

Report to the State of Montana: Legislative Mental Health Study



November 18, 2008

Prepared by

DMA Health Strategies



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EXECUTIVE SUMMARY

Purpose and Scope of the Report

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

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

Key Findings

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

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

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

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

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

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

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

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

Key Recommendations

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

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

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

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

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

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

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

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

Conclusion

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

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ADDENDUM:

SUMMARY OF CHANGES MADE IN FINAL REPORT

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

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

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

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

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SUMMARY OF RECOMMENDATIONS

Service Needs and Gaps

Child Mental Health Services

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

Adult Mental Health Services

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

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

Services for Special Populations

Native Americans.

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

Veterans.

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

Other Services

Crisis Services.

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

- Explore options for developing local partnerships like the Community Crisis Center in Billings
- Hospitals benefit from reduced costs for detoxification of uninsured individuals and may need to contribute to crisis service costs
- ▶ Build telemedicine capacity at MSH to support local crisis management, both in hospital emergency rooms and for law enforcement officers
 - Implement more aggressive recruiting of new psychiatrists at MSH or reissue an RFI/RFP based on more market research
 - Pilot and implement linkage to hospital emergency rooms
 - Add clinicians trained in forensic psychology and offer psychiatric consultation to police and sheriffs similar to the Community Crisis Center’s tele-health consultation to jails.
- ▶ The Legislature should request a formal one year review of implementation and utilization of crisis and stabilization services under presumptive eligibility including a review of populations denied presumptive eligibility or referred elsewhere

Montana State Hospital (MSH) and Other Inpatient Care

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

Cross Cutting Issues

Workforce Limitations

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

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

Primary Care and Mental Health Integration

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

Local Planning

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

Financing Opportunities

Financing of Children’s Mental Health Programs

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

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

Financing of Adult Mental Health Programs

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

Targeted Case Management and Rehabilitation Option

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

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

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

Maximize Medicaid revenues for IHS Facilities

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

Peer Services.

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

HIFA waiver.

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

Section 1915i.

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

Other Federal Revenue Opportunities

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

Potential for Research, Foundation, Philanthropic Support

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

Organizational Issues

Approaches to Improving Mental Health Service Delivery

Sharing Data & Information

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

Care Coordination

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

Opportunities for Improving Accountability

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

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

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

Options for Major System Reorganization

Consolidation of Functions Option

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

Medicaid Waiver Option

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

Criminal Justice Recommendations

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

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

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