

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

EXHIBIT ES/MS 14
DATE 2-4-09
HB _____



Brian Schweitzer
GOVERNOR

Anna Whiting Sorrell
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

PO BOX 4210
HELENA, MT 59604-4210
(406) 444-5622
FAX (406) 444-1970

February 3, 2009

Representative Teresa Henry, Chairman
Appropriation Subcommittee
Health & Human Services
State Capitol Building
Helena, MT 59620

Dear Chairman Henry:

The following is in response to questions raised by the Subcommittee on the Big Sky RX program.

As of February 1, 2009, the Big Sky Rx program has enrolled 7,984 clients. The average growth per month is 3.11% and the average monthly premium is \$28.50. DPHHS staff and Lois Steinbeck, LFD, discussed the growth pattern and percentage of growth in the premiums payments and have come to the following agreement: in Decision Package PL-11034 Big Sky RX, state special revenue can be reduced in FY 2010 by \$128,941 and in FY 2011 by \$420,299. This is on page B-240 of the Legislative Budget Analysis book and is number 71 on the running tally sheet that the Subcommittee is using.

If you have any other questions or concerns, please contact me at 444-4084 or mdalton@mt.gov

Sincerely,

Handwritten signature of Mary E. Dalton in cursive.

Mary E. Dalton
Medicaid & Health Services Manager
DPPHS Director's Office

cc: Subcommittee Members
Lois Steinbeck
Pat Sullivan
Laurie Lamson
Beckie Beckert-Graham

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PO Box 4210
HELENA, MT 59604-4210

January 30, 2009

Representative Teresa Henry, Chairman
Appropriation Subcommittee
Health & Human Services
State Capitol Building
Helena, MT 59620

Dear Chairman Henry:

The following is in response to Representative Morgan's question on what is the administrative percentage in each program - Medicaid, CHIP and Healthy Montana Kids (HMK).

Currently, Medicaid's administrative percentage is 4 percent, the CHIP program is 8.63 percent and in the DP11011-HMK (HRD division) is 6.52 percent. One item to note is how administrative costs are calculated. Medicaid's administrative expenditures are applied against adult and children benefit expenditures compared to CHIP's administrative costs which are only applied against children's benefit expenditures.

Also, I have attached the Children's Mental Health Legislative Report for SFY 2007 and SFY 2008. This report does contain expenditure and historical information on programs and provides information on services within the Children's Mental Health Bureau.

If you have any other questions or concerns, please contact me at 444-4084 or mdalton@mt.gov

Sincerely,

Handwritten signature of Mary E. Dalton in cursive.

Mary Dalton
Medicaid & Health Services Manager
DPPHS Director's Office

Cc: Laurie Lamson
Beckie Beckert-Graham

Recommendations for a Children's Mental Health Services System



Biennial Report Fiscal Years 2007-2008

Prepared by
The Children's Mental Health Bureau
Health Resources Division
Department of Public Health and Human Services
In cooperation with the Children's System of Care Planning Committee

January, 2009

Contents

- I. Overview: Children's Services System
- II. Service System Changes during the Biennium
- III. System of Care for Children and Families
- IV. Recommendations to the Legislature

Submitted in response to 53-21-1002(9) MCA which requires
the Department of Public Health and Human Services to report on activities and recommendations of the
Department and other children's services providers.

I. Overview: Mental Health Services for Youth

Responsibility

The Children's Mental Health Bureau (CMHB) is responsible for designing, developing, managing and evaluating the children's mental health services. The primary population served is children with serious emotional disturbances (SED) enrolled in Medicaid. The Bureau complies with state policy and "encourages the development of a stable system of care, including quality education, treatment, and services for Montana's high-risk children with multi-agency needs, to the extent that funds are available, and that serves them in their homes or in a community setting whenever possible and appropriate". (52-2-301 MCA)

The responsibility for developing a Children's System of Care was first established in Senate Bill 454 (2001) and further defined in Senate Bill 94 (2003). State policy, as articulated in 52-2-301 MCA, is to:

1. Serve high risk children with multi-agency needs;
2. Preserve the unity and welfare of the family, whenever possible;
3. Provide for the care and protection and the mental, social and physical development of high risk children;
4. Use out of state providers as a last resort;
5. Provide integrated services to high risk children with multi-agency needs;
6. Contain costs and reduce the use of high cost, highly restrictive out of home placements;
7. Increase the capacity of communities to serve high risk children;
8. Prioritize the available resources for meeting the essential needs of high risk children.

CMHB administrative cost for administering the children's mental health Medicaid and Children's Mental Health Service Plan is 2.8% of total dollars spent on Medicaid and CMHSP.

Funding

The Bureau's primary source of funding for the purchase of services from private mental health providers is federal Medicaid dollars matched with state general funds.

In addition, the Bureau has several other much smaller funding sources:

- 1) Temporary Assistance to Needy Families (TANF) maintenance of effort monies (which is state general fund match for the federal block grant) to support limited supplemental services for families/youth;
- 2) State general fund which supports a small Children's Mental Health Services Plan (CMHSP) for non-Medicaid, non-CHIP eligible youth with family income under 160% FPL plus limited hours of respite when these are provided by a licensed mental health center;

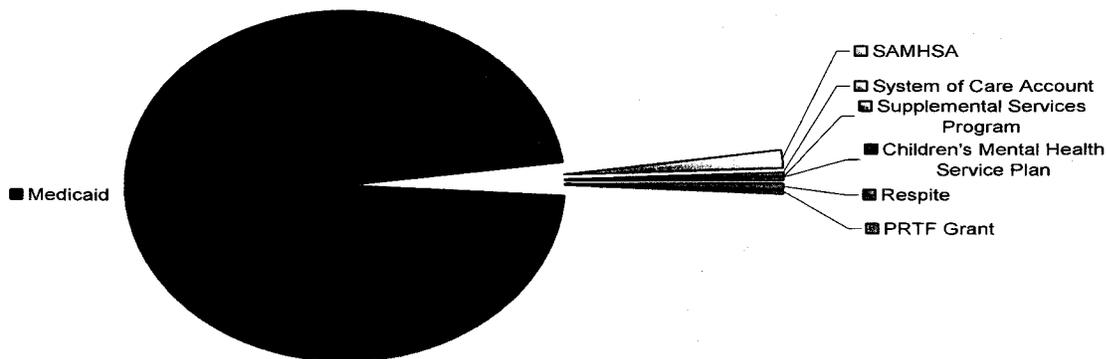
3) Federal SAMHSA grant dollars requiring state and local match and provided by contract to local Kids Management Authorities (KMAs) to support infrastructure development and to purchase additional services for youth; and

4) Federal CMS grant dollars which require state general fund match to support the administrative cost of developing waiver services for youth who would otherwise be served in a psychiatric residential treatment facility.

Until July 1, 2003 the Children's Mental Health Bureau was a part of the Addictive and Mental Disorders Division (AMDD). The 2003 Legislature transferred the responsibility for the children's mental health service system from AMDD to the Health Resources Division (HRD).

Funding for the Children's Mental Health bureau is a federal/state partnership, including federal funding of Medicaid and for two specific grants. 67.74% of the bureau's funding comes from the federal government. On the state side, the program is funded with 3.47% tobacco tax, .37% tobacco interest, and 28.42% general fund.

Breakdown of Funding for Children's Mental Health Bureau



Who is Served

The Children's Mental Health Bureau pays for mental health services for children and adolescents up to age 18 (or up until age 20 if enrolled in secondary school) with serious emotional disturbance. To receive services through the CMHB, a youth must be:

- ↓ Enrolled in Medicaid or
- ↓ Enrolled in the Children's Mental Health Services Plan and/or
- ↓ Served by a grant-funded KMA

Youth enrolled in the Children's Health Insurance Program (CHIP) have access to mental health services through that program.

Services Available from Medicaid

Medicaid eligible youth may receive any of these Medicaid covered services when they are medically necessary:

- ↓ **Inpatient psychiatric services** including acute hospitalization, acute and sub-acute partial hospital services (hospital outpatient services), and psychiatric residential treatment facilities (PRTF).
- ↓ **Community-based residential services** including therapeutic group care and therapeutic foster care, delivered within the geographic boundaries of the state (with one exception).
- ↓ **Community-based outpatient services** provided by licensed mental health professionals and licensed mental health centers. These services include individual, group and family therapy; psychotropic medication monitoring; assessment and evaluation; targeted youth case management; youth day treatment; community-based psychiatric rehabilitation and support services; comprehensive school and community treatment; and therapeutic family care.

Utilization Reports

MEDICAID SERVICES CHILDREN AND ADOLESCENTS				
(Based on ACS 301 Reports)				
This information is based on claims reports/date of payment				
State Fiscal Year	Number Served	Total Medicaid Dollars Spent	Change in Number Served	Change in Medicaid Dollars Spent
SFY 2004	9,208	\$50,762,128	-2.27%	-6.47%
SFY 2005	9,480	\$52,682,825	2.95%	3.78%
SFY 2006	9,551	\$59,034,150	0.75%	12.06%
SFY 2007	9,218	\$57,344,720	-3.49%	-2.86%
SFY 2008	8,942	\$55,305,080	-6.38%	-6.32%
Direct Care Wage Increase				
SFY 2006		\$1,069,383		
SFY 2007		\$1,822,187		
SFY 2008		\$2,548,601		

Medicaid Expenditures for Highest Cost Youth Served

	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2008
Cost to Serve Top 100	\$9,473,409	\$9,130,262	\$10,724,380	\$11,224,851	\$10,320,350
Average Cost per Youth of Top 100	\$94,734	\$91,303	\$107,244	\$112,249	\$103,204
Cost to Serve Youth 101 - 400	\$16,926,689	\$17,181,364	\$19,610,561	\$19,252,818	\$17,976,350
Average Cost per Youth 101 - 400	\$56,422	\$57,271	\$65,369	\$64,176	\$59,921
Cost to Serve Remaining Youths	\$24,362,030	\$26,371,199	\$28,699,209	\$26,867,051	\$27,008,380
Average Cost Per Youth of Remaining Youths	\$2,766	\$2,904	\$3,136	\$3,047	\$3,162
Average Cost per Youth of Total Served	\$5,513	\$5,557	\$6,181	\$6,221	\$6,185

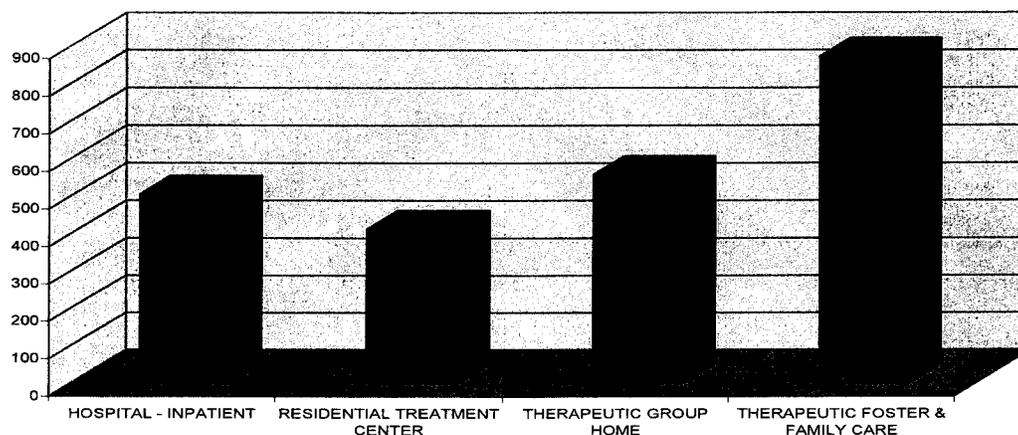
This excludes CSCT expenditures.

Out-of-home Services

The primary objective of the CMHB is to develop a mental health services system that provides effective treatment for Montana youth. Although it is the policy of the state to treat youth in the least restrictive setting that is appropriate, some youth receive treatment in out-of-home settings. As the charts indicate, fewer youth use the most restrictive levels of care than the less restrictive levels (inpatient and residential vs. therapeutic group home and therapeutic foster and family care).

Youths Served in Out-of-Home Placement Unduplicated by Provider Type						
	SFY 2006		SFY 2007		SFY 2008	
Provider Type	Net Pymts	Youths	Net Pymts	Youths	Net Pymts	Youths
HOSPITAL - INPATIENT	\$3,679,544	451	\$3,823,884	422	\$2,660,921	502
PRTF - INPATIENT	\$16,777,330	465	\$15,196,230	418	\$12,729,267	409
TOTAL	\$20,456,874		\$19,020,114		\$15,390,188	
THERAPEUTIC GROUP HOME	\$15,133,651	502	\$15,638,865	509	\$17,038,780	555
THERAPEUTIC FOSTER & FAMILY CARE	\$4,981,070	750	\$5,582,212	827	\$6,079,678	868
TOTAL	\$20,114,721		\$21,221,077		\$23,118,458	

Youth Served Per Provider Type
Based on Date of Payment: State Fiscal Year 2008



Youth are only served in out-of-state facilities when the services needed to meet a youth's needs cannot be obtained in Montana. The three in-state psychiatric residential treatment facilities may deny admission to a child 1) if they do not have available space; 2) if they do not have a treatment program that is appropriate for the youth's needs, or 3) if they cannot assure safety for the youth, or other youth in the facility or for the staff. Placement in an out-of-state facility requires that the youth be denied admission at all three in-state psychiatric residential treatment facilities. Youth who receive treatment out of state have longer lengths of stay than youth who receive care in Montana and that is reflected in the cost information below.

Psychiatric Residential Treatment Facilities (PRTF)						
DOP State Fiscal Year	Net Payments		Unduplicated Youth Served		Total	
	In State	Out of State	In State	Out of State Total	Net Payments	Youth Served
SFY 2002	\$12,291,358	\$4,373,181	444	85	\$16,664,539	502
SFY 2003	\$12,389,741	\$2,389,529	488	59	\$14,779,270	532
SFY 2004	\$12,517,015	\$1,779,083	418	38	\$14,296,098	445
SFY 2005	\$12,686,983	\$1,705,349	423	35	\$14,392,333	452
SFY 2006	\$12,666,745	\$4,110,585	393	95	\$16,777,330	465
SFY 2007	\$9,664,845	\$5,531,384	339	104	\$15,196,230	418
SFY 2008	\$8,125,599	\$4,603,668	329	92	\$12,729,267	409

* Statistics are based on date of payment.

Comprehensive School and Community Treatment

Comprehensive School and Community Treatment (CSCT) is a school based mental health service that provides mental health services for SED youth using local school funding to match Medicaid dollars. CSCT is administered through the Acute Services Bureau of HRD, working collaboratively with the Children's Mental Health Bureau and the Office of Public Instruction. There are currently 277 school teams in 86 cities in Montana, serving Headstart, elementary, middle school, and high school youth.

CSCT SERVICES		
State Fiscal Year	Youth Served	Total Expenditure
2005	1,469	\$5,822,441
2006	1,693	\$8,195,502
2007	1,952	\$9,956,738
2008	2,188	\$11,189,039

II. Service System Changes during the Biennium

The following are changes that have occurred during this biennium:

- ✚ In August, 2007 the Children's Mental Health Bureau received approval of the application for a demonstration under the Deficit Reduction Act to provide home and community based alternatives to psychiatric residential treatment placement. Montana will offer these services in five locations over the next five years. The first site, Yellowstone County, began enrolling youth in March, 2008 and has served six families so far. A second community will be chosen in early 2009, and a third before the end of the year. The purpose of the grant is to:
 1. Divert children with severe emotional disturbance from psychiatric residential treatment placement by providing in-home and community based services;
 2. Shorten the length of stay for children placed in psychiatric residential treatment facilities by wrapping services around children and providing therapeutic support as they transition back to their communities.

- ✚ Beginning in October, 2007 the Children's Mental Health Bureau launched the Supplemental Services Program (SSP) using TANF maintenance of effort funding. The program offers flexible funding for youth who will return home to their families, are Medicaid or CHIP eligible, and need services not funded by either of those programs. Previously, TANF maintenance of effort funding was used primarily for room and board payments on a short term basis.

- ✚ In June, 2008 the Children's Mental Health Bureau hired a parent with a seriously emotionally disturbed child to assist the bureau to increase family voice in policy making and system development. The bureau is also working with a group of seriously emotionally disturbed youth to reduce stigma of mental illness and to promote recovery strategies.

- ✚ Targeted Case Youth Management (TYCM), only available for Medicaid enrolled youth with SED, now requires prior authorization after 120 units/30 hours are used during a SFY.

- ✚ Beginning in 2008, the Children's Mental Health Bureau began using the System of Care Account (SOCA) as authorized by the Legislature. As of 12/1/2008, 18 unduplicated youth have received assistance from this fund. The purpose of the fund is to allow high-risk multi-agency youth to be served in the least restrictive setting, preferably either at home or in the community. None of the youth who received funding from this account went to the higher level of care they were at risk for.

- ✚ Beginning in 2009, a two week admission for assessment and stabilization will be available in Montana's three psychiatric residential treatment facilities. This new service creates an opportunity to admit a youth to an in-state facility for additional assessment before deciding to send the person out of state.

- ✦ The five grant funded Kids Management Authorities (KMAs) have enrolled 101 youth in the longitudinal study as of 12/1/2008. The six month follow-up evaluation of these youth indicates improvement in a number of behaviors as well as a reduction in the use of medication.

III. System of Care for Children's Mental Health

The Children's System of Care Planning Committee (SOC's)

State law requires a Children's System of Care Planning Committee (52-2-303 MCA). The committee is composed of representatives from the following:

- ✦ Department of Public Health and Human Services
 - Children's Mental Health Bureau
 - Adult Mental Health Services Bureau
 - Chemical Dependency Program
 - Child and Family Services Division
 - Disability Services Program
 - Early Childhood Bureau
- ✦ Supreme Court/Youth Courts
- ✦ Office of Public Instruction
- ✦ Corrections
- ✦ Youth Justice Council of the Board of Crime Control
- ✦ Other appointees of the director of public health and human services representing families of high-risk children with multi-agency services needs.

The legislature gave the Children's System of Care Planning Committee the following duties (52-2-304 MCA):

1. Develop policies aimed at eliminating or reducing barriers to the implementation of a system of care;
2. Promote the development of an in-state quality array of core services in order to assist the return of high-risk children from out-of-state placements, limit and prevent the placement of high-risk children out-of-state, and maintain high-risk children within the least restrictive and most appropriate setting;
3. Advise local agencies to ensure that the agencies comply with applicable statutes, administrative rules, and department policy in committing funds and resources for the implementation of unified plans of care for high-risk children and in making any determination that a high-risk children cannot be serviced by an in-state provider;
4. Encourage the development of local interagency teams with participation from representatives from child serving agencies who are authorized to commit resources and make decisions on behalf of the agency represented;
5. Specify outcome measures to evaluate the effectiveness of the system of care;
6. Develop mechanisms to elicit meaningful participation from parents, family members, and youth who are currently being served or who have been served in the children's system of care;

7. Pool funds from federal, state, and local sources to maximize the most cost-effective use of funds to provide services in the least restrictive and most appropriate setting;
8. Apply for federal waivers and grants to improve the delivery of integrated services to high risk children;
9. Provide for multi-agency data collection and analysis for data-driven decision making and for services based on client need and improved outcomes.
10. Develop mechanisms to pool human and fiscal resources;
11. Provide training and technical assistance at the local level to develop the system of care and integrated service delivery.

In addition to this statutorily required planning committee, a second group of community representatives meets regularly to plan for system of care development, to assist the efforts of the statutory planning committee by communicating local successes and barriers and to address the SAMHSA grant's sustainability challenges. This group has a majority of family members, youth and other advocates, as well as representatives of the KMAs, providers, and other community stakeholders.

The system of care planning efforts represent a new approach to the delivery of services. The values guiding this new approach include:

- ↓ Parents and family (and youth when possible) participate at all levels of the children's system of care from policy planning to participation in their child's treatment plan.
- ↓ The system is culturally competent meaning that agencies, programs and services are responsive to the needs and culture of the populations served.
- ↓ Planning, policies, and services focus on the strengths of the youth and family as contributors to treatment and recovery.
- ↓ Through partnerships with providers, youth receive evidence-based services delivered in community settings whenever possible.
- ↓ Services are co-occurring capable to promote an integrated focus on both mental health and chemical dependency treatment needs.

Goals for the Children's Mental Health System of Care

Among the goals for the System of Care are the following:

- Goal 1 Transform the children's public mental health system into a strengths-based, recovery oriented system of care for children with serious emotional disturbance (SED).
- Goal 2 Deliver children's mental health services on reservations in partnership with Native peoples.
- Goal 3 Develop a system where families and youth have a voice at all levels of government, state and local.
- Goal 4 Integrate services through a single treatment plan for children and adolescents with SED who impact multiple agencies in the community.
- Goal 5 Fund, using grant monies, the development of Kids Management Authorities and provide training and technical assistance to these KMAs in order to have working models from which to develop a statewide KMA system.
- Goal 6 Provide support to other KMAs not receiving grant funding
- Goal 7 Design and deliver services with an awareness of familial, cultural, racial, and ethnic differences.

- Goal 8 Focus on early identification, prevention and early intervention when possible.
- Goal 9 Develop system accountability by measuring results and outcomes.
- Goal 10 Integrate funding to deliver services to avoid duplication of service and cost.

KMA's Have Two Distinct and Important Functions:

The KMA is the local community infrastructure that supports a comprehensive and statewide system of care. The KMA has two primary functions:

- ↓ Development of a continuum of care within the respective community, and ultimately, the state as a whole.
- ↓ Individual youth case planning, coordination, service delivery with a focus on family preservation.

Communities with grant funded KMAs include: Yellowstone County, Butte, Helena, and the Havre Bear Paw Consortium. The state also contracts with the Crow Nation to develop a Kids Management Authority. Several other communities support KMAs without the benefit of grant funding.

Wrap around

As the Children's Mental Health Bureau enters its sixth year, it is continuing efforts to build a system of care for high risk multi-agency youth with serious emotional disturbance. The cornerstone of Montana's system of care is wraparound. Wraparound is neither a program nor a service, but rather a process based on the core elements of a family-driven, individualized, strength based, needs-driven plan and service delivery method. Wrap around is not something that you "get"; it is something you "do". The fundamental principles embody an unconditional commitment to team development, family empowerment and outcome based interventions. Informal supports are sometimes as important as the formal services provided. Collaboration and cultural competence are essential.

The bureau has supported the development of wraparound process by sponsoring three trainings in SFY 2008. More are planned for SFY 2009. To ensure fidelity to the national model of wraparound, the bureau plans to use both a certification requirement and a fidelity instrument. Eventually, the bureau hopes to use Medicaid funding to support the use of wraparound for the youth and families with the most intensive needs.

The ten core principles of wraparound are:

- ↓ Voice and Choice
- ↓ Team Based
- ↓ Community Based
- ↓ Culturally Competent
- ↓ Strength Based
- ↓ Individualized Services and Supports

"I thought I was doing wraparound, but now I realize I wasn't.

- a provider who attended wrap around training in June, 2008

- ✚ Natural and Informal Supports
- ✚ Continuation of Services and Supports
- ✚ Collaboration
- ✚ Outcome Based

System of Care Evaluation

Through the System of Care demonstration sites, KMAs have the opportunity to conduct in depth analysis of the families they serve, the family's' satisfaction with services, and whether families improve from KMA services. In May 2008, there was enough statistically significant data to look at six month data. In this study families are interviewed at intake into services and every six months thereafter for 3 years. Over six hundred different variables are being collected, and the data is yielding significant results.

The conceptual framework of the evaluation poses three research questions. The first question whether the system of care can demonstrate it is incorporating the System of Care principles with fidelity. The second question asks whether the families served in the demonstration projects improved. Lastly, are families satisfied with services received in the demonstration sites?

From the six month follow-up data, the following information is true:

- ✚ On all scales youth showed statistically significant improvement.
- ✚ The youth taking medication reported benefit from them.
- ✚ Fewer youth reported thoughts of suicide after six months.

IV. Recommendations to the Legislature

The following recommendations come from the System of Care Community Planning Committee during the course of their meetings over the past two years. This is not an exhaustive list, but represents the major suggestions captured in the minutes of the discussion about how to grow Montana's system of care and what are the core components of a system of care.

1. Take what we have learned in the grant funded and non-funded sites to other communities by sharing what is working well and training at the community level.
2. Give incentives to providers to shift to a wraparound philosophy.
3. Provide local or regional funding that the local community group controls.
4. Look to the accountability and leadership of the Children's System of Care Planning committee to direct and support local collaboration and agency participation.

5. Support wraparound with the Medicaid system by developing rules, a rate structure and parent participation.
6. Encourage and support parent participation by making rule, policy and services changes to the current system.
7. Provide outreach to schools and primary care providers to generate referrals to the system earlier.
8. Strengthen the voice of parents and youth in the development of the system and in individual treatment planning.
9. Have parent coordinators locally; Find out how other states contract with statewide family organizations.
10. Educate parents about services, treatment and advocacy opportunities.
11. Increase the availability and array of community services (respite, licensed clinicians, psychiatrists)
12. Develop the "one stop" concept for families seeking help.
13. Increase access to care for families without Medicaid or CHIP
14. Focus on earlier interventions and shift money from "a few kids too late" to "more kids earlier".
15. Require results (outcomes) in exchange for more resources (flexible funding)
16. Have strategies that de-stigmatize.
17. Ensure good transition plans for children returning home for out-of-home care and for those aging out of children's services.
18. Develop a waiver in order to have more flexibility in service delivery.