93	\$11.68	\$7.48
Max	\$81.79	\$101.73	\$119.82	\$43.87	\$4.81	\$28.16	\$16.39
Average	\$56.62	\$71.65	\$75.51	\$23.13	\$3.14	\$18.83	\$13.06
MT Rate	\$47.09	\$53.76	\$65.15	\$18.44	\$1.94	\$10.46	\$12.61
Rate Dif.	20.24%	33.27%	15.90%	25.44%	62.06%	80.07%	47.50%
FY 2007 Expenditures	\$758,870	\$2,957,468	\$1,032,491	\$98,576	\$2,702,623	\$1,227,286	\$5,140,369
Potential Impact	\$153,620	\$983,889	\$164,184	\$25,078	\$1,677,258	\$982,746	\$2,441,777
States Compared	Alabama Idaho Minnesota Nevada New Mexico North Dakota Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Texas Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Texas Utah Wyoming	Alabama Arizona Arkansas Florida Louisiana Nevada New Mexico North Carolina Oklahoma Rhode Island	Alabama Florida Minnesota Nevada New Mexico	Minnesota Nevada New Mexico Oklahoma Utah

*Child and adult combined.

Montana may also wish to review the rates paid by private health plans for these services when considering increased rates and give more weight to the states that Montana considers most likely relevant to its market. At FY 2007 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 \$3.6 million that would be eligible for FMAP.²³ However, if utilization of these services increases as desired, the eventual cost would exceed this amount. We also note that CFSD pays higher rates than Medicaid to get mental health assessments and treatment for some of its most complex cases, suggesting that raising rates can elicit greater willingness to deliver services.

Recommendations

Review Medicaid rates in comparison to nearby states that are part of Montana's labor market and raise Montana rates to a more competitive level. Rates for the following three services could be increased to the average of other Western states for a total of \$3.6 million.

- ▶ Ensure a competitive rate for psychiatry.
- ▶ Set rates for children's case management in the context of any changes necessary in the service to comply with new DRA requirements.
- ▶ Increase rates for individual and group therapy for children to be competitive for the region.

b) State Plan Services

Child and Family Service Division Services. CFSD is paying for services that could be covered by Medicaid at rates that usually exceed Medicaid rates. This is most true in complex cases that require specialty services and/or providers that do not bill Medicaid.

Recommendation

We believe that this can be addressed if HRD developed a Medicaid procedure with a rate that adequately reimburses the assessment and treatment of certain complex CFSD cases so that these services can be accessed through Medicaid. CFSD paid approximately \$1 million for these services in FY 2007, primarily from state general funds. Paying an increasing share through Medicaid would garner federal match for these amounts.

c) Targeted Case Management

Targeted Case Management rule changes have been proposed by CMS. More than \$5M is claimed for children's Case Management. See our discussion of this area in the adult section.

C. Financing of Adult Mental Health Programs

1. How are adult mental health services funded?

The state carries a substantial financial responsibility for DPHHS adult mental health services, with the largest program being state mental health institutions. Vocational rehabilitation services and MHSP together account for a little more than 10% of total expenditures. Health services for Native Americans can be improved through stronger Medicaid billing.

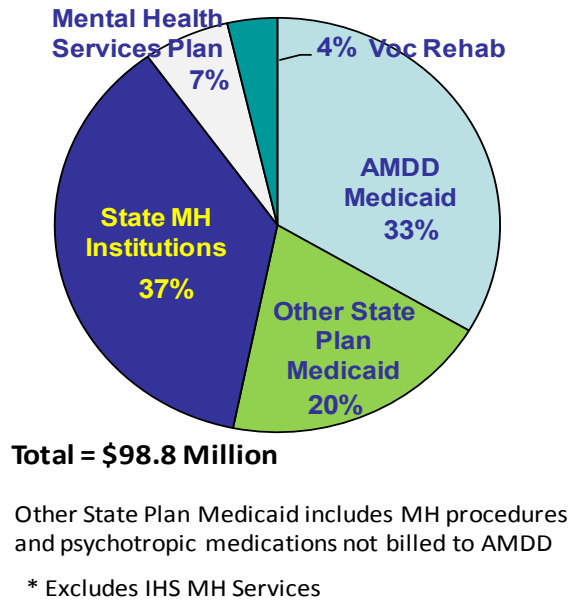
²³ We applied the percentage increase to payment rates to the amounts spent for these procedures in FY 2007 to reach this amount.

a) DPHHS

Figure IV-2 shows adult mental health service expenditures which totaled \$98.8M in FY 2007. State institutions, with combined budgets of \$36.3 million, and the Addiction and Mental Disorders Division (AMDD) Medicaid program with a budget of \$32.3 million dollars were the major components. When AMDD Medicaid expenditures are combined with mental health expenditures made through HRD for other state plan services, Medicaid is responsible for just over half (53%) of DPHHS adult mental health services. State funding is of considerable significance to AMDD covering the two state institutions (MSH and Montana Mental Health Nursing Care Center (MMHNCC)) and the Mental Health Services Plan (MHSP).

We note that this chart and our remaining analysis lack information on expenditures for mental health services provided by IHS facilities. However, these charges are passed through to the federal government, which fully reimburses them, so they are of no net cost to the state.

Figure IV-2
SFY2007 DPHHS Adult MH Expenditures* by Source



Source: DPHHS Special Report

However, IHS services are of relevance to the state because they are an important source of services for Montana Indians. IHS facilities receive a federal allocation for operations. They are able to bill Medicaid for their Medicaid enrolled patients, Medicare, and private insurance. Any such billings return to the facility. The more the facility can generate third party revenue, the more it can add to the federal allocation to support its services. The state has recognized its interest in assisting IHS to generate the maximum Medicaid revenue and is working with IHS to enroll more Indians in Medicaid. If the anomalies we found in claims for IHS mental health services are indicative of under billing, then improved billing practices may also generate greater Medicaid revenue.

b) Department of Corrections

Three quarters of adult mental health expenditures were for the secure facilities operated by the Department: Montana State Prison, Montana Women’s Prison, three regional prisons Glendive, Great Falls, and Missoula, and the private prison in Shelby. Most of the remaining mental health expenditures were through adult community corrections. A small percentage of DOC mental health spending is for the administrative expenditure of the salary of the Mental Health Liaison between DOC and AMDD. Overall, expenditures grew considerably, 16% (\$460,000) between the two years, due primarily to the expansion of community corrections, which almost doubled. Secure facilities expenses grew at a moderate 4%. Overall, the DOC spends the largest percentage of its funds (41%) on mental health staffing, a third (32%) on contracted mental health services, and another 27% spent for psychotropic medications.

	FY 2007	FY 2008	% of Total FY 2008	% Change 07 to 08
Secure Facilities	\$2,448,120	\$2,535,149	74%	4%
Adult Community Corrections	\$441,782	\$818,710	24%	85%
MH Liaison	\$79,526	\$79,454	2%	0%
Total	\$2,969,428	\$3,433,313	100%	16%

1) FTE and contract services provided in Meth TX centers/Passages/Regional Prisons are included in the per diem rate. These are the total cost from the facilities for mental health services.
2) The money transferred from DPHHS for Mental Health Services and medication was slow to start in FY 2008. FY 2009 expenditures should demonstrate more utilization of services
Source: Department of Corrections Mental Health Costs Fiscal Years 2007/2008, 10-Jul-08

In FY 2008, only 2% of adult community corrections expenditures were for mental health. In comparison to DPHHS' spending for adult mental health services, DOC mental health expenditures in its secure facilities are less than 7% of the DPPHS spending on mental health institutions. Adult community corrections spending (at FY 2008's expanded levels) is equivalent to 18% of DPHHS spending on outpatient services. But when other community based services and supports provided by AMDD are considered, the relative amount provided by DOC is quite small.

	Contracts	Personnel	Medication
Secure Facilities	30%	42%	28%
Adult Community Corrections	39%	38%	23%
Youth Services Division	72%	19%	8%
Total	32%	41%	27%

Source: Department of Corrections Mental Health Costs Fiscal Years 2007/2008, 10-Jul-08

2. Have Montana's funding streams for adults changed significantly over the past few years? If so, which ones and why?

DPHHS mental health expenditures decreased 6% between FY 2005 and FY 2007. The decreases were primarily in Medicaid as the implementation of Medicare Part D picked up pharmacy costs for dual eligibles. This more than offset increased state expenses for the state hospital and expenditures for MHSP from new tobacco initiative special revenues. Institutional expenditures are a key determinant of adult mental health spending.

In FY 2005, DPHHS expended approximately \$105.6 million for adult mental health services. There was little change in overall spending for adult mental health services from FY 2005 through FY 2006. However, in FY 2007, these expenditures decreased 6% to \$98.8M, a \$6.8M decrease. Tables IV-9 and IV-10 provide an overview of expenditures for adult mental health services by year and funding source.

DPHHS Fund Sources	2005	2006	2007
State General Revenue Funds Appropriation	\$32,098,155	\$32,057,360	\$34,624,339
Mental Health Services Plan (MHSP)	\$2,727,836	\$3,422,532	\$3,000,365
MHSP Block Grant Federal Funds	\$953,841	\$1,228,489	\$1,220,387
MHSP (SSR) /Tobacco I149 Initiative		\$3,047,434	\$2,700,077
State Hospital* - (SSR) Debt Service Bonds	\$1,785,072	\$1,775,375	\$1,792,631
State Hospital* - (SSR- DOC & Alcohol tax)	\$432,275	\$427,062	\$476,557
State Hospital - Federal	\$395,910		
MT MH Nursing Care Cent. - Federal	\$111,090		
Medicaid	\$64,205,110	\$60,005,967	\$52,129,719
FF- Rehab. Services: Voc Rehab to the States	\$2,873,000	\$2,920,968	\$2,862,460
Total DPHHS Adult Mental Health	\$105,582,289	\$104,855,187	\$98,806,534
<i>* Excludes mental health services provided in IHS facilities</i>			
<i>Source: DPHHS Special Report, rev. 9/15</i>			

The most significant changes in funding source were a 19% decrease in Medicaid expenditures and the ending of a federal grant related to employment:

- ▶ The Medicaid decrease was due to a reduction in spending for pharmacy services with the implementation of the Medicare Part D program. In 2006, the Medicare program assumed payment responsibility for covering pharmacy benefits for individuals who were enrolled in Medicare, including individuals who were dually eligible for Medicaid and Medicare. It is estimated that approximately one-third of all individuals in Montana with SDMI are dually eligible.
- ▶ Federal expenditures decreased for Montana State Hospital and the Montana Mental Health Nursing Care Center because a federal grant for a jobs program ended in FY 2005.

DPHHS Fund Sources	\$ Change from 2005-2006	\$ Change from 2005-2007	% Change from 2005-2006	% Change from 2005- 2007
State General Revenue Funds Appropriation	(\$40,795)	\$2,526,184	(0.13%)	7.87%
Mental Health Services Plan (MHSP)	\$694,696	(\$422,167)	25.47%	(12.33%)
MHSP Block Grant Federal Funds	\$274,648	\$266,546	28.79%	27.94%
MHSP (SSR) /Tobacco I149 Initiative	\$3,047,434	\$2,700,077	N/A	N/A
State Hospital* - (SSR) Debt Service Bonds	(\$9,697)	\$7,559	(0.54%)	0.42%
State Hospital* - (SSR- DOC & Alcohol tax)	(\$5,213)	\$44,282	(1.21%)	10.24%
State Hospital – Federal	(\$395,910)	(\$395,910)	(100.00%)	(100.00%)
MT MH Nursing Care Cent. - Federal	(\$111,090)	(\$111,090)	(100.00%)	(100.00%)
Medicaid	(\$4,199,143)	(\$12,075,391)	(6.54%)	(18.81%)
FF- Rehab. Services: Voc Rehab to the States	\$47,968	(\$10,540)	1.67%	(0.37%)
Total DPHHS Adult Mental Health	(\$697,102)	(\$6,775,754)	(0.66%)	(6.40%)
<i>*Excludes mental health services provided in IHS facilities</i>				
<i>Source: DPHHS Special Report, rev. 9/15</i>				

There were also increases in several funding sources:

- ▶ In FY 2006, Montana received an additional 29% in its Mental Health Block Grant from the Substance Abuse and Mental Health Administration. This increase restored the grant to its usual level from FY 2005, when a portion of the grant was withheld because the state had not met the grant’s maintenance of effort requirements.
- ▶ In addition there was an increase in state general revenue funds related to the increased costs for the Montana State Hospital. The 2007 Legislature approved both a supplemental appropriation and continued funding for 36.60 additional FTEs at MSH to address higher populations.

a) Expenditures by Type

Table IV-11 presents DPHHS adult mental health expenditures for SFY 2007 by service category. As for children, these expenditures include those for individuals with SDMI, as well as for individuals with minimal mental health needs. The two state institutions represent Montana’s largest service expenditures. Solely state funded, they constitute almost 40% of the total. Psychotropic medications and medication management are the next largest expenditure group, accounting for over 20% of total spending. Case management accounts for 11% of total expenditures, with expenditures for community based residential services and rehabilitation each accounting for 7%. All other service types, including other inpatient services and crisis intervention services account for 5% or less. Clearly institutional expenditures, which are primarily for the Hospital and Nursing Care Center, are the key determinant of adult mental health spending.

Table IV-11

**SFY2007 DPHHS Adult Mental Health Expenditures*
by Service Category**

State Inpatient and Nursing Home Services	\$36,220,741	37%
Medication Services	\$20,272,426	21%
Case Management	\$11,217,052	11%
Group Homes and Foster Care	\$6,542,607	7%
Rehabilitation	\$6,540,175	7%
PACT	\$4,581,423	5%
Outpatient Services	\$4,478,326	5%
Misc. Services**	\$3,640,432	4%
Inpatient	\$2,806,275	3%
Crisis	\$2,409,829	2%
Intensive Out-Patient	\$97,249	0%
Total	\$98,806,536	

* Excludes IHS MH Services

** Misc includes services for MH diagnoses provided by non-MH providers, including Personal Care Agencies, FQHCs, physicians, labs, and certain psychiatry services not included in standard MH procedure codes.

Source: DPHHS Special Report

We looked at the share of mental health services paid through each program. (We disregarded the costs of the institutions and of psychotropic medications.) We found that 84% of mental health service costs are paid through AMDD Medicaid, 11% are paid through MHSP, and the remaining 5% or \$2.2 million are paid by HRD Medicaid. It is not clear why mental health services would be adjudicated to HRD rather than to AMDD, and DPHHS has begun to examine why these service claims are not being assigned to AMDD. They may be legitimate claims for covered services that are being improperly routed in the claims payment system. However, if they are claims that AMDD would deny under their regulations and prior approval processes, then Montana may be able to adjudicate them under AMDD rules and reduce costs in the future.

3. How does the Montana adult consumer pay for services? Should consumers pay more?

DPHHS co-pay and cost sharing protocols are inconsistent for MHSP and Medicaid consumers. While co-pays can become a collections and revenue burden for providers, they are likely to increase consumer investment in personal recovery. The inconsistency between Medicaid and MHSP Co-pays should be eliminated.

There is an inconsistency in the way DPHHS has implemented co-payment and cost-sharing arrangements for MHSP and Medicaid adult mental health consumers. Table IV-12 represents the current co-payment and cost sharing arrangements for the MHSP and Medicaid populations for those services that require a co-payment or cost sharing arrangement. MHSP members pay more than twice the co-payment/cost-sharing amount for medications (Clozaril excluded) than Medicaid recipients. MHSP clients pay nothing for mental health services delivered by practitioners while Medicaid members pay \$3.00 - \$4.00 for such services.

Table IV-12 Co-Payment & Cost Sharing for Persons with a Serious Disabling Mental Illness – Provider Types & Services where Co-Payments & Cost Sharing is Specified for One or More Plan Type			
Provider Type/Service	MHSP	AMDD Medicaid	HRD Medicaid
<u>Prescription drugs (OP)</u>	\$12.00 generic & preferred \$17.00 brand & non-preferred \$0 Clozaril	Prescriptions paid through HRD →	\$1.00 - \$5.00 per prescription not to exceed \$25.00 per month
<u>Practitioner Services</u>			
Licensed Social Worker	None	\$3.00 per visit	Not Applicable
Licensed Prof. Counselor	None	\$3.00 per visit	Not Applicable
Licensed Psychiatrist	None	\$4.00 per visit	Not Applicable
Licensed Psychologist	None	\$3.00 per visit	Not Applicable
Psychological & Neuropsychological/behavioral testing (various CPT codes)	None	\$3 - \$4 (depends on provider type)	Not Applicable
<u>Dialectical Behavior Therapy (DBT)</u>			
DBT - Psychotherapy	\$3.00 per visit	\$3.00 per visit	Not Applicable
DBT – Skill development – individual	\$3.00 per visit	\$3.00 per visit	Not Applicable
DBT – Skill development – group	\$3.00 per visit	\$3.00 per visit	Not Applicable
<u>Hospital in-patient</u>	Not a covered MHSP service	\$100.00 per discharge	Not Applicable
<u>Out-of-home admission (non-hospital)</u>	None (although ARM 37.89.119(c) allows for a \$50.00 co-payment)	None	Not Applicable
<i>Source: AMDD & MHSP Fee Schedules 7/1/08 ARM 37.89.204 and Provider Manual October 2003</i>			

MHSP clients are generally not eligible for Medicaid because their incomes exceed Medicaid limits. Yet persons who are Medicaid eligible are assessed a co-payment for some services while MHSP clients are not assessed a co-payment for these same services. This is true for both individual practitioner services and psychological and neuropsychological testing services. There are other community based services provided through MHSP and Medicaid that have no co-payment or cost sharing requirements or are not specified in a rule or fee schedule.

A significant number of Montana community mental health services do not require a co-payment or co-payment rules are not specified. Table IV-13 includes services that do not

require a co-payment for MHSP clients according to the AMDD MHSP Fee Schedule. There is no clear policy or rationale for the lack of co-payments for MHSP services. ARM 37.89.119 allows AMDD to charge for MHSP outpatient services in addition to those prescribed by the AMDD.

Table IV-13		
Co-Payment and Cost Sharing for Persons with a Serious Disabling Mental Illness – Provider Types and Services where Co-Payments and Cost Sharing is “None” or service is “Not Covered”		
Provider Type/Service	MHSP	AMDD Medicaid
<u>Other Mental Health Center Services</u>		
Respite Care – Adult	Not Covered	None (service provided and paid 100% by GF)
MH. Group Home – Adult	None	None
MH. Group Home – Therapeutic Leave	Not Covered	None
Adult Foster Care	Not Covered	None
Adult Foster Care – Therapeutic Leave	Not Covered	None
Day Treatment – Adult Half Day	None	None
Community-based psychiatric rehabilitation & support – individ.	None	None
Community-based psychiatric rehabilitation & support – group	None	None
Crisis intervention facility	Not Covered	None
Program of Assertive Community Treatment (PACT)	None	None
Intensive Community Based Rehabilitation	Not Covered	None
Targeted Case Management – Adult – individual	None	None
Targeted Case Management – Adult – group	Not Covered	None
Acute Partial Hospitalization – Full day	Not Covered	None
Acute Partial Hospitalization – Half day	Not Covered	None
<i>Source: AMDD & MHSP Fee Schedules 7/1/08 ARM 37.89.204 and Provider Manual October 2003</i>		

Imposing minimal co-payments and cost-sharing arrangements (less than \$5.00) is generally an acceptable practice so long as charges do not exceed those paid by non-mental health recipients or the total cost of the service. Many states have implemented co-payments for physician office visits, independent practitioner visits, pharmacy encounters, laboratory services, hospital admissions or discharges and other outpatient services to offset the rising cost of health care. In developing co-payment and cost-sharing practices, states have generally kept the consumer payment low in order to ensure that it does not prevent people from accessing services. States have also considered how multiple co-payments within one day, even if they are small, might prevent people from accessing services.

Collecting co-payments and cost sharing can be difficult for providers. Providers and advocates usually resist such efforts, describing increases in the costs of collection, bad debt and barriers to access. Collection of co-payments can be less burdensome on providers if they establish routine procedures for collection of all member co-payments and other third party liabilities. Consistent policies for Medicaid and MHSP covered services will make these collection procedures easier to implement. Certain co-payment and cost sharing arrangements can be beneficial to a person’s recovery (by increasing personal investment), particularly for those who have established independent living treatment and financial goals. However, because Medicaid

eligible individuals in Montana are so far below federal poverty levels, providers will not be able to fully collect these co-pays, and this is likely to result in a net decrease in their revenues.

Findings

- ▶ Co-payments and cost sharing arrangements are significantly different among MHSP and Medicaid Populations, yet not all the differences appear to be income-based.
- ▶ Those eligible for Medicaid, the disabled and the “poorest of the poor” have higher co-payments and cost sharing arrangements for practitioner services than do those with higher income levels.

Recommendations

- ▶ Montana should implement co-payment and cost-sharing arrangements to ensure that Medicaid clients are not charged co-payments that are greater than MHSP members.
- ▶ While we understand the “costs” of implementing these co-payment procedures for consumers and providers, the inconsistency between Medicaid and MHSP should be eliminated. We do not see compelling reasons why the Medicaid co-pays should be eliminated. We also believe that these policies should be adopted for children’s mental health services.

4. How can Montana make better use of current funding streams and funding levels for adults?

Montana’s mental health services funding for adults can benefit from attention in five areas: Ensuring adequate rates for services and providers; Reducing utilization at Montana State Hospital; Developing a plan to ensure compliance with CMS regulatory changes regarding Targeted Case Management and the Rehabilitation Option; maximizing the enrollment in the HCBS waiver; and maximizing Medicaid revenues for IHS facilities.

a) Rates

Adequate rates that provide for attractive salaries and working conditions are a necessary component of a strategy to increase the capacity of Montana’s mental health workforce. The primary weakness in rates for adults is in psychiatry services, where comparisons between states illustrate low rates in Montana. Comprehensive psychopharmacology and psychiatric consults are critical to maintain SDMI adults in the community, and competitive rates are needed to attract participating psychiatrists.

b) Montana State Hospital

Montana’s most significant opportunity to make better use of state funds is to reduce unnecessary use of Montana State Hospital. In order to reap savings from reductions in use, the reductions have to be sufficient to, first, reduce beds to the licensed level and maintain this level. Ultimately, the goal should be to reduce utilization and capacity enough to allow for a unit to be closed or converted to other uses. Details and our recommendations for MSH are included in Section III.

c) Targeted Case Management and Rehabilitation Option

The Centers for Medicare and Medicaid Services (CMS) issued interim rules for Targeted Case Management in December, 2007 (72 Fed. Reg. 68077-68093). Across the country, CMS saw significant growth in state spending and acted on the belief that states were abusing optional services to claim excessive amounts of federal funds. These rules threaten to create havoc in

Code	90862	90806	90847	90853	H2014, H2015, H2017	H2012	H2015, T1016
Description	Medication Mgmt.*	Individual Counseling	Family Psychotherapy	Group Psychotherapy	Psychosocial Rehabilitation	Day Treatment	Case Mgmt.
Min	\$39.80	\$55.91	\$33.54	\$11.74	\$1.93	\$11.68	\$7.48
Max	\$81.79	\$101.73	\$119.82	\$43.87	\$4.81	\$28.16	\$16.39
Average	\$56.62	\$71.65	\$75.51	\$23.13	\$3.14	\$18.83	\$13.06
Montana Rate	\$47.09	\$51.84	\$61.95	\$17.34	\$1.91	\$12.18	\$18.60
Rate Difference	20.24%	38.20%	21.89%	33.40%	64.61%	54.65%	
FY 2007 Expenditures	\$758,870	\$2,583,472	\$88,982	\$41,289	\$1,238,225	\$2,888,440	
Potential Impact	\$153,620	\$986,994	\$19,477	\$66,367	\$799,965	\$1,578,401	
States Compared	Alabama Idaho Minnesota Nevada New Mexico North Dakota Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Texas Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Texas Utah Wyoming	Alabama Arizona Arkansas Florida Louisiana Nevada New Mexico North Carolina Oklahoma Rhode Island	Alabama Florida Minnesota Nevada New Mexico	Minnesota Nevada New Mexico Oklahoma Utah
*Child and adult combined.							

many states because for the first time they have clearly defined targeted case management services and outlined billing and reimbursement requirements. For example, case management services must be billed in 15 minute units and there can be only one case manager per consumer. Montana's adult system spends over \$11M in case management services covered by the terms of this new rule.

In August, 2008 CMS also issued notices of proposed rulemaking on Coverage for Rehabilitative Services. These rules formalized the documentation and planning requirements for state agencies and provide guidance for the first time on the boundaries for rehabilitation services. The proposed rule clarifies the services definition and states that Medicaid Rehabilitative Services do not include services furnished by other programs that are focused on social or educational development goals. Examples of other programs include foster care, child welfare, education, child care, pre-vocational and vocational services, housing, parole and probation, juvenile justice, public guardianship and any other non-Medicaid services. Employees of the child welfare system are specifically excluded from case management billing. The new rules restrict the ability of states to provide inter-governmental transfers for these functions. Recognizing the scope of the changes for virtually every state, and in response to intense lobbying, Congress intervened and delayed the implementation of these regulations until April, 2009. It is not clear what will happen then.

Montana's adult and child mental health systems are in reasonably good shape compared to those of other states. Montana's billing procedures for Targeted Case Management are in 15 minute increments, consistent with new requirements. However in both the adult and child systems, TCM services are probably used more broadly in Montana than the new rules will allow. The new CMS rule restricts TCM services only to assessment, care planning, referral and linkage, and monitoring/follow-up on services received. Most case management staff also provide assistance in life skills coaching and para-professional counseling and supports. Others may provide transportation to assist clients in reaching their appointments. These services are generally critical to recovery and stabilizing families, but they are not allowable under the new TCM rules and may have to be billed under some other codes if they are to qualify for Medicaid. Montana's School Based Services are also reasonably safe from CMS recovery and compliance issues, at least at the system level, because they are billed in 15 minute increments. In addition, they are considered to be transfers outside of state government and are not subject to the same level of scrutiny by CMS auditors as transfers between state agencies would be.

Rehabilitation claims must be for services that are covered by an individual rehabilitation plan. Updates to the plan must document consumer progress in reaching their goals, and if no progress is noted the plan must be modified. This distinguishes between rehabilitation and habilitation services. Under the new rules rehabilitation services will also have to be unbundled (separated) from other services, and these services billed in 15 minute increments. This is a huge issue for many states that have created daily or monthly rates for programs that combine multiple service modalities. AMDD's definition of rehabilitation services in the approved state plan is exceedingly broad, historically allowing for wide latitude in defining eligible services. Under the current administration and until the policies of the incoming administration are clearer, AMDD should not take any steps that would open up the state plan for federal review of this definition. It would open up almost \$18M in services (Group Home and Foster Care, Rehabilitation, and PACT) to be redefined under Medicaid.

The breadth and scope of changes that might have to occur upon final enactment of these regulations is enormous across the country. Montana's exposure is generally low. The scope of exposure for the reinterpretation of TCM services to adults and children is not clear at this time, and greater clarity is needed from CMS on their final interpretations of rehabilitation option rules and what types of billing practices they will ultimately allow for services that don't lend themselves to 15 minute interval recording. Some of the exposure is at the state level for denial of services, and other elements of risk are for providers if compliance audits identify records that don't properly document the medical or rehabilitative necessity of services.

Recommendations

- ▶ DPHHS should review claiming and rate setting methods for AMDD and CMHB services to determine specific services being claimed under these two rules. This review should identify the overall volume and number of people served, and should also provide a sample of detailed claims by provider, to provide a basis for review of a sample of provider records for these claims.
- ▶ It is recommended that Montana assess exposure and the risk of lost revenue in each of these services and identify actions that will mitigate this risk. The state should also work with provider leadership to develop an action plan for changes should be implemented now and those that will need to occur once the direction of the new administration is clear.

- ▶ Montana should also actively monitor changes in federal rules and seek support from SAMHSA and NASMHD on best practices to minimize Medicaid revenue risk.
- ▶ Under the current administration and until the policies of the incoming administration are clearer, AMDD should not take any steps that would open up the state plan for federal review of the definition of rehabilitation services.

d) Home and Community Based Services Waiver - 1915(c).

In what seems to be one of only two home and community based waivers for adults with mental illness in the country (the other being a combined 1915(b) and 1915(c) in Piedmont County, NC), Montana’s waiver allows eligible adults to receive a range of rehabilitative services to support them in home and community settings. The objectives of the waiver program are rehabilitation and recovery. Individuals over 18 with SDMI are eligible for services if they meet nursing home level of care standards. A comprehensive array of services including case management, illness management and recovery, supported employment, personal assistance and health related services are available. Enrollment has been slow, with about 80 of an eventual 120 slots currently filled. We were not able to independently identify what factors have made enrollment slower than anticipated.

Recommendations

- ▶ AMDD should review its enrollment experience to identify whether there are any impediments that need to be addressed with waiver modifications or through parallel provider participation.
- ▶ It might also consider whether HCBS services could be used for some individuals currently served at the Montana Mental Health Nursing Care Center that might allow that program to be downsized.

e) Assist IHS to Maximize Medicaid Revenues.

While Montana is just a pass through for IHS Medicaid billing, the state can play a constructive role in assisting the tribes to maximize their Medicaid revenues. This releases more of their federal appropriation to pay for additional health services.

Recommendations

- ▶ Montana should continue its efforts to assist IHS to enroll eligible Indians in Medicaid.
- ▶ Continue joint efforts with IHS to increase Indian enrollment in Medicaid to maximize Medicaid reimbursement for IHS services and free federal IHS appropriations to serve more people
- ▶ Collaborate with IHS, if it wishes, to investigate whether additional services are eligible to be billed to Medicaid.

D. Financing of Mental Health Programs for All Ages

1. What funding streams will support needed new services?

Compared to other states, Montana has done an excellent job of utilizing Medicaid revenue, which funds 85% of the cost of community based services. Medicaid can be used to support the growth of peer services, which can provide a critical element of service expansion. The pending HIFA waiver offers an exceedingly important opportunity to expand on the availability of health coverage and maximize federal revenues for several key population groups including adults with

SDMI. At this time, the pursuit of a 1915i waiver is not recommended. The collaboration with the Department of Corrections offers the most promising avenue for braiding funding streams. Limited federal grant opportunities are available; those that seem most suitable include funding for homeless veterans, children affected by substance abuse, and training.

a) Comparison of Montana mental health revenues to those of other states

Overview. The three traditional sources of mental health service funding are Medicaid, state general fund for operation of state institutions and other mental health services, and the federal Mental Health Services Block Grant, which supports states and local governments to fund services in the community. Table IV-15 compares Montana’s revenue sources for mental health to sources used by other western states and the U.S. average. Today additional sources of revenue are available to fund mental health systems and the specific sources used vary greatly from state to state. The National Association of State Mental Health Program Directors (NASMHPD) annually surveys state mental health agencies (e.g., AMDD) to gauge revenue and spending patterns and document the changes in revenue sources year to year. Each state budgets differently for mental health services and relies on different funding sources to meet the needs of its citizenry. State criteria for Medicaid eligibility as well as for state programs vary significantly. We have chosen to present percentages rather than total spending in order to account for these differences.

State *	State General Fund	Medicaid (Shared S and FMA)	Medicare (F)	CMHS Block Grant (F)	Other Federal	Local	Other Health Insurance	Misc.	Total
Arizona	14%	80%	0%	1%	0%	0%	5%	0%	100%
Idaho	59%	11%	0%	6%	23%	0%	1%	0%	100%
Oregon	13%	86%	0%	1%	0%	0%	0%	0%	100%
Montana	14%	85%	0%	1%	0%	0%	0%	0%	100%
No. Dakota	38%	27%	0%	3%	17%	0%	0%	15%	100%
So. Dakota	38%	54%	0%	4%	4%	0%	0%	0%	100%
Wyoming	68%	29%	0%	2%	2%	0%	0%	0%	100%
U.S. Avg.	37%	50%	1.3%	1.9%	2.1%	1.6%	1.4%	3.8%	100%

S = State / F = Federal
 *States with reporting 0% may equal 0% or > 1% of total spending. Totals may not add to 100% due to rounding.
 Source: NASMHPD/NRI, Inc., *State Mental Health Authority Profiles Systems and Revenue and Expenditure Study 2005*, Alexandria, Virginia, www.nri-inc.org, based on per capita spending percent by fund.

Medicaid Funding. For many states, the Title XIX Medicaid program has become a larger and larger portion of overall revenue. From FY 2001 to FY 2005, total Medicaid expenditures grew by more than 10% at the federal level.²⁴ A majority of states’ mental health system revenues are made available from the states’ general funds or from their Medicaid programs (approximately 87% of all funds). Montana (14%) is considerably below the U.S. average (37%) for general fund as a percent of total funds and is considerably above (85%) the U.S. average (50%) for Medicaid

²⁴ National Association of State Mental Health Program Directors, *State Mental Health Profiles Systems and Revenue and Expenditure Study 2005*, Alexandria, Virginia, www.nri-inc.org.

(state match and FMAP) as a percent of total funds. The revenue mix in Arizona and Oregon is similar to that of Montana. In stark contrast, Montana’s neighbor to the south, Wyoming, funds its mental health programs primarily from the general fund (68%) and relies significantly less on the Medicaid program (29%).

Table IV-15 also suggests that some states are reaching beyond the general fund and Medicaid to other funding sources. The U.S. average of funding from these other sources, including Medicare, the CMHS Block Grant, other federal grants, local funds, other insurance, and miscellaneous funds, exceeds 12%. Montana has reported that only 1% of their mental health revenue is derived from revenue sources other than the general fund or Medicaid.

Findings

- ▶ In 2005, 85% of Montana’s revenue supporting mental health programs was derived from Medicaid, more than most Western states and the national average.
- ▶ In 2005, 14% of Montana’s revenue was derived from the state general fund, less than most Western states and the national average.
- ▶ Montana’s use of Medicaid to finance much of its mental health program reduces the financial burden on the state. However, the state share will increase as its match rate increases.

State	FY 2008 SAMSHA Grant Awards
Idaho	\$11.3 million
Montana	\$18.9 million
North Dakota	\$7.6 million
South Dakota	\$8.9 million
Wyoming	\$9.9 million

Source: SAMHSA

State	FY 2008 SAMSHA Grant Awards
Arizona	\$65.3 million
Colorado	\$59.5 million
Montana	\$18.9 million
New Mexico	\$27.4 million
Colorado	\$59.5 million

Source: SAMHSA

Substance Abuse and Mental Health Services Administration (SAMHSA) Grants. After Medicaid, SAMHSA provides the largest number of dollars to states, in the form of government formula and discretionary grants for the planning of mental health programs and the treatment of mental health conditions. Formula grants are primarily population based while discretionary grants are competitively awarded, based on a state’s program design that meets or exceeds the federal grant requirements. According to SAMHSA reports, in FY 2008, Montana state, local, and non-profit organizations received \$18.9 million in SAMHSA funding. Montana’s neighboring states received much less than Montana did.

Other Western states – for example, Arizona, Colorado and New Mexico -- received a significantly greater amount of SAMSHA grant funding in FY 2008. However, these states’ populations are much larger than Montana’s.

Findings

Montana received \$18.9 million in SAMSHA Grants in FY 2008, exceeding its four neighboring states by as much as 100%. This is an indication that Montana has done well in making use of SAMHSA resources.

b) Additional Medicaid Options

Peer Services. Montana has a generally comprehensive set of rehabilitative services covered under its Medicaid State Plan. Currently, however, Montana has a limited number of peer providers. Montana should be able to use Medicaid to receive federal match for additional peer service development. In most instances, states use several funding streams to finance their Consumer Operated Service Programs (COSP) and peer providers working in traditional mental health agencies. Most states that fund COSP or peer providers use state general revenue or Mental Health Block Grant funds to develop and sustain them. However, states have used Medicaid to finance peer services. In these states, Medicaid is used to reimburse peer providers in COSP and traditional mental health agencies. Some states that have pursued Medicaid reimbursement for peer providers have included certified peer specialists or peer practitioners in their Medicaid state plan as an allowable practitioner. Other states have included a peer support service as a covered Medicaid benefit.

While the specific number of peer providers is not known, most of the Mental Health Centers in Montana reported using peer providers. They render an array of services, including rehabilitative and support services. There are limited efforts to certify peers. In FY 2007, AMDD provided a grant to the Center for Mental Health Services in Great Falls to develop and implement a peer certification program.

In FY 2008 the AMDD provided funding for five half-time community liaison officer positions to be filled by peers. The liaisons will offer community support to individuals who have been discharged from Montana State Hospital. They will assist these individuals during the discharge process and re-integrate them into the community by identifying and helping them access needed services and resources in the community. In addition, AMDD recently funded four consumer drop-in centers and a virtual on-line drop-in center focused on providing a means for consumer communication and support for individuals who are not within reach of a physical drop-in setting.

While drop-in centers are not generally Medicaid reimbursable, positions such as the community liaison officers could be added to the Medicaid plan. As discussed previously, peer providers may be able to extend access to mental health supports in parts of the state with less access to licensed mental health professionals. By supporting initial peer services with state and block grant funds, the state is developing experience with them and will be better able to design appropriate and effective expansions in the future.

Recommendations

- ▶ Build on the peer certification program in Great Falls and extend this to several additional sites in frontier areas to help address provider shortages.
- ▶ Provide small seed grants to implement peer service models in rural and frontier areas and study the use and adequacy of Medicaid to support these services.
- ▶ Review and modify, if necessary, the state plan to allow Medicaid billing for peer specialists once the new administration's approach to State Plan Amendments is clear.

Health Insurance Flexibility and Accountability (HIFA) Waiver.

The State of Montana undertook an extensive planning process for several years to develop and submit an amendment to the state's existing Research and Demonstration (1115) Waiver. This waiver amendment seeks to expand eligibility for and coverage of health benefits and mental health benefits by Medicaid with a particular focus on uninsured adults with SDMI and young adults who were leaving state custody. The amended waiver was submitted as a part of a demonstration authorized by the Health Insurance Flexibility and Accountability Initiative (HIFA). It builds in the features and concept of HIFA by allowing Montana to modify its usual Medicaid benefits to provide coverage for an expansion population; in this case adults with SDMI up to 200% of poverty and youth ages 18 to 20 with SED who have been in the custody of the state and who require services to assist with their transition from custody. The savings from MHSP as a result of the added federal revenue will be reinvested in health benefits for people with SDMI and in providing services for uninsured youth with Serious Emotional Disturbance ages 18-20. There were no additional state costs anticipated from the HIFA waiver.

Should Montana's proposed HIFA waiver be granted, it would be a very significant benefit to Montana. This was discussed in our recommendations for expanding eligibility, but it would have a great benefit in financing as well by better leveraging current state investments for the covered population.

Recommendation

Montana should continue to pursue its HIFA waiver request, with the new administration, if necessary.

2. What funding sources are not being accessed by Montana and why?

We found that the Montana mental health system has explored and applied for virtually all the traditional revenue sources that support mental health services. A new source, created in the Deficit Reduction Act, should be reviewed by state officials and tracked over the next one or two years. Other federal revenue opportunities and potential foundation sources are reviewed but the further options for true programmatic support are quite limited.

a) Other Federal Revenue Opportunities

There are many grants that the State of Montana could apply for that, if received, would increase revenue available for mental health services. DMA Health Strategies has reviewed the *FY 2007 Montana Single Audit Report*, the Catalog of Federal Domestic Assistance (CFDA), and based on our own experiences in other states, we have compiled two tables that represent Montana Federal Funding Opportunities for Mental Health (please see Appendix J).

- ▶ *Appendix J, Table 1:* This table represents the list of federal funds in the CFDA that were expended by Montana state agencies for FY 2007 as published in the *FY 2007 Montana Single Audit Report* in the amount of \$622,567,444. This table and total spending does not represent the federal funds spent on mental health services and mental health administration in Montana; rather, it represents federal grants for which a) the primary purpose is specifically focused on mental health functions and services and the funds can be spent for services as well as administration of mental health programs (7 grants), or b) the funds may be spent on mental health services and functions or to support a person who needs mental health services, but the primary purpose is not solely focused on mental health (37 grants). If these grants are fully utilized for other allowable purposes,

then other uses would have to be reduced in order to free up funds for mental health services. Montana may wish to review how these funds are being used and consider whether they should be reallocated.

- ▶ *Appendix J, Table 2:* This table represents a list of federal funds that have **potential** to become a revenue source for mental health services in Montana. These grants were not reported in the *FY 2007 Montana Single Audit Report*, yet that does not mean that an individual, non-profit or local government organization has not received a particular grant (and in some cases, only an individual or tribal government is eligible, leaving the state as an ineligible applicant). Table 2 provides a brief description of the grant as well as the most recent range and average financial assistance made by the granting agency.

According to our review, Montana received 44 grants or federal funding agreements in FY 2007 that can be used for mental health services. DMA Health Strategies has identified an additional 28 grants or federal funding opportunities for individuals, local governments, state agencies (including educational institutions), non-profits, and tribal governments. Many of these grants have multiple purposes but include mental health as a specific target. The range of funding last reported in the CFDA ranges from a low of \$2,470 (CFDA 93.923) to a high of \$1,722,872 (CFDA 93.441).

b) Potential for Research, Foundation, Philanthropic Support

The National Institute for Mental Health is increasingly moving into the areas of supporting services intervention research and uses of pooled data. A recent program announcement (currently closed) was entitled “Use of Pooled State Administrative Data for Policy Relevant Mental Health Services Research”. While Montana’s pooled data for Medicaid and people with serious and disabling mental illnesses would be ideal for this program, the focus would be on research to inform policy not on the efforts to actually develop new policy. The state should not independently pursue these sources of support but should be willing to find partnerships with researchers in special studies that might benefit the system indirectly.

Few national or regional foundations provide sources of support for mental health programs. This issue was recognized in 2004 in a Health Affairs article by Brousseau et al entitled “Are Foundations Overlooking Mental Health?” Since that time the situation has become more serious. The McArthur Foundation has pulled back much support for programming and focused instead on national policy and research. The Robert Wood Johnson Foundation has also dropped its significant commitment to substance abuse services and the key staff person in mental health left the foundation. The California Endowment and Texas’ Hogg Foundation are notable in their continued strong support for mental health programs, though those foundations are restricted to funding efforts in their states.

For children’s mental health services, the Annie E. Casey Foundation (AECF) has been a strong supporter of mental health services in past years, but their support has also declined and been replaced by a focus on community change, child welfare, and juvenile justice. In fact AECF funds three Juvenile Detention Alternatives programs in Hill, Cascade and Missoula counties.

In short, there are currently few if any national foundations that would be able provide resources to fund state program innovations in mental health for adults or children.

Finding

In general, Montana has done an admirable job of finding, applying for and receiving federal grants for the support of its mental health system. While there are some areas of opportunity that we turned up in our review of the Catalog of Federal Domestic Assistance, these opportunities are focused on specific niches such as homeless veterans. PRA has identified some grants specifically relevant to corrections and mental health, but there is little scope for other federal or foundation funding.

Recommendations

- ▶ Continue excellent work in applying for and winning federal grants.
- ▶ Consider retaining a grant writer on staff or retainer as grant opportunities arise.
- ▶ Several current grants stand out from the list in Appendix J, Table 2 as deserving of close review. These include several different grants for homeless veterans (Reintegration, Grant and Per Diem, and Adult Day Health), services to enhance the safety of children affected by adult methamphetamine or other substance use (could focus on treatment for attachment disorder and trauma) and several of the training programs.
- ▶ In the area of criminal justice, the state should monitor SAMHSA for any new funding in its collaboration with Bureau of Justice Assistance (BJA) for Mental Health and Justice, as well as new funding through the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) in 2009.
- ▶ DPHHS should review the remaining grant program requirements and consider whether they are a good fit for Montana's goals, priorities, and resources.
- ▶ If DPHHS does not already do so, it should regularly review the Catalog of Federal Domestic Assistance and refer to the Federal agency websites for additional information on mental health granting opportunities. The on-line Catalog of Federal Domestic Assistance, <http://12.46.245.173/cfda/cfda.html>, provides access to the Federal Government's database of programs authorized by Congress and available to U.S. territories, federally recognized Indian tribes, non-for-profit organizations, state governments and their political subdivisions. While many of the grants contained in the CFDA do not entail financial match requirements, federal agencies may file notice with the Federal Register that implements a financial match (either direct or in-kind) for a particular grant cycle. Montana should be made aware of these changes when planning on applying for grants, paying particular attention to the Request for Application (RFA) and changes filed with the Federal Register.

c) Section 1915i.

The Deficit Reduction Act (DRA), P.L. 109-171, was passed by Congress and signed by the President on February 8, 2006. The law creates new options under the Medicaid program that allow states greater flexibility to furnish community-based services while Section 6086 of the DRA gives states the ability to provide home and community-based services to elderly individuals and people with disabilities without requiring a waiver or demonstrating cost neutrality generally required under a 1915b or 1115 Waiver. Services approved under this option are intended to help individuals delay or avoid institutional stays or other high cost out-of-home placements. The initiative has become known as a 1915i State Plan Amendment.

Section 6086 gives states, at their option, the opportunity to offer home and community-based services (HCBS) to elderly individuals and people with disabilities who have incomes up to 150% of the federal poverty level; it does not require a waiver or a demonstration of cost neutrality. A state need only amend its Medicaid plan to provide any of the services now covered under HCBS

waivers. Section 6086 expands on the populations not previously eligible for HCBS waivers; covered now are adults from ages 22 through 64 who have a mental disorder. This new program is referred to as a 1915i State Plan Amendment (SPA). Only Iowa has an approved 1915i SPA, under which it provides case management and habilitation services for adults with serious mental illness. At least four other states are looking closely at adopting a 1915i SPA.

Only one state, Iowa, has an approved 1915i program for individuals with mental illness. Iowa's new benefit will provide statewide HCBS case management services and habilitation services at home or in day treatment programs that can include such things as support in the workplace. Many other states have contemplated developing a 1915i. States see the 1915i as an opportunity to contain program expenditures by limiting the number of individuals that can participate. In addition, the 1915i also provides consumers with the opportunity to self direct their care—an opportunity that is not afforded for regular state plan services.

However, some states have expressed concerns regarding the 1915i program. One concern is the requirement that individuals must be Medicaid eligible and have incomes less than 150% of the FPL. States that have expanded their eligibility for children beyond 150% are particularly concerned that the 1915i will exclude many children that need these services. This would not be a concern for Montana.

Another concern is the limited benefit package available under a 1915i. Specifically, CMS will only allow a 1915i to cover the statutory services discussed above. States have indicated that the additional statutory services do not meet the needs of the target population that would be considered for the 1915i. For instance, many statutory services such as adult day health, personal care and homemaker services are not relevant for children. Other statutory services, such as rehabilitation, day treatment and clinic services can be included as regular state plan services and do not require 1915i. Another concern is the ability and the cost of developing an independent assessment and treatment planning process. A final concern is the ability to target the 1915i to the intended recipients. Unlike the 1915c Waiver, the eligibility criteria for the 1915i program cannot be based on specific diagnosis or illnesses.

The 1915i program may not be a useful tool for mental health services in Montana. While most youth and adults could meet the financial eligibility under a 1915i, it would not provide Montana with significant opportunities to expand service coverage or refinance services currently purchased through state only funds. For instance, Montana already covers many statutory services including rehabilitative services, case management, day treatment and services that may be considered as habilitative services such as adult mental health group home and adult foster care. In addition, the state would need to develop the necessary infrastructure (either by developing or building the capacity) for independent assessment and treatment plans. Even though the cost of these functions could be claimed under the Medicaid program it would be an additional cost to the state for operating a 1915i.

In addition, the submission of a 1915i application may “open up” the current state's Medicaid plan for rehabilitative services. CMS is currently reviewing many states' Medicaid rehabilitative services. Based on this review, CMS is requesting that certain services which do not appear to be rehabilitative (e.g. group home services) be removed from the plan. In addition, CMS is reviewing the states' rate setting methodology for rehabilitative services and is requiring that all rates for rehabilitative services be reimbursed in 15 minute increments. This is hugely problematic for services that are priced on a monthly or per diem basis.

Recommendations

The needs for use of the 1915i are minimal given the comprehensiveness of rehabilitation services, the HCBS Waiver for adults, and the PRTF Demonstration grant. Furthermore the risks of opening up the State Plan right now are very high for the next year or more. Montana should monitor the use of the 1915i by other states and make a decision later. One area many states are considering is services to developmentally disabled people (particularly youth) who also have mental illness.

3. What is needed to blend or braid funds to improve efficiency?

To achieve a truly integrated system, restructuring must take place to ensure that there is a full continuum of services available in sufficient supply to serve all who need care. The primary requirement, however, for braided funding initiatives is an accounting system that can track expenditures properly; optimally this should be an information system that can be deployed to caseworkers. In the ideal world, this information system, based upon the eligibility of the consumer for various services, should track service utilization and assign the costs to the appropriate revenue stream. Such systems remain a long way from the ideal.

On a statewide basis, services are available across much of the needed continuum. They are not available everywhere, however. There are also some notable gaps. Data reporting across state agencies is inconsistent and does not allow for data matching outside of DPHHS agencies. Within DPHHS they have done a remarkable job at this data matching. The lack of inter-agency data makes it difficult to do the tracking necessary to braid or blend funds across these sources. For instance, CMHB Medicaid includes all child welfare mental health placements and certain juvenile justice placements. Currently there is duplication between the numbers reported by CMHB and Juvenile Justice for residential treatment services because half of the figures reported by Juvenile Justice are Medicaid enrollees included in CMHB.

A comprehensive accounting and reporting system that includes all mental health services to children and adults would facilitate coordination and collaboration to make best use of all agency resources to minimize stays and ensure successful community transition. Many of the barriers to data sharing agreements are in the perception but not the reality of barriers created by confidentiality regulations.

Improved data sharing and continued interagency planning are essential for any braided funding effort. Effective accounting for expenditures according to eligibility categories of youth or adults is not possible without a good IT system. Restructuring IT systems and administrative functions in the adult and child mental health systems can create the needed reporting to effectively “braid” the funding and allow Montana to achieve the optimal outcome; the choice of the most appropriate service occurs without being constrained by the funding stream. Unfortunately, virtually all systems across the country are a long way from this ideal.

V. How Can Montana's Mental Health System Be Organized Differently to Deliver Services More Efficiently?

Montana has accomplished a great deal over the last decade and continues to move in very positive directions. We have, however, identified some organizational changes that could improve service delivery. Greater integration for children's mental health services and co-location of CMHB with AMDD would be desirable. Other issues that should be addressed include data sharing, improved care coordination strategies and improvements in accountability and performance.

We have also developed recommendations for major system restructuring. We do not offer these recommendations lightly, but achieving some of the goals outlined in the President's New Freedom Commission requires that they be undertaken. In the system envisioned under the New Freedom Commission, Montanans would all understand that mental health is central to good health. Consumers would expect that services would be responsive to their needs and truly consumer driven. Mental health screening and early intervention would be common. Services would be evidence based and oriented toward recovery and resiliency. Disparities would be eliminated. To achieve these goals, many stakeholders argue, requires a fundamentally different way of doing business. It requires some form of Medicaid waiver for the needed flexibility and coordination, and it requires a reorganization of some aspects of DPHHS. While there are several different organizational approaches possible, we recommend that the state plan for and establish a quasi-public entity to coordinate care.

A. Approaches to Improving the Current Organization of Mental Health Service Delivery

Organizational changes in Montana's state agencies can address some of the issues we identified in our analysis. With multiple agencies involved in delivering mental health services, improved data sharing, local planning, improved care coordination and increased accountability are needed. Specifically:

1. Issue: Sharing Data & Information

State agencies routinely experience barriers to sharing information that occur because many of the information systems are separate, and privacy rules create both real and perceived barriers to data sharing. Even when the technical capacity exists and there is permission to share data, information is not routinely shared because of organizational boundaries and the lack of time. Data sharing is essential for continuity of care, transition planning and effective care coordination.

Currently information sharing among state agencies is limited. There is a lack of systematic reporting between state agencies and programs. For example, there were needs for data sharing identified for the following topics:

- ▶ Linking primary care with mental health treatment.
- ▶ Services to youth who are in transition to adulthood.
- ▶ Utilization of Medicaid specialty resources that can meet needs of foster children.

- ▶ Coordination of Medicaid services with other case services.
- ▶ Coordination of Home and Community Based Services Waiver slots.
- ▶ Development of vocational services and coordination of cases for people with serious mental illnesses.
- ▶ Jail diversion options and coordination.
- ▶ Mental health conditions of youth and adults entering and leaving correctional facilities.
- ▶ Development of affordable housing options.
- ▶ Coordination of housing and support services.

Findings. Our specific findings included the following:

- ▶ The Medicaid data system reports on AMDD, CMHSB and Other State Plan mental health services, but there is no systematic delivery of cross-division reports.
- ▶ As identified in Chapter III, current reporting doesn't clearly distinguish utilization and expenses for the high need SED and SDMI populations from those with less intensive mental health needs.
- ▶ Standard CHIP reports do not adequately address mental health services provided, and basic CHIP and Enhanced CHIP benefits for youth with SED are tracked with different data systems.
- ▶ DPHHS can un-duplicate mental health clients across all its mental health purchasing Divisions; however this is not done routinely and it has not been done for CHIP services.
- ▶ The Corrections system collects only limited information on prisoners' mental health needs.
- ▶ There are few systematic processes for sharing relevant clinical information between the judicial system and mental health providers.

Recommendations

- ▶ Develop standard reporting formats to review mental health service provision and expenditures across all DPHHS divisions on a periodic basis – at least every two years to inform the budget and planning process.
- ▶ CMHB should develop a report that counts the unduplicated number of children receiving services that are restricted to children with SED so it can better assess this group's access to services statewide, and on a regional and local basis.
- ▶ DPHHS and AMDD should further analyze patterns of service use in AMDD Medicaid and other State Plan Medicaid to better understand the range of mental health needs being met by AMDD's network of specialty services for SDMI, and those being met within the broader medical system. Based on what is learned, DPHHS and AMDD should periodically generate reports that measure access and utilization of individuals with SDMI, as well as reports that measure access and utilization for adults with less serious mental health needs. These data can inform efforts to improve access for adults with SDMI, better integrate primary and mental health care, and design disease management approaches.
- ▶ Design standard reports on CHIP services that adequately cover the funding of mental health services. Add this to the vendors' reporting requirements. Develop parallel routines for state data on the Enhanced CHIP SED benefit.
- ▶ Review laws governing information sharing by CMHCs, police, jails and the judicial system, and ensure that they are written to allow sharing of relevant information about the mental health needs of an individual in police or judicial custody.
- ▶ Develop and authorize routine data sharing protocols between DPHHS Divisions if needed and between DPHHS and DOC that meet HIPAA and other legal requirements. This may require legislation.

- ▶ Train CMHCs, police, jails and staff of the judicial system on legal protocols for information sharing.
- ▶ Develop plans over the next five years to move toward a more integrated and comprehensive information system that not only tracks consumers, utilization and cost but that also allows for reporting on clinical outcomes and other quality measures.

2. Care coordination

Multiple state agencies are involved in delivering services to adults and children with mental health problems. Survey respondents identified poor service coordination as a significant problem, and interviews confirmed this. DPHHS has developed a multi-agency review process for extraordinary cases that brings DPHHS divisions together to manage high cost cases involving services from more than one division. This is a promising approach that needs further expansion and dedicated staff support.

Other findings include:

- ▶ KMAs serve a very small number of youth and families (120 cases are currently enrolled). They have been difficult to start in some areas. It has not yet been determined how they will be sustained over time. Their relationship to LACs and SAAs is not clear, but they provide an important voice for children’s service needs.
- ▶ KMAs are developing family leadership and attempting to implement wraparound planning. This approach to local planning and the development of wraparound service planning is important. However:
 - Funding for flexible services is currently very limited, and yet it appears that there are vehicles such as the System of Care Account that enable the Department to flexibly utilize the state portion of Medicaid savings; and
 - Funds to sustain the KMA infrastructure are not secured.
- ▶ The current KMA model is resource intensive for a small number of cases. The scarce resource is not necessarily funding, but rather people’s time. Planning meetings and follow-up place huge demands on the schedules of many of the same people in case after case.
- ▶ On the adult side, the expanding network of providers for MHSP services will likely require additional attention to case coordination between them.
- ▶ Both MSH and community providers have noted that discharge planning for MSH can be 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.

Recommendations

Several of the most important recommendations for improving the coordination of care are summarized below. Many of these have been touched on in previous sections of the report.

- ▶ Strengthen linkages between police, jails, prisons and crisis centers.
 - Develop a pilot for mental health screening for individuals entering jails or prison, and develop processes for collecting and sharing results across the treatment and judicial system. Use the data as the basis for a needs assessment of individuals who need services while in custody, and ensure that pre-release planning incorporates referral to and monitors access to services where needed. A small seed grant may be all that is needed to spark this effort with prison officials and pre-release staff.

- ▶ Consider opportunities to coordinate and unify management of CHIP and Medicaid mental health, at least from a reporting perspective.
- ▶ Expand the scope and improve the efficiency and effectiveness of KMAs or related entities:
 - Make the current KMA process more efficient by increasing support staffing and other resources.
 - Implement a scaled back KMA system on a statewide basis, particularly for rural areas. Consider a clinical home approach with strong family supports and a regional pool of flex funds that are accessed by approved clinical home providers.
 - DPHHS should find methods to cover KMA case service planning activities as administrative expenses under Medicaid. This can be accomplished through the 1115 or 1915(b) waivers.
 - Finance continued training in systems of care and measuring fidelity to systems of care principles.
 - Provide state flex funding through the System of Care account authorized by HB 98 to replace federal grant funds when the grant terminates. Under a waiver option some of these flexible funds could be covered through Medicaid savings; however most of the funds would have to be state or federal funds. Allocate a meaningful set of funds for each KMA to use. These could be allocated under the current authority given DPHHS and other agencies through the System of Care Account. A statewide total of at least \$250,000 may be sufficient to create meaningful regional pools of flex funds. As regions and local provider become better trained these funds could be expanded and more authority delegated to the provider level.
- ▶ Expand the DPHHS Extraordinary Case Review initiative and consider whether a more extensive chronic disease management approach should be implemented that focuses on mental illness. Review evidence on available models to identify those most likely to be both effective and efficient.
 - Provide pharmacy consultation and outreach for certain diagnostic groups.
 - Implement statewide telephonic support for individuals not receiving case management but needing education, support and referral and follow up.
 - Ensure that existing case managers coordinate closely with the primary care providers of their clients

3. Opportunities for Improving Accountability

Survey respondents suggested system priorities that included improving quality, measuring and monitoring client outcomes and implementing evidence based practices. In fact, measuring outcomes of importance to consumers and to systems is an important form of monitoring and provides a basis for quality improvement. However, regulations governing the Medicaid fee for service system limit the ability to establish direct incentives for accountability and performance. Federal funds cannot be used to provide direct financial incentives to providers other than certain hospitals. Montana's limited provider network reduces competition that could foster performance and quality improvement.

AMDD's Recovery Markers Project is collecting data from case managers on the progress achieved by their consumers in recovery. This reinforces an emphasis on recovery principles in care by actively measuring relevant aspects of recovery. This is a national best practice. The Legislature should support its further expansion. The web based system that AMDD has set up for reporting recovery markers may be useful for children's mental health outcomes reporting

also. The system also has the capabilities of providing pharmacy claims and other utilization data to case managers for them to review with their clients.

In addition, individual providers are initiating innovative service and quality improvement initiatives of their own. However, the state currently has had little focus on changing important aspects of provider performance, such as:

- ▶ Discharge planning for MSH
- ▶ Implementing person centered or wraparound planning
- ▶ Adoption of Evidence Based Practices

Recently, health systems and a limited number of mental health care purchasers have been seeking to improve the quality of care offered to their recipients or target population through pay for performance strategies. Pay for performance strategies also seek to control costs by reducing practice errors and/or inappropriate utilization. The most common approach to pay for performance is to set a single benchmark level of performance that represents “good” quality and pay a bonus to providers that meet or exceed this threshold.

Existing pay for performance initiatives are sponsored by government purchasers such as Medicare, Medicaid and some state mental health authorities, as well as private employers, coalitions of employers, and health plans. A recent study suggested that the majority of pay for performance programs generally target primary care physicians, specialists and hospitals. In addition, CMS has recently begun designing a nursing home pay for performance demonstration project. The Delaware Department of Health and Social Services has developed a pay for performance strategy to improve access and retention for individuals seeking addiction treatment. In addition, several state mental health authorities have developed incentive strategies to reduce the use of state inpatient hospital services. These strategies are often structured to allow counties or providers to keep all or a portion of funds that remain unexpended due to lower inpatient use for individuals who reside in their geographic area.

A state’s option to implement pay performance in its Medicaid program can vary greatly. These options are dependent on how a State administers its Medicaid and State Children’s Health Insurance Programs. If the pay for performance program is a part of a fee-for-service delivery system, a state may include its initiative in its State Plan. Paying an enhanced rate for the use of evidence based practices is one example of an approach the state could take. The state can use its Medicaid disproportionate share hospital payments²⁵ for incentive payments to hospitals, or state general funds for incentive payments to other types of providers. Other states have established their pay for performance initiatives through their managed care contracts, in which the managed care organizations may use a portion of their capitated payments for incentive payments.

Public purchasers of mental health care services have been slow to develop pay for performance plans. Traditionally, these purchasers have not developed clear or consistent outcome performance measures, which is true of public sector contracts in general. In addition, the information systems at both the purchaser and provider level may not have the capability to accurately track outcomes.

²⁵ States receive disproportionate share payments based on a pre-set formula so that they can appropriately reimburse hospitals that serve a disproportionate number of low-income patients with special needs.

AMDD contracts currently contain some language that would allow the Division to either pay for performance or withhold payments if the “contractor is failing to perform its duties and responsibilities in accordance with the terms of the contract”. The AMDD contracts also allow the Division to terminate a contract if a provider fails to perform the services or any requirement of the contract.

Most of the AMDD contracts do not specify any outcome expectations, with the exception of the contract for outreach services related to the federal Projects for Assistance in Transition from Homelessness (PATH). The PATH contract requires agencies to submit outcome data in several areas and tie payment to reporting outcomes, yet without defining any outcome threshold. The areas for which PATH providers must submit outcome information include primarily the change in the individual’s stable housing and work status. The federal Substance Abuse and Mental Health Administration (SAMHSA) requires states to provide this information for the PATH program. However, only MHSP services are provided under contracts. To participate in AMDD’s fee for service Medicaid programs, providers simply have to meet requirements to be enrolled as a Medicaid provider.

Currently, the Children’s Mental Health Services Bureau is developing one example of a pay for performance approach. It is developing a new two-week assessment in a residential treatment program designed to stabilize youths, evaluate them and prepare a plan for them to return to the community. This service is paid at a higher rate than the program’s regular rate, and the program gets the extra payment only if the child actually returns to the community within the two-week period, and is able to be maintained in the community for at least 30 days. In this case, the provider gets a base payment of its regular daily rate, and the additional payment is made when the performance conditions have been met. This establishes an incentive for the residential provider to complete the assessment within the two weeks allowed and develop a realistic and practical plan for community care. It will be important for CMHB to closely monitor the effort as the payments may need to be adjusted to be more effective.

The state might also consider developing a pay for performance initiative that seeks in some way to reduce the utilization of Montana State Hospital. Providers, such as crisis stabilization providers operating under the 72 hour presumptive eligibility program, could receive an enhanced payment to divert certain types of consumers or facilitate a more timely discharge of individuals from MSH after their admission. Another example might be to increase the rate of annual primary care visits for Medicaid eligible individuals with severe disabling mental illness. Providers could receive a quarterly payment if they met or exceeded thresholds set by the state. DPHHS may use Medicaid disproportionate share funds for payments made to hospitals serving individuals with low income or enrolled in Medicaid. Payments for other individuals could be made using state or other federal funds.

Since pay for performance would be a new concept to purchasers and providers, the Department might consider phasing in such an initiative. For instance, the Department may want to pilot test the payment strategy in a limited geographic area, or may want to begin with voluntary participation of providers.

DPHHS may want to identify one or two simple benchmarks and raise the standards over time, or begin with rewarding data collection and reporting and introduce performance incentives over time. Establishing aggressive performance measures and targets make little sense, however, if the state or the providers have poor information and tracking systems.

Recommendations

- ▶ Review and develop plans for pay for performance options in Medicaid and begin a planning process to implement them. This process will need to include key purchaser, consumer and ultimately provider stakeholders, and content experts in performance measurement and improvement. Develop a strategy for a small pilot.
- ▶ Designate a small pool of state general funds to be used for a pilot of performance contracting. Establish incentives for performance and/or tie them to attaining desirable client outcomes. Implement, measure (monthly or quarterly) and revise as needed over the next two or more years.
- ▶ Implement other quality improvement projects to create action on important performance improvement areas. These should be voluntary and intended to promote professional development as well as performance improvement. They should follow the Quality Improvement (QI) models proposed by the Network for Improvement of Addiction Treatment or the Institute for Healthcare Improvement.
- ▶ Develop provider reporting that includes key performance measures of client outcomes and can inform quality improvement with specific and periodic measures.
- ▶ Develop more specific contract and licensing service standards and performance requirements, and monitor provider performance more closely, with regular performance based contract reporting measures such as length of stay, re-admission rates, etc.

B. Options for Major System Reorganization

DMA has identified two major options for organizing the administration of public mental health services differently. One involves considering consolidation of many functions for CMHB, CHIP and AMDD services. The other involves the development of Medicaid waiver options for better coordination of care.

1. Options for Coordination among CMHB, CHIP and AMDD

Currently, AMDD is its own Division, with responsibility for adult mental health and substance abuse services. CMHB is a bureau within the Health Resources Division, and a sister to the Health Care Resources Bureau that includes CHIP. CHIP and CMHB frequently collaborate to assist in administering CHIP mental health services. For the implementation of the CHIP Extended Benefit, CHIP does not have mental health professionals on its staff, so CMHB clinical staff are available to CHIP for consultation when significant clinical issues arise. Children's Medicaid and the CHIP Basic and Extended Benefit Plan for children with SED are administered through three separate processes and personnel: CMHB, Blue Cross Blue Shield and the Health Care Resources Bureau that includes CHIP.

With similar benefits and serving some of the same families, there would be advantages to consolidating certain administrative aspects of CHIP and children's Medicaid mental health services. This could be accomplished by assigning responsibility for oversight of CHIP mental health directly to CMHB or making significant improvements in reporting that break out mental health utilization and spending. This would allow for greater attention to CHIP mental health services. Because children's mental health is a relatively small part of total health care, mental health gets relatively little attention in the general health world. This is part of the reason why the CHIP Extended benefit is administered by HRD staff, rather than Blue Cross. CMHB

experience with managing high cost services and experience with local systems of care can be helpful for the care of children receiving the Extended CHIP benefit.

In the past, adult and children's mental health were managed by the same Division. Operating as separate entities and in different locations cannot help but increase the division between child and adult services. While our analysis has shown that there are significant differences between the child and the adult systems in financing, scope of eligibility and provider networks, it is important for children to make an effective transition to the adult system at 18, and for both systems to work collaboratively to serve families that have both children and adults with mental health problems. A number of stakeholders identified the transition into the adult system as a problematic and difficult transition that should be improved. Shared administrative functions between AMDD and CMHB could lead to some savings and both divisions might end up functioning better. Efficiencies and improvements could be realized in consolidated regional planning, contracting and quality improvement. This could create savings and benefit both the child and adult entities. At the same time it is important that children's services not find themselves subsumed under the "weight" of the adult system, something that many state children's mental health agencies experience.

We considered the option of merging Children's Mental Health Bureau and AMDD again, which might increase efficiencies in certain administrative functions and facilitate the ability of both groups of staff to better plan for services to transition age youth. However, a disadvantage is that it would move CMHB away from CHIP which covers a large number of youth. Some of the advantages of a merger of CMHB and AMDD could be achieved simply by co-locating the staff and leadership, increasing the opportunity for more frequent communication, requiring joint local planning frameworks and approaches and creating a cross-agency effort to identify and better serve shared families. The creation of the CCO, even with separate Child and Adult divisions would accomplish these same objectives.

Recommendations

The state can achieve improvements by reorganizing administration of its mental health agencies to consolidate certain functions

- ▶ Give CMHB more authority over the mental health benefit and the coordination of care within CHIP and for the CHIP extended benefit.
- ▶ Co-locate AMDD and CMHB management staff and share certain administrative functions. These shared functions should include purchasing, network management, revenue and TPL functions, among other functions. This should not be a merger.
- ▶ Give CMHB more authority over the mental health benefit and the coordination of care within CHIP and for the CHIP extended benefit.
- ▶ Co-locate management staff and share administrative functions between AMDD and CMHB. These shared functions should include purchasing, network management, revenue and TPL functions, among other functions.

2. Care Coordination through Section 1915b Managed Care/Freedom of Choice and 1115 Research and Demonstration Waivers

The Center for Medicare and Medicaid Services (CMS) allows states to develop and operate waivers to implement delivery systems designed to better coordinate care, control costs, and limit individuals' choice of providers under Medicaid. States may request Section 1915b Waiver authority to operate programs that impact the delivery system for some or all of the individuals

eligible for Medicaid in a state. Section 1915(b) Waiver programs may be implemented in regions; they do not have to be operated statewide. Recipient eligibility must be consistent with the approved state plan. States also have the option to use savings achieved by using managed care to provide additional services to Medicaid beneficiaries not typically provided under the state plan through the 1915(b)(3) Waiver. Some 1915(b) waivers are voluntary programs and some have the option for fee-for-service or managed care. There must be assurance that the Medicaid recipient has a choice of at least two providers.

There are nearly 100 1915b Waivers in operation with one or more in most states. Under a 1915b authority, States are permitted to waive “state wideness”, comparability of services, and freedom of choice. There are four types of 1915b Freedom of Choice Waivers:

- ▶ 1915(b) (1) Mandates Medicaid enrollment into managed care.
- ▶ 1915(b)(2) Utilizes a "central broker".
- ▶ 1915(b)(3) Uses cost savings to provide additional services.
- ▶ 1915(b)(4) Limits the number of providers for services.

States that have implemented 1915b Waivers have generally had two sometimes competing goals: increasing the effectiveness of services, and controlling expenditures for behavioral health services. In their Waiver application, states must provide information to CMS on their goals to maintain or increase access to services, while maintaining or reducing costs. They must also outline their strategies to achieve these goals. The solution to this apparent conflict lies in increasing access to outpatient and support services while reducing the length of stay and use of high cost inpatient, residential and other costly services.

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas that show policy merit including all the options possible under the more limited 1915(b) waiver authority. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems. There are two types of Medicaid authority that may be requested under Section 1115:

- ▶ Section 1115(a)(1) – allows the Secretary to waive provisions of section 1902 to operate demonstration programs, and
- ▶ Section 1115(a)(2) – allows the Secretary to provide Federal Medicaid Assistance Percentage (FMAP) for costs that otherwise cannot be matched under Section 1903.

The differences between the 1915b and 1115 Waivers are significant. States have much more flexibility under a 1115 Waiver. The 1915b can only waive provisions of Section 1902 of the Social Security Act, including freedom of choice (1902(a)(23)), State wideness (1902(a)(1)), and comparability of services (1902(a)(10)). Provisions of Title XIX other than 1902 provisions may not be waived. The 1115 Waiver can waive other sections of the Act. Both the 1915b and 1115 Waiver would allow the state to reinvest savings into the mental health system. However, under capitation rate²⁶ setting rules for the 1915b, savings can only be reinvested in services

²⁶ Note that “capitation rates” refer to rates paid to a health insuring organization or similar entity to provide coverage for a set of defined services. In Medicaid, these are generally expressed as per member per month rates. As with personal health or other types of insurance, they are paid for everyone who is eligible in the rate category regardless of whether they need services or of

that are part of the current state plan in order to be included in future capitation rates. This is an important distinction, while savings can be used to pay for services not typically provided under the state plan, this usage will lead to lower capitation rates in future years of the 1915b Waiver.

States that have 1915b or 1115 Waivers often contract with a Prepaid Inpatient Health Plan (PIHP) or a Prepaid Ambulatory Health Plan (PAHP) to implement and administer their managed care programs. A PIHP is an entity that provides, arranges for or otherwise has responsibility for the provision of any inpatient or institutional services for its enrollees. A PAHP does not provide or arrange for (and is not otherwise responsible for) the provision of any inpatient hospital or institutional services for its enrollees. PIHPs and PAHPs often receive pre-paid capitation payments or other payment arrangements to provide services to enrollees. PIHPs and PAHPs are generally private companies (profit and non-profit). However, some PIHPs and PAHPs are administered by state or local governments (e.g. Hawaii Child and Adolescent Mental Health Division and Philadelphia County).

From 1997 to 1999 the State of Montana used the 1915b Waiver authority for mental health services. The state no longer operates the mental health 1915b Waiver program. A number of factors led to the demise of the program, including but not limited to the following: multiple changes in ownership of the contractor, a poorly constructed contract which left far too much discretion to the contractor, weak contract oversight initially, provider and consumer resistance and lack of trust, and perhaps most importantly, rates that were set too low as a result of the state pulling funding from the program.

Montana does, however, currently perform certain “managed care functions” through its contract with First Health. Specifically, First Health provides Medicaid utilization review services for the State of Montana. This includes prior authorization, continued stay and retrospective review of the medical necessity of the following services:

- ▶ Adult and Children’s Outpatient Therapy Services
- ▶ Adult Acute Inpatient Services – Prior Authorization and Continued Stay for Out of State services only. (In state services are reimbursed with Diagnostic Related Groups)
- ▶ Adult Acute State Hospital Services for individuals under 21 and 65 years of age or older.
- ▶ Adult Intensive Outpatient services
- ▶ Adult Crisis Stabilization
- ▶ Youth Residential Treatment
- ▶ Therapeutic Home Visits
- ▶ Therapeutic Living Services
- ▶ Targeted Youth Case Management Services

In addition to the prior authorization and continuing stay review services, First Health also provides regional care coordination services for youth receiving Mental Health services under Medicaid. These staff facilitate treatment planning, communicate with the various parties involved in the care, and they provide liaison to First Health clinical reviewers, physicians and state and provider case managers.

the level of need. Rate categories can be established to break the population into subsets and to control the risk. For instance in Medicaid this is often done in categories for individuals eligible under Temporary Assistance for Needy Families (TANF) rules; aged, blind or disabled individuals (SSI) and perhaps children in state custody.

Finally, First Health provides retrospective review services of selected providers, reviewing medical records and documentation for a range of Medicaid services provided by a sample of providers selected according to criteria determined by DPHHS.

Nationwide, Montana has one of only two 1915c Home and Community Based Services Waivers for adults covering a planned 120 people who would otherwise be receiving nursing home level of care. The waiver is unique and unusually broad in eligibility, covering a range of rehabilitative services, including respite and adult foster care among other services. In addition, Montana applied for and received a CMS PRTF Demonstration grant that serves up to 100 children per year. These are examples of the state's creativity and forward looking approach.

The sections below summarize our observations and recommendations on Organizational Structure and Reimbursement.

a) Organizational Structure.

Over the year and a half prior to this study, beginning in August 2006, a number of state officials and other interested parties met on at least four occasions to develop a set of recommendations for the state to consider in restructuring its operations to achieve the goals outlined by the President's New Freedom Commission (NFC). The major goals in this report were that:

- ▶ American understand that mental health is essential to overall health
- ▶ Mental health care is consumer and family driven
- ▶ Disparities in mental health services are eliminated
- ▶ Early mental health screening, assessment and referral to services are common practice
- ▶ Excellent mental health care is delivered and research is accelerated
- ▶ Technology is used to access mental health care and information

There was widespread agreement on these goals and a strong feeling that system reorganization was needed to accomplish some of the major goals of the NFC. Three different approaches were suggested. These include:

- ▶ Contracting with a specialized Managed Behavioral Healthcare Organization (MBHO) to provide managed care functions. This would be similar in some ways to the state's previous managed care initiative and its contract with Magellan Health Services. It could include features such as braided funding similar to the work in New Mexico²⁷. Contract terms and conditions will need to be quite specific and detailed for it to address the likely fears and concerns of many other stakeholders based on Montana's earlier experience with managed mental health care.
- ▶ Developing a quasi-public Coordinated Care Organization (CCO) to administer a managed care program under a 1915b or 1115 Waiver authority. The CCO has been proposed as a quasi-public authority under the auspices of state government and would have a Board of Directors comprised of leadership from the various state agencies and stakeholders including consumers and providers. The CCO would hire a chief executive officer and authorize spending levels for the CEO, staff and infrastructure. The CCO would be

²⁷ Braided funding is an approach that a number of states have used to try to provide greater integration of services for consumers. New Mexico is the best example of the work nationally. In this approach, states use an intermediary organization (a managed care organization, a provider or the state or county itself) to provide open access to services across several different federal and state funding streams. The goal is to create a system where the restrictions and limits on a service associated with a funding stream are hidden from the consumer but the unique eligibility and reporting requirements are retained for reporting and accounting purposes.

responsible for purchasing and overseeing all mental health services. The CCO could be paid on a risk based, partially risk based or administrative fee contract. Under a risk arrangement, savings generated by the CCO would be reinvested in mental health services.

- ▶ Using existing or reorganized state agencies for the management of care. This approach is best suited to incremental improvements and retains many of the negative features of the current system, including annual financing, spending restrictions, hiring restrictions, etc. Under effective leadership and with a clear mandate, public agencies can transform themselves. Unfortunately leadership and mandates in the public sector are too often subject to changes in administrations and changing priorities to be effective in sustaining systems transformation over time.

Table V-1 summarizes potential advantages and disadvantages of different managed care organization structures.

**Table V-1
Potential Managed Care Organizational Structures: Advantages and Disadvantages**

Org. Structure	Advantages	Disadvantages
Private Contractor	<ul style="list-style-type: none"> • National managed care companies would compete for the services • May allow more rapid start up from organizations with experience in the field • Larger national firms can potentially bring more talented employees to Montana • Highly flexible in compensating employees • Profit motive spurs change • Potential to braid funds more easily and defragment the system 	<ul style="list-style-type: none"> • Increased administrative costs and profit • Procurement process is burdensome • Risk of appeal and litigation if process not run carefully • Still requires extensive oversight and public administrative support in agencies • May reduce access to services as less funding would likely be available for services • Easy to become politically charged • Montana history with managed care is traumatic • Changes the nature of the relationships with providers – more difficult to make the goal be about public benefit • Difficulty for the Legislature in directly impacting managed care decisions
Quasi-Public Authority or Non-Profit Corporation	<ul style="list-style-type: none"> • May offset concerns regarding previous managed care experience—it may be viewed as closer aligned with the mission of state agencies • Higher level of initial perceived public trust • Profit is reinvested back into system • Lower level of oversight needed for a “public” CCO • Several positive examples of public or quasi-public systems managing care (Philadelphia, Wraparound Milwaukee, Piedmont Behavioral Health (NC), and CAMHD (Hawaii)) • Can potentially by-pass public hiring and procurement rules to reduce costs • Would allow for more flexible financing and retained savings • Could have bonding authority to finance housing for mentally ill • Could develop a risk pool • Potential to braid funds more easily and defragment the system • “Authority” could contract for the technical expertise it needs. 	<ul style="list-style-type: none"> • Enabling legislation is required and negotiating the details will result in suboptimal decisions on many items • Separate bonding and financial authority is risky and requires separate oversight structures • Over time public “authorities” can become highly political and not necessarily more productive than state agencies. • Less legislative and executive branch control though some of this can be worked out in enabling legislation or through governance • Transition to quasi-public entity would be more difficult than people believe, though not more difficult than a private contractor • Difficulty in getting federal approval for some initiatives and the quasi-public nature of this may raise some questions • Requires legislative authority to retain revenue
Use Existing or Reorganized Public Agencies	<ul style="list-style-type: none"> • Marginal increases in costs • Known processes for administration • May be easier to create incremental change • Can be effective if there is a strong public mandate for change • Strong leadership is needed in any of the scenarios. Public agencies can be just as effective when the leadership is there, e.g. Goal 189 success and recent successes in reducing out of state placements for youth • Reorganizing staff within existing public agencies may help to initiate major change 	<ul style="list-style-type: none"> • Budgeting and hiring processes are restrictive • Little flexibility in compensation • Can be harder to accomplish transformative objectives • Political distractions • Status quo is often the path of least resistance • More difficult (though not impossible) to roll over savings

Any managed care plan in Medicaid requires a waiver. Whether delivered through a public or quasi-public agency or a contracted BHO, the waiver provides states with tools that are not available otherwise to control mental health care costs, coordinate care, and control utilization. These tools include the ability to implement:

- ▶ Selective contracting in the provider network rather than any willing and qualified provider;
- ▶ Assignment of recipients to providers for the coordination of care; and
- ▶ Capitated rate setting methods.

In addition, the use of an 1115 or 1915(b) waivers allow states to structure contracts with organizations to jointly administer Medicaid and state general funds. In Montana this would permit the consolidation of a number of administrative resources from several divisions that purchase and manage these services. The managed care entity can achieve this in many ways because it is a third party with a focus on implementation and execution. In our opinion, particularly in mental health services, the public purchaser should retain the responsibility of planning and responding to the public, other agencies and elected officials.

A risk based contract also provides an opportunity to obtain additional FMAP for administrative functions that may be currently funded with state general funds or that are reimbursed by Medicaid at the administrative match rate of 50%. Our review did not uncover any significant areas missing from the state's allocation and administrative cost plan for Medicaid. However, the added federal matching rate that would result from including administrative functions as a part of a capitation rate compared to the current administrative rate could conservatively amount to \$300,000 to \$400,000 in additional federal revenue. Calculation of this is as follows: The difference between the capitation rate (matched at 68%) compared to the current administrative rate (50% for most functions; higher for some functions such as IT and Quality which are matched at 90% and 75% respectively) is approximately 18%. Multiplying this 18% difference in FMAP rate times an estimated \$2M in eligible administrative costs equals roughly \$300K -\$400K. This estimate may understate the administrative costs for both adult and child divisions.

The CCO model assumes that a quasi-public organization would have many of the reimbursement and financing related advantages of a contractor, but that public trust would be higher, transition to the new entity would be easier and a lesser degree of oversight would be required of the public authority. The CCO model also assumes that most if not all of the functions performed by AMDD and CMHB would transition over to the new entity. This is a significant undertaking that will require detailed planning for both state staff and contractors (such as First Health).

There are a number of examples of quasi-public authorities that have been quite successful in administering mental health services. These include Philadelphia Community Behavioral Health (CBH), Hawaii's Child and Adolescent Mental Health Division, and Wraparound Milwaukee. In Philadelphia's case, the city created a non-profit organization, CBH, to manage the behavioral (mental health and substance abuse treatment services) health benefit for the city. Wraparound Milwaukee and Hawaii are both run by a county or state division. There are also several California counties that manage capitated mental health services as integrated delivery systems. All of these organizations have been in existence for five or more years; a decade in the case of Wraparound Milwaukee. None of them have chosen to contract out administrative functions to a managed care organization. They all have developed their own claims and IT

solutions. While all of them had challenges in their implementation, as a group they have been surprisingly free of problems.

New Mexico has undertaken a compelling approach in many ways, attempting to consolidate the administration of mental health and substance abuse funding streams across all state agencies. However, we do not recommend the governance and oversight strategy that New Mexico has established, because it has resulted in oversight by committee. The state created a large purchasing group (the “Behavioral Health Purchasing Collaborative”), a statewide Behavioral Health Planning Council and disparate local advisory groups called “Local Collaboratives”. Decision making and staffing of these groups have been very resource intensive and overly time-consuming, and the quality and timing of decision making has been sub-optimal.

In any managed care scenario, the state must structure payment incentives so that they are aligned with its goals, which must be clearly specified as part of the contract or enabling language for the CCO. For instance, will the state use a risk based contract to achieve its goals of increased access, or will the state consider an administrative services-only contract with performance incentives to manage enrollees’ services? Risk based contracts use capitation or case rate payments to provide incentives to an organization to maximize efficiency of services, yet these are not always the best ways to improve effectiveness. Administrative service contracts generally use an administrative fee with some form of incentive payment to meet goals and objectives of increased access and improved outcomes.

b) Reimbursement.

The table below presents a framework for considering reimbursement options for a managed care organization under a 1915b or 1115 Waiver authority in Montana. It outlines advantages and disadvantages of each approach and should be viewed independently from the organizational or contracting design.

Reimbursement Options	Advantages	Disadvantages
Non-Risk, Administrative Services Organization Contract	<ul style="list-style-type: none"> • Matching federal funds for administrative services would be included in ASO contract (50% of all administrative costs) • The PIHP or PAHP may need less financial reserves for a risk pool 	<ul style="list-style-type: none"> • State of Montana would continue to hold the risk for all service expenditures • State may have to expend additional resources to develop or contract for needed managed care functions
Risk Based Managed Care Contract	<ul style="list-style-type: none"> • Matching federal funds for administrative services would be included in the risk based managed care contract (68% of all administrative costs). This marginal increase might result in \$300-400K in additional revenue. • State of Montana would have less risk for service expenditures. • Can negotiate rates that differ from Medicaid rates. Could pay a premium for services in underserved areas. 	<ul style="list-style-type: none"> • Managed care administrative costs come out of service funding unless the state makes up the difference • State will still need to maintain oversight functions • There will be rate setting difficulties and likely added costs of incorporating the HCBS waiver and the PRTF Demonstration

Managed care initiatives are often undertaken when a state believes that the patterns of care being used are unnecessarily intensive and expensive. Utilization management controls, selective contracting, and resetting prices of service can all be implemented by a managed care contractor to drive changes that keep care closer to the community whenever possible. Montana already has a utilization review organization (First Health) to help reduce use of residential facilities for children and to manage authorization for some of the more intensive adult services. These same “controls” are not possible under current admission and commitment rules for Montana State Hospital. The state resources for the PRTF Demonstration and the Home and Community Based Services Waivers are explicitly focused on substituting community resources for residential and nursing home levels of care wherever possible. These waivers provide considerable flexibility in using Medicaid funds in non-traditional ways. It would be challenging (though not impossible) to incorporate these services in the managed care approach; alternatively these waivers could be terminated.

On both the child and adult side, Montana lacks enough current providers to benefit from selective contracting or from increased competition. As a result, Montana’s strategy should be to build and maintain effective partnerships with its “suppliers”. This partnership should find effective ways to foster a focus on recovery among its provider network and to ensure that providers make the changes in practice necessary to implement it. An enhanced focus on recovery is sorely needed, according to many of the comments we received from stakeholders.

An optimal strategy for Montana depends upon a number of factors including the perceived capacity of the public organization to effect change, whether authority for the needed financing strategies can be obtained in the public agency (e.g. retention of reserves for reinvestment), contracting and hiring flexibility, and ultimately the availability of leadership and experience. Public sector compensation levels are often the barrier to these last two attributes.

Recommendations

DPHHS should develop and hold a public review process of a detailed plan for a public Care Coordination Organization (CCO) to manage mental health services to children and adults under a 1915(b) or 1115 Waiver. A detailed design and plan for the waiver and, ultimately, procurement will require considerable effort by the state and is beyond the scope of this paper. An 1115 Research and Demonstration Waiver would allow the state to consolidate its HIFA Waiver terms into the managed care approach. The CCO should consolidate all children’s and adult mental health services and administrative activities. The state should consider whether to include substance abuse services also.

Montana agencies have demonstrated their abilities to accomplish needed system changes through their various efforts over the past years. Reducing out of state residential placements for youth and reducing the Montana State Hospital census are examples of agency capabilities. The challenge for these agencies is to maintain their attention and focus on transformation and cost management. This takes sustained leadership and cooperation throughout the administration. The use of a third party to manage care can change the dynamics of the system markedly. Splitting planning and implementation functions between the state and the managed care entity, consolidating administrative functions across the several agencies, and creating an effective non-profit governance strategy for a statewide quasi-public entity are important elements of success. The added federal revenue will permit the state to fund certain needed administrative functions.

If the state ultimately does not decide to pursue this plan, many of the same goals can be achieved by AMDD and CMHB with effective leadership, new financing rules and other changes. This will require a firm commitment by the administration and strong project management and leadership within the state agencies.

c) Implementation Plan

While the state should continue its many current efforts to improve the existing service system during the implementation process, the following activities are essential to plan for and implement the CCO:

- ▶ Create an internal working group to undertake the detailed planning and analysis needed to implement the effort.
- ▶ Develop and seek input on a detailed workplan. Ensure that there are some dedicated resources to the efforts and a realistic timeline developed for start up. It is not likely that anything could happen sooner than 2012 despite the best wishes of many in the system.
- ▶ Study the current mental health positions in AMDD, CMHB, and Extended CHIP. Identify the functions, current staffing and costs of all subcontractors including ACS (the Medicaid claims payment subcontractor), Blue Cross and First Health. This should include an assessment of capacity of existing staff.
- ▶ Collect data on other mental health administrative costs in AMDD, CMHB, First Health Services and the CHIP contract with Blue Cross. Evaluate where there may be savings or efficiencies in consolidating staff and contractor functions into a quasi-public CCO. To minimize disruption during the transition, the state should ensure that current employees will continue to have a job either in the new entity or will be placed in a comparable position. There needs to be an overlap in the start up and wind down of the work of any contractor. This will incur start up costs.
- ▶ Review the options for governance and legal organization of the CCO. The basic options include: 1) establishing a non-profit corporation (subject to IRS approval) with shared governance, similar to what Philadelphia has established; 2) creating a public authority as a separate governmental entity; or 3) designating a division within one of the agencies, similar to what Hawaii or Wrap Around Milwaukee have established at the state and county levels. The central issues will revolve around the flow of funds from the Medicaid agency and the legal, governance and reporting relationship between the new entity, DPHHS and the Legislature. Care should be taken to avoid the appearance of inter-governmental transfers since those have been under scrutiny at CMS. With respect to non-profit governance issues, the details of the board composition and oversight functions in Philadelphia and in other sites can provide some guidance for Montana officials. However, there is no template for Montana to follow. Planning will require considerable discussion and negotiation and it should include public hearings, since the concerns about any form of managed care are likely to be strong. If the state's plans call for a separate non-profit, it will require IRS approval for federal tax exemption. Legislative authorization and clear enabling language about the public purposes and mission of the new entity may be necessary to ensure that IRS approval or tax-exempt status is received.²⁸
- ▶ Develop a plan to identify and define the scope of services to be included in the CCO. We have assumed that it would include all AMDD contracted services; however, there will surely be a debate over how to handle Montana State Hospital and the Montana Mental

²⁸ In the late 1990's the IRS was concerned about the legitimacy of tax exempt status of many non-profit managed care organizations. While the concerns of attorneys and others seem to have relaxed on this in recent years, the public benefit and purpose of the organization needs to be very clear.

Health Nursing Care Center costs. The choices are that the cost of MSH and MMHNCC be either 1) excluded from the CCO benefit; 2) paid for on a capacity, grant type basis with annual capacity; 3) covered through some form of risk adjusted case rate; or 4) purchased on a fee for service basis.

- ▶ Develop financial estimates for the costs of the transition including estimation (based upon existing expenditures) of capitated rates or premiums, any additional cash flow requirements for fee for service claims incurred but not reported, the potentially overlapping capitation payments, and other one-time expenses.
- ▶ Develop publicly accountable and responsible procedures to retain revenue in the CCO. These would be used initially to fund needed risk reserves within the CCO, and second be reinvested in services. Initially, the state would have to retain risk. Over the first several years of CCO operation, however, savings must be retained to build the required reserves. Once an appropriate level of reserves is achieved (consider one or two months of operations and service expenses at a minimum), the savings would be captured by the state. These should be reserves based upon a full accrual method of accounting (after an allowance is made for claims incurred but not yet reported and pending but not yet paid).
- ▶ Review the HIFA application and other changes needed for the design of a more comprehensive 1115 Waiver that incorporates the adult eligibility expansion in the current HIFA Waiver and brings the administration of existing children's mental health benefits and substance abuse services into a more comprehensive and coordinated Medicaid initiative. At a minimum, the waiver document should incorporate the plans for a capitated benefit and CCO administration.
- ▶ Draft and submit the waiver for approval to the new administration.
- ▶ Develop legal documents including any needed organizational papers and memoranda of understanding.
- ▶ Establish financial mechanisms, including banking arrangements for cash management, billing and claims processing procedures. DPHHS' contract with ACS will likely need modification to ensure that reporting for mental health utilization and expenditures is discrete and separate, both organizationally and financially. There are at least three acceptable ways to handle this: 1) Establishing separate check runs and using separate bank accounts; 2) Establishing completely separate check runs for the CCO as a separate legal entity or Org. Code (accounting code); and 3) Processing a consolidated check run with separate Org. Code financial accounting for all mental health checks. The check registers and claims reports should be accessible for the CCO independently of DPHHS. To ensure appropriate separation of powers and internal controls, CCO checks should not be run without explicit authorization of the CCO leadership. As a result, Options 1 or 2 are likely the preferred approach.
- ▶ Develop a comprehensive organizational plan for the new entity with positions and reporting structure clearly laid out.
- ▶ Develop and implement a detailed plan for the transfer all existing contracts and provider relationships.
- ▶ Establish and hold initial meetings of the Board.
- ▶ Implement a formal hiring process, particularly for the senior staff positions. Ensure that some key positions are hired prior to the transition in order to focus on some of the critical project tasks.

Additional steps will become clearer as the planning process expands to involve others, and after the strategy and direction has been set by the Legislature and administration. Leadership on the planning teams and within the administration will be key to success. With several recent

and future retirements, this may be a factor that needs to be considered. Strong project management skills will be needed as will strong group facilitation skills. A transparent planning process will be critically important to build and maintain trust. We hope that this study has set a tone which will be helpful going forward.

d) Potential Costs of the CCO

In implementing managed care approaches, there is a general assumption that the staff and services needed to accomplish the care coordination goals will come from restructuring existing staff, efficiencies achieved by eliminating redundancy, and possibly increased revenue from increased federal match for administrative costs. While increasing resources for the better coordination of services can improve consumer outcomes, given the gaps in services that we have documented, the state of Montana should not develop a plan that seeks to reduce overall service costs. In our experience, any savings from these areas are often/usually offset by the costs of the additional functions needed to achieve the improvement, increased capital outlays for new technology, one-time costs for the transition, risk reserves and what economists call risk premiums (the additional percentage point or more to cover the “costs” of taking on risk), and profits. Advocates and others always fear that reductions in services to consumers and families will finance profits for the managed care entity. The CCO proposal, using either a non-profit Montana corporation or organized within a state agency, avoids some of these concerns about profit making.

There will be certain one-time costs associated with the transition. These may include actuarial and consulting costs, legal costs, costs of moving staff and changing functions between agencies. With a conservative approach, assuming that the waiver application can be completed by DPHHS staff, these functions can be accomplished for \$250,000 to 300,000. In addition to one-time costs, there are certain new or incremental functions that can and should be performed by the CCO. These include increased activities in contract management and oversight for providers, added staff for provider reporting and new technology investments in reporting and internet functionality. These are likely to cost \$300,000 for 3-4 FTEs (salaries, benefits and some allowance for increased overhead) and the technology.

The costs of most other administrative functions can be addressed as the state consolidates staff from AMDD, CMHB, those staff from CHIP Extended Benefit, and First Health Services. If the final decision is that the CCO should be a separate non-profit organization, some level of administrative oversight will need to be retained in DPHHS. At its simplest level, an individual in the administration must be designated as the Single State Agency Director for SAMHSA Block Grant planning and oversight. Similarly, a clear designation should be made of the unit or staff responsible for oversight of mental health services and expenditures in Medicaid. Philadelphia and Wraparound Milwaukee have addressed this by separating the planning functions and keeping them in the County agency. The implementation and care coordination functions were moved to CBH. This separation of functions may have some cost implications for Montana although there may be some creative ways to handle these requirements.

Total first year costs incremental costs are likely to be from \$550,000 to \$600,000. Subsequent additional costs are estimated at \$300,000. These can be offset by the savings from the added federal match that we have estimated for a shift from administrative to service match rates. We have not projected savings in service premiums, since we believe that all savings should be reinvested in filling service gaps and making other system improvements.

We are cognizant that we are making these projections and assumption at a time of potentially dramatic changes in state revenues given the national financial crisis. If state revenues are going to be dramatically affected and cuts will be needed, it is important that the cuts take place before any of the restructuring. Great care should be taken that the two issues are not confused in the minds of providers or consumers and families.

VI. Montana Mental Health Needs Assessment in the Adult Criminal Justice System

A. Introduction

This section was prepared by Policy Research Associates, Inc. (PRA) based on site visits and research. The Sequential Intercept Model is the basis for analysis of the mental health needs of adults in the criminal justice system. The model is already being used by Montana as a planning tool in the development of criminal justice/mental health initiatives.

This section will include:

- Discussion of the prevalence rate of persons with co-occurring disorders in the justice system
- Description of population characteristics and special needs
- Strength assessment by and across intercepts - Montana has initiated several cutting edge initiatives in recent years, and strengths of Montana's mental health criminal justice collaboration will be described.
- Gap assessment by and across intercepts – Program/service gaps that cut across intercepts will be identified. Gaps within each intercept will also be identified.
- Recommendations
 - ▶ Action steps.
 - ▶ Relevant resources such as articles, model program descriptions, and evidence-based program descriptions are included in the attachments. (Attachments mentioned in this section are listed in Appendix G and are available from the Legislative Services Division upon request.)

The increase in the number of persons with mental illness in the criminal justice system is well documented²⁹. Since the late 1960s when deinstitutionalization began, the community criminal justice system and mental health and social services agencies have sought to develop appropriate responses and interventions to effectively provide for a life of recovery in the community. But the reality is that service delivery systems have not been able to adequately meet all needs, and some people are spending more time in jail and prison than in community treatment. This trans-institutionalization takes place against a backdrop of “get tough on crime” and “war on drugs” legislation and policies, along with the underfunding of many states’ community mental health services and a continuing push to reduce state inpatient psychiatric bed capacity. In addition, headlines about violent crime involving persons with mental illness increase suspicion and fear of justice-involved persons with mental illness. Public wariness may indirectly limit community treatment alternatives.

As incarceration rates and costs rise, states and communities are beginning to look for alternatives to incarceration that provide improved service linkage and improves public safety. Programs that have generated cost savings are cited within this report. A study by the Rand Corporation of the Allegany County Mental Health Court found that the program significantly decreased criminal justice costs and after an initial increase in mental health service costs during the first year, mental health service costs decreased significantly in the third and fourth quarters of the second year resulting in taxpayer savings (Rand Corp., 2007).

²⁹ Sourcebook of Criminal Justice Statistics. (2005). *Adults on probation, in jail or prison, and on parole.* http://www.albany.edu/sourcebook/tost_6.html#6_a.

B. Number and Characteristics of Mentally Ill Offenders

1. Prevalence

Various studies estimate the prevalence of persons with mental illness in the justice system to be anywhere from 8% to upwards of 60%. Discussion of these rates is important if policymakers are to better understand the population and develop targeted strategies for intervention. In September, 2006 the Bureau of Justice Statistics (BJS) issued a report based on a self-report questionnaire consisting of a checklist of mental health symptoms (e.g., “persistent anger or irritability”).³⁰ If a respondent answered yes to having any of the symptoms, he or she was considered to have “a mental health problem.” The positive response to any one symptom was upwards of 60%. In 1999 the BJS issued another report on mental health prevalence based on a survey. This time the self-report questionnaire had asked, “Have you ever had treatment for an emotional condition?” or “Have you ever had an overnight stay in a mental hospital?” The study found a prevalence rate of 16%.³¹ Linda Teplin, studying inmates held in the booking area of Cook County Jail in Chicago, found a 12% prevalence of serious mental illness in women and 6.4% prevalence for men, using the Structured Interview for DSM Disorders (SCID).³² The National GAINS Co-Occurring Disorders and Justice Center, a PRA project, regards the Teplin research as the most rigorous study of prevalence for serious mental illness (SMI). The 1999 BJS survey reporting 16% prevalence for any mental illness represents a fair estimate of prevalence when compared to statistical reports reviewed from individual states.

Based on the above data, our expectation regarding prevalence of mental illness in Montana is as follows (Table VI-1):

	Total Population*	Mental Illness**	Severe Mental Illness***
Prison	2,467	395	171
Male	2,258	361	145
Female	209	34	26
Jail	1,521	243	106
Male	1,385	222	89
Female	136	21	17
Parole	844	135	60
Male	743	119	48
Female	101	16	12
Probation	8,770	1,403	680
Male	6,665	1,066	427
Female	2,105	337	253

* Montana DOC, 2007
 ** 16% general mental illness prevalence rate among incarcerated individuals per Bureau of Justice Statistics.
 *** 6.4% prevalence rate of Severe Mental Illness (SMI) among incarcerated men and 12.4% prevalence rate of Severe Mental Illness (SMI) among incarcerated women per Linda Teplin.

³⁰ James, D.J. & Glaze, L.E. (2006). *Mental health problems of prison and jail inmates*. Washington, DC: United States Department of Justice, Office of Justice Programs.

³¹ Ditton, P.M. (1999). *Mental health and treatment of inmates and probationers*. Washington, DC: United States Department of Justice, Office of Justice Programs

³² Teplin, L.A. (1994). Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health*, 84 (2): 290-293

Review of the University of Montana study³³ suggests rates of mental illness for persons who are entering Department of Corrections (DOC) Pre-Release Centers at Helena, Missoula, Great Falls, Butte, and Billings are much higher than prevalence rates discussed above. Prevalence reported in the University of Montana study is 69% for women and 41% for men.

The operational definition of mental illness in the University of Montana study is somewhat broader than in the BJS 1999 survey. The BJS 1999 mental illness criteria included an overnight stay in a mental hospital or a current emotional condition. The University of Montana study includes the BJS criteria and history of an Axis I disorder. The prevalence data from the University of Montana study is broader in that it identifies people as having mental illness if they have either current mental health treatment needs or merely a history of an Axis I disorder.

Review of mental health service activity at the facilities visited is as follows:

Facility	Population	Psychiatric Meds	SMI Estimate
Yellowstone County Detention Center	350	200 (57%)	50 (14%)
Lewis and Clark County Detention Center	58	8 (13%)	Unknown
Montana State Prison	1,400	384 (27%)	Unknown
Montana Women’s Prison	173	60 (35%)	Unknown
Passages	155	62 (40%)	Unknown
<i>Source: Montana DOC 207</i>			

Montana’s mental health service utilization rates as reported by the facilities visited by PRA are higher than what might be expected from the prevalence studies reported above.

It should be noted, however, that Yellowstone County Detention Center and Lewis and Clark County Detention Center have insufficient mental health staff to properly assess, diagnose, provide consistent therapy contact or offer more than medication and monitoring services. Service utilization rates at Montana State Prison (MSP) do not seem unreasonably high since it is likely that persons with more severe mental illness might be excluded from pre-release centers or other DOC transitional programming, resulting in a higher percentage of persons with mental illness housed at MSP. Five therapists at MSP treat and monitor almost 400 inmates. The medication caseload of the psychiatrist is 384. Improved treatment capacity at these sites could result in better screening and triage, fewer persons placed on medication, reduced length of time on medication or faster resolution of mental health problems, and reduced need for ongoing mental health services.

³³ Conley, T.B. & Schantz, D.L. (2006). *Predicting and reducing recidivism: Factors contributing to recidivism in the State of Montana Pre-release Center population & the issue of measurement: A report with recommendations for policy change.* University of Montana School of Social Work.

While it appears that rates of mental illness in Montana's jails and prisons are higher than national rates, the high rates might be affected by a lack of treatment capacity resulting in inappropriate utilization of mental health services, inability to provide prompt treatment and follow-up, and inability to determine the acuity of the mental health caseload.

2. Population Characteristics

To intervene effectively, it is important to understand the characteristics of the justice involved population. These statistics pertain to the national population of offenders:

- ▶ Approximately three quarters (72%) of inmates at Cook County Jail have co-occurring disorders, that is, both a mental illness and substance use or substance dependence disorder.³⁴
- ▶ Approximately 90% of the men and women with mental illness participating in a jail diversion program have a lifetime experience of trauma, and approximately 50% of men and women report an episode of trauma (an emotional or psychological injury, usually resulting from an extremely stressful or life threatening situation) within the year prior to arrest (unpublished TAPA evaluation data)³⁵.
- ▶ Rates of homelessness and unemployment are higher for inmates with mental illness.³⁶

At time of arrest, many persons with co-occurring disorders have not received any treatment in the year prior to arrest, and it is unlikely they have received integrated mental health and substance abuse treatment.³⁷

Justice-involved women have unique needs, and it is important that programs and services be trauma informed and gender specific. That is, they should establish procedures, environments and interventions suited to the specific needs of women that avoid re-traumatizing them and include evidence based treatments for trauma recovery, including skills for self-protection. One of the specific needs of women is the importance, to most, of their role as mother. Nationally, more than 65% of women in state prisons compared to 55% of men in state prisons report being parents of children under 18. About 64% of mothers in state prisons lived with their children before prison, compared to 44% of men. (<http://www.womenandprison.org/facts-stats.html>) New Hampshire passed legislation establishing the position of an administrator of women offenders and family services within the department of corrections and establishing an interagency coordinating council on women offenders (Attachment 2).

A Bureau of Justice Statistics (BJS) report indicates that there were 140,000 veterans in state and federal prisons in 2003. Afghanistan and Iraqi war veterans accounted for 3.4% of the total number of veterans, up from 1.9% two years earlier.³⁸ Trauma and post traumatic stress disorder (PTSD) in Afghanistan and Iraqi war veterans are well documented. In order to promptly and effectively engage veterans into treatment, it is important to establish screening methods so that they can be identified and referred for institutional and community services upon release. Collaboration with the Veterans Administration and veterans' groups is essential.

³⁴ Abram, K.M. & Teplin, L.A. (1991). Co-Occurring disorders among mentally ill jail detainees. *Am. Psychologist*, 46 (10): 1036-1045.

³⁵ TAPA unpublished TCE data. Technical Assistance and Policy Analysis Center for Jail Diversion. Policy Research Associates. 345 Delaware Ave. Delmar, NY 12054.

³⁶ Ditton, 1999

³⁷ <http://oas.samhsa.gov/NSDUH/2k5NSDUH/2k5results.htm#8.1.4>

³⁸ Noonan, M.E., & Mumola, C.J. (2007). *Veterans in state and federal prison, 2004*. Washington, DC: United States Department of Justice, Office of Justice Programs

In Buffalo, NY, where over 300 veterans reportedly entered the criminal justice system in 2007, City Court Judge Robert T. Russell, Jr. established a Veterans Court in January 2008 (Attachment 3).

C. Resources for Financing Mental Health Services for Offenders

In many states, state and local mental health department planning for justice-involved persons with mental illness is fragmented. Often, criminal justice agencies fund mental health positions or services due to insufficient mental health funding to service the population, and parallel treatment systems are developed.

Federal block grant funds and PATH (Projects for Assistance in Transition from Homelessness) funds are given to states to fund programs for persons with serious mental illness. Most states do not use these funds to develop programs specific to justice-involved persons. Instead, the planning process focuses on persons in the community, without input from criminal justice agencies, and consequently, funded services do not provide outreach to justice-involved persons. Block Grant and PATH funds are nevertheless ideal for use with the justice-involved population to facilitate initial engagement in treatment. This population typically is not enrolled in benefits programs, including Medicaid and Social Security, and access to services is thus restricted. Use of Block Grant and PATH funds can overcome the service access issue and provide transition funding until more permanent funding for services can be arranged.

Input from police, courts, jails, prisons, and probation and parole should be sought in developing statewide mental health planning to utilize Block Grant and PATH funding.

D. Strengths and Gaps in Montana Sequential Intercepts

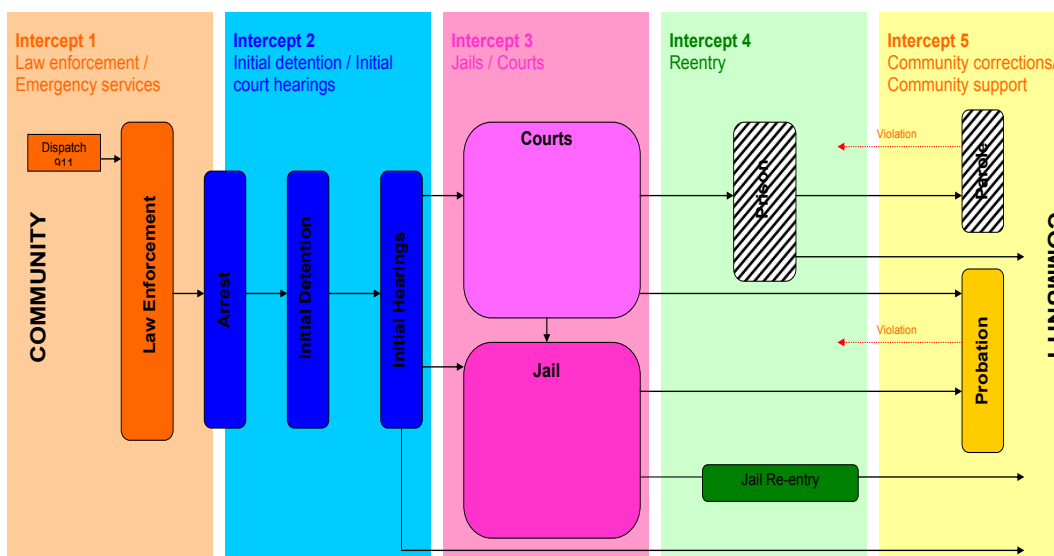
1. Sequential Intercept Model

People with mental illness who come in contact with the criminal justice system cycle through it in predictable ways. A visual and conceptual model of this process has been developed by Patricia A. Griffin, Ph.D., and Mark Munetz, M.D.³⁹ The Sequential Intercept Model (See Figure IV-1) highlights the concept that at any juncture in the criminal justice system there is opportunity to “intercept” with diversion. The use of this model is helpful to identify the points of intervention where people can access treatment services so jail or prison can be avoided.

Regardless of the entity providing the service, diversion involves identifying eligible individuals, screening and assessing their needs, engaging them in a services plan, negotiating the terms of services, and linking them to those services. The reduction of recidivism is the ultimate objective.

³⁹ Munetz, M.R., & Griffin, P.A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57 (4): 544-549.

Figure VI-1
Sequential Intercepts for Change: Criminal Justice - Mental Health Partnerships



The Sequential Intercept Model provides a template for discussion and exploration of the innovative work being conducted across the country to provide diversion. Each intercept involves different community agencies that have a significant role in identifying people with mental illness and linking them to services designed specifically to respond to their identified needs. It is important to note that justice agencies whose primary roles have little to do with the treatment of mental illness now are addressing the needs of people whose clinical condition is unstable. Heroic efforts are seen at every juncture.

- ▶ Intercept 1: Intervention by local law enforcement, local emergency services
- ▶ Intercept 2: Arrest, initial detention/initial court hearings
- ▶ Intercept 3: Jails/courts/specialty courts
- ▶ Intercept 4: Reentry following stay in jail or prison
- ▶ Intercept 5: Community corrections/community support

2. Strength Assessment Across Intercepts

a) Strengths of the Correctional System as a Whole

Behavioral Health Program Facilitator. Establishing the role of Behavioral Health Program Facilitator as a staff position shared between DPHHS and DOC has been a key factor in improving criminal justice collaboration, coordination, and planning. This boundary spanner role is key to integration of two complex systems with different missions and cultures but sharing the same population. Through the Facilitator’s efforts, improved collaboration and coordination was evident as we toured Montana and spoke to criminal justice and mental health program staff.

The Law and Justice Interim Committee (LJIC). Key to initiating, implementing, and sustaining change in a state is a coordinating body, a group of stakeholders from across state and community agencies and the provider community that have the focus and authority to identify problems, prioritize action, and initiate and sustain change. The LJIC took the lead as a coordinating body in this legislative interim.

b) Intercept 1: Intervention by Local Law Enforcement and Emergency Services

Police Crisis Intervention Team Initiatives and Community Crisis Center in Billings. Two police Crisis Intervention Teams (CITs) currently operate in Montana, one in Billings and one in Helena. The program in Billings is exemplary in that a crisis stabilization unit is available as a drop-off center. Yellowstone County Detention Center regards the police CIT program and the crisis stabilization unit as significant factors in the reduction of the Center's census over the past year. In addition, Yellowstone County Detention Center allowed some corrections officers to take part in the police CIT training. Corrections officers reported that it was the best training they ever had and jail administrators reported the training improved response to persons with mental illness. The GAINS Center has heard similar reports in other jurisdictions where corrections officers received police CIT training, with similar benefits reported.

Aside from the established programs, there are ongoing plans to expand police crisis intervention training across the state and to enhance mental health training at the Montana Law Enforcement Academy.

c) Intercept 3: Jails, Courts, Specialty Courts

Missoula Mental Health Court. Operating since 2006, the Missoula Mental Health Court was initially funded by a Criminal Justice Mental Health Collaboration Grant and is now supported by Missoula County. It provides important diversion options for persons with co-occurring disorders who are charged in either the district court or justice court. Staffed by one case manager/coordinator with in-kind staffing contributions from probation, county attorney and public defender, and Winds of Change, a mental health provider, the program has current capacity of 24. Program need is estimated to be twice that, meaning an additional case manager is required. Program staff report that some persons from neighboring counties have asked to enroll in the Missoula Mental Health Court program as an alternative to incarceration in their home counties, where mental health services and diversion alternatives were not available.

d) Intercepts 4 and 5: Re-entry After Release, Community Corrections and Community Support
Department of Corrections Assessment and Sanction Units at Billings (BASC) and Missoula (MASC). We visited the BASC unit and reviewed materials on the MASC unit. We found these programs to be innovative in that they provide both prison diversion options for persons committed to DOC and a violation diversion option for persons who have violated conditions of probation or parole. Further, the centers provide transition programming for those nearing release from prison. The programs have capacity to provide mental health treatment to program participants. While persons with serious mental illness and low functional ability may not be able to meet the demands of the programs, program staff felt that few would be unable to participate. At BASC, a contract with Billings Clinic enhances continuity of care and facilitates transition planning to the community.

Gap Funding for medication and case management services between prison release and Medicaid enrollment. Montana joins only a few states that have taken the initiative to provide gap funding to assist persons with mental illness in transition from jails and prisons to the community. Gap funding is essential because Medicaid eligibility typically takes several weeks to determine, making it impossible for people reentering the community to immediately obtain needed medications and pay for community services. During our visit it was apparent the program's implementation was just beginning, but field staff were appreciative of the initiative. Gap funding provides medication for persons released from secure facilities and under

community corrections supervision for up to 60 days subsequent to release or until Mental Health Services Plan (MHSP) or Medicaid funding becomes available. Funding also provides a clinical staff position that supports treatment and case management services for probation/parole offices at up to six sites across the state. Again, these positions are not all filled, but when hiring is complete will enhance service linkages and promote engagement in services.

Cross Systems Integration. Cross system integration was apparent as we traveled among programs operating in Intercepts 4 and 5. Cross system integration initiatives included:

- ▶ Mental health training of probation and parole officers
- ▶ Establishing clinical staff positions at probation and parole offices
- ▶ Integrating the discharge planner from Montana State Prison into the Admission, Discharge, Review Team meetings held at Montana State Hospital to insure that individuals with mental illness who are released from prison have appropriate access to community resources

Trauma Screening and Assessment at Montana Women's State Prison and Passages Program. Programs at the Montana Women's Prison and at Passages both addressed screening and assessment of trauma in their medical records and incorporated trauma-specific interventions. Under contract to DOC, Passages provides a 65-bed pre-release center, 40-bed alcohol and drug treatment unit and 50-bed assessment, sanction and revocation center.

The above initiatives are considered exemplary and demonstrate Montana's commitment to and innovation in improving recovery-based outcomes and enhancing public safety by addressing critical issues for justice-involved persons with mental illness.

E. Gap Assessment Across Intercepts

1. Gaps in the Correctional System as a Whole

a) Data

We found no organized method or strategies for collecting data on mental health populations except at Montana State Hospital. Both Yellowstone County and Lewis and Clark County Detention Centers, for example, had contracts with local mental health centers but no organized data collection regarding numbers seen, diagnostic profiles, or transition planning. While the state prison programs had some information regarding current mental health service recipients, diagnostic and acuity information was lacking, as was systematic reporting on transition planning.

Similarly, the DOC lacked a centralized database of persons receiving mental health care in the state prisons. The absence of such a database impedes service planning, implementation of quality assurance initiatives, and continuity of care.

b) Information Sharing

Access to treatment records is critical to continuity of care and yet lack of access to records appeared to be a widespread problem. Yellowstone County Detention Center reported they did not receive referral information from Montana State Prison when prisoners were transferred to Yellowstone County for court appearances for other pending charges. While neither Lewis and

Clark nor Yellowstone County had a systematic method for obtaining community treatment records for new admissions, both could obtain some treatment records if the person had previously been seen at the local mental health center. At Yellowstone County Detention Center, due to liability and confidentiality concerns, a formal treatment record is not even maintained, although the services are actually provided by the Billings Clinic.

c) Lack of Forensic Intensive Case Management (FICM), Program for Assertive Community Treatment (PACT) and other Evidence-Based Practices

FICM provides case management by staff who have special training in the processes and requirements of the forensic system and the special needs of individuals released from correctional facilities so that they can provide appropriate services to this population. The level of service intensity can be high so that clients' needs can be fully met. PACT teams composed of multi-disciplinary mental health professionals and paraprofessionals provide support in the community at an even higher level of intensity. Staff at Yellowstone County and Lewis and Clark County Detention Centers, and at Montana State Hospital, commented on the lack of access to generic case management and PACT for their population and felt the lack of case management contributed to incarceration and unnecessary hospitalization.

Transition planning from jail is limited to telling consumers to walk into local clinics. Forensic Intensive Case Management and Transition Case Management are emerging as best practices in many communities due the complexity of the needs of the population and the multiple system coordination required to develop plans for effective and safe reentry. There were no specialized community forensic case management teams identified.

d) Lack of Integrated Dual Disorder Treatment

An impression was conveyed by programs visited that community services lacked Integrated Dual Disorder Treatment Programs to address both mental health and substance use disorders. Prison-based programs had well-designed chemical dependency programs, which reported a significant number of persons with co-occurring disorders. We were unable to determine over the course of our visit how effectively both disorders were being addressed in prison-based programs. Mental health and chemical dependency programs at Passages and the Montana Women's Prison appeared to be integrated, with treatment of both disorders considered, and medical records included a supplemental assessment of co-occurring disorders. Mental health and chemical dependency staff at Montana State Prison spoke about the need to work more closely to address issues pertaining to co-occurring disorders.

e) Lack of Trauma Screening and Assessment in Jails and Montana State Prison for Men

Trauma screening and assessment were not addressed in either of the detention centers visited, although Yellowstone County Detention Center had an outside provider come in to facilitate a weekly anger management group for women. At Montana State Prison, there was an acknowledged need to focus more on trauma issues in their population.

f) Screening and Care Coordination for Veterans

There is no consistent screening for veterans at the jails visited. It was noted, however, that at both the Lewis and Clark County Detention Center and Montana State Prison there is a linkage to veterans' services. Lewis and Clark County Detention Center staff report that some Iraq and Afghanistan war veterans are beginning to come through. An article in the May 30, 2008 edition of the Bozeman Daily Chronicle (Attachment 4) highlights the need for screening and organized

response for returning veterans who may become justice involved as a consequence of combat stress and trauma.

The extent of coordination of behavioral health services with Veterans Administration programs, Vet Centers, and other groups was unclear from our visit. Reports from around the country describe incidents of arrests of veterans suffering from combat stress and PTSD and highlight the need for proactive service relationships and coordination with law enforcement and justice agencies.

g) Lack of Local Planning Capacity to Address Diversion Options

Effective diversion and reentry programs require a broad range of community partnerships. While there is evidence that effective partnerships are being forged at the state level and in Billings, it is not clear that local advisory councils have sufficient awareness of diversion issues or have established partnerships to initiate local responses to increase diversion opportunities for justice-involved persons with mental illness. Stakeholders at the community level would include behavioral health providers, law enforcement, probation/parole, Veterans Administration and veterans groups, social services and Social Security Administration field offices, housing providers, judges, prosecutors, public defenders, consumers, and local National Alliance on Mental Illness (NAMI) affiliates.

h) Lack of Funding for Community-Based Services

While this is addressed in the DMA Health Strategies portion of the report, jail staff, Montana State Hospital staff, and Missoula mental health staff report waiting lists for treatment, delays in accessing MHSP and Medicaid, and insufficient access to PACT team slots for the justice-involved population.

2. Intercept 1: Intervention by Local law Enforcement and Emergency Services

a) Insufficient Pre-Booking Diversion Options

The Billings Police Department CIT team and newly opened crisis stabilization unit are described by jail staff as very effective and contributing to a decrease in jail census. However, the police CIT program in Helena, according to jail staff there, while improving police response to persons with mental illness, has few alternatives to arrest or hospitalization since there is no crisis stabilization center. Police must transport individuals to St. Peter's Hospital emergency room. Processing procedures are not timely and police must wait for extended periods for an evaluation. There are no local inpatient psychiatric beds, so if hospitalization is needed transport to Warm Springs is required.

3. Intercepts 2 and 3: Arrest, Initial Detention/Court Hearings, Jails, Courts, Specialty Courts

a) Lack of Post Booking Diversion Options

We identified no communities offering diversion at Intercept 2, and there is only one mental health court in the state. There appears to be a lack of organization and collaboration at the community level to initiate the implementation of diversion programs. Consequently, persons who could be released on bond with referral to community services remain in jail. Documents reviewed and discussion at the stakeholders meeting indicate there has been discussion of funding additional mental health courts, but funding is not available to date.

b) Lack of Consistent Jail Screening and Treatment Capacity in Jails

Yellowstone County and Lewis and Clark County Detention Centers were the only Montana Jails visited. These jails were selected by region (one from the eastern part of the state and one from the western part of the state) and by size. One (Yellowstone) has a capacity of approximately 300 and one (Lewis and Clark) has a capacity of approximately 60. Information from the stakeholders' meeting and from jail administrators at Yellowstone County and Lewis and Clark County Detention Centers, suggests that both Centers are similar to others in the state, although smaller jails may have even fewer resources.

Both Yellowstone County Detention Center and Lewis and Clark County Detention Center contract with local mental health centers to provide basic crisis assessment, medication, and monitoring services. Both jails routinely screen for mental health needs and refer to mental health center staff. Mental health staff are responsive but have limited capacity to provide treatment, close monitoring and supervision of care, and meaningful transition planning services. Both jails have high supervision areas, restraint chairs, and some inpatient access which is used sparingly. Mental health screening and assessment services for Yellowstone will be increased from 24 hours a week to 40 hours a week. Yellowstone reports that 200 of 350 inmates are on medication and 50 of the 200 have a serious mental illness, so while increasing mental health coverage will help, capacity to provide meaningful treatment and transition planning will remain limited.

There is no one state entity that collects information on jails so it is difficult to determine level of need in other counties but if impressions are accurate, most counties are struggling to meet the needs of persons with mental illness in their jails. Of particular concern is lack of collection of annual suicide numbers for jails and a mechanism to monitor and correct custody/program deficiencies that may have contributed to the event.

c) Secure Forensic Treatment Unit and GBMI population

Both Montana State Hospital staff and Montana State Prison staff acknowledge the need for a secure forensic unit for guilty but mentally ill (GBMI) persons or state prison inmates who require hospital-level care. Physical security is one issue since there is no perimeter fence. Staff safety is a second issue since there is a history of assaults on staff by this population.

The Secure Treatment and Examination Program (STEP) Unit was a proposed but unsuccessful solution to the problem in the 2007 Legislature. Some GBMI persons have been moved to Montana State Prison when clinical condition and security needs permitted. The GBMI population at Montana State Prison requires close monitoring. Given current mental health staffing and psychiatric coverage, appropriate care for this population presents a challenge.

4. Intercepts 4 and 5: Re-entry After Release, Community Corrections and Community Support

a) Lack of Jail Transition Planning

Neither Yellowstone County Detention Center nor Lewis and Clark County Detention Center had capacity to do transition planning. Transition planning was limited to telling a person to walk into the local community mental health clinic.

b) Lack of Funding for Psychiatric Medication for Jail Releases

Lewis and Clark County Detention Center does not have capacity to provide psychiatric medication upon release. Yellowstone County Detention Center provides seven to ten days of

psychiatric medications upon release. However, unless an individual is under probation supervision and covered by the Medication Assistance Program, paying for medication following release is a problem, since it takes longer than seven to ten days to be enrolled in Medicaid and thereby have subsequent prescriptions paid for.

c) Insufficient Treatment Capacity at Montana State Prison

As noted above, lack of a centralized database for prison-based mental health services detracts from informed service planning and quality services. Available data suggests the mental health services at Montana State Prison for men, in particular, are understaffed.

Current staffing includes:

- ▶ Clerical: 1
- ▶ Administrative: 1
- ▶ Nursing: 2
- ▶ Therapists: 5
- ▶ Mental Health Technicians: 5
- ▶ Discharge Planner: 1
- ▶ Activity Therapist: 1
- ▶ Psychologist: 1
- ▶ Psychiatrist: 1 at 40 hours/week

Current caseload is 384 for Dr. Schaeffer. The unit caseload is 400 plus.

Except for individuals housed on the mental health unit, most persons receiving services receive group therapy or brief monitoring services. Two high-risk classes of service recipients are currently being served: persons who have had forced medication orders in place and persons found GBMI and transferred to prison from Montana State Hospital. Although numbers are small, monitoring for compliance with management protocols for this group is essential.

F. Recommendations

1. Data management requires improvement across systems.

We recommend that the state facilitate standardized collection of mental health data across intercepts to improve planning. Attached are screening forms for police CIT encounters, and the Brief Jail Mental Health Screen (Attachments 5 and 6), which can be used by jail staff or probation staff. Once reliable screening information is collected, input into a database with predetermined data elements will aid in planning and development of services for this population. Data elements should include specific information about special populations, including veterans and Indians, to facilitate planning and development of behavioral health programs that are geared to meeting their needs.

One suggestion is for the state to fund pilot sites in police CIT programs or jail programs at the largest jails. The grants would provide money for hardware, software, and technical support to aid in the development of a mental health database or integration of mental health data into an existing database. Each grant recipient would be required to submit an annual report describing system implementation issues. These sites would then be used as learning sites for other communities.

2. Information Sharing Procedures are Required

Procedures are required to insure flow of clinical information for continuity of care. Attention should be given to building capacity to match justice system data with mental health databases to improve screening and information for police, jails, and prisons.

Flow of treatment data, to jails in particular, is lacking. Texas (SB 839), Illinois Mental Health Jail Data Link Project, and Kentucky Mental Health Crisis Network (see Attachment 7), employ matching of mental health and criminal justice databases to identify persons with past or current treatment histories who are incarcerated. These programs report prompt screening and triage of high risk cases and increased opportunity for diversion and have added funding for case management services to facilitate diversion.

3. Expand Crisis Stabilization Capacity

We are aware of the work done by of the LJC this interim to study expansion of crisis capacity across the state. Montana joins Washington State, Colorado, Florida, and the District of Columbia in seeking to expand crisis stabilization units to divert people from hospitalization, provide alternatives to incarceration for low-level misdemeanor crimes, and improve efficiency of law enforcement by reducing emergency room wait times and visit costs. Stabilization units are essential elements of police CIT Team response. Especially innovative is a suicide prevention proposal to link jail services to crisis stabilization centers through videoconferencing links, which is similar to the successful Kentucky Crisis Mental Health Network program. We recognize that Montana is currently studying proposals mentioned above, and would like to emphasize that the state is on the right track and in step with other states in addressing these service gaps.

San Antonio, Texas, has a model crisis stabilization program and has assisted several communities in the development of crisis stabilization units. The CMHS National GAINS Center has worked with the San Antonio site to provide technical assistance to Washington State in planning and implementing its crisis stabilization unit initiatives. A site visit to San Antonio may be instructive to Montana's efforts.

4. Expand Post Booking Options

The Missoula Mental Health Court reports over 90% of participants have co-occurring mental health and substance use disorders. Reports reviewed indicate federal funds are received for drug courts in Montana. Given the high prevalence of substance abuse among the mental health court participants, perhaps drug court dollars could be used to fund an additional mental health court or supplement services in the Missoula Mental Health Court. If regulations allow, supplementing existing drug courts with mental health staff or adding substance abuse staff to mental health courts might be a cost efficient strategy to expand capacity for persons with co-occurring disorders.

While mental health courts are proving to be an important diversion option, other diversion options should also be considered to provide opportunities earlier in the justice process. Diversion can take place as early as the first court appearance and at bail or pre-trial probation proceedings. Criminal sanction is not always required for diversion. In one jurisdiction, low-level charges are dismissed on the condition a person attend a 3-hour treatment assessment and

orientation session. Following completion of the session, participants can accept the case management services offered or not. (See Attachment 8)

Expansion of diversion options can take many forms. Grant and foundation funding is used in many states. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Bureau of Justice Assistance (BJA) have funded Mental Health and Justice collaborations for the past several years. Congress is moving forward with continuing to fund programs through the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) in 2009.

States such as Florida, Texas, Michigan, and Washington direct local mental health authorities to plan for jail diversion programs:

- ▶ Michigan: Michigan Mental Health Code 330.1207, Section 207 (diversion)
Each community mental health services program shall provide services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate.
- ▶ Texas (2003): House Bill No. 2292 (diversion)
The department shall require each local mental health authority to incorporate jail diversion strategies into the authority's disease management practices for managing adults with schizophrenia and bipolar disorder to reduce the involvement of those client populations with the criminal justice system.
- ▶ Florida (1999): House Bill 2003
Directs the Department of Children and Family Services to develop cooperative agreements with local agencies for diverting persons with mental illness arrested for a misdemeanor from criminal justice system to civil mental health system

In addition, Florida recently appropriated \$4,000,000 for planning, implementation, or expansion grants for jail diversion programs. A 100% county match is required except for "fiscally constrained" counties where a 50% match is required.

- ▶ Washington (2007) SB5533
SB 5533 authorizes counties to levy a 0.1% sales tax for criminal justice/mental health initiatives with a focus on establishing crisis stabilization units. The bill also expands authority of the police to divert non-serious misdemeanor cases to crisis stabilization units.

The National Association of Counties (NACo), through a grant from Eli Lilly, awarded counties up to a \$5,000 seed grant to form a planning committee to address mental health/criminal justice issues. In Montana, Yellowstone County, was a recipient of a grant and successfully implemented a police CIT and crisis stabilization unit.

Recognizing Montana's fiscal limitations, it is noteworthy that a relatively small award from NACo facilitated successful planning and implementation of a police CIT Team and Crisis Stabilization Center. State strategies could include funding relatively small local projects designed to improve local planning infrastructure and encourage planning for jail diversion programs.

5. Expand jail-based treatment capacity

Discussion at Yellowstone County Detention Center, Lewis and Clark County Detention Center, with the Missoula Mental Health Court Team, and with stakeholders, indicated that a lack of jail standards makes it difficult to identify statewide jail mental health needs and access to services. Further, there is no guidance for local jail administrators around staff training or service provision for persons with mental illness. States having statewide jail standards include: Kentucky, Maryland, New York, Ohio, Texas, and Idaho.

As jail standards are developed, there will be opportunity for particular attention to mental health standards. State jail standards can address reporting of suicides, suicide attempts, special watches, restraints, the number of persons on psychiatric medication, staff training, and other performance measures that might help assess mental health needs in the state jails and improve services.

Currently, responsibility for providing mental health services in jails is not fixed. County sheriffs are often left to pay for services through contracts although other arrangements may exist. Current contract funding appears to provide for only minimal services and does not allow for transition services nor pay for medication upon release. Mental health services in the jails should be addressed by LACs to insure that mental health needs of all local residents can be addressed in statewide planning.

6. Consider expanding gap funding to jails and diversion programs for transition planning

Gap funding initiatives provide funding for persons transitioning from institutional services to the community until Medicaid and other benefits can be arranged. Montana's "Mentally Ill Offender Drug Program" and "Services for Mentally Ill Offenders Program" are examples of gap funding. These programs provide funding for medication and services for persons released from the state hospital or prison or persons under probation or parole supervision. Uncovered populations include persons participating in mental health courts, other jail diversion, or persons released from jails. Expansion of funding would provide necessary support to bridge persons to services upon release from jail and insure sufficient medication were available until community aftercare services were in place. Funding available for jail diversion participants would insure that participants would not have to be placed on probation to access funding for medication. Both Alaska and New York developed methodologies to determine how much funding was required to implement programs that provide transition medication and case management assistance for inmates being released from jail and prison. Montana's Medication Assistance Program, though new, should also help in developing a methodology to estimate funding need for expanding the Medication Assistance Program.

7. Develop specialized Forensic Case Management and Transition Case Management Teams. Increase forensic expertise on PACT team.

Insufficient case management resources in the community likely puts additional burdens on emergency rooms and scarce inpatient beds and likely results in increased recidivism for persons who are justice involved. Case management is the backbone of any mental health service system and can help compensate for system deficiencies and fragmentation.

Case management for the justice-involved population often requires additional expertise and funding to effectively manage transition from jails to the community and to maintain close collaboration with criminal justice professionals.

While achieving funding for additional case management is likely difficult, many communities have justified additional funding by analyzing the cost of not having essential services in place.

As a result of the multiple needs of the population, the fragmented systems of care and poor access to care, persons with co-occurring disorders tend to cycle from the streets, to various treatment services, to shelters, and to jail. A New York Cost Study⁴⁰ documented that approximately \$36,000 a year is spent on someone who cycles through various service providers, shelters, jails, and prisons. A study by the Nebraska Coalition of Homelessness (see Attachment 1) estimates that it costs almost \$600,000 a year for the top 13 homeless users of emergency services. Thirteen is about the size of a single intensive case management caseload. It costs \$7,443 a year to house someone in a supportive housing bed in Nebraska. In other words, it costs more not to provide someone with coordinated and effective services.

United States Interagency Council on Homelessness recently highlighted innovative strategies that focus on increasing services to high users, which results in cost savings. (See Attachments 9 and 10)

8. Training the community mental health workforce on successfully working with justice-involved persons with mental illness should include an overview of the criminal justice system and specific characteristics of the justice-involved population.

Working with a justice-involved population requires a familiarity with and understanding of the criminal justice system. Providers must be aware of existing criminal justice sanctions or pending charges to be able to support compliance with justice system mandates. They should understand the need of the justice system for treatment information and have procedures developed for information sharing. Providers also need to understand the characteristics and program needs of the justice-involved population. Integrated Dual Disorder Treatment, trauma-specific interventions and emerging use of cognitive behavior treatment are a key focus for this population.

In addition, persons with significant history of incarceration may have developed a cultural behavioral response to the experience of incarceration. Adaptive behaviors learned in the jail or prison setting may be antithetical to adaptive behaviors in the community or in community treatment settings. (See Attachment 11.)

9. Facilitate partnership building at the community level.

LACs are uniquely positioned to address criminal justice/mental health issues. Discussions with stakeholders suggest that not all advisory councils have sufficient criminal justice representation, nor are they sufficiently familiar with diversion and reentry literature. Reviewing

⁴⁰ Metraux, S., Culhane, D., & Hadley, T. (2001). *The New York/New York Agreement Cost Study: The impact of supportive housing on services use for homeless persons with mental illness in New York City*. Philadelphia, PA: Center for Mental Health Policy and Services Research, University of Pennsylvania.

the membership of local advisory councils and developing a training curriculum for them may facilitate improved community collaboration and action.

10. Review staffing and programming at Montana State Prison.

With the mental health contract for the Montana State Prison expiring and positions reverting to state-funding, an opportunity exists to critically examine mental health staffing levels, mental health performance measures and data management, psychiatry recruitment issues, DOC staff mental health training, and refining and expanding current mental health programming.

Without a better understanding of the acuity of the current mental health caseload, it is difficult to make specific recommendations regarding enhanced staffing for Montana State Prison. Certainly additional psychiatric coverage is needed. One psychiatrist prescribing for over 380 inmates is insufficient. Telemedicine can be an option as discussed below. During our visit, the onsite psychiatrist reported he felt he could recruit an additional psychiatrist if funds were available and pay attractive. Some states have provided pay differentials to attract psychiatrists to hard-to-recruit areas.

Programmatically, 16 residential psychiatric beds at Montana State Prison would seem insufficient, considering the active caseload for the mental health unit is over 400 inmates, approximately 30% of the total prison population. Communication with DOC mental health staff indicates that an assessment of the need for step down beds is underway. The current caseload should be reviewed to identify individuals with repeated residential admissions, frequent disciplinary infractions or who are not able to meaningfully participate in prison programs. Mental health residential programs in prison settings have been shown to decrease disciplinary infractions, reduce suicidal behavior, reduce mental health crises, and reduce the need for hospitalization.⁴¹

Improving integration between the mental health services and the chemical dependency programs should also be considered. Staff from both units cited the need for improved program integration and collaboration.

11. Continue to explore use of telemedicine to address provider shortages.

We are aware that Montana is exploring the use of telemedicine, but implementation is limited by lack of providers. Still, telemedicine is being used successfully in state corrections in other states. Review of attached articles indicates that telemedicine is used in federal prisons, state prisons, jails, and for forensic evaluations. Telemedicine is also a valuable resource in transition planning from jails, prison, or the state hospital where distance may preclude face-to-face interviews or assessment by community providers. Telemedicine is also used to support primary physicians practicing in rural settings. Articles report both physicians and patients accept the practice. (See Attachments 12-17.)

Implementation requires the telemedicine units be strategically placed and that separate agencies, for example, DPHHS and DOC, consult on equipment requirements to insure that telemedicine equipment is compatible. State psychiatric resources are meager. Perhaps

⁴¹ Condelli, W.S, Bradigan B., & Holanchock H. (1997). Intermediate care programs to reduce risk and better manage inmates with psychiatric disorders. *Behav Sci Law*. Autumn; 15 (4):459-67. PMID: 9433748 PubMed - indexed for MEDLINE

arrangements could be made with an out-of-state university medical center or with out-of-state practitioners.

12. Explore use of peer services in transition planning and community services.

Peers can be used as “bridgers” in reentry planning or as part of multidisciplinary teams. Peer-delivered programs such as Wellness Recovery Action Planning (WRAP) have proven effective with the justice-involved population in many communities (See Attachments 18 and 19). Similarly, peer drop-in centers or support centers that are justice informed can provide additional support to persons with justice involvement.

13. Develop trauma informed systems and implement trauma specific services

Approximately 90% of the men and women with mental illness participating in a jail diversion program will have a lifetime experience of trauma, and approximately 50% of men and women report an episode of trauma within the year prior to arrest (unpublished TAPA evaluation data).

- ▶ States are beginning to develop statewide initiatives to address trauma issues.
- ▶ In New Hampshire, SB 262 (see Attachment 20 and 21) established the position of an administrator of women offenders and family services within the department of corrections and established an interagency coordinating council on women offenders.
- ▶ Maryland, Maine, and Connecticut have established statewide trauma initiatives that have also been implemented with justice-involved populations.
- ▶ At the Correctional Center of Northwest Ohio trauma training led to trauma-informed practices, which improved inmate management (see Attachment 22).

14. Involve veterans groups in planning for their constituents

Involve the Veterans Administration, Veterans Centers, and veterans support groups in planning activities at all levels to insure appropriate screening and response is available across intercepts for veterans who become justice involved.

Both California and Minnesota have passed legislation authorizing jail diversion for veterans whose crimes are related to combat stress. (Attachment 23 and 24)

VII. Conclusion

DMA Health Strategies and our consulting partners, Policy Research Associates and independent consultants John O'Brien and Leslie Schwalbe, are pleased to have had the opportunity to work collaboratively with the leadership of Montana's mental health system in order to document prevalence and community needs and develop structural and financial recommendations for systems transformation. In comparison to many other states, Montana has made great progress, yet the needs for expanded community based services and supports are significant in a state challenged by poverty, a culturally diverse population and service access issues typical of rural and frontier states. Examples of the range of systems issues faced by Montana leadership include a limited range of provider agencies, a critical shortage of psychiatric providers for children and adults, needs for improved crisis response and gaps in transitional case management and intensive community based treatment options for serious mental illness and co-occurring disorders. These are true in the general and especially in the corrections population.

The state's track record for creative and effective use of state and federal resources can be strengthened in a number of ways. Some potential new Medicaid Waivers can augment the current HIFA Waiver, which will increase federal matches for administrative Medicaid costs. Broadened Medicaid eligibility and enrollment will permit expanded health care access for people with SDMI and transition age youth. The community service system for adults and children needs to support access to care in the community rather than in more restrictive and higher cost services such as residential placements for children, the state hospital for adults, and Corrections for youth and adults. The system would be improved through rate enhancements in targeted areas such as psychiatry, and through the development of a broader range of intensive community based services that include paraprofessional and peer supports.

Stronger coordination of and/or consolidation of child and adult mental health agencies will address systems fragmentation, and increased standardization and consistency of data reporting across state agencies and local advisory groups will assist all stakeholders in informed systems planning and evaluation. At the heart of these changes is the recommended coordination of service delivery, reimbursement and regular, standardized cross-system data reporting by a Care Coordination Organization (CCO), in a quasi-public arrangement that includes state/CCO risk sharing as well as performance incentives for providers and the CCO. Adherence to guiding principles of transparency and accountability in collaboration with all stakeholders, including consumers, local advisory groups and providers will enhance joint ownership and alleviate historical concerns about managed care. While this level of change may appear dramatic, we believe that it is necessary to achieve the promise of the President's New Freedom Commission. It is clearly achievable through the vision that Montana leadership has shown in significant system of care transformation efforts to date.