Montana
Mental Health Study

Legislative Briefing

June 10, 2008

DMA
Health
Strategies

Overview

- Three site visits with a wide variety of state officials, providers, advocates and others. Additional call to be scheduled
- Additional meetings and calls on program and financing issues scheduled for June and July
- Mental Health Oversight Advisory Council visit - July 18
- Web Survey to be released this week
- Data request received ~ two weeks ago. It is extraordinarily comprehensive. Very preliminary statewide findings follow

March Visit

Anita Roessmann, Disability Rights Montana
AMDD Staff - D. Sanchez, D. Ladd, M. Armstrong, A. Hwong
Anna Whiting-Sorrell, Governor's Policy Advisor on Families
Mignon Waterman, Former Senator, Former MHOAC Chair
Jim FitzGerald, Chairman, MHOAC and Intermountain Children's Home
Gene Haire, Executive Director, Mental Disabilities Board of Visitors
Joyce DeCunzo, Administrator, Addictive & Mental Disorders Division
Gary and Sandy Mihelish, NAMI Montana
Pat Sullivan, Budget Analyst, Governor's Office of Budget & Program Planning
Shirley Brown and Management Team, Child & Family Services Division
John Chappuis, Deputy Director of DPHHS with his Senior Managers

- Joyce DeCunzo, AMDD;
- Mary Dalton, Administrator, Health Resources Division, Medicaid;
- Bonnie Adee, Chief Children's Mental Health Bureau;
- Shirley Brown, CFS

May Visit

Lou Thompson and staff, AMDD
Mary Dalton, Administrator, Health Resources Division, Medicaid
Bonnie Adee, Chief Children's Mental Health Bureau
Pamela Helms, Helena KMA Project Director
Tom Peluso, Central SAA, Bozeman LAC, NAMI MT
Ed Amberg, Psychiatrists, Consumers and staff at Montana State Hospital
Dan Aune, MHA Board Member
Dennis Alexander, MT Mental Health Association
Gail Briese-Zimmer, DPHHS, Administrator
Kathy McGowan, Council of Community MH Centers, Sheriff's and Peace Officer's Association, Attorney, CMHC Leaders and County DAs;
- Paul Meyer, Western Missoula HC;
- Robert Ross, South Central MHC, Billings;
- Mike McLaughlin, Center for Mental Health, Great Falls;
- Mike Menahan, Lewis and Clark County Deputy Attorney;
- Leo Gallagher, Lewis and Clark County Attorney;
- Karen Mahar, Ravalli Cty. Deputy Attorney

Focus Group with Eastern SAA

May Visit - Corrections and Justice

- **May 14, 2008 Stakeholders Meeting**
  - Gary Mihelish, NAMI;
  - Eve Franklin, MH Ombudsman;
  - Brent Doig, Governor's Budget Office;
  - Sue O'Connell, Legislative Services;
  - Sheri Heffelfinger, Legislative Services;
  - Jerry Williams, MT Law Enforcement Academy;
  - Rick Alan Deady, Dept. of Correction;
  - Mike Menahan, Deputy County. Atty., Lewis and Clark County;
  - Steve Gibson, DOC Youth Services;
  - Leslie Halligan, Deputy County Atty. Missoula County

- **May 15, 2008 Missoula MHC Meeting**
  - Brenda Desmond, Standing Master;
  - Kim Lahiff, Probation;
  - Aaron Hedges, Winds of Change;
  - Theresa Conley, MHC Coordinator;
  - Leslie Halligan, County Attorney;
  - Catherine Sohlberg, Public Defender;
  - Corey Simonson, Graduate

Facilities Visited

- Montana State Hospital
- Passages
- Montana Women's Prison
- Yellowstone County Detention Center
- Pine Hills Youth Correctional Center
- Lewis and Clark County Detention Center
- Montana State Hospital Forensic Unit
- Montana State Prison

Assessment of Needs and Gaps

What is covered: Medicaid and MHSP

- Wide range of services are covered within Medicaid state plan
- MHSP benefits fill an important gap given the tight income limits on Medicaid TANF and Disability. They are more limited than Medicaid and do not include a hospital benefit.
    - The medication benefit ($425 per month) is an extremely important benefit for many yet people report it is not sufficient for expensive or multiple medications
    - The planned shift from grants to FFS may create additional financial pressures
- Home and community based waiver for adults is unique
- Children's services benefit significantly from the system of care grant.
- The child system needs more of a continuum of community based services to avoid residential
- As in many states, the transition from youth to adult services is "rocky"

Who is covered?

Eligibility – Medicaid and MHSP

- Disability and income requirements for Medicaid eligibility place significant limits on who can receive Medicaid mental health services.
  - For adults, a person must be made eligible through a diagnosis of SDMI. This also limits who can receive services and increases people's chances for negative outcomes including hospitalization and involvement with the criminal justice system.
  - An SED diagnosis is required for children who are Medicaid eligible and outpatient services are limited to 24 visits. This may prohibit some children from receiving needed services. Only a small amount of funding is made available for children who are not SED (minimal state-only program).
- MHSP coverage is available to adults with SDMI whose income is up to 150% of FPL rather than the statutorily set threshold of 160% FPL.
- A large number of people discharged from MSH to the community have no eligibility for drugs or services.
- Eligibility for and the communities understanding of EPSDT services to children appears to be limited

Where are services available?

Service capacity and availability

- Most aspects of a comprehensive system are available somewhere within the state; however services are not available in all areas of the state
- Having only one state hospital in Warm Springs creates significant access issues for other regions
- Psychiatric, prescribing and crisis services throughout Montana should be a top priority for service expansion
- Encourage competition in service delivery for new providers and clearly define services to be purchased.
- Explore additional expansion of mental health services at Federally Qualified Health Centers, perhaps in partnerships with CMHCs
- Rates for Medicaid services appear to be a barrier for children who are in the care and custody of the state when they need mental health evaluations and services
- Physician wait time can be as extreme as six months in some parts of the state. This has become somewhat of an accepted “norm”.
- Consider additional educational reimbursement, other subsidies and/or tax incentives to expand the mental health workforce.

State Hospital

Access and Community Discharge Coordination

- The State Hospital census in many ways functions as a barometer for the "health" of the system
- Because of strict income and disability eligibility requirements, the state Hospital is often the only initial publicly financed treatment option for many people (until the recent 72 hour presumptive eligibility)
- Admissions and discharges between Warm Springs and the community need more coordination with community providers
  - Ensure that community providers participate in admissions and discharge planning for known consumers
  - Increase timeliness of post-discharge follow-up in the community
  - More information needed concerning community treatment "compliance" and "conditions for release". There are different meanings for treatment providers, hospital staff, law enforcement and the courts.
- DPHHS' "Extraordinary Case" Initiative is coordinating care across agencies, assigning responsibility, and sharing funding for common clients. This is a best practice and may be able to be expanded.

Administrative and Interagency Issues

- Many felt that the communication between levels of the community planning process could be improved
- There is some confusion over what should be the role of State Agency staff in SAA process and how they can best support the work of the committees
- Support the tracking of Recovery markers for adult consumers and use of pharmacy and service data by case managers
- Contracts for the community mental health systems do not contain performance measures for client outcomes
- Evaluate the feasibility of performance contracting with mental health centers to reduce state hospital readmissions and achieve other goals. Performance contracting makes a portion of reimbursement contingent on achieving performance results. This is often in the form of bonuses or penalties
- Consider a more active value based purchasing approach to contract with a more comprehensive continuum of services, at least in urban areas
- Consider legislation to encourage employment of consumers in the mental health system and reduce liability risk for provider/employers

Selected Finance Issues

- Montana ranks 12th among 51 states and territories reporting per capita spending (NASMHPD, FY 2005 Revenue and Expenditures Report)
- Explore options for federal or third party collections for persons receiving treatment at the State Hospital. May require accreditation by the Joint Commission at the State Hospital. Further inquiry re: the MH Nursing Care Center needed.
- DMA team will review details of County reimbursement for involuntary detention and assessment at MSH, including methods for setting MSH rates and "billing" counties
- Montana might increase Medicaid enrollment for MHS patients through more frequent eligibility matching and/or requiring MHSP clients to apply for Medicaid more frequently.
- We will explore the feasibility of various revenue enhancement options including , managed care waivers, 1915 (i) State Plan Options and strategies designed to maintain existing revenue for school based services, targeted case management and rehab option.

Adult Criminal Justice

Strengths:

- Behavioral Health Program Facilitator
- DOC Assessment and Sanction Units
- Gap Funding – The concept is strong, but more information is needed to explain current low spending levels
- Cross system integration at the state level
- Police CIT Initiatives
- Billings Community Crisis Center

Gaps

- Data exchange and information sharing
- Insufficient pre- and post-booking options
- Lack of consistent jail screening and treatment capacity
- Lack of case management/PACT, forensic case management and EBP's
- Improve local planning capacity for diversionary services
- Need for Adult Secure Treatment Unit
- More information needed on youth justice issues

Preliminary Adult Justice Recommendations

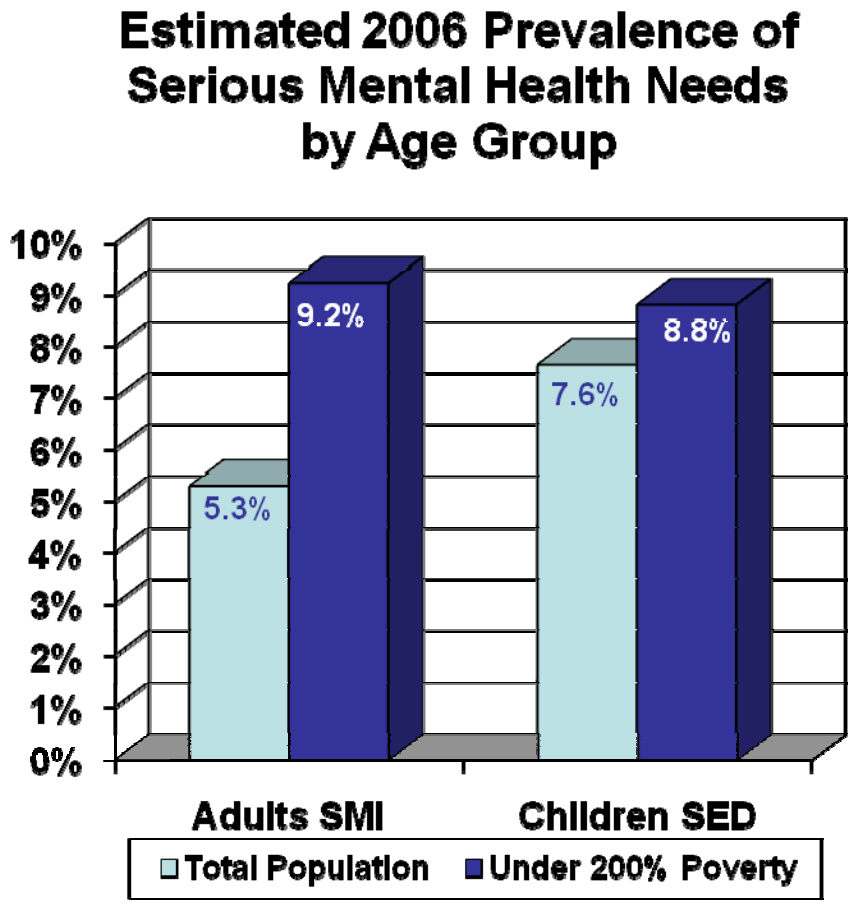
- Improve data collection
- Improve flow of clinical information between systems
- Expand crisis stabilization capacity
- Expand post booking options
- Develop specialized forensic case management and transition case management
- Increase training for MH workforce on justice issues
- Facilitate partnership building at the local level
- Examine mental health staffing and programming at Montana State Prison
- Expand peer initiatives for justice involved persons
- Address Veterans issues
- Some data has been collected on the Juvenile Justice system, however more analysis is needed.

Preliminary Statewide Prevalence, Penetration and Spending Data

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

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

How many people need mental health services?

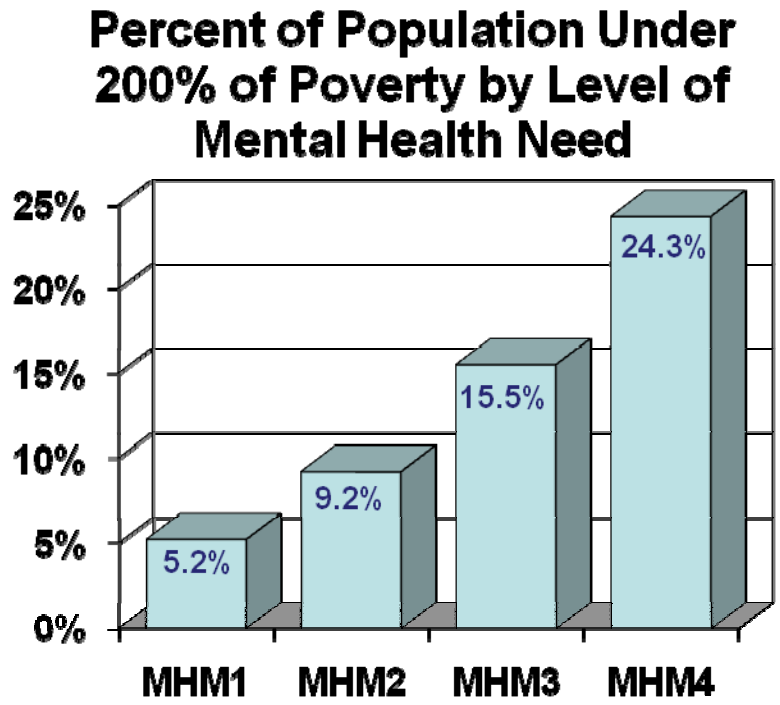


Source: Estimates by Charles Holzer based on CPES and Census Estimates

- **Adults with Serious Mental Illness (SMI)**
  - 38,500 in the total population
  - 22,000 under 200% of poverty
- **Children with Serious Emotional Disturbance (SED)**
  - 16,500 in the total population
  - 8,900 under 200% of poverty

Definitions of Adult Mental Health Need

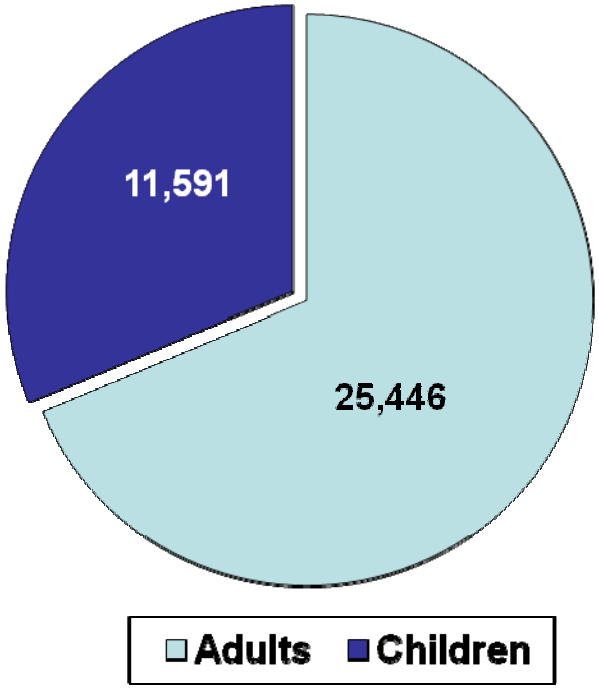
Need level is based on: Diagnosis, Impairment and Days off work



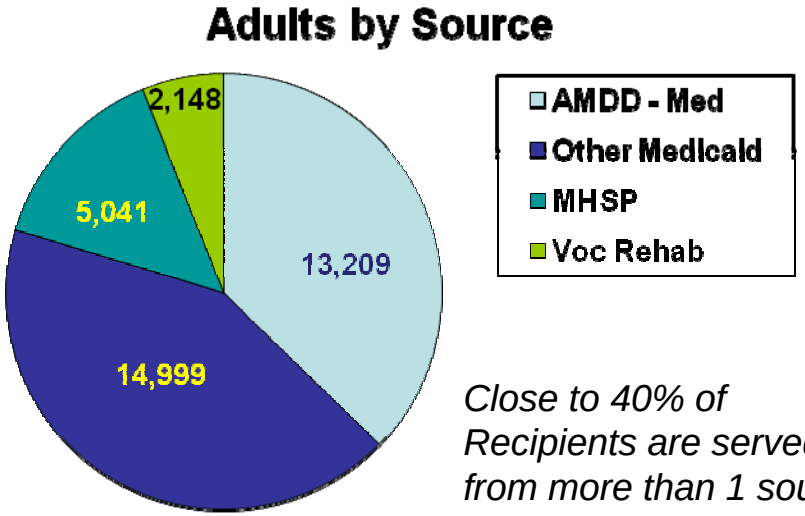
Source: Estimates by Charles Holzer based on CPES and Census Estimates

- **MHM1 – comparable to SPMI**
  - Chronic Major MH Diagnosis
  - Average impairment >=7
  - More than 4 months off work
- **MHM2 – comparable to SMI, but more conservative**
  - Chronic MH diagnosis
  - Average impairment >=7
  - More than 4 months off work
- **MHM3**
  - Current MH diagnosis
  - Average impairment >=5
  - More than 1 month off work
- **MHM4**
  - Any current mental health need
  - Average impairment >=3
  - More than 1 week off work
- **Children's Levels of Need**
  - Surveys and research do not provide sufficient detail to estimate more than one level of need

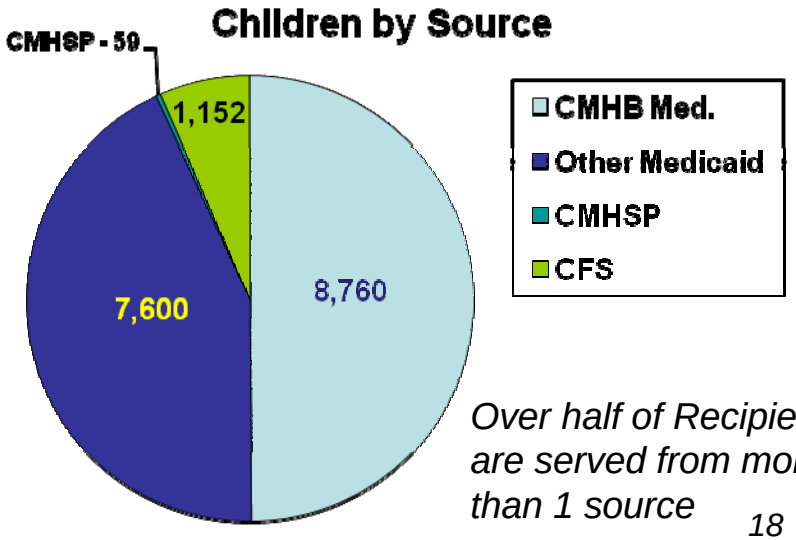
What services are being delivered?



AMDD, CMHB, CFS, & Voc Rehab



Close to 40% of Recipients are served from more than 1 source

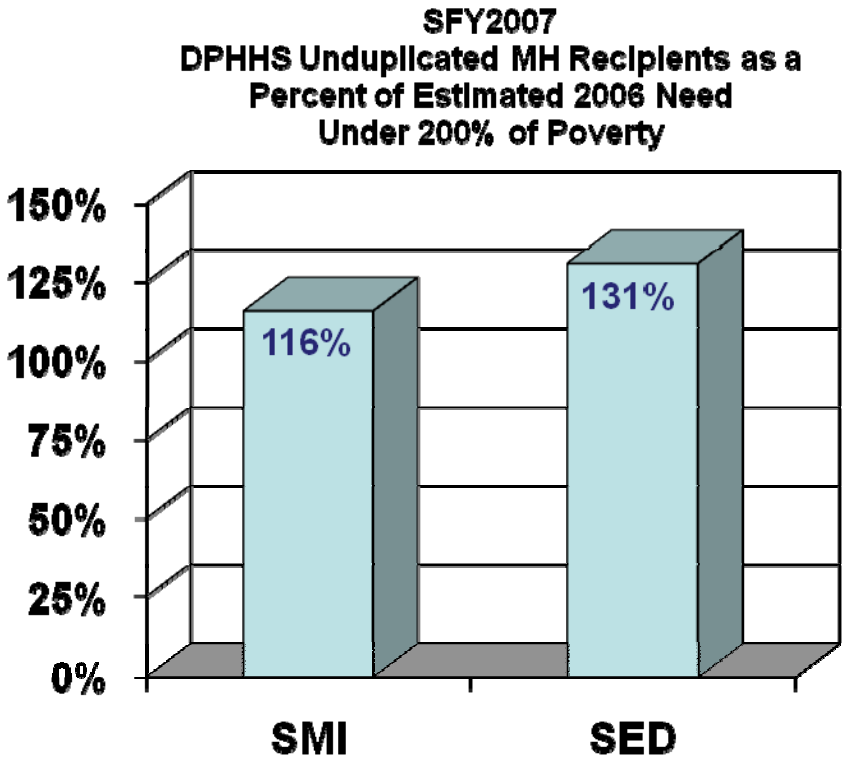


Over half of Recipients are served from more than 1 source

Source: DPHHS Special Report

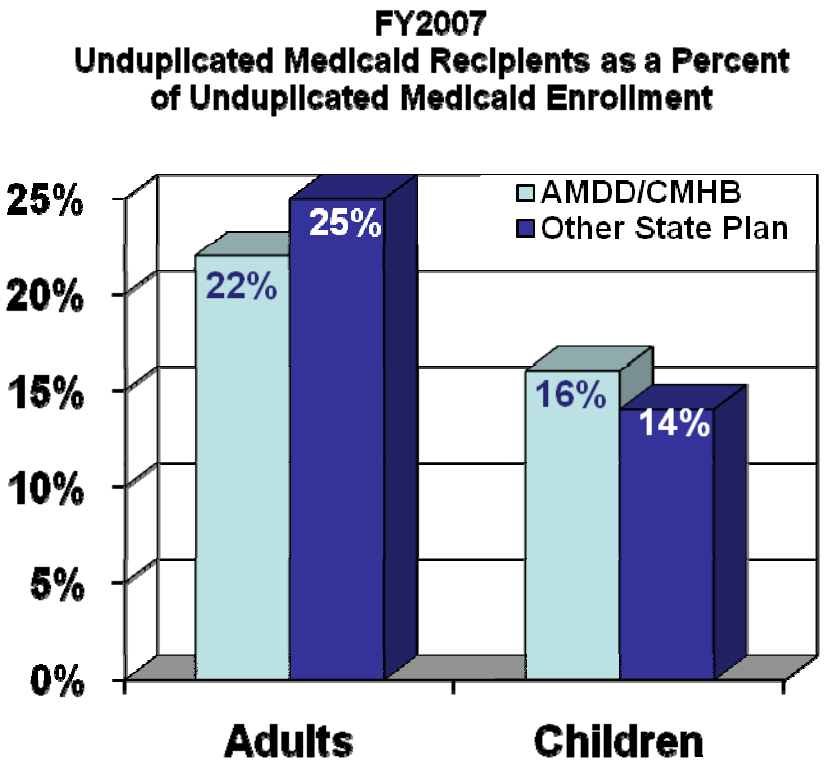
How well are services meeting needs?

Overall Penetration



Note: Excludes CHIP services and enrollment

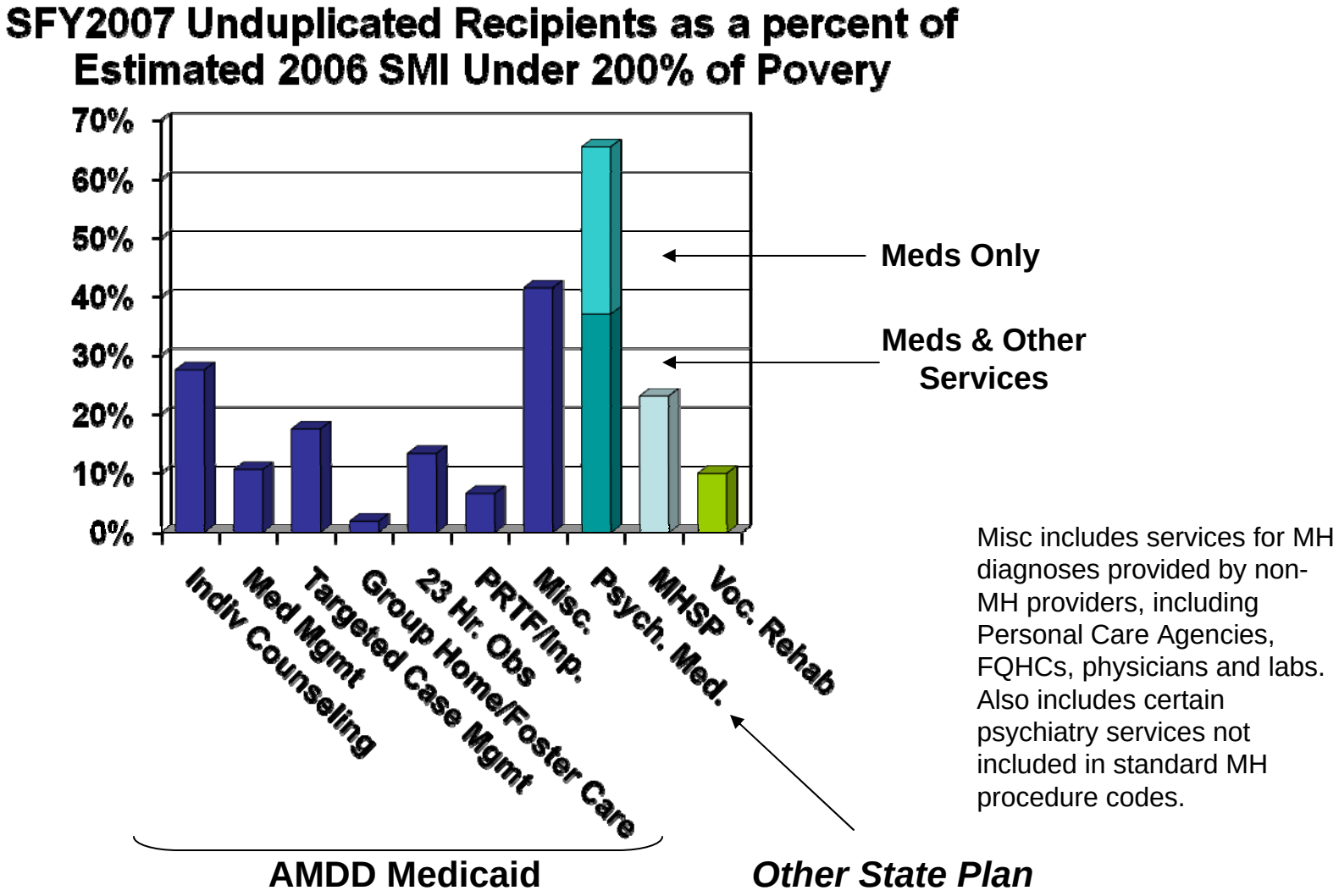
Medicaid Penetration



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

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

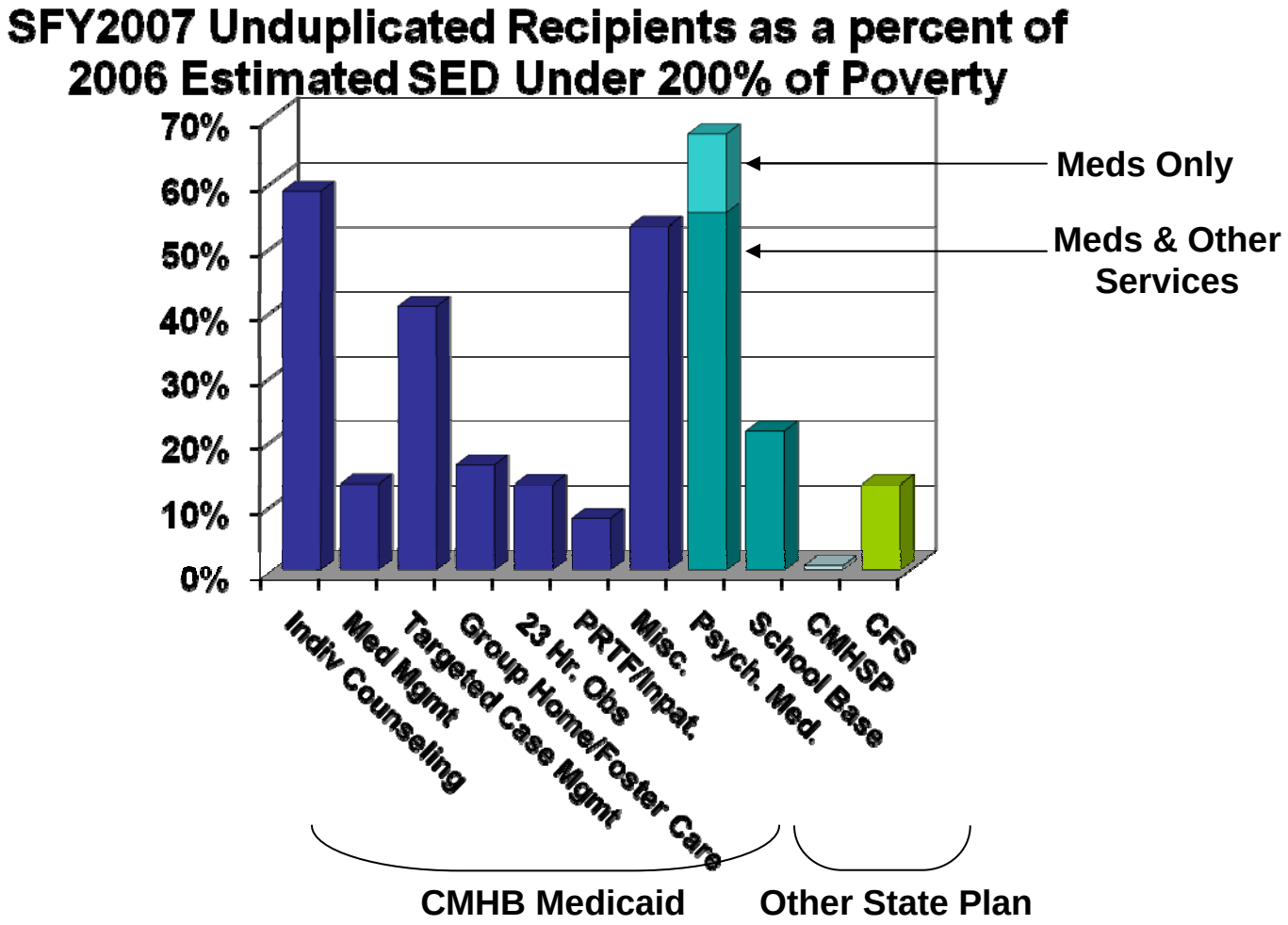
Adult SMI Penetration
by Selected Service Type



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.

Source: DPHHS Special Report and Estimates by Charles Holzer based on CPES and Census Estimates

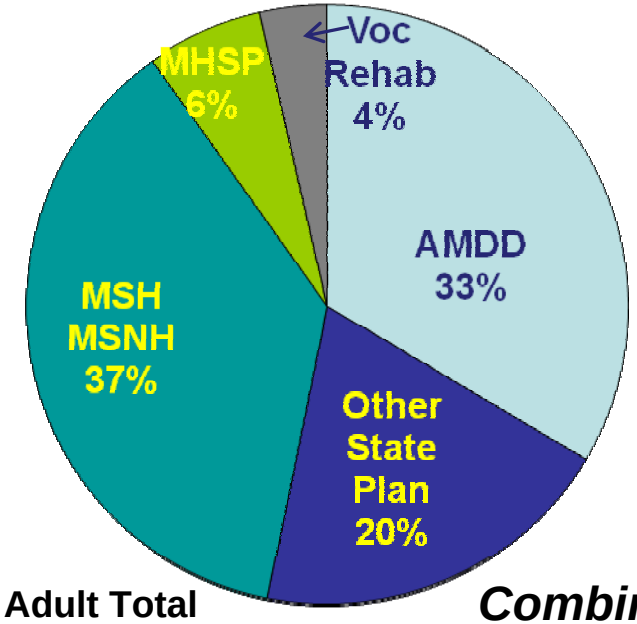
Child SED Penetration
by Selected Service Type



Source: DPHHS Special Report and Estimates by Charles Holzer based on CPES and Census Estimates

How are services funded?

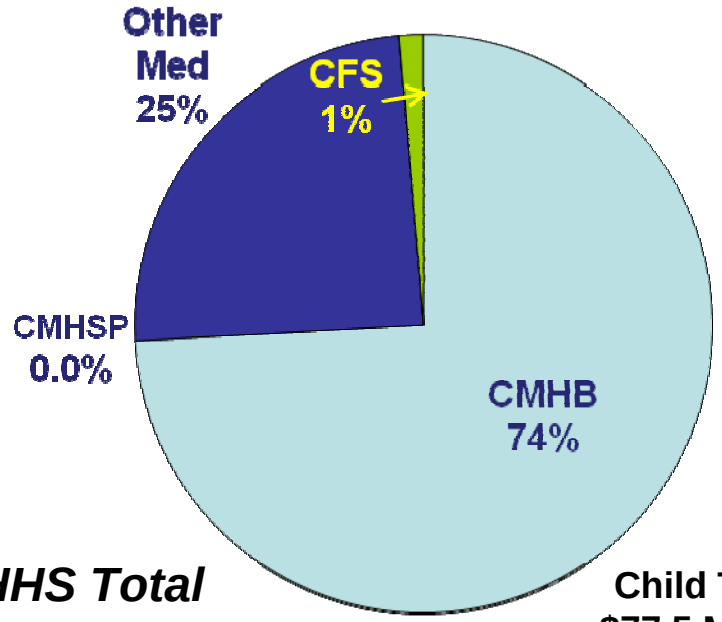
SFY2007 DPHHS Adult MH Expenditures by Source



Adult Total $98 Million

Combined DPHHS Total $175.5 Million

SFY2007 DPHHS Child MH Expenditures* by Source



Child Total $77.5 Million

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

SFY2007 DPHHS Adult Mental Health Expenditures by Service Category (draft)

Inpatient and Nursing Home Services	$37,214,174	38%
Medication Services	$20,260,592	21%
Case Management	$11,095,853	11%
Group and Foster Care	$ 6,524,737	7%
Outpatient Services	$ 4,214,948	4%
PACT	$ 4,095,092	4%
Rehabilitation & Peer Support Services	$ 3,850,180	4%
Misc. Services*	$ 3,632,220	4%
Intensive Out-Patient	$ 2,955,817	3%
Crisis	$ 2,362,473	2%
PRTF	$ 1,812,843	2%
Total	**$98,018,929**	

* *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.*

SFY2007 DPHHS Children's Mental Health Expenditures by Service Type (Excluding CHIP MH Services) (draft)

Group Homes and Therapeutic Foster Care	$20,918,122	27%
PRTF	$18,968,560	24%
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%
Inpatient	$ 74,007	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.*

Next Steps

- Address the many questions that will arise from the statewide and County prevalence and penetration data
- Complete a more detailed financial analysis to identify revenue opportunities
- July site visit includes MHOAC and finance related meetings
- Issue survey and then summarize the web survey data
- Present recommendations to Interim Committee in August
- Prepare draft and final report incorporating Committee input

Thank you

Questions?