HB 422 Study: Children's Mental Health Outcomes

The idea of tracking and improving children's mental health outcomes first came before the Legislature during the 2011-2012 interim, when providers proposed the idea to the Select Committee on Efficiency in Government.

That committee introduced House Bill 100 in the 2013 session, to require DPHHS to develop pilot project legislation to improve outcomes and to pay providers based on whether the children they treat attain certain identified outcomes. The bill also created a task force that was to work with DPHHS to develop the legislation and make recommendations to the Legislature.

The Legislature passed the bill, but Gov. Steve Bullock vetoed it. His veto message said in part:

> *The bill is unnecessary in that the measures in the bill may be effectuated under existing state statutory authorities. The Department of Public Health and Human Services is proceeding under those existing authorities with studies and measures that will serve the purpose of this bill. This bill, in duplicating existing authorities and efforts, would not efficiently serve the public's interests in the services to be studied.*

However, in the absence of indications that DPHHS was measuring outcomes or developing pay-for-performance measures, the 2015 Legislature passed HB 422. The main elements of the bill were similar to HB 100. However, during the course of the legislative session, the bill was amended to require the Children and Families Committee to undertake the work originally assigned to a task force of stakeholders.

Requirements of HB 422

Under HB 422, the committee was to study the children's mental health system and recommend to the next Legislature "a system for evidence-based outcomes for services provided to youth and options for performance-based reimbursement for providers." The recommendation was to include legislation for a pilot project to be implemented by DPHHS on July 1, 2017.

As part of its study activities, the committee was to review:

- the current array of children's mental health services;
- the state's system for collecting data related to mental health services and payment for those services;

- evidence-based outcomes and performance-based reimbursement models used by other states; and

- research, recommendations, and other public comment submitted to the committee.

Despite carrying out those activities, committee members found they were unable to develop pilot project legislation. They came to that conclusion after learning that DPHHS does not have a system for collecting data and determining that the executive branch did not appear willing to work with the committee on ideas for developing a database for the outcomes identified by the committee.

Study Activities

The committee began the study in September 2015 with presentations on the scope of children's mental health services in Montana. Members learned that in FY 2014, the most recent year for which information was available, more than 19,500 children received mental health services funded either through the Medicaid program or the Children's Health Insurance Program (CHIP). Medicaid-funded services cost nearly $124 million for 16,771 children, while $3.6 million was spent on CHIP-funded services for just under 3,000 children. For both the Medicaid and CHIP programs, the federal government pays the majority of costs while the state pays the remainder.

In addition, the state paid about $1.2 million in general fund for services that don't quality for federal funds.

The largest amount of money went to the Comprehensive School and Community Treatment program, which served nearly 5,000 children at a cost of about $32.8 million. The next highest amount — about $19.5 million — was spent on therapeutic group home services for 655 children, followed by $18.2 million on psychiatric residential treatment facility services for 549 children.

Most children receiving services must meet the state's definition of serious emotional disturbance, or SED. To do so, children 6 years of age or older have to be found by a licensed mental health professional as having one of 59 mental disorders to a moderate or severe degree. They also must have a moderate to severe functional impairment in at least three of the following areas: self care, community, social relationships, family, or school. A child under 6 years of age must meet the functional impairment criteria in at least two of those areas but does not need to have a specific mental health diagnosis. The family and school criteria also differ somewhat from those for older children.

After learning about the scope of services provided and the number of children served, the committee heard presentations on the following topics during the course of the study:

- the development and use of evidence-based practices that have been proven to result in certain outcomes when treatment is provided in accordance with the practice model;

- the different models for performance-based contracting and the ways in which some states have implemented pay-for-performance for children's mental health or foster care services;
- the need for using measurement tools to determine if outcomes have been achieved;
- the wide variety of items that could be measured;
- the factors that might influence outcomes other than the treatment that is provided; and
- the potential costs of developing state-based measurement tools or using private vendors to collect and analyze data.

Narrowing the Focus

By the end of its January meeting, the committee decided the study should focus on three outcomes for children who had received mental health services: whether they were at home, in school, and out of trouble after receiving services.

In March, the committee heard ideas for pilot project legislation from providers who had offered to work on a plan for the committee. The committee had accepted that offer, recognizing that the scope of the study tasks required more time and expertise than the committee could provide given its limited number of meetings and other study responsibilities.

The providers suggested several types of information that could be collected for each of the three outcomes. They also identified potential groups of children to include in a pilot project. And they outlined required tasks for both providers and DPHHS during the course of the pilot project.

However, DPHHS representatives told the committee during the March meeting that the agency doesn't have a database it could use to collect the suggested information. In May, the committee heard from state officials about the potential time and cost involved in creating a new database or modifying existing databases to collect the information. In June, private vendors discussed the types of surveys they could undertake and the data analysis services they provide.

Although some committee members offered to work on potential pilot project legislation for the August meeting, they subsequently determined that executive branch support may not exist for any proposal developed for the committee.