

Montana Legislative Mental Health Study

Overview



October 14, 2008



Goals of the Study

- 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



Methods

- This report outlines:
 - key findings
 - options for improvement, and
 - recommendations for improvement and system change
- Our methods included: interviews and focus groups with numerous stakeholders; a data request from state administrators; purchase of state and county prevalence data; and the analysis of prevalence and utilization data using population based methods to determine utilization and access rates per capita (or per thousand).
- Where possible findings and recommendations are presented separately for child and adult mental health systems



Study Questions

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? Is additional outreach needed?
4. How can the system be organized differently to deliver services more efficiently? Should Montana provide services through some type of managed care? Why?
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, if at all? Should consumers/families 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. Based on the sequential intercept model, what are the needs, services, gaps, barriers, and best options for providing and financing mental health services for justice-involved adults and juveniles?



General Findings

- Montana officials have been creative and proactive in financing the mental health system
- Eligibility for services, while well-defined, has significant gaps for many
- There is a need for an over-arching structure to coordinate policy and services
- There are inequities in access for children and adults, in regions of the state, and for people who need early intervention and treatment
- While generally a comprehensive benefit, some services, such as crisis services, need expansion to improve the system of community based care
- Native Americans, adults and juveniles in the Corrections system and Veterans are three special populations that need to be addressed.
- There is a need to provide increased support for local and regional planning through Local Advisory Councils, Service Area Authorities, and other local entities



Principles

President's New Freedom Commission

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

Institute of Medicine: Crossing the Quality Chasm

1. Care is based upon continuous healing relationships.
2. Customization is based on patient needs and values.
3. The patient is the source of control.
4. Shared knowledge and the free flow of information is essential.
5. Decision-making is evidence based.
6. Safety is a system priority.
7. There is a need for transparency in all aspects of healthcare delivery.
8. Needs are anticipated.
9. The reduction of waste is ongoing.
10. Cooperation among clinicians is a priority.



Transformation and Levels of Change

- Don Berwick of the Institute for Healthcare Improvement noted that true systems must occur at the following levels*:
 - Experience of Consumers and Communities
 - Micro-systems of care (Primary, specialty and support staff)
 - Healthcare Organizations (Provider Organizations)
 - Health Systems (Purchasers)
 - Public Environment
- Our report tries to address many of these levels.
- The challenge is to create the needed changes at the practice level; changes to the administrative structure and financing are not worthwhile unless they generate the needed changes in practice

* Adapted from Berwick, 2002



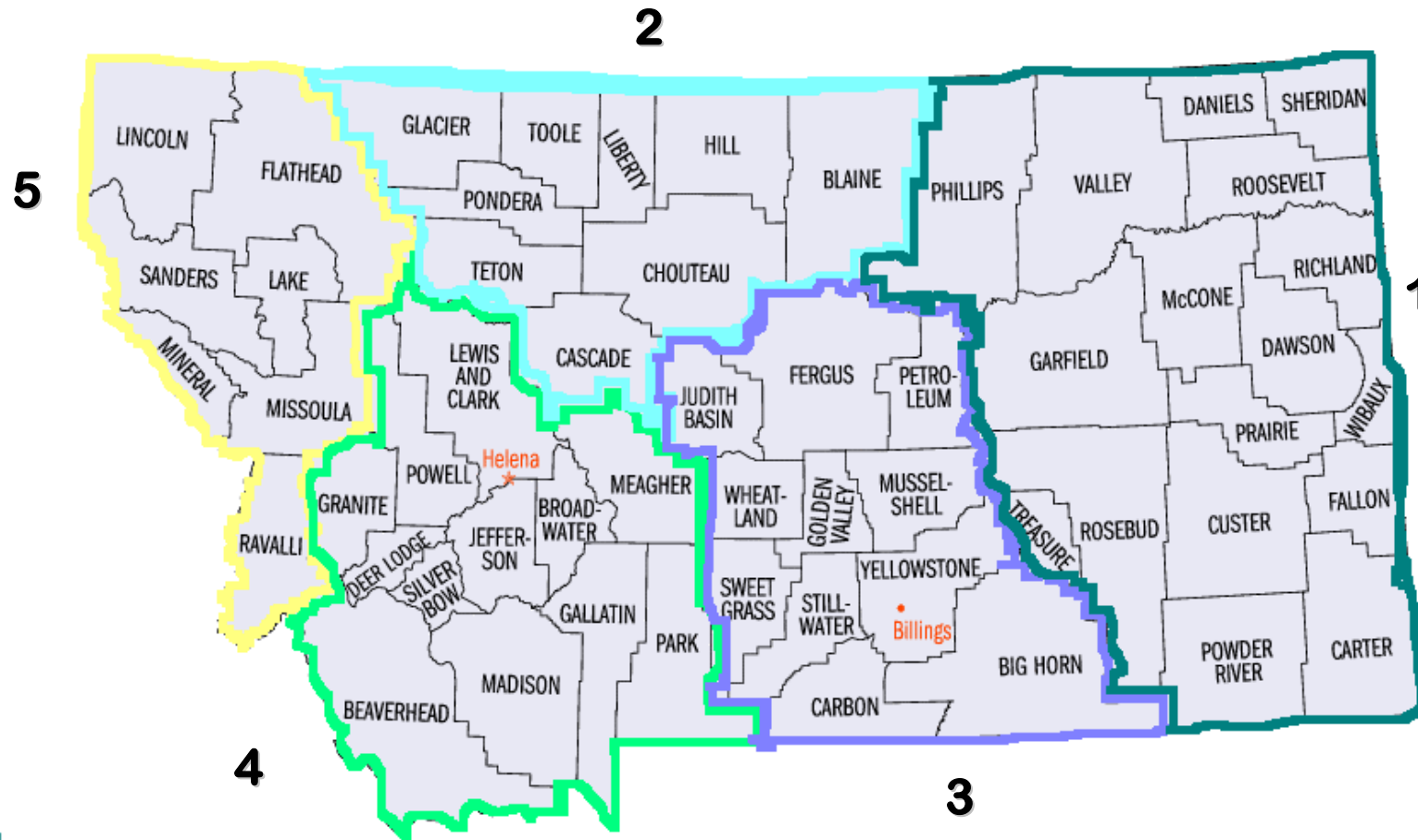
Montana Legislative Mental Health Study

Needs, Services and Gaps



Regions for Analysis – CMHSB Regions

For analysis purposes we used the following regional definitions for child and adult services.





Findings on Children's Eligibility and Coverage

- Eligibility and Coverage
 - Medicaid and CHIP together provide basic mental health services to children up to 175% of poverty
 - Enrollment appears to be high among income eligible children
- Basic mental health services
 - DPHHS programs other than CHIP provided a mental health service and/or a psychotropic medication to an unduplicated total of 11,591 children through Medicaid, CMHSB and CFSD. Medicaid penetration exceeded the rate at which children are expected to experience a mental health or substance abuse disorder.
 - DPHHS data provided a count of children receiving mental health services across a broad range of need, ranging from a single prescription for a psychotropic medication to an extended stay in a residential facility. Some children in this count may have received very minimal mental health services or even used a psychotropic medication for a non-mental health problem.
 - IHS is an important provider of basic mental health services for children, but its services are not included in this analysis
 - CHIP is an important piece of the picture, its penetration rates should be reviewed
 - Medicaid has begun screening for mental health problems in very young children to provide the best opportunity for early intervention



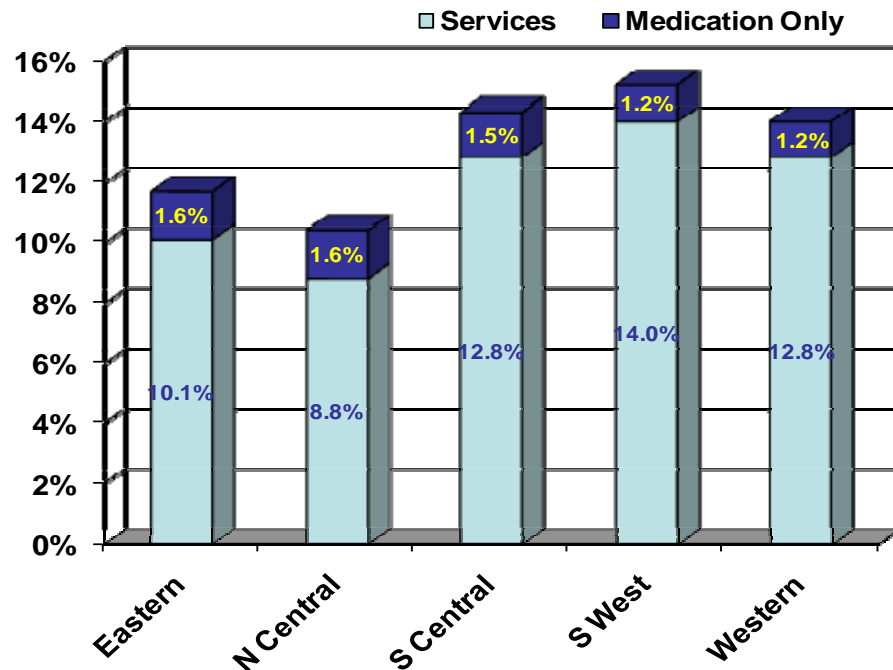
Findings on Services for Children with SED

- Medicaid provides a comprehensive continuum of care for children with SED
- Extended CHIP provides access to most needed services
- CMHSP's small enrollment has an increasingly limited benefit
- Our estimates suggest that services are not reaching all the Medicaid children with SED
 - 4065 children received Medicaid funded outpatient mental health or other Medicaid services for children with SED. This is 7.4% of Medicaid enrollment, less than our prevalence estimate of 8.8%. This 7.4% does not include children receiving services (e.g. medication or primary care only) that are provided outside of the mental health specialty network (CMHB) who likely have less intensive needs.
 - One of the key services for youth with SED, targeted case management, was received by 3285 children
 - Child Psychiatry is very limited. There are only 17 Board Certified child psychiatrists in 5 communities in the state
 - Crisis services with clinicians who have expertise with children are not an emphasis
 - Funds available to purchase services outside of the standard benefit provide needed flexibility in preventing or shortening residential stays, but are limited and not all children meet eligibility criteria



Services are not Uniformly Available Across Regions

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

- There was a differential of 59% between the highest and lowest MH service utilization region for children, and almost a 10-fold difference between the highest and lowest prevalence counties.
- Exclusion of Medicaid mental health services delivered by Indian Health Service Centers contributes to the degree of variation in utilization rates
- School services are not available in 22 counties



Recommendations for Children's Mental Health

- Strengthen crisis services for children
 - 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 that is consistent with and aligned with AMDD's 72 hour presumptive eligibility services.
- Family peer providers can help meet gaps in services for children with SED in frontier areas. They can:
 - Conduct outreach
 - Facilitate service planning,
 - Coordinate care
 - Deliver support services
- Conduct marketing and recruitment efforts for child psychiatrists
 - Raise rates to better reflect average of nearby states



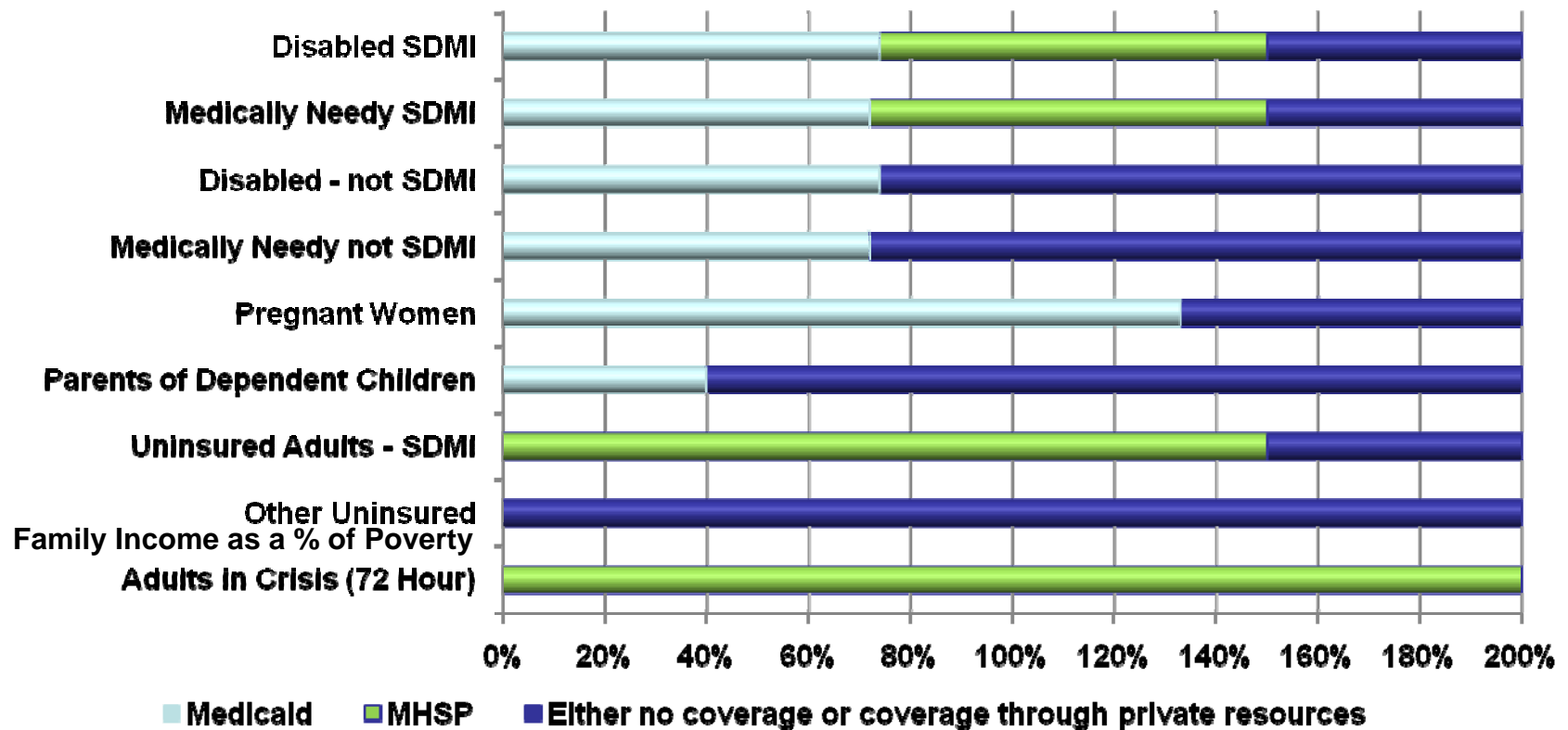
Child Recommendations, cont.

- Develop a strategy for increasing training in treatment of very young children and continue efforts to identify problems through primary care screening.
- Define a Medicaid procedure code for CFSD specialty assessments to reduce state costs and increase federal revenue
- Further expansion of school based services can also help address these gaps
- 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 frontier locations.
 - Find or fund small grants that can finance collaborative approaches with primary care and family support programs
- Continue flexible fund support to CMHB
 - Flex funding can help to reduce the use of residential care and maintain youth with SED in their homes and communities.



Findings on Adult Mental Health Coverage

Coverage for Montana Medicaid and MHSP MH Services of Adults Under 200% of Poverty by Selected Eligibility Category





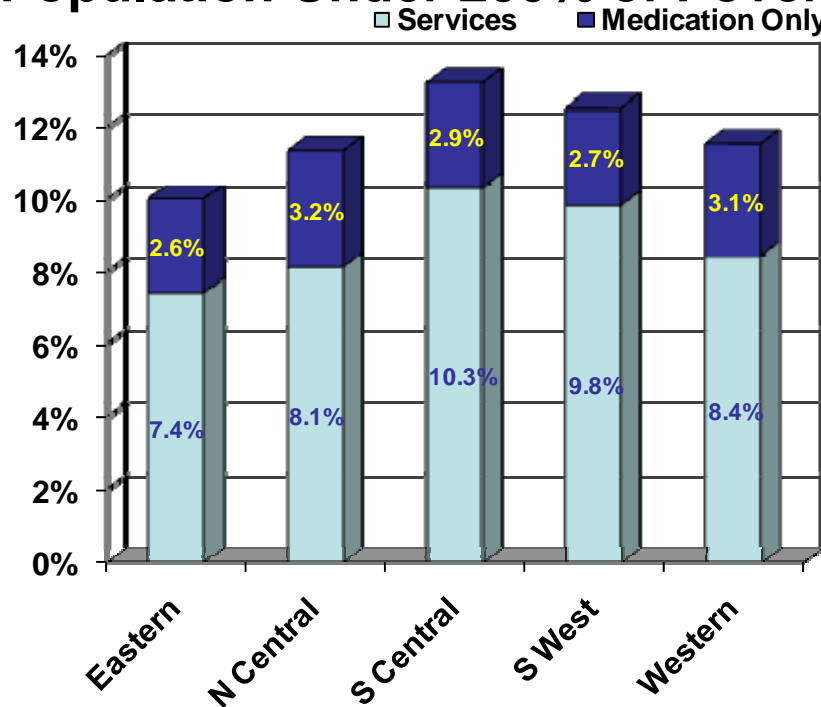
Findings on Adult Access to Services

- **Basic mental health services**
 - The Medicaid benefit is comprehensive for adults with SDMI
 - However, adults with less serious mental health problems can get services from physicians, Federally Qualified Health Centers and other non-specialty providers
 - Within Medicaid, at least 18,631 adults accessed some form of mental health service or medication, exceeding the estimated number of adults likely to have a mental health problem that would cause them to lose a week of work
 - However, among all adults under 150% of poverty, far fewer received Medicaid or other AMDD mental health services than were estimated to have that level of mental health problem
- **SDMI**
 - Within Medicaid, at least 5791 individuals received SDMI services, equivalent to the number estimated to have a serious mental illness
 - Among all adults under 150% of poverty, somewhat fewer received SDMI services through Medicaid or MHSP than were estimated to need that level of care.
- **Service Types**
 - Crisis services are not yet fully developed
 - Only 4 inpatient units exist
 - Until recently, the MSH has consistently been over census
 - MSH has limited ability to control its census



Regional Access to Services

FY2007 DPHHS Adult MH Service & Medication Users* as a Percent of Population Under 200% of Poverty



- The Eastern region has the lowest access to services overall
- It also has the lowest access to specialized SDMI services
- There are no psychiatrists in the Eastern region
- Eastern and North Central have no community inpatient beds

* 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



Adult Recommendations: Eligibility

- Continue to seek federal authorization for targeted eligibility expansion (Health Insurance Flexibility and Accountability) Section 1115 waiver
 - Adults with SDMI up to 150% of poverty
 - Transition age youth with SED who don't meet SDMI criteria
 - 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 crisis services. This should include policies for extending the time period for certain cases.
- Promote maximum enrollment into Medicaid
 - Increase Medicaid application rates through requiring Medicaid application upon MHSP renewal.
 - Keep Medicaid eligibles on a suspended enrollment basis while incarcerated so that they qualify for services immediately upon release.
- If HIFA approach is not approved, consider a general eligibility expansion
 - Expand Medicaid income eligibility
 - Relax SDMI criteria in Medicaid and MHSP



Services for Special Populations

- Native Americans
 - Develop a long-term strategy to enhance collaborations
 - Collaborate with IHS to develop better information about access to mental health services
 - Continue joint efforts with IHS to increase Indian enrollment in Medicaid
- 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 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 connect troubled veterans to VA resources.
 - Identify training and capacity needs as they arise, and develop collaborative plans to address them.
 - Work with the police and court system to screen for veteran status and promote access to military services and supports.



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.
 - Ensure that Medicaid and MHSP funding mechanisms appropriately reimburse the full costs of the service. Consider:
 - Simplifying the rate structure;
 - Grant or deficit funding mechanisms to purchase capacity
 - Limit providers to one designated organization per geographic area as the service expands further across the state
 - Explore options for developing local partnerships like Billing Crisis Clinic
 - Hospitals may need to contribute to crisis service costs
- **Build telemedicine capacity at MSH to support hospital emergency rooms and 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 teleconsultation to jails
- **Request a formal one year review of implementation and utilization of crisis and stabilization services under presumptive eligibility**
 - Review populations denied presumptive eligibility or referred elsewhere



Montana State Hospital 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 for difficult cases
 - Utilize video-conferencing capacity for discharge planning that includes providers and family members
 - Compensate providers for travel time to MSH to attend discharge planning meetings
 - Measure MSH and provider performance in participation in discharge planning and outcomes for discharged clients
 - 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
 - Clearly commit to providing this service on an ongoing basis.
 - Consider developing legislation limiting facilities' medical liability for non-Medicaid consumers.
 - Identify available general hospital beds (e.g. Billings Clinic)
 - Investigate financing models used by other rural states that currently provide this as a Medicaid service



Other Adult Services

- Work with LACs, SAAs and tribes to address service gaps
 - Develop peer service models suitable for frontier areas.
 - Prioritize the needs of Eastern Montana and other frontier areas
 - Pursue small grant sources or appropriate funds for small grants that can finance creative pilots.
 - 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.



Cross Cutting Issues

- Workforce Limitations
 - Telemedicine
 - Review telemedicine service capacity and utilization
 - Consider using enhanced rates under Medicaid to cover reimbursement for operating costs
 - Conduct more comprehensive and systemic recruiting for psychiatry and other mental health professionals
 - Participate in conferences and recruiting fairs,
 - Develop incentives for relocation
 - Develop retention policies based on proven practices.
 - Expand funding for Montana's APRN program or develop recruiting affiliations with other programs to train more practitioners qualified to prescribe psychotropic medications.



Cross Cutting Recommendations

- Local Planning
 - Develop broader consensus on the vision, mission and goals of LAC and SAA community oversight.
 - Make the geographic boundaries for planning areas consistent for adults and youth systems so that resources can be consolidated to work more closely with communities.
 - Clarify relationships between planning groups, councils and authorities.
 - Modify LAC membership to include law enforcement representatives from local authorities and state offices.
 - Provide information to LACs and SAAs needed for planning and monitoring.
 - 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.



Questions?

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Mental Health and Justice Involved Individuals



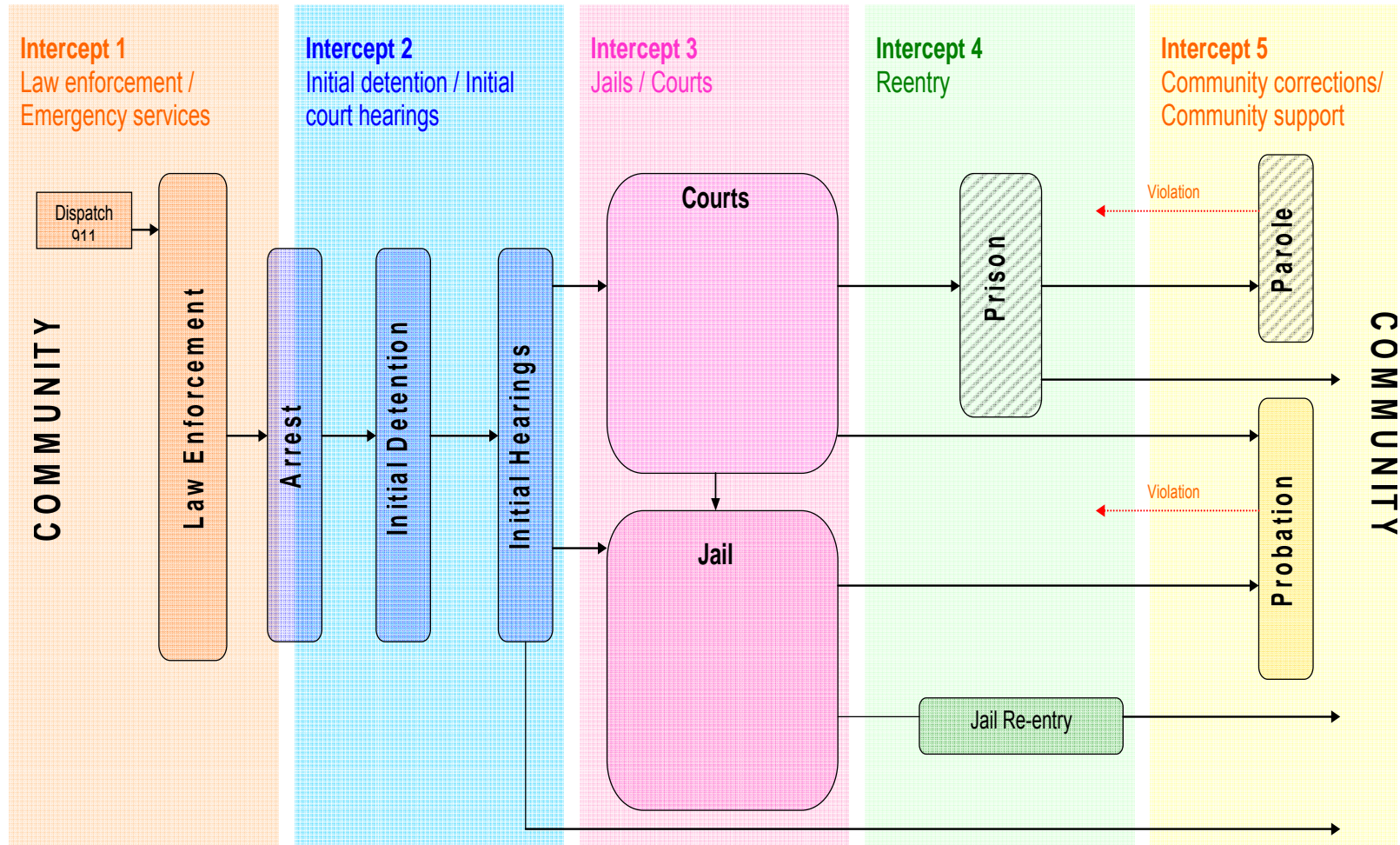
Needs and Gaps

- The national prevalence rate for serious mental illness in prison is estimated at 16%
- Other studies, including a Univ. of Montana study document the frequency of any mental health problem as high as 60%
- Medication and utilization rates for services in Montana State Prison are approximately 27% of the prison population
- Co-Occurring (MH/SA) and trauma related disorders are a major problem nationally
- Across the country there is a need for more MH screening and treatment in correctional settings



Sequential Intercept Model

Sequential Intercepts for Change: Criminal Justice - Mental Health Partnerships





Funding of Correctional Mental Health

**Table IV-7
FY 2007 and FY 2008 Adult DOC Mental Health Expenditures by Program**

	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



Type of MH funding for Corrections

**Table IV-8
FY 2008 DOC Mental Health Total Expenditures
by Type and Program**

	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

MH funding is somewhat balanced between contracts, personnel and medication costs



Strengths of the Correctional MH System

- Behavioral Health Program Facilitator
- Police Crisis Intervention Teams and Billings Crisis Stabilization Center
- Missoula Mental Health Court
- DOC Assessment and Sanctions Unit at Billings and Missoula
- Medication and Case Management Gap funding post-release
- Cross system integration including MH training for probation and parole coordination with MSH
- Trauma screening and assessment at Montana Women's Prison and Passages Program



Recommendations for Correctional MH services

- Data and information sharing – Standardize collection of data across all intercepts. Fund a pilot with several Police CIT programs.
- Information sharing procedures are needed. Build on screening protocols
- Expand Crisis services - Insufficient Pre-Booking Crisis intervention services result in few disposition options for CIT Teams.
- Expand post-booking options – only one MH Court – no communities reported to have diversion options
- Consider expanding gap funding for jails and diversion programs
- Develop more intensive forensic case management and transition case management teams
- Improve training of Community MH teams in forensic issues
- Facilitate local partnership building



Recommendations for Correctional MH services (2)

- Review MSP staffing and programming
 - Consider secure treatment options
 - Continue to explore use of telemedicine to address shortages
- Explore use of peer services in transition planning and community services
- Develop trauma informed and implement trauma specific services – 50% of men and women report recent trauma prior to arrest
- Involve veterans groups in planning

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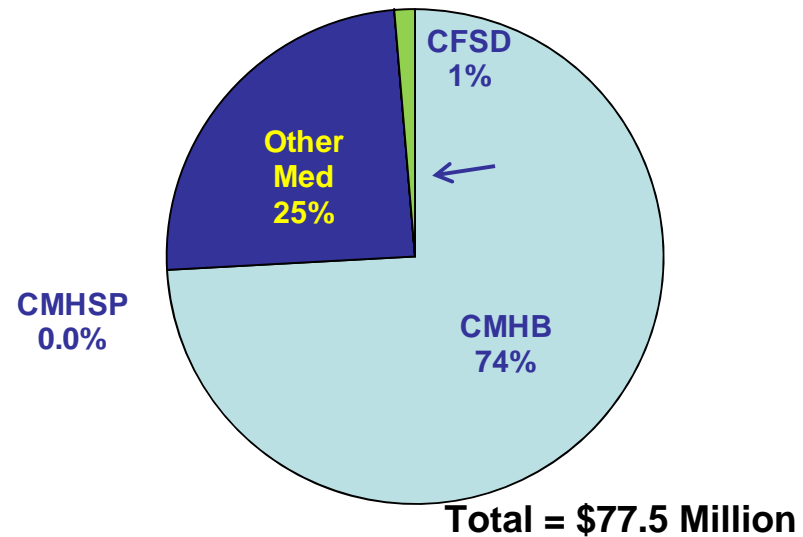
System Financing and Opportunities for New Revenues



Financing Findings: Children's Mental Health Programs

- All but a small percentage of children's mental health services are supported by Medicaid or CHIP (not shown), leveraging federal revenues
- CMHB has several sources of flexible funds, but some have significant restrictions

SFY2007 DPHHS Child MH Service Expenditures* by Source



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



Children's Mental Health Program Funding

Table IV-5

- About half of the service budget goes to 24 hour care
- The PRTF waiver and SOC Account are helping to address this (Grant funding not shown here)
- Crisis service spending is extremely low

SFY2007 DPHHS Children's Mental Health Expenditures by Service Type

(Excluding CHIP and IHS MH Services)

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.

Source: DPHHS Special Report



Financing Recommendations: Children's Mental Health Programs

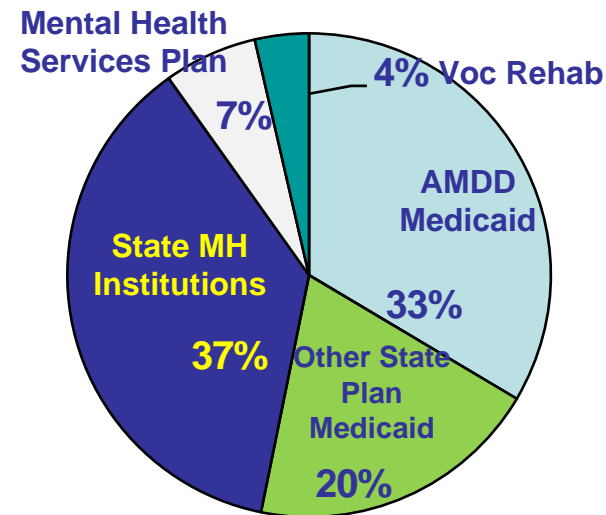
- **Co-Payments**
 - Montana should establish reasonable and fair co-pays that are consistent across both children's and adult's mental health services as allowed by Medicaid, CHIP and DRA regulations. 2006 Budget Reconciliation bill now allows copayments for children
- **Strategic Rate Increases**
 - Raise Montana rates to a more competitive level. Rates for the following 3 services could be increased to the average of other Western states for a total of \$3M.
 - 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.
- **CFSD Services**
 - Develop a Medicaid procedure code 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 Findings: Adult Mental Health Programs

- The state carries substantial responsibility for adult mental health programs
 - State institutions account for the largest share
 - Medicaid accounts for just over half of total expenditures
 - MHSP and Voc Rehab, which each receive federal grant support, account for 11% together

SFY2007 DPHHS Adult MH Service Expenditures* by Source



Total = \$98.8 Million

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

* Excludes IHS MH Services

Source: DPHHS Special Report



Adult Mental Health Program Spending

- Outside of state institutions services, psychotropic medications account for the next largest share of expenses at 21%
 - Targeted case management accounts for 10%
 - All other service types account for less than 10% of the total

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



Financing Recommendations: Adult Mental Health Services

- **Co-Payments**
 - DPHHS co-pay and cost sharing protocols are inconsistent for MHSP and Medicaid consumers, with poorer individuals sometimes charged more than those with more resources.
 - Implement co-payment and cost-sharing arrangements to ensure that Medicaid clients are not charged co-payments that are greater than MHSP members.
- **Home and Community Based Services Waiver - 1915(c).**
 - HCBS allows AMDD to provide a flexible and expanded set of community based services to enable individuals at risk of or in nursing homes to be served in the community
 - 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 further downsized.
- **HIFA waiver**
 - Montana should continue to pursue its HIFA waiver request, with the new administration, if necessary.



Cross Cutting Medicaid Financing Findings

- Compared to other states, Montana has done an excellent job of utilizing Medicaid revenue to fund community based service costs.

Table IV-15
Revenues to Community Mental Health Programs for
Selected and US Average – 2005

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%
US Average	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*, www.nri-inc.org, based on per capita spending percent by fund.



Cross Cutting Medicaid Financing Recommendations

- Assist IHS to Maximize Medicaid revenues
 - Continue efforts to assist IHS to enroll eligible Indians in Medicaid.
 - Collaborate with IHS to investigate its billing rates in case additional services are eligible to be billed to Medicaid.
- 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.



Medicaid Financing Options for the Future

- Prepare to add peer services to the Medicaid State Plan
 - 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 this in these areas and 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
- Consider future use of Section 1915i.
 - Monitor the use of the 1915i by other states and make a decision in a year or more.
 - May be of value in serving developmentally disabled people (particularly youth) who also have mental illness.
- Plan for using administrative Medicaid to cover certain service planning functions in systems of care for children



Cross Cutting Findings on Grant Opportunities

- Montana received \$18.9 million in SAMSHA Grants in FY 2008, exceeding its four neighboring states by as much as 100%.
- Montana received grants or other funding from 44 federal sources.
 - Seven can only be used for mental health purposes
 - The remainder can be used for mental health, but it is not their primary purpose
- An additional 28 federal funding opportunities can be used for mental health
- Some are targeted to recipients other than state governments.

SAMSHA Grant Awards and Neighboring States FFY 2008

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



Other Revenue Opportunities

- **Federal Grants**
 - Continue excellent work in applying for and winning federal grants
 - Consider retaining a grant writer on staff or retainer as grant opportunities arise.
 - 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
- **Potential for Research, Foundation, Philanthropic Support**
 - Limited potential for large grants
 - Active encouragement of community foundations and other sources for small grants to invest in innovative mental health programming may have promise



Questions?

Montana Legislative Mental Health Study

Changes to Improve System Integration



Summary of Recommendations

Recommendations to improve system integration include the following

- Sharing data and information
- Improvements in the organization and coordination of care
- Opportunities to improve accountability
- AMDD and CMHB Organization
- Establish a Care Coordination Organization



Sharing Data & Information

- Standardize Reporting for:
 - MH service provision and expenditures across all DPHHS divisions on a periodic basis
 - CHIP and Expanded CHIP benefit.
- Data sharing protocols
 - Between CMHCs, police, jails and judiciary
 - Between DPHHS divisions
 - Between DPHHS and DOC
- Train community programs, police and others on data sharing protocols
- 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.



Care Coordination

- Pilot mental health screening for individuals entering jails or prison.
- 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



Care Coordination (2)

- 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.
 - As federal grant ends, cover KMA case service planning activities as administrative expenses under Medicaid now and through 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. 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.



Care Coordination (3)

- Strengthen linkages between police, jails, prisons and crisis centers.
- Expand the DPHHS Extraordinary Case Review initiative
- Extend the chronic disease management approach to focus on mental illness.
 - Support mental health care provided by primary care physicians and other health practitioners.
 - Provide pharmacy consultation and outreach
 - Implement statewide telephonic support for individuals not receiving case management but needing education, support and referral and follow up.
 - Coordinate closely with existing case managers
- Strengthen linkages and care coordination activities with primary care
 - Focus on physicians serving individuals diagnosed with mental illness who are receiving prescriptions but no specialty services.



Opportunities for Improving Accountability

- **Performance Contracting**
 - Develop a pay for performance pilot in Medicaid . Incorporate this into the CCO scope or begin a planning process to implement it .
 - 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.**
 - Follow approaches proposed by the Network for Improvement of Addiction treatment (NIATx) or the Institute for Healthcare Improvement (IHI)



Opportunities for Improving Accountability (2)

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



AMDD and CMHB Organization

- If the state does not decide to pursue the CCO or other managed care options
 - 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.
 - Purchasing,
 - Network management,
 - Revenue and TPL functions, among others.
- This should not be a merger of the units.



Establish a Care Coordination Organization

- 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 Research and Demonstration waiver.
 - Consistent with the recommendations of the Whitefish Group
 - Allows for a focus on cross agency implementation and more consistent approaches to child and adult systems through consolidated administrative structure
 - Medicaid waiver required for private or quasi-public entity and for additional federal revenue. 1115 waiver has advantage of incorporating expanded eligibility consistent with HIFA waiver
 - Waiver would allow more selective approaches to fill service gaps (through selective contracting)
 - Develop a detailed implementation plan for approval
 - Expand on the Utilization Management functions performed by First Health.



Private Contractor

The tables on the pages below summarize potential advantages and disadvantages of the three different methods to administer the waiver program

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 • 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 • 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 Entity

Org. Structure	Advantages	Disadvantages
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 (, Wraparound Milwaukee, Piedmont Behavioral Health (NC), and CAMHD ()) • 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



Existing or Reorganized Public Agencies

Org. Structure	Advantages	Disadvantages
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



Reimbursement Options

Waiver programs can be reimbursed on a risk or non-risk basis. The following table summarizes some of the advantages and disadvantages of each.

Table V-2

Managed Care Reimbursement Options: Advantages and Disadvantages

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 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 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



Implementation Planning

- Create a workgroup
- Develop a plan for stakeholder input
- Study all current positions and costs in CMHB, AMDD and other agencies/contractors
- Review governance and legal options
 - Non-Profit corporation
 - Creating separate governmental authority
 - Designate a division within public agencies
- Develop plan for inclusion of MSH and MMHNCC – Options include:
 - Exclusion from CCO benefit
 - Capacity grant with annual negotiations
 - Risk adjusted case rate
 - Fee for service



Implementation Planning (2)

- Develop a plan for revenue retention
 - Initially state would retain risk
 - Build risk reserves largely through state hospital and residential savings
 - Reinvest these in the system once reserves are established
- Draft waiver
- Develop legal documents and financial arrangements including claims payment support
- Implementation steps including contract and staff transfers.



Costs

- Added federal revenue permits state to add new staffing in contract oversight and technology,
- One time costs of \$250,000 to \$300,000 needed
- Recurring costs estimated at \$300,000
- Plan should not include assumptions for decreased service costs
- Costs need further study particularly as efficiencies are identified from staffing analysis and further analysis is done on existing administrative claims and rate setting
- These costs do not include any costs associated with service gaps, rate setting or other administrative actions



Summary

- These organizational changes will require considerable planning and ongoing leadership
- The organizational changes are designed to provide greater focus for planning and implementation activities and they should increase the likelihood of consistent leadership over time
- The organizational recommendations are based on current Medicaid and CMS rules which may change under the new administration
- The planning process should be transparent and open. Memories of the problems with managed care in the 1990's linger and will raise fears among many.

Questions?



Montana Mental Health Study