Report to the Montana Legislature

Required Out-of-State Placement and Monitoring Report
July 1, 2015 through December 31, 2015
Submitted May 24, 2016

This report was prepared by Children's Mental Health Bureau (CMHB) staff with data provided by the Child and Family Services Division (CFS) of the Department of Public Health and Human Services (DPHHS), Department of Corrections, and Youth Court (juvenile probation).

The following statutorily required report is completed by the DPHHS, CMHB, in compliance with:

> **52-2-311. Out-of-state placement monitoring and reporting.**
> (1) The department shall collect the following information regarding high-risk children with multiagency service needs:
> (a) the number of children placed out of state;
> (b) the reasons each child was placed out of state;
> (c) the costs for each child placed out of state;
> (d) the process used to avoid out-of-state placements; and
> (e) the number of in-state providers participating in the pool.
> (2) For children whose placement is funded in whole or in part by Medicaid, the report must include information indicating other department programs with which the child is involved.
> (3) On an ongoing basis, the department shall attempt to reduce out-of-state placements.
> (4) The department shall report biannually to the children, families, health, and human services interim committee concerning the information it has collected under this section and the results of the efforts it has made to reduce out-of-state placements.

Methodology

This report includes children placed out of state by *all State agencies and divisions,* though the report is compiled by the Children's Mental Health Bureau (CMHB), which is a Medicaid bureau within DPHHS. The CMHB is not a placement agency. The report distinguishes between youth who are placed by a parent or guardian (Medicaid only), those placed by a State agency using Medicaid funds, and those placed by a State agency using that Agency's funds (either general fund or braided funding).

The report includes only children who were placed out of state (OOS) on or after July 1, 2015 and on or before December 31, 2015. This is the biannual report to the Legislature covering the first half of SFY16 (7/1/15 through 12/31/15).

Organization

The organization of this report follows the list of required report variables prescribed in statute. The number of youth placed out of state by agency is discussed first, followed by the cost and reasons each youth was placed out of state. Care is given to describe the reasons for placement in OOS psychiatric residential treatment facilities (PRTF) for youth receiving Medicaid funds. Then, the report focuses on potential factors relating to placement in an OOS PRTF. Finally, attention is given to ways that the CMHB is working to reduce OOS placements.

Number of Youth Placed in Out-of-State PRTF's

Table 1 shows the number of youth placed in OOS for the last four six-month periods. During this reporting period there were youth who were placed in more than one out-of-state placement. These youth are counted *each time they entered a new placement if more than 30 days had elapsed between the discharge from one facility and entrance into another.* Thus, a single youth may be counted twice if s/he had more than one placement during the studied time period.

In Table 1, the youth with both Child and Family Services and juvenile justice involvement are only counted once in the total placements. So the total number of youth placed with Medicaid funding (41) is equal to the number placed by Parent or Guardian (20) plus the number placed by each agency (15+5+1+1) minus the number with joint agency involvement (-1).

Table 1. Number of Youth Placed in OOS Psychiatric Residential Treatment Facilities				
	1/1/14-6/30/14	**7/1/14-12/31/14**	**1/1/15-6/30/15**	**7/1/15 to 12/31/15**
Placed by Parent or Guardian with Medicaid Funding	25	30	33	20
Placed by Child and Family Services (CFS) Division with Medicaid Funding	9	12	9	15
Placed by Department of Corrections (juvenile parole) with Medicaid Funding	0	2	0	5
Placed by District Court (juvenile probation) with Medicaid Funding	0	4	6	1
Placed by Child and Family Services ineligible for Medicaid Funding	2	0	0	0
Placed by Department of Corrections ineligible for Medicaid Funding	1	2	1	1
Placed by District Court ineligible for Medicaid Funding	0	2	0	0
Number of youth with both CFS and either Department of Corrections or District Court involvement	0	0	1	0
Total youth placed during period with Medicaid funding	**34**	**48**	**47**	**41**
Total youth placed during period without Medicaid funding	**3**	**4**	**1**	**1**

**Tribal social services placements would have shown as parent or guardian placements in previous reports.

Looking at the number of youth placed in out-of-state PRTFs during a given time frame is one way to look at the population of youth placed out of state. It can occasionally be somewhat misleading because all Medicaid providers have 365 days to bill Medicaid; based on this timing there may be unbilled claims. We know that some out-of-state youth placements have been missed in previous reports because of a billing lag.

Another way to look at placements in OOS PRTF is seen in Tables 2 and 3, which show the number of youth in placement in- and out-of state over time, *as a point in time*. As one can see from the table the percentage of youth in out-of state placements has grown, but so has the overall number of youth in in-state placements. In the past two years, about 30% of the youth in PRTF placement have been in OOS placement.

Table 2. Youth in Placement In State and Out of State as of December*

Number of Youth in:	In-State PRTF	Out-of-State PRTF	Total Placements	Percent Out-of-State Placements (%)
December 2009	104	8	112	7%
December 2010	94	19	113	17%
December 2011	83	22	105	21%
December 2012	104	30	134	22%
December 2013	118	45	163	28%
December 2014	113	46	159	29%
December 2015	121	45	166	27%

*Note: Some historical data on this table has been corrected from previous reports.

Table 3. Youth in Placement In State and Out of State as of June

Number of Youth in:	In-State PRTF	Out-of-State PRTF	Total Placements	Percent Out-of-State Placements (%)
June 2009	92	31	123	25%
June 2010	91	15	106	14%
June 2011	94	19	113	17%
June 2012	104	32	136	24%
June 2013	97	39	136	29%
June 2014	125	53	178	30%
June 2015	133	48	181	27%

In the October 2014, we added an additional caseload to our utilization review contractor's (Magellan Medicaid Administration) responsibilities. In order to be on the list, youth had to have been in a PRTF for an extended period of time, had multiple placements, or be difficult to place. The purpose in creating the caseload was to see what impact we could have on PRTF numbers. CMHB believes that the model has had initial success as the number of youth in PRTF is flat relative to the CMHB population, which is growing. We now have 2.0 FTE Regional Care Coordinators (RCCs) who work with our regional staff to follow all the youth who are placed out of state. This change went into effect in October 2015.

Out-of-State Montana Medicaid PRTFs

Cottonwood and Copper Hills Youth

As reported in September 2015, Montana was alerted that Cottonwood Treatment Center, Utah, was going to close its doors effective July 2015. The State discovered that the facility had been cited by the state of Utah for licensure violations. Montana Medicaid (Children's Mental Health Bureau) also determined that Copper Hills Treatment Center, Utah, would no longer be utilized for Montana youth based on license violations.

Other OOS residential treatment facilities

The OOS residential treatment facilities that remain Montana Medicaid providers as of the end of this period are: Provo Canyon School (Provo, Utah), Benchmark (Woodscross, Utah), Desert Hills (Albuquerque, New Mexico), Coastal Harbor (Savannah, Georgia), Kids Peace (Schnecksville, Pennsylvania), Lakeland Behavioral Health System (Springfield, Missouri), and Teton Peaks (Idaho Falls, ID). The following is a description of each program.

Provo Canyon, Orem, UT

Provo Canyon's Behavioral Hospital adolescent continuum of care offers a variety of programs targeted to meet the needs of youth with conditions such as: conduct and oppositional defiant disorder, comorbid medical disorders, social development disorders, and reactive attachment disorders.

Benchmark, Woods Cross, UT

Benchmark serves adolescent and young adult males, ages 13 to 20, providing treatment for a variety of psychiatric and behavioral disorders including conduct disorder, sexual disorders/sexual misconduct issues, fetal alcohol spectrum disorders, Asperger's disorder, developmental disorders, mood disorders, anxiety disorders, personality disorders and substance abuse issues.

Desert Hills, Albuquerque, NM

Desert Hills provides treatment to youth with serious emotional disturbance, ages five to 21. Specialized units provide for: sexually maladaptive behaviors, PTSD, intellectual disabilities, depression, substance abuse, and behavioral disturbances resulting in multiple treatment failures.

Coastal Harbor, Savannah, GA

Coastal Harbor provides specialized units for males and females who have developmental delays or mild to moderate intellectual disabilities. They also have specialized units for treatment of sexually aggressive or reactive behaviors; aggressive behaviors; self-harming/suicidal behaviors; psychotic symptoms; and histories of trauma.

Kids Peace, Schnecksville, PA

Kids Peace addresses a wide range of issues requiring specialized care, including: bipolar disorder, borderline personality disorder, conduct disorder, co-occurring disorders (psychiatric/substance abuse), depression, dissociative identity disorder, learning disabilities,

psychiatric disorders, PTSD, severe attention-deficit/hyperactivity disorder, and sexual abuse victims/perpetrators.

Lakeland Behavioral Health System, Springfield MO

Lakeland Behavioral Health Systems provides intense, individualized, comprehensive treatment for children and adolescents ages 9 to 20 who demonstrate severe emotional problems prohibiting them from living in a less restrictive community environment. Specialized units for males and females with a long-standing history of displaying behavior problems in their peer groups, school, community and/or their families and a variety of family, social, behavioral, educational, substance abuse, and mental health issues including youth who have issues with poor sexual boundaries and sexually maladaptive behaviors.

Teton Peaks, Idaho Falls, ID

Teton Peaks provides treatment for a variety of disorders, specializing in the treatment of depression, mood disorders, anxiety, post-traumatic stress, psychosis, medical issues complicated by a psychiatric disorder and drug or alcohol related issues associated with a primary psychiatric disorder.

Number of Youth Placed in Out-of-State Therapeutic Group Homes

Normative Services in Sheridan, Wyoming was for many years the only OOS therapeutic group home (TGH) provider approved through Montana Medicaid. Normative Services specializes in youth 13 to 17 who present with psychiatric or behavior problems. The program has a substance abuse component. Table 4 shows the number of youth placed in this group home between July and December of 2015.

Staff secure means there are no locks, but the child needs a high level of constant staff supervision to be maintained in the community.

In November of 2015, Montana Medicaid added a second OOS therapeutic group home in Mountain Home, Idaho. Sequel TSI of Idaho's Mountain Home Academy is a sixty-bed therapeutic residential treatment center providing 24-hour supervision in a staff-secure therapeutic setting for moderate to high-risk adjudicated and non-adjudicated adolescent males, ages ten to 18 with sexually maladaptive behavior problems. The program has a substance abuse component. The campus includes a six-bed dorm for students with Neurodevelopmental Disorders who also exhibit sexually maladaptive behaviors. Two youth were placed at the Mountain Home facility during this reporting period. Montana Medicaid does not pay for sexual offender treatment when a youth is placed at Mountain Home for this purpose.

Table 4. Number of Youth Placed in OOS Therapeutic Group Home (Normative Services and Mountain Home), 7/1/15 to 12/31/15		
	Normative Services	Mountain Home
Placed by Parent or Guardian with Medicaid Funding	1	0
Placed by Child and Family Services (CFS) Division with Medicaid Funding	5	0
Placed by Department of Corrections (juvenile parole) with Medicaid Funding	1	2
Placed by District Court (juvenile probation) with Medicaid Funding	4	0
Placed by Child and Family Services ineligible for Medicaid Funding	0	0
Placed by Department of Corrections ineligible for Medicaid Funding	0	0
Placed by District Court ineligible for Medicaid Funding	0	0
Number of youth with both CFS and either Department of Corrections or District Court involvement placed	7	0
Placed by Tribal Social Services with Medicaid Funding	2	0
Total youth placed during period with Medicaid funding	**20**	**2**
Total youth placed during period without Medicaid funding	**0**	**0**

Number of Youth Placed in Out-of-State Non-Therapeutic Placements

District Court (juvenile probation), Department of Corrections (juvenile parole), and Child and Family Services, the State agencies who are statutory placement agencies, occasionally place with non-Montana Medicaid providers. Usually these programs are not able to be Medicaid mental health placements because they specialize in treatment of offenders (sexual or conduct), substance abuse, or physical health issues. Sometimes they are mental health placements that have not become Montana Medicaid providers. There were two reported placements in non-Medicaid facilities during this period.

It should be noted that the DPHHS has no way of keeping track of youth placed by private entities out of state in non-Medicaid placements.

Costs for Each Youth

Table 5 lists the costs associated with OOS PRTF placements. Please note that the costs listed for Medicaid clients include both the general fund (state-funded) portion, and the federal match. The federal match is based on the FMAP (federal matching assistance percentage) and for FFY15 (10/14 to 9/15) is 65.90, for FFY16 (10/15-9/16) is 65.56. This means that about one third of the cost for Medicaid placements was covered by state general fund dollars. The table includes non-Medicaid residential placements, but does not include OOS TGH placements.

Table 5. List of Total Costs of Stay (as of March 2016) per Youth Placed in PRTF, 7/1/15 to 12/31/15		
1. 43,650.00	2. 22,098.00	3. 30,099.00
4. 42,750.00	5. 13,050.00	6. 38,350.00
7. 23,400.00	8. 21,804.00	9. 51,551.50
10. 360.50	11. 37,852.50	12. 23,040.00
13. 9,750.00	14. 66,332.00	15. 74,100.00
16. 900.00	17. 90,350.00	18. 79,300.00
19. 53,550.00	20. 78,750.00	21. 43,620.00
22. 82,800.00	23. 10,800.00	24. 106,600.00
25. 23,400.00	26. 23,241.00	27. 82,800.00
28. 17,755.50	29. 9,900.00	30. 3,244.50
31. 51,912.00	32. 50,850.00	33. 119,600.00
34. 59,400.00	35. 11,175.50	36. 66,537.00
37. 74,100.00	38. 19,812.00	39. 25,875.00
40. 68,850.00	41. 20,548.50	42. 14,310.00*

*Non-Medicaid Placement

Reasons Youth are placed in OOS PRTF (For youth admitted 7-1-15 through 12/31/15)

Placement in an OOS PRTF through Medicaid can only occur after a youth has been certified as needing treatment at the PRTF level of care but denied at all three in-state PRTF's. In order to be certified as needing care at the PRTF level, a youth must exhibit behaviors or symptoms of serious emotional disturbance of a severe and persistent nature requiring 24-hour treatment under the direction of a physician. In addition, for a youth to be certified at this level of care, the prognosis for treatment at the PRTF level of care must reasonably be expected to improve the clinical condition/serious emotional disturbance of the youth or prevent further regression based upon a physician's evaluation.

When an in-state PRTF denies admission to a youth, a letter is generated by the provider indicating the reason for denial. The actual letters were not available for review; the following data was retrieved from the Magellan Medicaid Administration (MMA) system.

For the period of July through December of 2015, there were 44 initial prior authorization requests for out of state PRTF's entered into the MMA site. No data are included on those youth who did not meet PRTF medical necessity criteria and were denied Medicaid payment. The data on reasons for denial at in state PRTF's is based on 44 initial prior authorizations. In many cases, multiple reasons for denial were noted.

The first MT PRTF noted the following reasons for denial:

- 25%: Conduct disorder behavior or mentioned conduct disorder in the reason for denial
- 20%: Met maximum therapeutic benefit at last stay or made minimal progress during last treatment
- 18%: Level of disruptive behavior is not manageable on the current milieu; unable to manage level of aggression; displays aggressive, threatening and grooming behavior that cannot be managed; cannot safely manage level of aggression; assault risk; level of aggression is not appropriate for PRTF Level of Care (LOC) and could not be managed; unable to manage youth's inappropriate behavior on current milieu; denied placement due to youth's severe violence/physical aggression
- 14%: No reason given. The Bureau intends to follow up when this occurs.
- Less than 1%:
  - No beds
  - No sex offender treatment offered
  - Severe suicide risk requires 1:1 staffing; cannot manage suicidal self-injurious behavior with current milieu with multiple suicide patients
  - Provider does not have chemical dependency (CD) component and cannot treat youth
  - Cannot manage regressed behavior
  - Parents want a behaviorally based program

The second MT PRTF noted the following reasons for denial:

- 73%: Not screened for admittance because no bed available
- 16%: No reason entered into the system. Follow-up will occur.
- Less than 1%:
  - Severe violence & physical aggression means a series of physical assaults without response to therapeutic intervention
  - History of PRTF placement without benefit, youth unlikely to benefit from admission
  - Sexually reactive or sexually offending behavior
  - Primary presenting problem is chemical dependency

The third MT PRTF noted the following reasons for denial:

- 23%: Severe violence/physical aggression; facility can't assure safety of youth, peers, staff
- 18%: Sexually reactive or sexually offending behavior
- 16%: No reason entered into the system. Follow-up will occur.

- 14%: Developmentally delayed, IQ too low to benefit from program
- Less than 1%:
    - Not screened for admittance because no bed available
    - Severe suicide risk
    - Elopement risk
    - Too young for program (1 youth)
    - Disregard for limit setting, requiring 1:1 staffing more than 75% of time
    - Primary problem is substance abuse

Substance abuse disorder was noted in 25% of the youth screened for placement as evidenced by either a formal diagnosis or a reference to a history of substance abuse. (Tobacco use was noted in some cases, but unless there was an additional substance noted, tobacco was not counted in the total.) Substance abuse is likely *underreported* in these data.

The primary diagnoses noted are as follows: 59% had a diagnosis of mood disorder; three of these youth also had psychosis. 11% had post-traumatic stress disorder (PTSD); 18% had oppositional defiant disorder (ODD). 12% had other diagnoses. Breakdown of the 44 records reviewed:

By Primary Diagnosis:

- Eight had a diagnosis of oppositional defiant disorder.
- Sixteen had a diagnosis of bipolar disorder and psychosis was added to two of these.
- Seven had a diagnosis of major depressive disorder with psychosis was added to one of these diagnosis.
- One had episodic mood disorder NOS. Even though this diagnosis isn't a reimbursable primary diagnosis, another secondary diagnosis was present.
- One had depressive disorder NOS. Even though this diagnosis isn't a reimbursable primary diagnosis other secondary diagnosis was present.
- One had dysthymia.
- Five had PTSD with one of these with an added diagnosis of psychosis.
- One had schizoaffective disorder.
- One had reactive attachment disorder.
- One had ADHD.
- One had autism.
- One had psychosis.

38 out of the 44 prior authorizations also had a secondary diagnosis:

- PTSD - 36%.
- ODD - 27%.
- Attention deficit/hyperactivity disorder (ADHD) – 25%.
- Conduct disorder- 16%.
- Reactive attachment disorder – 16%.
- Obsessive compulsive disorder (OCD) - 1%
- Less than 1% include:

- Mood disorder not otherwise specified (NOS)
- Major depressive disorder with psychosis
- Intermittent explosive disorder

While not listed as a primary diagnosis, two youth had a diagnosis of autistic disorder or pervasive developmental disorder. Five youth were noted as having borderline IQ and/or moderate mental retardation.

These data reflect the age of youth as of 12/31/15:

- 30% of the youth were age 17.
- 18% were age 16;
- 16% were age 15;
- 14% were age 14,
- Less than 1% of the youth were between the ages of 10 to 13; and
- One youth turned 18 before Dec 31 2015.

The youngest youth in the study in an out of state PRTF during this time period was eight years of age. The increasingly younger age of clients going to PRTF (whether in- or out-of-state) is a cause for concern. Possible factors include children getting sicker and providers in Montana have not found an effective way to treat behavior associated with early childhood mental illness.

Process Used to Avoid OOS Placements

Occasionally youth meeting dual diagnosis criteria for mental health and developmental disability are sent to OOS placements. While youth meeting dual diagnosis criteria can generally be served in their homes, youth at the extreme end of this spectrum (one to three in the population served per year) have extremely specific needs. The majority of youth meeting dual diagnosis criteria are receiving in-home services (which seems positive). Due to the small number of youth in this group and the ability of the Developmental Services Division to serve the relatively small number of high needs youth, this population is identified as a population to watch.

For the purpose of this report, dual diagnosis means that a youth is both developmentally disabled and emotionally disturbed. Co-occurring means that a youth has both a serious emotional disturbance and a substance abuse disorder.

The development of the Autism State Plan Amendment (SPA) is likely to reduce, over time, the number of youth with autism age birth to age 21, with a diagnosis of Autism Spectrum Disorder (ASD) or related condition being served at the PRTF level of care. The Department does not anticipate that we will be able to see the effect of such a program for five to ten years. Members must be enrolled in Montana Medicaid and meet identified medical necessity criteria to be eligible for treatment. This new plan will be overseen by

the Developmental Disabilities Program within the Department of Public Health and Human Services.

Clearly there is a need to address the population of youth with co-occurring disorders. As noted in the data, at least 25% of the youth entering OOS PRTF had a substance abuse disorder evidenced by either a formal diagnosis or a reference to a history of substance abuse. (Tobacco use was noted in some cases, but unless there was an additional substance noted, tobacco was not counted in the total.)

CMHB is coordinating the sustainability of two grants through Medicaid resources. A partnership between the Chemical Dependency Bureau and the CMHB has been established and a collaboration effort is ongoing. One of the grants, Integrated Co-Occurring Treatment, is currently in a no-cost extension through SAMHSA. The CMHB is applying for a state plan service in order to sustain this treatment modality. Upon approval from the Centers for Medicare and Medicaid Services, this program will be able to sustain many of this co-occurring population in their homes and communities.

The Bureau is continuing to explore additional opportunities for the integration of substance abuse and mental health treatment, including a behavioral health home option for transitional aged (16-25) youth. The number of youth in PRTF who are 17 is indicative of an issue that has been long-standing; namely that transition from children's to adult's services is difficult.

As noted near the beginning of this report, the number of youth in PRTF is flat relative to the CMHB population, which is growing. As noted, we credit much of this change to the care coordination function we added through our UR contractor, MMA. CMHB is beginning to glean data from this program and hope to use it to make policy decisions in the future. One policy decision already made as a result of data from RCCs is to review PRTF placements every 30 days for medical necessity. 30 days is still a long time relative to the utilization review practices in much private insurance, which often requires a review every seven to 14 days.

As of October 2015 CMHB staff has taken on the prior authorization of therapeutic group home services (TGH). We now review both initial and continued stay requests for therapeutic group homes to ensure that youth are in the least restrictive level of care throughout the system. CMHB expects to gain insight on the utilization of TGH through prior authorization oversight.

In addition to the above, CMHB is in the process of instituting more precise PRTF medical necessity criteria. These criteria have been reviewed by psychiatrists, facilities, and our utilization review contractor. The rules adopting these criteria are anticipated to go into effect in July 2016. The criteria should more clearly distinguish between youth requiring a medical model of care (PRTF) and a community model of care (e.g., a therapeutic group home).

We are also exploring placing additional limitations on OOS placement, such as an age restriction for placement of young children as well as an additional level of utilization review.

Number of Youth Participating in the Pool

Pursuant to HB565 and effective October 26, 2012, Children's Mental Health Bureau supplied the posting of a secure HIPAA-compliant, Department-approved data management system to allow sharing and review of confidential treatment plans for youth who are currently placed out of state or who are at risk of being placed out of state for mental health services in a therapeutic youth group home (TGH) or psychiatric residential treatment facility (PRTF). To date, this resource has not been accessed or used by any providers.