

PRESENTATION TO THE 2022 INTERIM BUDGET COMMITTEE

Behavioral Health and Developmental Disabilities Division

Medicaid and Health Services

Department of Public Health and Human Services

THE FOLLOWING TOPICS ARE COVERED IN THIS REPORT:

- **Overview**
- **Summary of Major Functions**
- **Highlights and Accomplishments during the 2023 Biennium**
- **Efficiencies and Cost Savings**
- **Funding and FTE Information**
- **Change Packages**

OVERVIEW

The Behavioral Health and Developmental Disabilities Division (BHDD) administers a wide range of services to fulfill its mission of facilitating the efficient delivery of effective services to adults and children with behavioral health challenges and/or developmental disabilities. BHDD's work is guided by a goal of providing Montanans with the support to live full lives within their communities.

BHDD consists of four bureaus and two programs:

PREVENTION BUREAU

Mary Collins has been the Prevention Bureau Chief since December 2021. Prior to becoming the Prevention Bureau Chief, Mary worked for the Department for two years during which she led efforts to develop Montana's behavioral health crisis system. Mary received her Master of Social Work from the University of Montana and has over ten years of experience working in social services.

Bureau Staff

The Prevention Bureau employs Program Officers that manage distinct grants and programs. The Bureau's Program Officers oversee every aspect of their assigned programs, including developing Requests for Proposals, establishing and monitoring of contracts, managing budgets, providing technical assistance, and working with internal and external stakeholders to advance programmatic goals. The Bureau also includes a Program Evaluator and two Epidemiologists, which provide data collection support and conduct data analysis to monitor program utilization and outcomes.

TREATMENT BUREAU

Melissa Higgins is the Treatment Bureau Chief for the BHDD. Melissa has worked for the Montana Department of Public Health and Human Services for over 13 years, the past six years of which has been to oversee Montana's publicly funded substance use disorder and adult mental health community-based services. Prior to coming to the department, Melissa worked for eight years in child support enforcement in Colorado.

Bureau Staff

The Treatment Bureau is comprised of three distinct sections: Medicaid State Plan, Severe and Disabling Mental Illness 1915(c) waiver, and a Special Populations section. Each section has program officers who manage distinct Medicaid and Non-Medicaid services and programs. The Bureau's Program Officers oversee every aspect of their assigned programs, including developing Requests for Proposals, establishing and monitoring of contracts, completing state plan and waiver amendments, managing budgets, and providing technical assistance. In addition to central office staff, the Bureau has two Community Program Officers who each cover half of the state providing important assistance and support to waiver provider agencies, case managers, and members and their families. The Bureau employs two Licensed Addictions Counselors and has an AmeriCorps Vista who assists with the imperative work around behavioral health crisis services.

CHILDREN'S MENTAL HEALTH BUREAU

Meghan Peel is the Children's Mental Health Bureau Chief for BHDD and has served in this role for four years. Prior to joining the Bureau, Meghan managed the CHIP program and was part of the implementation and operations team for Medicaid Expansion. During her tenure with the Bureau, she has focused on working closely with providers and stakeholders to evaluate and improve services within our continuum of care, focusing on family engagement and outcome measurements. Additionally, Meghan has a degree in Business Accounting, and worked in public and private accounting for seven years prior to joining the department.

Bureau Staff

In addition to Central Office Bureau staff who oversee operations of the Bureau including program oversight and provider support, the Bureau also employs a clinical team which includes a part-time Board-Certified Child and Adolescent Psychiatrist, Licensed Mental Health Clinicians, and Regional Resources Specialists. The Bureau's clinical team provides care coordination for Medicaid enrolled youth admitted to out of state PRTFs. Care coordination duties include, attendance at treatment team meetings, assistance with discharge planning, monitoring of quality of care, and engagement with parents and caregivers of youth. Additionally, the Regional Resource Specialists provide information and resources on service availability, including community-based therapeutic group homes and community services available by region. Regional Resource Specialists serve parents and caregivers, behavioral health providers, Child and Family Service employees, and other organizations within the children's systems.

SUICIDE PREVENTION

Karl Rosston is the Suicide Prevention Coordinator for the Montana Department of Public Health and Human Services. He provides evidenced-based programs to all Montana secondary schools, implements the State Suicide Prevention Plan, supports the Montana Suicide Prevention Lifeline, implements firearm safety programs and statewide media campaigns, provides suicide prevention trainings, and coordinates suicide prevention efforts around the state. Karl is adjunct faculty at the Montana Law Enforcement Academy and a nationally certified trainer in QPR and Mental Health First Aid.

Program Staff

The program operates out of a central office in Helena. The program includes a Suicide Program Manager and a grant manager for the Adult American Indian Zero Suicide Grant. The Suicide Program Manager oversees the implementation of the 988 Crisis Lifeline and works with the Montana VA and National Guard on prevention efforts to reduce the rate of suicide in Montana Veterans. The grant manager for the Adult American Indian Zero Suicide Grant helps tribal health and Urban Indian Health Centers establish a suicide care policy promoting suicide safe care as an organizational priority and facilitates training to create a confident and competent workforce where at-risk individuals are identified.

DEVELOPMENTAL DISABILITIES PROGRAM

Lindsey Carter is the DDP Bureau Chief. Prior to her work as Bureau Chief, Lindsey worked as a DDP Waiver Specialist, Regional Manager and Community Services Supervisor. Lindsey began

her career as a Direct Service Professional, primarily working with youth with a diagnosis of autism.

Program Staff

The DDP operates out of a central office in Helena and five regions across the state with offices located in Helena, Missoula, Great Falls, Billings, Glasgow, Miles City, Butte, Bozeman, and Kalispell. The regional offices provide important assistance and support to DDP provider agencies, and case managers, as well as members and their families. Each region has a Regional Manager who provides oversight to the region which includes, quality assurance activities, incident management activities, and serves as the local liaison. In addition, the regions have Quality Improvement Specialists who work directly with provider agencies and members and complete many quality assurance activities. Some regions also provide state targeted case management services.

OPERATIONS BUREAU

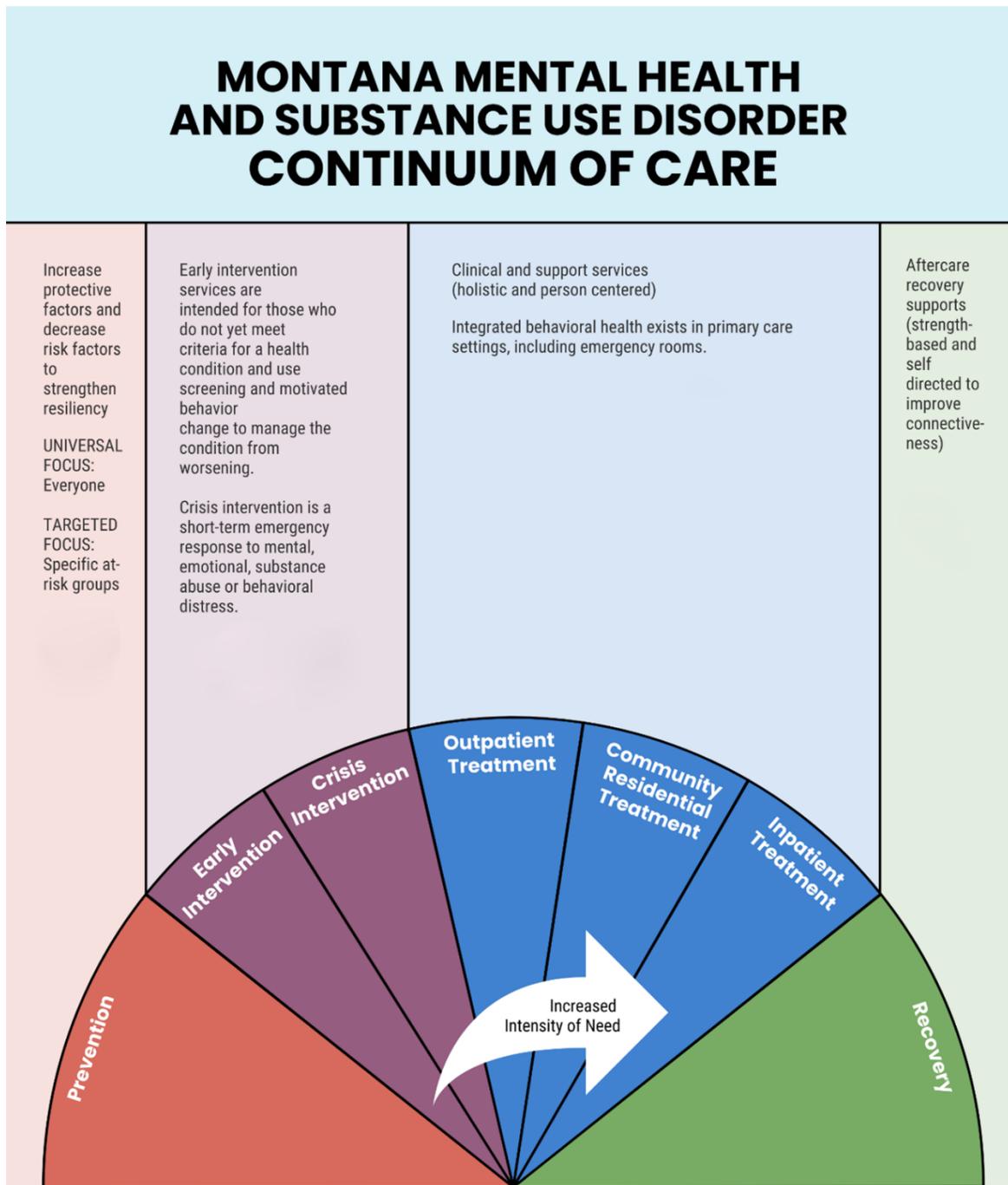
Natacha Bird is the Operations Fiscal Bureau Chief for the BHDD. Natacha has a bachelor's degree in accounting and has worked for the State of Montana for 21 years. Prior to joining the department, Natacha worked as the Fiscal Bureau Chief at the Department of Justice for 7 years, and as an accountant for the Commissioner of Securities and Insurance.

Bureau Staff

The Operations Bureau operates out of a central office in Helena. The bureau is comprised of 8.75 FTE and provides fiscal, budgetary, and contract support to the division.

SUMMARY OF MAJOR FUNCTIONS

BEHAVIORAL HEALTH CONTINUUM OF CARE



Behavioral health is essential to one's overall health. Prevention works, treatment is effective, and people recover from mental health and/or substance use disorders.

— Federal Substance Abuse and Mental Health Services Agency (SAMHSA)

Figure 1 – The Continuum of care.

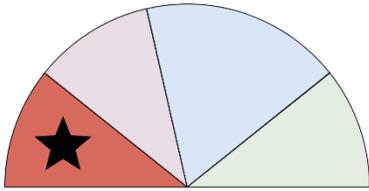


Figure 2 - Prevention section of continuum of care.

PREVENTION SERVICES

Mental illness and substance abuse affect tens of thousands of Montanans and have a huge impact on the public's health and productivity. Behavioral health conditions are associated with a wide range of health and social problems.

Effective prevention strategies are critical to provide both individuals and communities the skills to develop and promote healthy behaviors that can prevent or delay the negative consequences of behavioral health conditions.

A large body of scientific research supports the implementation of effective prevention programs. If programs are consistently administered to fidelity over time, they have the potential to reduce the number of Montanans impacted by behavioral health issues.

BHDD supports the implementation of community-based substance use prevention initiatives across Montana. Community-based prevention promotes public health and coalition-based approaches to enact effective, community-driven prevention strategies. Prevention initiatives include both universal strategies to prevent children and youth from engaging in substance use and targeted interventions to mitigate substance use amongst at-risk populations.

BHDD implements programming that enables communities to have a dedicated prevention specialist who leads the community through evidence-based processes, including the completion of a needs assessment, the development of a strategic prevention plan, and the implementation of interventions that meet the community's unique needs and goals. These efforts are bolstered by technical assistance and training offered by BHDD.

Prevention strategies are also implemented via school-based programs and dedicated resources for those in a parenting role. The PAX Good Behavior Game (GBG) is a school-based intervention used to teach self-regulation, self-management and self-control in children, which has shown evidence of short-term and long-term benefits including improved classroom behavior, academics, and mental health and the prevention of substance use and suicide. PAX GBG is currently implemented in 28 school districts and is expanding to new schools every year.

Along with PAX GBG, BHDD also implements ParentingMontana.org, a web-based resource for Montana parents and those in a parenting role. The resources and strategies incorporated within the website are rooted in prevention science and tailored to Montanans. It is a prevention program that braids together the supports grounded in evidence-based practices to help kids and families thrive, with the specific goals of cultivating a positive, healthy culture among Montana parents with an emphasis on curbing underage drinking; providing resources to engage parents or those in a parenting role; and providing tools for everyday parenting challenges from ages zero to nineteen.

By starting early, both parents and children learn how to grow skills such as self-awareness, self-management, responsible decision-making, and social awareness, all of which protect children from negative outcomes associated with adverse childhood experiences (ACEs) and bolster resilience.



Figure 3 - Parenting Montana logo.



FIGURE 4 - EARLY INTERVENTION SECTION OF CONTINUUM OF CARE.

EARLY INTERVENTION SERVICES

Early intervention services implement specific practices to target individuals who are at risk of developing an illness. Early intervention services can mitigate the need for individuals to engage in higher levels of care, resulting in less disruption to their lives and improved health outcomes. BHDD facilitates several early intervention programs targeted toward individuals engaging in substance use, including evidence-based education programs for individuals charged with a Driving Under the Influence (DUI) or Minor in Possession (MIP) and a program focused on naloxone, an opioid antagonist that can successfully reverse the effects of an opioid overdose. The naloxone program focuses on increasing awareness of naloxone, providing training on its administration, and distributing units throughout the state. The program facilitates a statewide media campaign and provides training to first responders, Emergency Medical Services (EMS), healthcare providers, community organizations, and members of the public on how to safely and effectively administer naloxone. Training materials, including step by step instructions on administration, are also available on naloxone.mt.gov and are included with every shipment of naloxone. BHDD utilizes federal grant funding to cover the cost of naloxone, so

Opioid overdoses are on the RISE

Opioids include illegal drugs such as heroin, synthetic opioids such as fentanyl, and some prescription pain relievers.

Naloxone is a medication that can reverse opioid overdose. If you or someone you know uses opioids, get Naloxone. Having Naloxone on hand can save a life.

Naloxone is available at no cost through select community organizations in Montana or ask a pharmacist.

REVERSE
opioid overdoses with Naloxone.

naloxone.mt.gov

MONTANA
DPHHS

Figure 5 - Opioid overdoses and naloxone information.

communities and organizations are able to order up to 500 units at a time at no cost. Since October 2021, nearly 12,000 units of naloxone have been distributed throughout Montana.

BHDD has recently implemented the Montana Angel Initiative to provide another means of accessing substance abuse treatment. The initiative allows an individual struggling with addiction to go to any participating law enforcement office and receive assistance in locating and being connected with treatment, without consequences or questions (subject to certain limitations).

The Angel Initiative launched in late 2021 and is currently active in Cascade, Lewis and Clark, and Yellowstone counties. BHDD has partnered with the Police Assisted Addiction and Recovery Initiative (PAARI) to provide training to the participating counties. Over the next year, BHDD and PAARI will expand those trainings to other counties that have committed to participate in the Angel Initiative.



Figure 6 - Angel initiative logo.

Early intervention services can also mitigate negative outcomes for individuals experiencing mental health issues. BHDD supports the implementation of a First Episode Psychosis (FEP) program. FEP is an evidence-based program that facilitates early identification of an initial psychosis episode in youth and young adults, early access to wraparound treatment services, and ongoing support services for both the individual and their family. FEP programs are a required set aside within the Mental Health Block Grant as the programs have been shown to be highly effective in reducing or ameliorating adult psychosis. BHDD currently funds one FEP program at Billings Clinic and is actively working to establish two additional programs to serve other regions of Montana within the next year.

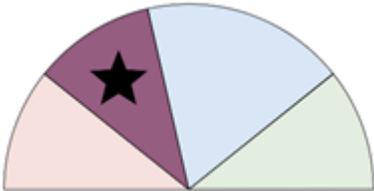


Figure 7 - Crisis intervention section of continuum of care.

CRISIS INTERVENTION SERVICES

Following the 2020 release of the SAMHSA’s National Guidelines for Behavioral Health Crisis Care, the BHDD has increasingly focused on Montana’s behavioral health crisis system through the dedication of staff resources and the creation of a Crisis System Strategic Plan. The strategic

plan establishes goals, objectives, and strategies to improve Montana’s crisis system and align Montana’s crisis system with the Crisis Now best practice model.

The Crisis Now model has four core components:

- High-tech crisis call centers;
- 24/7 mobile crisis response services;
- Crisis stabilization programs; and
- Essential principles and practices, including:
 - trauma-informed care;
 - the use of peer support specialists; and
 - collaboration with law enforcement.

These four components provide the framework for a behavioral health crisis response system that has parity with the existing emergency response system for physical health.

Essentially: Someone to call, someone to respond, and somewhere to go.

Implementing a Crisis Now Model throughout Montana requires an enormous amount of coordination and collaboration with stakeholders. To that end BHDD has collaborated with the Montana Healthcare Foundation and the Montana Public Health Institute to host a series of monthly calls related to crisis system development.

While BHDD has accomplished much over the past two years, we continue to move forward with several other initiatives outlined within our strategic plan. BHDD is working on restructuring all crisis-related Medicaid and state general fund programs with the goal of providing sustainable funding and increasing the availability of effective crisis programming.

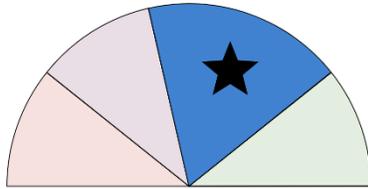


Figure 8 - Treatment section of continuum of care.

TREATMENT SERVICES

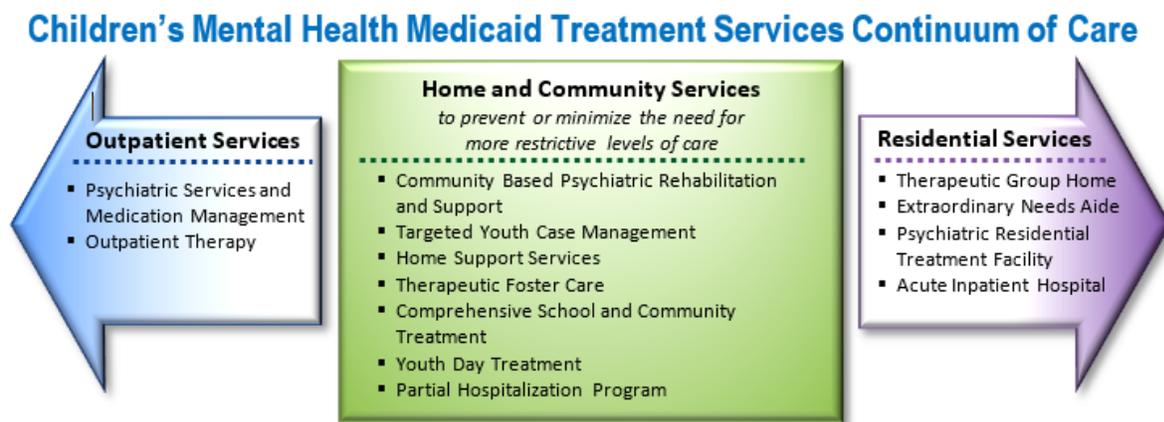


Figure 9 - Children’s mental health treatment programs.

Children’s Mental Health Treatment Services

The Children’s Mental Health Bureau (CMHB) supports and strengthens Montana youth and families through the provision of Medicaid mental health services. Services range from home and community-based services to facility-based services. CMHB managed and funded mental health services for over 21,000 youth enrolled in Montana Medicaid in FY 2021.

Community Based Services

Community-based services such as outpatient therapy, targeted case management, comprehensive school and community treatment, and home support services are supportive interventions added to a child’s everyday life. These services focus on improving a youth’s functional level by facilitating the development of appropriate behavioral and life skills. CMHB funds services that span the entire continuum of the behavioral health service spectrum. These services range from 24 sessions of preventive outpatient therapy to acute inpatient hospitalization and residential treatment.

The Bureau strives to emphasize community based as opposed to institutional services in order to maintain children within their homes, schools, and communities. Throughout the biennium, the bureau has completed work to improve quality and access to Targeted Case Management, Home Support Services, and Comprehensive School and Community Treatment.

Enhancements to the service included family engagement, operational flexibility for providers, and outcome measurements. Of the 21,169 youth who received children’s mental health services in FY 2021 99.9% received community-based services. This demonstrates not only CMHB’s commitment to community-based services, but also that essentially all children who receive services in a facility also receive services within the community.

Standardized Functional Assessment

CALOCUS-CASII is a standardized assessment tool used to make medical necessity determinations and provide level-of-service intensity for children and adolescents aged 6 to 18. The CALOCUS-CASII assesses service intensity needed across six dimensions.

CMHB implemented this tool in Targeted Case Management, Home Support Services, and Comprehensive School and Community Treatment. Additionally, CALOCUS-CASII has been utilized as a tool by the Child and Family Services Division to support the implementation of the Family First Prevention Services Act.

CMHB has supported provider success in statewide implementation by involving mental health centers in the selection of a standardized assessment tool, utilizing a gradual implementation schedule throughout the continuum of care, and providing mental health centers with reimbursement for training.

CALOCUS-CASII currently serves two major functions within CMHB. First, it has been utilized as medical necessity criteria in Home Support Services and Comprehensive School and Community Treatment. CMHB will continue to expand the use of the CALOCUS-CASII as medical necessity criteria throughout the continuum of care. The second function of the CALOCUS-CASII is for individual providers to use assessment findings to drive treatment planning and define desired treatment outcomes. CMHB is currently exploring additional ways to use the CALOCUS-CASII to reduce reliance on higher levels of care, reinforce quality of care, and collect meaningful data to inform decision making and policy design.

Comprehensive School and Community Treatment Update

CSCT is an outpatient service provided by Mental Health Centers under contract with public school districts: the school district is the provider of record. Services are focused on improving the youth’s functional level by facilitating the development of skills related to exhibiting appropriate behaviors in the school and community settings.

During the 2023 biennium, CMHB worked closely with the Office of Public Instruction and stakeholders, such as superintendents, school business officials, mental health centers, on the

“Vivian’ is the mother of young child ‘Samantha’, who was placed in a therapeutic foster home due to the trauma of physical and sexual abuse. The perpetrators were unsafe adults who were allowed in the home throughout Samantha’s childhood.

Through a neuropsychological evaluation and work with Vivian, it became clear that she did not know how to make safe decisions for her child. In aftercare planning for the reunification of the family, a team consisting of a targeted case manager, home support specialist, and outpatient therapist worked with the group care staff and family prior to discharge for a supported transition home and no gap in services.

This team continues to work with the family, strengthening Vivian’s parenting skills and deepening the parent-child relationship.”

*Barb Cowan, Executive Director,
Partnership for Children*

implementation of HB 671, which requires the OPI and DPHHS to collaborate to facilitate school districts in securing federal reimbursements for services eligible under Medicaid or CHIP.

CMHB implemented changes to the CSCT benefit designed to increase flexibilities to school districts and mental health centers, implement outcome measurements, and modify the funding structure. CMHB utilized \$2.3 million in appropriated bridge funding to fund continued CSCT services while an alternative funding structure was developed and submitted for approval through a Medicaid State Plan Amendment (SPA).

In December 2021, the Centers for Medicare and Medicaid (CMS) approved the SPA allowing for the required state match to be paid through an intergovernmental transfer (IGT). DPHHS has executed memorandums of understanding (MOU) with OPI and 58 school districts throughout Montana. Through a modification in the claims processing system, CMHB and OPI have successfully processed IGTs each month from January 2022 through today.

CMHB continues to provide technical assistance to both school districts and their contracted mental on topics such as IGT, monthly claims and required state match reports, and other topics as they arise. Additionally, CMHB continues to engage with OPI through monthly internal meetings and participation in state-wide district calls to increase access to school-based mental health services and improve existing processes.

Children's Mental Health Medicaid Treatment Services Continuum of Care Descriptions

<p><u>Psychiatric Services and Medication Management</u> Medication treatment and monitoring services typically include the prescription of psychoactive medications by a physician (e.g., psychiatrist) that are designed to alleviate symptoms and promote psychological growth. Treatment includes periodic assessment and monitoring of the child's reaction(s) to the drug(s).</p> <p><u>Outpatient Therapy</u> Psychotherapy and related services provided by a licensed mental health professional including individual, family, and group therapy.</p>	<p><u>Community Based Psychiatric Rehabilitation and Support (CBPRS)</u> Adaptive skill building and integration services provided in-person for a youth in home, school or community settings in order to help the youth maintain participation in those settings. The focus of the services is to improve or restore the youth's functioning in identified areas of impairment to prevent or minimize the need for more restrictive levels of care.</p> <p><u>Targeted Youth Case Management (TCM)</u> Services furnished to assist youth and families in gaining access to needed medical, social, educational, and other services. Case management services include assessment, determination of need, development and periodic revision of a specific care plan, referral and related activities, and monitoring and follow-up activities.</p> <p><u>Home Support Services (HSS)</u> In-home therapeutic and family support services for youth living in biological, adoptive or kinship families who require more intensive therapeutic interventions than are available through other outpatient services. Services are focused on the reduction of symptoms and behaviors that interfere with the youth's ability to function in the family and facilitation of the development of skills needed by the youth and family to prevent or minimize the need for more restrictive levels of care.</p> <p><u>Therapeutic Foster Care (TFOC or TFC)</u> TFC services are in-home therapeutic and family support services for youth living in a therapeutic foster home environment, for youth unable to live with their biological or adoptive parents, in kinship care, or in regular foster care. These youth require more intensive therapeutic interventions than are available through other outpatient services. Services focus on skill building and integration for adaptive functioning to minimize need for more restrictive levels of care and to support permanency or return to the legal guardian.</p> <p><u>Comprehensive School and Community Treatment (CSCT)</u> A comprehensive planned course of community mental health outpatient treatment that includes therapeutic interventions and supportive services provided in a public school-based environment in office & treatment space provided by the school. Services are focused on improving the youth's functional level by facilitating the development of skills related to exhibiting appropriate behaviors in the school and community settings.</p> <p><u>Youth Day Treatment (Day Tx)</u> A set of mental health services provided in a specialized classroom setting (not a regular classroom or school setting) and integrated with educational services provided through full collaboration with a school district. The services are focused on building skills for adaptive school and community functioning and reducing symptoms and behaviors that interfere with a youth's ability to participate in their education at a public school, to minimize need for more restrictive levels of care and to support return to a public school setting as soon as possible.</p> <p><u>Partial Hospitalization Program (PHP)</u> Structured day program provided by a hospital under the direction of a physician with frequent nursing and medical supervision. Partial hospitalization has acute level and sub-acute level services.</p>	<p><u>Therapeutic Group Home (TGH)</u> A community-based treatment alternative provided in a structured group home environment. TGH is appropriate for youth requiring specific therapeutic treatment services and social supports which require higher intensity of specific therapeutic services and social supports than are available through traditional outpatient services and exceed the capabilities of support systems for the youth.</p> <p><u>Extraordinary Needs Aide (ENA)</u> Extraordinary needs aide services are additional one-to-one, face-to-face, intensive short-term behavior management and stabilization services provided in the TGH by TGH staff</p> <p><u>Psychiatric Residential Treatment Facility (PRTF)</u> Provides interventions directed at addressing and reducing the specific impairments that led to the admission and at providing a degree of stabilization that permits safe return to the home environment and/or community-based services. A PRTF is a secure residential facility that typically serves 10 or more children and youth and provides 24-hour staff and psychiatrist supervision, and may include individual therapy, group therapy, family therapy, behavior modification, skills development, education, and recreational services.</p> <p><u>Acute Inpatient Hospital</u> Psychiatric facilities that are devoted to the provision of inpatient psychiatric care for persons under the age of 21 for observation, evaluation, and/or treatment. Services are medically oriented and include 24-hour supervision; services may be used for short-term treatment and crisis stabilization. A youth might be admitted to an acute hospital if s/he is considered dangerous to self or others.</p>
<p>Note: Some services can be offered concurrently with other services. Other services have restrictions or exemptions.</p> <p>Please refer to the Children's Mental Health Bureau Medicaid Provider Manual for requirements.</p> <p>https://dphhs.mt.gov/dsd/CMB/Manual</p>		

Figure 10 - Children's mental health treatment services with descriptions.

Adult Mental Health Treatment

The Treatment Bureau manages the delivery of publicly funded mental health services for adults with a mental health diagnosis, primarily focused on individuals with severe and disabling mental illness. Services range from home and community-based services to residential services.

Rehabilitative Services

Rehabilitative services such as outpatient therapy, targeted case management, day treatment, and assertive community treatment are services intended to help individuals develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills. Rehabilitative services are delivered in the community with the goal of maximizing the reduction of mental disability and the restoration of a member to their best possible functional level. The Treatment Bureau managed and funded rehabilitative mental health services for over 50,000 adults enrolled in Montana Medicaid in FY 2021.

Severe and Disabling Mental Illness (SDMI) 1915(c) Home and Community Based Services (HCBS)

The SDMI HCBS waiver provides long term supports that are comprised of supportive, independent living, habilitative, and other services. SDMI HCBS services are intended to provide an individual with a SDMI a choice of receiving long term care services in a community setting as an alternative to receiving long term care services in a nursing home setting. The Treatment Bureau currently funds services for 452 adults enrolled in the SDMI HCBS waiver.

Substance Abuse Treatment

Substance use is a major public health issue in the state of Montana, affecting individuals and families across the lifespan. Over the past decade, BHDD has expanded access to evidence-based treatment and recovery services. Medicaid, Medicaid Expansion, and other innovative programs being implemented in Montana are significantly expanding access to substance use disorder treatment. Montana Medicaid funds an array of community-based treatment programs to provide services to individuals in their own community which spans outpatient, residential, and inpatient services based on the nationally recognized American Society of Addiction Medicine (ASAM) Criteria. The ASAM Criteria is an evidence-based practice that is the most widely used and comprehensive set of guidelines for placement, continued stay, transfer or discharge of individuals with addiction and co-occurring conditions.

BHDD has partnered with DPHHS' Licensure Bureau to further align Montana's substance use disorder treatment services with The ASAM Criteria. In addition, as part of the Healing and Ending Addiction through Recovery and Treatment (HEART) Initiative, BHDD will be submitting a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) to add the following two levels of care to Montana's Medicaid benefit plan:

ASAM 3.2 WM: Clinically Managed Residential Withdrawal

ASAM 3.3: Clinically Managed Population Specific High Intensity Residential

With the addition of these two ASAM Levels of Care, Montana's Medicaid benefit plan will include a comprehensive offering of all ASAM levels of care.

Treatment for Opioid and Stimulant Use Disorders

Although the state has made progress in addressing SUD, more work is required to expand access to SUD prevention and treatment services and prevent drug overdoses. Medication for Opioid Use Disorder (MOUD) utilizes a care team to provide individuals experiencing an Opioid Use Disorder with treatment to reduce or eliminate reliance on opioids. Authorized medications include methadone, buprenorphine, and naltrexone, all of which work to mitigate opioid receptors.

Montana is currently operating eight pilot sites and is working toward establishing Medicaid reimbursement for Contingency Management within the HEART 1115 Waiver. Contingency management is an evidence-based treatment for substance use disorders and has demonstrated considerable effectiveness for treating stimulant use disorders and increasing client retention in treatment programs. Contingency management reinforces positive behaviors by providing small, monetary incentives to individuals who successfully screen negative for stimulants throughout the duration of the program.



Figure 12 - Recovery section of continuum of care.

RECOVERY

Recovery services provide the ongoing support for individuals to successfully maintain their recovery from substance use and mental illness. Peer support services are a critical resource for individuals in recovery as they are provided by individuals who have lived experience with a mental health or substance use disorder and have successfully maintained their own recovery. Certified Behavioral Health Peer Support Specialists (CBHPSS) guide individuals through their treatment and recovery processes by providing an additional supportive service based on mutual understanding. CBHPSS trainings are available at no cost to individuals seeking to obtain their certification and services are currently funded by both Medicaid and federal grant funding.

The four major dimensions of recovery include health, home, purpose, and community. Drop-In Centers promote the four dimensions of recovery by providing community-based, recovery-support



Figure 11 - Recovery medication for opioid use disorder.

services in a low-barrier, peer-led setting. Individuals experiencing behavioral health issues, seeking resources, or maintaining their recovery are able to attend support groups and skill development classes, receive supportive services and referrals to other social service providers, and establish healthy relationships with staff and other clients. Montana currently has 11 Drop-In Centers across the state. BHDD is also leading the process to establish a Montana affiliate of the National Alliance of Recovery Residences (NARR). The affiliate will certify recovery residences that meet the standards established by NARR so individuals in need of safe, substance-free, community-based housing can access quality services.

SUICIDE PREVENTION PROGRAM

In 2007, MCA 53-21-1101 established a suicide prevention coordinator attached to the Director's Office of DPHHS. Since then, the position has been reassigned to the BHDD Division and over the last decade has been working with stakeholders across the state to bring the issue of suicide to the forefront and ensure that suicide prevention efforts in Montana are informed by national research and current best practices.

A list of resources implemented or expanded through the suicide prevention program in the past biennium includes:

Implementation of the 988 Crisis Line

The national suicide prevention Lifeline is being changed from 1-800-273-8255 to 988 on July 16, 2022. 988 is more than just an easy-to-remember number—it's a direct connection to compassionate, accessible care and support for anyone experiencing mental health-related distress – whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support.

Montana Zero Suicide Grant

Based on research that shows the majority of people who attempt suicide had seen a health care professional within a month of their attempt, Zero Suicide is a systematic approach to identifying and addressing suicidality within the larger healthcare system. The goals of Montana's Zero Suicide grant include:

- Establishing a suicide care policy promoting suicide safe care as an organizational priority.
- Creating a confident and competent workforce where at-risk individuals are identified.
- Ensuring all patients who are at risk receive immediate, safe and personalized treatment

Current Partners include:

- All Nations Health Center – Missoula
- Billings Urban Indian Health and Wellness Center – Billings
- Blackfeet Tribal Health Center – Browning
- Butte Native Wellness Center – Butte
- Confederated Salish and Kootenai Tribal Health – Ronan
- Fort Belknap Tribal Health – Harlem
- Fort Peck Tribal Health – Poplar
- Northern Cheyenne Tribal Health – Lame Deer

Accomplishments to date:

- All-site calls have led to a good exchange of information between Tribal Health Facilities and Urban Indian Health Centers.
- Trainings have been done with all partners
- Tribal Consultation has led to increased collaboration between the state and Tribal Partners, which has led to more partners
- NativeWellness Life, a Native owned magazine, has been a strong conduit of education, outreach and support
- Facilities have been creative: having Zoom classes in ribbon skirt making and beading, supporting individual patients with the ability to have fresh food grown at home, and the development of community gardens.
- Partners have developed clear policies and procedures and trained all staff to support their patients that may be at risk of suicide.

Rural Community Suicide Postvention Toolkit

In collaboration with Columbia University, a postvention toolkit is meant to be used after a suicide occurs in your community. It provides a series of action steps that you can take to safely offer support and reduce the risk of additional suicides from occurring in your community. These efforts are collectively referred to as **suicide postvention** because the response occurs after a suicide has happened.

Suicide Prevention Toolkit for Primary Care Physicians

Suicide assessment and intervention training designed for healthcare providers practicing in rural communities.

- Training provided every semester for college students in nursing, P.A., social work, counselors, psychology.
- Project ECHO for pediatricians
- Training at numerous medical conferences
- Training for the Montana Medical Association
- Collaboration with the National Council for Mental Wellbeing to provide train-the-trainer in Suicide Safe Care so that Montana has over 80 trainers around the state.

Suicide Prevention Trainings

In 2021, more than **1,200** community members, employers, first responders, educators, and others, were trained in suicide awareness. In addition, an additional **900** healthcare and behavioral health providers were trained in suicide risk assessment and intervention.

DEVELOPMENTAL DISABILITIES PROGRAM

The mission of the Developmental Disabilities Program (DDP) is to create a system that coordinates resources, supports, and provides services for individuals to have meaningful lives in their communities. DDP offers community based developmental disability services for individuals throughout their lifetime.

DDP managed and funded services for 3,386 Montanans with developmental disabilities in FY 2021. Services are primarily delivered through Medicaid waiver and State Plan services. Of the 3,386 individuals served by DDP in FY 2021, 99.7% received a community-based service. DDP serves the entire continuum of developmental disability needs from individuals who require minimal support to thrive in the community to individuals with very intensive needs who require 24-hour care.

Home and Community Based Services Waiver

The DDP's Home and Community Based Service (HCBS) Waiver is the 0208 Comprehensive Waiver (HCBS DD). This waiver is designed to support successful community living for individuals with developmental disabilities and offers an important alternative to institutionalization. The 0208 Waiver offers 32 separate services such as supported living and other residential services, employment support, day program services and transportation.

The DDP serves around 2,550 Montanans with a developmental disability through HCBS DD waiver. These services are in addition to the standard Medicaid benefit package. An individual's service and the cost of those services range significantly depending on the needs of the individual. The DD waiver is designed to meet a wide variety of needs for the duration of the individual's life.

Developmental Disabilities Program – Member Success Story

"I like the quiet, and my favorite part of my day is drinking coffee with staff," Is what Logan says about living a life with greater independence.

With a lot of hard work on developing independence skills and advocacy for himself, Logan moved out of the group home and into his own apartment with reduced direct supports.

This adjustment required Logan to start using his cell phone to reach out, and a lot of reaching out he did, initially!

Logan learned WHEN he should reach out and how often.

With more hard work he learned how and when to text his questions and needs.

Logan has since texted the manager Megan, not with a question or a concern but rather just a text wishing her a good day.



Figure 13 - Image of Logan.

Medicaid State Plan Services

Targeted Case Management (TCM) is available to individuals of any age that are enrolled in DDP Waiver services, as well as individuals ages 16 and older who have been determined eligible for the Developmental Disabilities Program. TCM services are comprehensive and include assessment of an eligible individual, development of a specific care plan, referral to services, and monitoring. These services are delivered across the state by either a DDP Case Manager or a Contracted Case Manager. Approximately 3,200 individuals statewide are currently enrolled in Developmental Disabilities TCM.

The BHDD has made significant changes to Autism Treatment Services, including renaming the program to “**Applied Behavior Analysis (ABA) Services**”. The changes expand access to and reduce delay in individuals receiving these services. Applied Behavioral Analysis (ABA) is a type of therapy that can improve social, communication, and learning skills through positive reinforcement. Many experts consider ABA to be the gold-standard treatment for children with Autism Spectrum Disorder (ASD) and other developmental conditions, but it can be used in the treatment of other conditions as well. This therapy is provided by a licensed Board Certified Behavior Analyst (BCBA). DDP is offering ABA services for individuals enrolled in Montana Medicaid (members) with the following diagnoses:

- Autism Spectrum Disorder (ASD) (the member is no older than 20 years of age).
- Serious Emotional Disturbance (SED) (the member is no older than 17 years of age or the member is no older than 20 years of age and enrolled in an accredited secondary school. and meet certain functional impairment criteria)
- Intellectual and/or Developmental Disability (defined as having been deemed eligible for the receipt of state sponsored developmental disabilities services and no older than 20 years of age) and meet certain functional impairment criteria.

HIGHLIGHTS AND ACCOMPLISHMENTS DURING THE 2023 BIENNIUM

HEALING AND ENDING ADDICTION THROUGH RECOVERY AND TREATMENT (HEART)

Governor Gianforte’s HEART Initiative, included in H.B. 701, seeks to invest significant state and federal funding to expand the state’s behavioral health continuum to:

- Expand efforts to strengthen state’s evidence-based behavioral health continuum of care for individuals with a SUD, Serious Mental Illness (SMI), or a Serious Emotional Disturbance (SED);
- Enable prevention and earlier identification of behavioral health issues; and
- Monitor the quality of care delivered to members with behavioral health needs across all settings through improved data collection and reporting.

The HEART initiative refers to the package of programs and services that will be provided using HEART funding, Medicaid state plan, and the substance abuse block grant. The HEART waiver is specifically one piece of the HEART initiative and refers to the 1115 behavioral health waiver for which BHDD has applied.

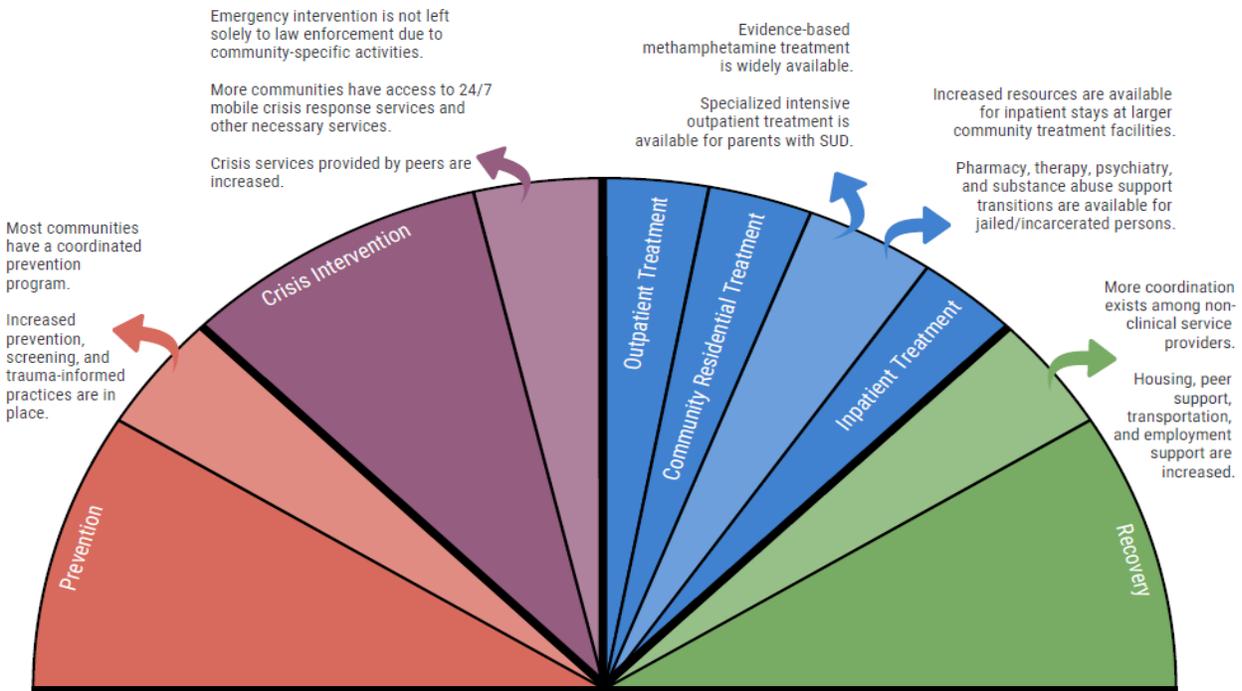


Figure 14 - Continuum of care with resource information.

Through the HEART initiative, BHDD is leveraging funds from the substance abuse block grant and HEART funds to promote prevention services, provide grants to jails, and grants to tribes.

Grants to Tribes: The HEART funding provided \$500,000 in grants to be issued directly to Tribal Nations each year for substance use disorder (SUD) prevention; mental health promotion; mental health crisis, treatment, and recovery services; and tobacco prevention and cessation. Each Tribal Nation received \$62,500. DPHHS will receive a report from each Tribal Nation at the end of July with specific details of how the funds were used.

Grants to jails: The HEART funding provides \$1,100,000 per year to support the implementation of a comprehensive behavioral health continuum within local county and tribal detention facilities. DPHHS issued an RFP in April to facilitate applications from county and tribal governments for two-year grants to implement jail-based behavioral health therapy, Certified Behavioral Health Peer Support services, care coordination, medication prescription, management, and monitoring, and Medication for Opioid Use Disorder (MOUD).

Medicaid State Plan Services:

BHDD intends to file a state plan amendment effective October 1, 2022, to align our substance use disorder treatment services with The ASAM Criteria. There are two levels of care of the American Society of Addiction Medicine (ASAM) which Montana Medicaid does not currently reimburse.

- ASAM 3.2 WM: Clinically Managed Residential Withdrawal Management
- ASAM 3.3: Clinically Managed Population-Specific High Intensity Residential Services

Community mobile crisis intervention services are a critical part of states' crisis and behavioral health systems of care. BHDD has a contract with the Western Commission for Higher Education to complete a statewide assessment to provide recommendation regarding:

- the development of additional mobile crisis teams including outlining what types of mobile crisis services will work, particularly in rural and frontier areas;
- considerations regarding how licensing and reimbursement structures can facilitate statewide mobile crisis coverage; and
- necessary changes to policy landscapes.

BHDD will seek authority for mobile crisis teams effective January 1, 2023.

HEART 1115 Demonstration Waiver

On October 1, 2021, DPHHS submitted a Section 1115 Demonstration Waiver to the Centers for Medicare and Medicaid to build upon the strides made by the state over the last decade to establish a comprehensive continuum of behavioral health—mental health and SUD—services for its Medicaid members. This Demonstration is a critical component of the state's commitment to expand coverage and access to prevention, crisis intervention, treatment and recovery services through the HEART Initiative. DPHHS is seeking to add new Medicaid Services which include:

Contingency management: This Demonstration seeks to add contingency management, a best practice, outpatient treatment model for Medicaid members ages 18 and older with stimulant use disorder (e.g., cocaine, methamphetamine and similar drugs). Contingency management is a behavioral-modification method that provides immediate reinforcement for individuals adhering to the goals of the program. The contingency management program provides small monetary rewards to individuals who screen negative for stimulants.

Tenancy support: This Demonstration proposes to add coverage for a tenancy support services program to assist Medicaid members ages 18 and older with SUD, SMI or SED, who are experiencing chronic homelessness or frequent housing instability and frequently engage with crisis systems and institutional care. Tenancy support services will include pre-tenancy supports and tenancy sustaining services to support an individual's ability to prepare for and transition to housing, as well as assist individuals in maintaining services once housing is secured.

Pre-release care management and limited Medicaid services to be provided to inmates in the 30 days pre-release: In the 30 days prior to release from state prisons, eligible Medicaid members will receive limited community-based clinical consultation services provided in-person or via telehealth, in-reach care management services, and a 30-day supply of medication for reentry into the community. Individuals will also receive coverage of certain medications that include long acting or depot preparations for chronic conditions (e.g., schizophrenia, SUD); acute withdrawal medications; or suppressive, preventive or curative medications, include PrEP and PEP (HIV, HCV, and SUD) that will facilitate maintenance of medical and psychiatric stability upon release. DPHHS is seeking to implement this initiative on January 1, 2023.

In addition, DPHHS is requesting expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of Institutions of Mental Disease (IMD) obtaining treatment for SUD.

CHILDREN'S MENTAL HEALTH TARGETED CASE MANAGEMENT EVALUATION

During a significant overhaul of Targeted Case Management (TCM) in 2020, the Children's Mental Health Bureau (CMHB) designed its TCM model to emphasize assisting and empowering families of children with SED to obtain the necessary services to remain in school, at home, and out of trouble. Together, the CMHB and the University of Montana's Center for Children, Families, and Workforce Development (the Center) developed the following evaluation objectives:

1. Manage fidelity to the state's program model for TCM, with an emphasis on family engagement;
2. Create actionable data that supports that youth and families served, as well as other stakeholders, are satisfied with how the TCM program is administered and delivered; and
3. Demonstrate the effectiveness of TCM defined by Montana Code Annotated (MCA) § 53-21-508 (HB583/HB589).

Over the evaluation period, the Center reviewed and analyzed existing data sets that have historically been collected with the goal of creating distinct actionable recommendations to meet CMHB's objective of assuring fidelity to a quality system of TCM delivery. Data sets reviewed included claims data, the Mental Health Statistics Improvement Program (MHSIP), and "In Home,

In School, and Out of Trouble,” outcome measurements required in MCA § 53-21-508. Through the evaluation, the Center offered 19 actionable recommendations for the improvement and further evaluation of the CMHB TCM System in five broader categories: Claims Data, MHSIP Data, HB 583/589, Fidelity to Program Standards, and CASII/ECSII.

CMHB is currently evaluating and prioritizing these recommendations for rollout beginning in July 2022 and continuing through the 2025 biennium. CMHB anticipates using the recommendation to drive program improvements, cost savings, and resource prioritization. Additionally, findings will be used to highlight key program areas to seek feedback and recommendations from stakeholders, and will serve as a vehicle for structured, transparent, and intentional public program administration for the ultimate benefit of the children and families served by CMHB.

One area of interest of CMHB is the promotion and measurement of quality family engagement and utilization of the “golden thread.” The golden thread is the consistent inclusion of relevant clinical and environmental information throughout all stages of mental health treatment. Beginning at intake and assessment through the utilization of the CALOCUS/CASII functional assessment, clinical assessment, and needs assessment, the family and youth’s strengths, preferences, and needs should be clearly identified in treatment plans.

In an effort to provide resources to TCM providers and measure these qualitative outcomes, the Center developed two innovative tools. CMHB’s TCM Metrics to measure Fidelity to Family Engagement is a clear, well-defined document which identifies CMHB’s priorities for quality service delivery and ties them directly to Administrative Rule and guidance from the CMHB provider manual. Priority areas include: Natural Supports, Assessment, Client Satisfaction, Quality Case Notes, Supervision and Training, Treatment Plans, Treatment Teams, Discharge Planning, and Systems of Care. Further, the Center developed a Fidelity to Family Engagement Audit Tool, which will be used as an educational, non-punitive, instrument to measure and improve quality of service delivery and documentation. Each identified priority area has well-defined measurements to identify performance. CMHB is currently working to roll out this tool in the summer and fall of 2022.

Fidelity Marker	Rule/ Authority	Not yet	Emerging	Developing	Proficient	Advanced
Treatment Planning	37.87.823 _ (5) Case management plans for youth with SED must be completed within the first 21 days of admission to targeted case management services and updated at least every 90 days or whenever there is a significant change to the youth’s condition. The case management plan must: (a) use the standardized assessment tool approved by the department to determine the appropriate level of service intensity needed by the youth and the youth’s family or caregivers; (b) incorporate standardized assessment tool findings into the plan; (e) identify the strengths of the youth and the youth’s family or caregivers	Treatment plans do not exist or are clearly electronically cloned and lack any level of individualization.	Treatment plan is in place but not highly individualized. Generic treatment goals utilized across client groups. No indication that treatment plan is driven by treatment team including youth served, family or caregivers.	Treatment plan sections are completed and minimally include crises (urgent and emergent needs and planning), strengths, natural supports, support of family and caregivers, and at least 1 goal clearly linked to functional assessment.	Plan identifies specific skills to be developed. Plan is based on assessed strengths. Plan utilizes CASII scores and dimensions to determine appropriate areas of priority and determine the appropriate level of service intensity needed by the youth and the youth’s family or caregivers.	There is a clear link between assessment information and all treatment plan goals. All treatment goals are definable, measurable and data is collected to demonstrate attainment The plan is regularly updated (every 90 days) in a way that reflects use of data, ongoing assessment and developing strengths and skills The family and caregiver skills needed to case manage themselves are identified and targeted as goals.

Figure 15 – Sample from Fidelity to Family Engagement Audit Tool. Credit: University of Montana

DEVELOPMENTAL DISABILITIES PROGRAM FAMILY ENGAGEMENT INITIATIVES

National Core Indicators

DDP joined National Core Indicators (NCI) in July 2021. NCI is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). The purpose of the program, which began in 1997, is to support State Developmental Disabilities agencies to gather a standard set of performance and outcome measures that can be used to track their own performance over time, to compare results across states, and to establish national benchmarks.

In Montana’s first year of membership, DDP utilized the Adult Family Survey, Child Family Survey and Staff Stability survey. In the second year of membership, DDP will be deploying Quality Improvement Specialists to meet directly with individuals in services to gather important feedback through the in-person NCI survey. These survey results will provide important information for DDP in setting priorities and developing policies.

Family to Family

Beginning in 2021, DDP began partnering with Family to Family (F2F), which is Montana’s Family Health Information Center. F2F is housed in the Rural Institute for Inclusive Communities on the University of Montana Campus. This collaboration provides an important opportunity for DDP to provide information directly to individuals in services and their family members as well as obtain feedback from this important part of the service delivery system. To date, DDP and F2F have conducted five evening presentation/listening sessions with more planned.

“Montana families of children with disabilities and healthcare challenges need information about available services, presented in family-friendly language with the opportunity to ask questions. The Developmental Disabilities Program has made unprecedented effort this past year to ensure families and their case managers are knowledgeable about DDP services.

DDP leadership has been responsive and available to help navigate particularly complex family situations, and the implementation of regular PoP (Partnering our Programs) meetings has meant more direct family engagement than ever before. The clear result is better service for Montana’s most vulnerable children, and more informed case managers serving them.”

Shawna Hanson, F2F Outreach Coordinator

EFFICIENCIES AND COST SAVINGS

ESTABLISHMENT OF BHDD

The merger of the AMDD and DSD into the BHDD has created many efficiencies in operations, communications, and provider relations. In addition to administering services across the entire behavioral health continuum, it has provided the opportunity for the Prevention and Treatment Bureaus and the Children’s Mental Health Bureau to work more cohesively on programs which impact children, such as PAX Good Behavior Game. The Children’s Mental Health Bureau has also worked closely with the Prevention and Treatment Bureaus to fund programs aligning with the goals and priorities of the Children’s Mental Health Bureau such as enhancing family engagement, outcome measurement, and data driven decision making. During the biennium the Children’s Mental Health Bureau funded several important projects with the SAMHSA block grants including Targeted Case Management Evaluation, innovation grants and learnings collaboratives on family engagement, and a children’s behavioral health focused community health worker pilot program.

DEVELOPMENT OF INVOICE PROCESSES

BHDD recently implemented an electronic invoicing system to increase workflow efficiencies. The system was developed in coordination with the Technology Services Division to meet the unique needs of BHDD’s fiscal operations, which include the daily receipt, review, approval, and payment of invoices from a variety of contractors. The new system streamlines the approval process, reduces the opportunities for manual mistakes to be made, and provides an electronic record of the entire process that can be referenced during review periods.

FUNDING AND FTE INFORMATION

BHDD	FY 2022 Request	FY 2023 Request
FTE	106.00	106.00
Personal Services	\$8,970,779	\$7,682,470
Operating Expenses	\$7,083,159	\$4,675,531
Local Assistance	\$2,340,442	\$2,340,442
Grants	\$41,404,320	\$6,054,028
Benefits & Claims	\$468,011,936	\$516,238,847
Transfers	\$9,765,329	\$90,000
Debt Service	\$7,330	\$1,864
TOTAL COSTS	\$537,583,294	\$537,083,182
	FY 2022 Request	FY 2023 Request
General Fund	\$103,078,695	\$125,947,242
State Special	\$39,837,980	\$41,149,944
Federal Funds	\$394,666,619	\$369,985,996
TOTAL FUNDS	\$537,583,294	\$537,083,182