

IV. Montana Financing Opportunities

A. Introduction

Our analysis of the funding sources for Montana's public mental health services is based on information provided by DPHHS on service expenditures for fiscal years 2005 through 2007 (the last available year with full claims). These data include service expenditures from the various Divisions within DPHHS: the Health Resources Division; Disability Services Division; Addictive and Mental Disorders Division; and the Child and Family Service Division. Mental health expenditures for CHIP and for services provided by Indian Health Service facilities were not available. We are able to provide data on FY 2008 CHIP expenditures. Data on IHS mental health expenditures are excluded because they were incomplete. These data do not include administrative costs for DPHHS divisions or expenditures under certain special federal grants received by the state.

In this section, we describe our findings regarding the financing of services for adults and children with mental health needs, in the course of which we will suggest potential sources of new funding and recommend strategies the State might want to pursue to access those sources. We provide an overview of total funding sources in DPHHS, followed by a more detailed analysis of children's services and adult services with specific recommendations for each. Finally, we look at the funding sources used by Montana across both child and adult and identify opportunities for additional funding.

1. Overview of Service Expenditures

Table IV-1 provides an overview of expenditures for mental health services in Montana by fund source and fiscal year. The cost of DPHHS's mental health services are shared by the state and federal governments. Over the three years, 2005 to 2007, the state share for state-only programs increased from 22% to 25%, while the share for programs with some federal contribution has decreased from 78% to 75%. The federal share comes primarily from Medicaid, which accounts for all but 1% of federal programs. Medicaid requires a state matching effort, and the state's funding is included in the total Medicaid expenditures. The Federal Medicaid Assistance Percentage (FMAP) is declining as a result of increases in Montana's per capita income relative to the national level. The remaining federal contribution comes from two grant programs: Vocational Rehab for the States and the Mental Health Block Grant. State General Funds account for an increasing share of the state-only funding, increasing from 19% to 22% of the total. State special revenues accounted for a constant 3% share.

In FY 2007, DPHHS expended \$176.3 million on mental health services inclusive of all federal and state funding sources. This is an increase of \$4.2 million (2%) from FY 2005 expenditures of \$172.1 M. The most significant changes in expenditures by fund source were:

- ▶ \$5.5 million increase in State General Fund expenditures
- ▶ \$1.2 million decrease in overall Medicaid expenditures
- ▶ \$395,000 decrease in federal funds for the State Hospital
- ▶ \$270,000 increase in MHSP expenditures (state-only)

FY 2007 expenditures were 2% less than FY 2006 (\$180 M), with the majority of this decrease being in Medicaid expenditures. The state share for mental health services is likely to continue to increase because the state's Medicaid percentage match is due to increase to 32%.

**Table IV-1
DPHHS Mental Health Service Expenditures (Excluding CHIP and IHS)
FY 2005 – FY 2007**

DPHHS Fund Sources	2005	2006	2007
State General Fund Appropriations	\$29,708,799	\$32,774,571	\$35,224,309
Mental Health Service Plan (MHSP)	\$2,727,836	\$3,422,532	\$3,000,365
Children's Mental Health Service Plan	\$9,841	\$7,838	\$6,553
TANF Maintenance of Effort (State General Fund)	\$335,222	\$377,346	\$395,013
MHSP (SSR) Tobacco / I149 initiative	\$2,931,799	\$3,047,434	\$2,700,077
State Hospital - (SSR) Debt Service Bonds	\$1,785,072	\$1,775,375	\$1,792,631
State Hospital - (SSR) State Special Rev. (DOC & Alcohol tax)	\$432,275	\$427,062	\$476,557
Subtotal State-Only Programs	\$37,930,844	\$41,832,158	\$43,595,505
SSI (Federal Funds)	\$12,813	\$26,363	\$40,670
MHSP Block Grant - Federal Funds	\$953,841	\$1,228,489	\$1,220,387
State Hospital - Federal	\$395,910	-	-
MT Mental Health Nursing Care Center - Federal	\$111,090	-	-
Medicaid	\$129,828,424	\$134,113,480	\$128,588,428
Rehab Services: Voc Rehab to the States – Fed. Funds	\$2,873,000	\$2,920,968	\$2,862,460
Subtotal Federal and Federal/State Programs	\$134,175,078	\$138,289,300	\$132,711,945
Total	\$172,105,922	\$180,121,458	\$176,307,450
<i>Source: DPHHS Special Report, rev. 9/15.</i>			

2. Department of Corrections Mental Health Expenditures

Relative to DPHHS and as a percentage of its own overall budget, Department of Corrections (DOC) spending on mental health is relatively small. DOC provides mental health services in its adult correctional facilities, adult community corrections, youth services, and the mental health liaison position. Total spending of \$3.9M in FY 2007 was equivalent to 3% of the mental health services spending for DPHHS. Virtually all DOC funding is from the state.

B. Financing of Children’s Mental Health Programs

1. How are children’s mental health services funded?

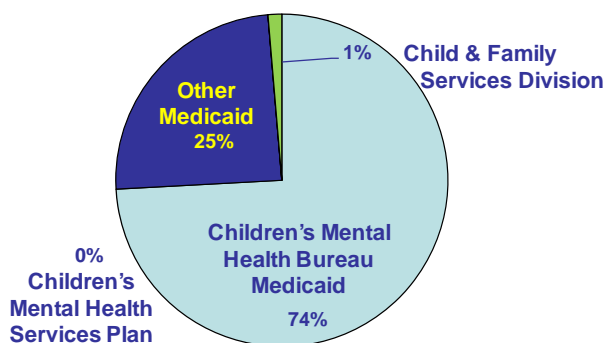
Montana’s mental health services for children are primarily funded through Medicaid and CHIP; each has a substantial federal match. A very small portion is solely state financed. Less than 6% of the Juvenile Corrections budget is expended on mental health.

a) DPHHS

Figure IV-1 shows Montana FY 2007 service expenditures for DPHHS children’s mental health services by program. These expenditures totaled \$77.5M excluding CHIP program mental health expenditures. In FY 2008, CHIP mental health expenditures totaled \$1.4 million, equivalent to 1.8% of the \$77.5 M spent on the other three programs in FY 2007.

Children’s services are funded almost exclusively by the Medicaid program. The Medicaid services provided through the Children’s Mental Health Bureau (CMHB), with a budget of \$57.4 million, accounted for almost 75% of the total children’s mental health expenditures. “Other Medicaid” (which covers school based services administered by the Office of Public Instruction, as well as psychotropic pharmacy services), accounts for a quarter of expenditures. State funded mental health services provided by the Child and Family Services Division (CFSD) account for only 1% of the total, and the Children’s Mental Health Services Plan accounted for even less.

Figure IV-1
SFY2007 DPHHS Child MH Expenditures* by Source



Total = \$77.5 Million

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

* Excludes CHIP MH Services and IHS MH Services

Source: DPHHS Special Report

In addition to the above service expenditures, DPHHS has received two grants supporting children’s mental health services. The SAMHSA System of Care Grant totals approximately \$500K per year for the last four years, and provides infrastructure and training support to create and operate children’s system of care. They are in the last year of this grant. The CMS Psychiatric Residential Treatment Facility (PRTF) Demonstration provides from \$430K to \$980K in potentially new federal support to the system. Approximately two-thirds of this is for services; the balance for administrative support.

b) Juvenile Corrections

Expenditures on mental health services in Juvenile Corrections are growing, and most of these funds are spent on residential placements for a relatively small number of youth. A relatively small proportion of the Youth Service Division budget is spent on mental health services. Almost

\$1.2M (under 6%) of the FY 2008 budget for Juvenile Corrections was expended on mental health services. The vast majority of this was for contracted residential treatment services. The Youth Services Division accounts for 25% of total DOC spending on mental health and it grew at the same rate as other mental health expenditures for youth. Youth Services spends a full 72% of its expenditures for contracted services for youth in residential treatment. Mental Health personnel account for only 19% and medications for 8%.

	FY 2007	FY 2008	% change 07 to 08
Total MH Expenditures	1,006,670	1,154,861	15%
Type of Expenditure	Contracts	Personnel	Medication
Percent of FY 2008 Total Mental Health Expenditures	72%	19%	8%

Source: Department of Corrections Mental Health Costs Fiscal Years 2007/2008, 10-Jul-08

DOC's expenditures for youth residential are a fairly small part of the total spent by the State on residential mental health services for youth. The \$772,180 spent on residential services for DOC youth in FY2007 was equivalent to only 4% of DPHHS expenditures on PRTF level of care in the same period. However the issue has generated a considerable amount of attention.

Medicaid pays for all or some of the DOC youth in residential facilities who have mental health problems. Almost 20% of the 26 youth with mental health problems in residential facilities under DOC auspices were fully paid for by Medicaid. Another 30% were partially paid by Medicaid, and half were fully paid by DOC state general fund dollars. The amounts included in the Table IV-3 above are the DOC share of mental health spending for those youth.

2. Have Montana's children's mental health funding streams changed significantly over the past few years? If so, which ones and why?

DPHHS expenditures for children's mental health services increased by 16% between FY2005 and FY2007, with most of the increase in Medicaid because of expanding eligibility for basic mental health services. CMHSP decreased, likely because fewer children needed it. However, the relative state and federal shares remained constant. Montana has effectively leveraged resources through its Medicaid and CHIP programs. The state is spending small amounts for non-Medicaid services for children, but may be spending more than it needs to on complex cases that are likely to have Medicaid coverage.

Expenditures for children's mental health services increased by \$11M (16.5%) between FY 2005 and 2007, from \$66.5 million to \$77.5 million. There were no changes in state and federal shares. Tables IV-3 and IV-4 provide an overview of expenditures for children mental health services by year and funding source.

Several factors were directly related to the increase seen in expenditures for children's Medicaid mental health services over the three year period:

- ▶ The state removed the restriction that only children with Serious Emotional Disturbance could receive Medicaid children's mental health services.
- ▶ Funds from the Tobacco tax were designated to raise Medicaid mental health reimbursement rates.

Table IV-3				
DPHHS Children's Mental Health Service Expenditures*				
by Fund Source and Fiscal Year				
DPHHS Fund Sources	2005	2006	2007	
State General Fund Appropriations	\$542,443	\$717,211	\$599,970	
State GF (TANF of maintenance of effort)	\$335,222	\$377,346	\$395,013	
CMHSP	\$9,841	\$7,838	\$6,553	
Medicaid	\$65,623,315	\$74,107,513	\$76,458,709	
SSI (Federal Funds)	\$12,813	\$26,363	\$40,670	
Total	\$66,523,634	\$75,236,272	\$77,500,914	
<i>*Excludes CHIP mental health service expenditures</i>				
<i>Source: DPHHS Special Report, rev. 9/15</i>				
Table IV-4				
Changes in DPHHS Children's Mental Health Service Expenditures*				
by Fund Source and Fiscal Year				
DPHHS Fund Sources	\$ Change from 2005-2006	\$ Change from 2005-2007	% Change from 2005-2006	% Change from 2005-2007
State General Fund Appropriations	\$174,768	\$57,527	32.22%	10.61%
State GF (TANF maintenance of effort)	\$42,124	\$59,791	12.57%	17.84%
CMHSP	(\$2,003)	(\$3,288)	-20.35%	-33.41%
Medicaid	\$8,484,198	\$10,835,394	12.93%	16.51%
SSI (Federal Funds)	\$13,550	\$27,857	105.75%	217.41%
Child Total	\$8,712,637	\$10,977,281	13.10%	16.50%
<i>*Excludes CHIP mental health service expenditures</i>				
<i>Source: DPHHS Special Report, rev. 9/15</i>				

- ▶ There was an increase in the utilization of targeted case management. Specifically, the number of units per child increased during this three year period (the state has subsequently placed additional cost controls on this service).
- ▶ School-based health services grew during this period as the number of participating schools increased.

There was a slight decrease in CMHSP expenditures for the three year period. This may have been directly related to changes in eligibility for the state's CHIP program, which was raised from 150% to 175% of the federal poverty level during the three year period. Less revenue for the CMHSP program was needed as additional children qualified for Medicaid or CHIP. In FY 2008, the \$1.4 million in CHIP mental health expenditures were spent almost equally on inpatient services and outpatient services, showing a similar pattern to that seen for the other DPHHS mental health expenditures.

a) Expenditures by Type

Table IV-5 shows children's mental health expenditures by service type. This table includes DPHHS' total expenditures for children's mental health services and psychotropic medications. As is true for our service data, these expenditures include a broad range of service needs. Some services, like PRTF, and targeted case management are used by children with SED, while others are used by children whose needs can be met by a few counseling sessions or a medication. Over half of total expenditures supported residential treatment options, with slightly more than a quarter of total expenditures paid for group homes and therapeutic foster care (which can

often, but not always, serve children in their communities). Another 25% of total expenditures supported inpatient and psychiatric residential treatment programs, (a number, but not all of which, are located out of state). These expenditures also included payments for those times when a child with a primary psychiatric diagnosis was served in a non-psychiatric bed. The two next largest expenditure groups were school based services for children with emotional disabilities, and medications plus medication management services. Together they accounted for another quarter of children's mental health expenditures. The remaining service types, of which the main components are outpatient and targeted case management, comprised the final 25%.

The Child and Family Service Division pays for \$1M in outpatient services, primarily from state funds. These services include assessments and individual and family therapy. Since most of these children are in state custody, they qualify for Medicaid. However, the Division has found that the specialized providers needed to assess children with complex needs are not always participating in Medicaid, or are not available as quickly as their services are needed. In these cases, the Division pays a higher rate to obtain services outside of the Medicaid system.

b) Flexible Funds

CMHB has some sources of flexible funding that can be used to pay for additional services needed by a child with serious emotional disturbance when those services are not covered by Medicaid or CMHSP. One source is the almost \$400,000 spent in FY 2007 that the state is required to spend to demonstrate that it has maintained its contributions to the Temporary Assistance for Needy Families program (TANF). These funds can only be provided to children who are Medicaid or CHIP eligible, are under 150% of the Federal Poverty level, and are not receiving cash assistance. However, for those that do qualify, funds can be used very flexibly, such as for transport or lodging that allows a family to visit a child in residential treatment, for a wilderness camp, or for room and board for a group home when a family can't afford it. CMHB is gathering data on the outcomes of the flexible services they purchase to determine which of these services that fall outside the standard benefit are effective.

A second source is a new System of Care Account created by the Legislature. In the current biennium, state agencies are allowed to deposit up to \$500,000 of unmatched or other general fund into the account to be used, flexibly, for children with multi-agency needs. No additional funds are appropriated for this account. In the first year, FY 2008, \$40,000 of the System of Care Account was channeled through the account for 11 children, mostly to avoid residential placements.

Table IV-5

SFY2007 DPHHS Children's Mental Health Expenditures by Service Type (Excluding CHIP and IHS MH Services)		
Group Homes and Therapeutic Foster Care	\$20,918,122	27%
Inpatient/PRTF	\$19,042,567	25%
School Based Services	\$10,000,899	13%
Medication	\$ 8,806,414	11%
Outpatient	\$ 5,617,624	7%
Targeted Case Mgmt	\$ 5,140,369	7%
Rehabilitation and Support	\$ 3,042,231	4%
Day/Intensive OP	\$ 2,429,740	3%
Misc. Services*	\$ 2,122,380	3%
Crisis	\$ 380,569	0%
Total	\$77,500,914	

* Misc includes services for MH diagnoses provided by non-MH providers, including Personal Care Agencies, FQHCs, physicians, labs, and certain psychiatry services not included in standard MH procedure codes.

Source: DPHHS Special Report

The third source is part of Montana's PRTF demonstration grant. This grant is using a system of care approach to enroll 100 children annually and provide them with community based services intended to prevent or minimize their stays in a PRTF level of care. If the number of children using PRTFs is reduced, those who continue to need this level of care are more likely to be able to be served in-state. The grant provides five years of federal funding matched with state funding for the administration of the demonstration, and allows Medicaid to reimburse services not otherwise covered. These include: respite services (currently available only through 100% state funding); a new form of lab testing relevant to children on complex medication regimens; non-medical transportation; and flexible funding for other needs. If the demonstration is successful, Montana may request a waiver that would allow this program to continue.

- ▶ *Montana has effectively leveraged federal resources through its Medicaid and CHIP programs.* Very little funding is required from the state outside of these programs. Winning a PRTF grant from CMS is allowing Montana to use Medicaid funding much more flexibly to reduce use of one of its highest cost treatment modalities.
- ▶ *The spending level for non-Medicaid services to children is very small.* For middle class families with incomes above Medicaid or CHIP eligibility, the costs of caring for a child with mental illness are significant; coverage by commercial insurance plans is limited.
- ▶ *Montana is paying from state CFSD funds for some outpatient services for complex cases that could be reimbursed by Medicaid.* Since most children receiving these services are enrolled in Medicaid, the state could develop a method for paying the higher rates needed to procure these services through Medicaid, thereby garnering federal match for \$1M.
- ▶ *CMHB has a number of sources of flexible funding, which are very important to be able to meet a child's needs that fall outside of the covered services.* The System of Care Account provides an important source of flexible funding not limited by the restrictions applicable to TANF maintenance of effort and PRTF waiver services.

3. How does a child/family pay? Should families pay more?

Families of child consumers have no co-pays now. Co-Pays should be implemented for outpatient services to make the system equitable with that for adults.

Children's Medicaid is prohibited by federal regulation from assessing co-payments. CHIP does have co-payments for certain mental health services for some enrollees; those with incomes under 100% of poverty and Native Americans are exempt. The adult section of this chapter provides additional detail on principles for assessing co-payments. These call for co-payments to be consistent across Montana's programs to the degree allowed by regulation, and to be set at levels that appropriately and consistently consider families' financial resources.

Recommendations. Montana should establish reasonable and fair co-pays that are consistent across both children's and adult's 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.

4. How can Montana make better use of current children's mental health funding streams and funding levels?

Montana's comprehensive mental health benefit makes good use of Medicaid and CHIP, but its rates for psychiatry, case management and individual and group therapies for children are low compared to other states, and raising them should improve use of Medicaid funds and community based service utilization.

Montana has made good use of Medicaid and CHIP to provide a comprehensive mental health benefit to children within the income eligibility limits. By winning a system of care grant and following it with the PRTF demonstration grant, the state has laid a good foundation for eventually becoming able to administer Medicaid community services flexibly for children at highest risk. The PRTF grant provides a funding stream that can encourage the further development of community based services and foster creativity in making best use of community resources. Active evaluation of this effort will provide valuable information to inform the design of an ongoing waiver, and lessons learned may be able to be translated to CHIP, CMHSP, and other levels of care.

a) Strategic Rate Increases

Adequate rates that provide for attractive salaries and working conditions are a necessary component of a strategy to increase the capacity of Montana's mental health workforce. We compared Medicaid/MHSP rates for certain Montana mental health services to rates for neighboring states and found that the rates for the following services were considerably lower than those of other Western states. (See Table IV-6)

- ▶ Montana's medication management rate was lower than for other states. Given the state's difficulties in recruiting psychiatrists, ensuring that rates are competitive may be a necessary part of a workforce development strategy.
- ▶ Targeted case management (TCM) rates for children are lower than other states and much lower than for Montana adult TCM services. In addition, these services may need to be restructured to be compliant with new CMS rules. This would provide an opportunity to modify the service and reset the rates. However, as one of the services that has grown the fastest and is used by a high proportion of Medicaid children, it behooves the state to address rates as part of a comprehensive management plan for this service.
- ▶ Family and Group therapies are a core component of children's MH services. Low rates may affect the availability of services as well as the attractiveness of counseling positions.

Montana may also wish to review the rates paid by private health plans for these services when considering increased rates and give more weight to the states that Montana considers most likely relevant to its market. At FY 2007 utilization levels, rates for medication management, case management and family and group therapy could be increased to the average of other Western states for an estimated total of approximately \$3 million that would be eligible for FMAP.¹ However, if utilization of these services increases as desired, the eventual cost would exceed this amount. We also note that CFSD pays higher rates than Medicaid to get MH assessments and treatment for some of its most complex cases, suggesting that raising rates can elicit greater willingness to deliver services.

¹ We applied the percentage increase to payment rates to the amounts spent for these procedures in FY 2007 to reach this amount.

Code	90862	90806	90847	90853	H2014, H2015, H2017	H2012	H2015, T1016
Description	Medication Mgmt.	Individual Counseling	Family Psychotherapy	Group Psychotherapy	Psychosocial Rehabilitation	Day Treatment	Case Mgmt.
Min	\$39.80	\$55.91	\$33.54	\$11.74	\$1.93	\$11.68	\$7.48
Max	\$81.79	\$101.73	\$119.82	\$43.87	\$4.81	\$28.16	\$16.39
Average	\$56.62	\$71.65	\$75.51	\$23.13	\$3.14	\$18.83	\$13.06
Montana Rate	\$47.09	\$53.76	\$65.15	\$18.44	\$10.46	\$10.46	\$12.61
Rate Difference	20.24%	33.27%	15.90%	25.44%	62.06%	80.07%	47.50%
FY 2007 Expenditures	\$758,870	\$2,957,468	\$1,032,491	\$98,576	\$2,702,623	\$1,227,286	\$5,140,369
Potential Impact	\$153,620	\$164,184	\$164,184	\$25,078	\$1,677,258	\$982,746	\$2,441,777
States Compared	Alabama Idaho Minnesota Nevada New Mexico North Dakota Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Texas Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Texas Utah Wyoming	Alabama Arizona Arkansas Florida Louisiana Nevada New Mexico North Carolina Oklahoma Rhode Island	Alabama Florida Minnesota Nevada New Mexico	Minnesota Nevada New Mexico Oklahoma Utah

Recommendations. Review Medicaid rates in comparison to nearby states that are part of Montana’s labor market 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 \$3M.

- ▶ 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.

b) State Plan Services

CFSD Services. CFSD is paying for services that could be covered by Medicaid at rates that usually exceed Medicaid rates. This is most true in complex cases that require specialty services and/or providers that do not bill Medicaid.

Recommendation. We believe that this can be addressed if HRD developed 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. CFSD paid approximately \$1 million for these services in FY 2007, primarily from state general funds. Paying an increasing share through Medicaid would garner federal match for these amounts.

c) Targeted Case Management

Targeted Case Management rule changes have been proposed by CMS. More than \$5M is claimed for children’s Case Management. See our discussion of this area in the adult section.

C. Financing of Adult Mental Health Programs

1. How are adult mental health services funded?

The state carries a substantial financial responsibility for DPHHS adult mental health services, with the largest program being state mental health institutions. Vocational rehabilitation services and MHSP together account for a little more than 10% of total expenditures. Health services for Native Americans can be improved through stronger Medicaid billing.

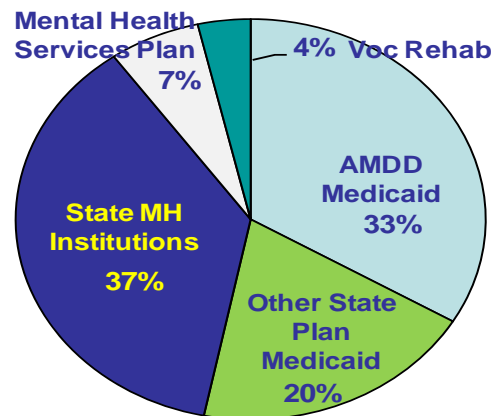
a) DPHHS

Figure IV-2 shows adult mental health service expenditures which totaled \$98.8M in FY 2007. State institutions, with combined budgets of \$36.3 million, and the Addiction and Mental Disorders Division (AMDD) Medicaid program with a budget of \$32.3 million dollars were the major components. When AMDD Medicaid expenditures are combined with mental health expenditures made through HRD for other state plan services, Medicaid is responsible for just over half (53%) of DPHHS adult mental health services. State funding is of considerable significance to AMDD covering the two state institutions (MSH and Montana Mental Health Nursing Care Center (MMHNCC)) and the Mental Health Services Plan (MHSP).

We note that this chart and our remaining analysis lack information on expenditures for mental health services provided by IHS facilities. However, these charges are passed through to the federal government, which fully reimburses them, so they are of no net cost to the state.

However, IHS services are of relevance to the state because they are an important source of services for Montana Indians. IHS facilities receive a federal allocation for operations. They are able to bill Medicaid for their Medicaid enrolled patients, Medicare, and private insurance. Any such billings return to the facility. The more the facility can generate third party revenue, the more it can add to the federal allocation to support its services. The state has recognized its interest in assisting IHS to generate the maximum Medicaid revenue and is working with IHS to enroll more Indians in Medicaid. If the anomalies we found in claims for IHS mental health

Figure IV-2
SFY2007 DPHHS Adult MH Expenditures* by Source



Total = \$98.8 Million

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

* Excludes IHS MH Services

Source: DPHHS Special Report

services are indicative of under billing, then improved billing practices may also generate greater Medicaid revenue.

b) Department of Corrections

Three quarters of adult mental health expenditures were for the secure facilities operated by the Department: Montana State Prison, Montana Women’s Prison, three regional prisons Glendive, Great Falls, and Missoula, and the private prison in Shelby. Most of the remaining mental health expenditures were through adult community corrections. A small percentage of DOC mental health spending is for the administrative expenditure of the salary of the Mental Health Liaison between DOC and AMDD. Overall, expenditures grew considerably, 16% (\$460,000) between the two years, due primarily to the expansion of community corrections, which almost doubled. Secure facilities expenses grew at a moderate 4%. Overall, the DOC spends the largest percentage of its funds (41%) on mental health staffing, a third (32%) on contracted mental health services, and another 27% spent for psychotropic medications.

Table IV-7				
FY 2007 and FY 2008 Adult DOC Mental Health Expenditures by Program				
	FY 2007	FY 2008	% of Total FY 2008	% Change 07 to 08
Secure Facilities	\$2,448,120	\$2,535,149	74%	4%
Adult Community Corrections	\$441,782	\$818,710	24%	85%
MH Liaison	\$79,526	\$79,454	2%	0%
Total	\$2,969,428	\$3,433,313	100%	16%
<p>1) FTE and contract services provided in Meth TX centers/Passages/Regional Prisons are included in the per diem rate. These are the total cost from the facilities for mental health services.</p> <p>2) The money transferred from DPHHS for Mental Health Services and medication was slow to start in FY 2008. FY 2009 expenditures should demonstrate more utilization of services</p> <p>Source: Department of Corrections Mental Health Costs Fiscal Years 2007/2008, 10-Jul-08</p>				

In FY 2008, only 2% of adult community corrections expenditures were for mental health. In comparison to DPHHS’ spending for adult mental health services, DOC mental health expenditures in its secure facilities are less than 7% of the DPPHS spending on mental health institutions. Adult community corrections spending (at FY 2008’s expanded levels) is equivalent to 18% of DPHHS spending on outpatient services. But when other community based services and supports provided by AMDD are considered, the relative amount provided by DOC is quite small.

Table IV-8			
FY 2008 DOC Mental Health Total Expenditures by Type and Program			
	Contracts	Personnel	Medication
Secure Facilities	30%	42%	28%
Adult Community Corrections	39%	38%	23%
Youth Services Division	72%	19%	8%
Total	32%	41%	27%
<p>Source: Department of Corrections Mental Health Costs Fiscal Years 2007/2008, 10-Jul-08</p>			

2. Have Montana’s funding streams for adults changed significantly over the past few years? If so, which ones and why?

DPHHS mental health expenditures decreased 6% between FY 2005 and FY 2007. The decreases were primarily in Medicaid as the implementation of Medicare Part D picked up pharmacy costs for dual eligibles. This more than offset increased state expenses for the state hospital and expenditures for MHSP from new tobacco initiative special revenues. Institutional expenditures are a key determinant of adult mental health spending.

In FY 2005, DPHHS expended approximately \$105.6 million for adult mental health services. There was little change in overall spending for adult mental health services from FY 2005 through FY 2006. However, in FY 2007, these expenditures decreased 6% to \$98.8M, a \$6.8M decrease. Tables IV-9 and IV-10 provide an overview of expenditures for adult mental health services by year and funding source.

DPHHS Fund Sources	2005	2006	2007
State General Revenue Funds Appropriation	\$32,098,155	\$32,057,360	\$34,624,339
Mental Health Services Plan (MHSP)	\$2,727,836	\$3,422,532	\$3,000,365
MHSP Block Grant Federal Funds	\$953,841	\$1,228,489	\$1,220,387
MHSP (SSR) /Tobacco I149 Initiative		\$3,047,434	\$2,700,077
State Hospital* - (SSR) Debt Service Bonds	\$1,785,072	\$1,775,375	\$1,792,631
State Hospital* - (SSR- DOC & Alcohol tax)	\$432,275	\$427,062	\$476,557
State Hospital - Federal	\$395,910		
MT MH Nursing Care Cent. - Federal	\$111,090		
Medicaid	\$64,205,110	\$60,005,967	\$52,129,719
FF- Rehab. Services: Voc Rehab to the States	\$2,873,000	\$2,920,968	\$2,862,460
Total DPHHS Adult MH	\$105,582,289	\$104,855,187	\$98,806,534
<i>* Excludes MH services provided in IHS facilities Source: DPHHS Special Report, rev. 9/15</i>			

The most significant changes in funding source were a 19% decrease in Medicaid expenditures and the ending of a federal grant related to employment:

- ▶ The Medicaid decrease was due to a reduction in spending for pharmacy services with the implementation of the Medicare Part D program. In 2006, the Medicare program assumed payment responsibility for covering pharmacy benefits for individuals who were enrolled in Medicare, including individuals who were dually eligible for Medicaid and Medicare. It is estimated that approximately one-third of all individuals in Montana with SDMI are dually eligible.
- ▶ Federal expenditures decreased for Montana State Hospital and the Montana Mental Health Nursing Care Center because a federal grant for a jobs program ended In FY 2005.

There were also increases in several funding sources:

- ▶ In FY 2006, Montana received an additional 29% in its Mental Health Block Grant from the Substance Abuse and Mental Health Administration. This increase restored the grant to

DPHHS Fund Sources	\$ Change from 2005-2006	\$ Change from 2005-2007	% Change from 2005-2006	% Change from 2005- 2007
State General Revenue Funds Appropriation	(\$40,795)	\$2,526,184	(0.13%)	7.87%
Mental Health Services Plan (MHSP)	\$694,696	(\$422,167)	25.47%	(12.33%)
MHSP Block Grant Federal Funds	\$274,648	\$266,546	28.79%	27.94%
MHSP (SSR) /Tobacco l149 Initiative	\$3,047,434	\$2,700,077	N/A	N/A
State Hospital* - (SSR) Debt Service Bonds	(\$9,697)	\$7,559	(0.54%)	0.42%
State Hospital* - (SSR- DOC & Alcohol tax)	(\$5,213)	\$44,282	(1.21%)	10.24%
State Hospital – Federal	(\$395,910)	(\$395,910)	(100.00%)	(100.00%)
MT MH Nursing Care Cent. - Federal	(\$111,090)	(\$111,090)	(100.00%)	(100.00%)
Medicaid	(\$4,199,143)	(\$12,075,391)	(6.54%)	(18.81%)
FF- Rehab. Services: Voc Rehab to the States	\$47,968	(\$10,540)	1.67%	(0.37%)
Total DPHHS Adult MH	(\$697,102)	(\$6,775,754)	(0.66%)	(6.40%)

*Excludes MH services provided in IHS facilities
Source: DPHHS Special Report, rev. 9/15

its usual level from FY 2005, when a portion of the grant was withheld because the state had not met the grant's maintenance of effort requirements.

- ▶ In addition there was an increase in state general revenue funds related to the increased costs for the Montana State Hospital. The 2007 Legislature approved both a supplemental appropriation and continued funding for 36.60 additional FTEs at MSH to address higher populations.

a) Expenditures by Type

Table IV-11 presents DPHHS adult mental health expenditures for SFY 2007 by service category. As for children, these expenditures include those for individuals with SDMI, as well as for individuals with minimal mental health needs. The two state institutions represent Montana's largest service expenditures. Solely state funded, they constitute almost 40% of the total. Psychotropic medications and medication management are the next largest expenditure group, accounting for over 20% of total spending. Case management accounts for 11% of total expenditures, with expenditures for community based residential services and rehabilitation each accounting for 7%. All other service types, including other inpatient services and crisis intervention services account for 5% or less. Clearly institutional

State Inpatient and Nursing Home Services	\$36,220,741	37%
Medication Services	\$20,272,426	21%
Case Management	\$11,217,052	11%
Group Homes and Foster Care	\$6,542,607	7%
Rehabilitation	\$6,540,175	7%
PACT	\$4,581,423	5%
Outpatient Services	\$4,478,326	5%
Misc. Services**	\$3,640,432	4%
Inpatient	\$2,806,275	3%
Crisis	\$2,409,829	2%
Intensive Out-Patient	\$97,249	0%
Total	\$98,806,536	

* Excludes IHS MH Services
** Misc includes services for MH diagnoses provided by non-MH providers, including Personal Care Agencies, FQHCs, physicians, labs, and certain psychiatry services not included in standard MH procedure codes.
Source: DPHHS Special Report

expenditures, which are primarily for the Hospital and Nursing Care Center, are the key determinant of adult mental health spending.

We looked at the share of mental health services paid through each program. (We disregarded the costs of the institutions and of psychotropic medications.) We found that 84% of mental health service costs are paid through AMDD Medicaid, 11% are paid through MHSP, and the remaining 5% or \$2.2 million are paid by HRD Medicaid. It is not clear why mental health services would be adjudicated to HRD rather than to AMDD, and DPHHS has begun to examine why these service claims are not being assigned to AMDD. They may be legitimate claims for covered services that are being improperly routed in the claims payment system. However, if they are claims that AMDD would deny under their regulations and prior approval processes, then Montana may be able to adjudicate them under AMDD rules and reduce costs in the future.

3. How does the Montana adult consumer pay for services? Should consumers pay more?

DPHHS co-pay and cost sharing protocols are inconsistent for MHSP and Medicaid consumers. While co-pays can become a collections and revenue burden for providers, they are likely to increase consumer investment in personal recovery. The inconsistency between Medicaid and MHSP Co-pays should be eliminated.

There is an inconsistency in the way DPHHS has implemented co-payment and cost-sharing arrangements for MHSP and Medicaid adult mental health consumers. Table IV-12 represents the current co-payment and cost sharing arrangements for the MHSP and Medicaid populations for those services that require a co-payment or cost sharing arrangement. MHSP members pay more than twice the co-payment/cost-sharing amount for medications (Clozaril excluded) than Medicaid recipients. MHSP clients pay nothing for mental health services delivered by practitioners while Medicaid members pay \$3.00 - \$4.00 for such services.

MHSP clients are generally not eligible for Medicaid because their incomes exceed Medicaid limits. Yet persons who are Medicaid eligible are assessed a co-payment for some services while MHSP clients are not assessed a co-payment for these same services. This is true for both individual practitioner services and psychological and neuropsychological testing services. There are other community based services provided through MHSP and Medicaid that have no co-payment or cost sharing requirements or are not specified in a rule or fee schedule.

A significant number of Montana community mental health services do not require a co-payment or co-payment rules are not specified. Table IV-13 includes services that do not require a co-payment for MHSP clients according to the AMDD MHSP Fee Schedule. There is no clear policy or rationale for the lack of co-payments for MHSP services. ARM 37.89.119 allows AMDD to charge for MHSP outpatient services in addition to those prescribed by the AMDD MHSP Fee Schedule.

Table IV-12			
Co-Payment & Cost Sharing for Persons with a Serious Disabling Mental Illness – Provider Types & Services where Co-Payments & Cost Sharing is Specified for One or More Plan Type			
Provider Type/Service	MHSP	AMDD Medicaid	HRD Medicaid
Prescription drugs (OP)	\$12.00 generic & preferred \$17.00 brand & non-preferred \$0 Clozaril	Prescriptions paid through HRD →	\$1.00 - \$5.00 per prescription not to exceed \$25.00 per month
Practitioner Services			
Licensed Social Worker	None	\$3.00 per visit	Not Applicable
Licensed Prof. Counselor	None	\$3.00 per visit	Not Applicable
Licensed Psychiatrist	None	\$4.00 per visit	Not Applicable
Licensed Psychologist	None	\$3.00 per visit	Not Applicable
Psychological & Neuropsychological/behavioral testing (various CPT codes)	None	\$3 - \$4 (depends on provider type)	Not Applicable
Dialectical Behavior Therapy (DBT)			
DBT - Psychotherapy	\$3.00 per visit	\$3.00 per visit	Not Applicable
DBT – Skill development – individual	\$3.00 per visit	\$3.00 per visit	Not Applicable
DBT – Skill development – group	\$3.00 per visit	\$3.00 per visit	Not Applicable
Hospital in-patient	Not a covered MHSP service	\$100.00 per discharge	Not Applicable
Out-of-home admission (non-hospital)	None (although ARM 37.89.119(c) allows for a \$50.00 co-payment)	None	Not Applicable
<i>Source: AMDD & MHSP Fee Schedules 7/1/08 ARM 37.89.204 and Provider Manual October 2003</i>			

Table IV-13		
Co-Payment and Cost Sharing for Persons with a Serious Disabling Mental Illness – Provider Types and Services where Co-Payments and Cost Sharing is “None” or service is “Not Covered”		
Provider Type/Service	MHSP	AMDD Medicaid
Other Mental Health Center Services		
Respite Care – Adult	Not Covered	None (service provided and paid 100% by GF)
MH. Group Home – Adult	None	None
MH. Group Home – Therapeutic Leave	Not Covered	None
Adult Foster Care	Not Covered	None
Adult Foster Care – Therapeutic Leave	Not Covered	None
Day Treatment – Adult Half Day	None	None
Community-based psychiatric rehabilitation & support – individ.	None	None
Community-based psychiatric rehabilitation & support – group	None	None
Crisis intervention facility	Not Covered	None
Program of Assertive Community Treatment (PACT)	None	None
Intensive Community Based Rehabilitation	Not Covered	None
Targeted Case Management – Adult – individual	None	None
Targeted Case Management – Adult – group	Not Covered	None
Acute Partial Hospitalization – Full day	Not Covered	None
Acute Partial Hospitalization – Half day	Not Covered	None
<i>Source: AMDD & MHSP Fee Schedules 7/1/08 ARM 37.89.204 and Provider Manual October 2003</i>		

Imposing minimal co-payments and cost-sharing arrangements (less than \$5.00) is generally an acceptable practice so long as charges do not exceed those paid by non-mental health recipients or the total cost of the service. Many states have implemented co-payments for physician office visits, independent practitioner visits, pharmacy encounters, laboratory services, hospital admissions or discharges and other outpatient services to offset the rising cost of health care. In developing co-payment and cost-sharing practices, states have generally kept the consumer payment low in order to ensure that it does not prevent people from accessing services. States have also considered how multiple co-payments within one day, even if they are small, might prevent people from accessing services.

Collecting co-payments and cost sharing can be difficult for providers. Providers and advocates usually resist such efforts, describing increases in the costs of collection, bad debt and barriers to access. Collection of co-payments can be less burdensome on providers if they establish routine procedures for collection of all member co-payments and other third party liabilities. Consistent policies for Medicaid and MHSP covered services will make these collection procedures easier to implement. Certain co-payment and cost sharing arrangements can be beneficial to a person's recovery (by increasing personal investment), particularly for those who have established independent living treatment and financial goals. However, because Medicaid eligible individuals in Montana are so far below federal poverty levels, providers will not be able to fully collect these co-pays, and this is likely to result in a net decrease in their revenues.

Findings.

- ▶ Co-payments and cost sharing arrangements are significantly different among MHSP and Medicaid Populations, yet not all the differences appear to be income-based.
- ▶ Those eligible for Medicaid, the disabled and the "poorest of the poor" have higher co-payments and cost sharing arrangements for practitioner services than do those with higher income levels.

Recommendations.

- ▶ Montana should implement co-payment and cost-sharing arrangements to ensure that Medicaid clients are not charged co-payments that are greater than MHSP members.
- ▶ While we understand the "costs" of implementing these co-payment procedures for consumers and providers, the inconsistency between Medicaid and MHSP should be eliminated. We do not see compelling reasons why the Medicaid co-pays should be eliminated. We also believe that these policies should be adopted for children's mental health services.

4. How can Montana make better use of current funding streams and funding levels for adults?

Montana's mental health services funding for adults can benefit from attention in five areas: Ensuring adequate rates for services and providers; Reducing utilization at Montana State Hospital; Developing a plan to ensure compliance with CMS regulatory changes regarding Targeted Case Management and the Rehabilitation Option; maximizing the enrollment in the HCBS waiver; and maximizing Medicaid revenues for IHS facilities.

a) Rates

Adequate rates that provide for attractive salaries and working conditions are a necessary component of a strategy to increase the capacity of Montana's mental health workforce. The primary weakness in rates for adults is in psychiatry services, where comparisons between

states illustrate low rates in Montana. Comprehensive psychopharmacology and psychiatric consults are critical to maintain SDMI adults in the community, and competitive rates are needed to attract participating psychiatrists.

Code	90862	90806	90847	90853	H2014, H2015, H2017	H2012	H2015, T1016
Description	Medication Mgmt.	Individual Counseling	Family Psychotherapy	Group Psychotherapy	Psychosocial Rehabilitation	Day Treatment	Case Mgmt.
Min	\$39.80	\$55.91	\$33.54	\$11.74	\$1.93	\$11.68	\$7.48
Max	\$81.79	\$101.73	\$119.82	\$43.87	\$4.81	\$28.16	\$16.39
Average	\$56.62	\$71.65	\$75.51	\$23.13	\$3.14	\$18.83	\$13.06
Montana Rate	\$69.55	\$51.84	\$61.95	\$17.34	\$1.91	\$12.18	\$18.60
Rate Difference	20.24%	21.89%	21.89%	33.40%	64.61%	54.65%	
FY 2007 Expenditures	\$758,870	\$2,583,472	\$88,982	\$41,289	\$1,238,225	\$2,888,440	
Potential Impact	\$153,620	\$986,994	\$19,477	\$66,367	\$799,965	\$1,578,401	
States Compared	Alabama Idaho Minnesota Nevada New Mexico North Dakota Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Texas Utah Wyoming	Alabama Hawaii Idaho Minnesota Nevada New Mexico North Dakota Oklahoma Texas Utah Wyoming	Alabama Arizona Arkansas Florida Louisiana Nevada New Mexico North Carolina Oklahoma Rhode Island	Alabama Florida Minnesota Nevada New Mexico	Minnesota Nevada New Mexico Oklahoma Utah

b) Montana State Hospital

Montana’s most significant opportunity to make better use of state funds is to reduce unnecessary use of Montana State Hospital. In order to reap savings from reductions in use, the reductions have to be sufficient to, first, reduce beds to the licensed level and maintain this level. Ultimately, the goal should be to reduce utilization and capacity enough to allow for a unit to be closed or converted to other uses. Details and our recommendations for MSH are included in Section III.

c) Targeted Case Management and Rehabilitation Option

The Centers for Medicare and Medicaid Services (CMS) issued interim rules for Targeted Case Management in December, 2007 (72 Fed. Reg. 68077-68093). Across the country, CMS saw significant growth in state spending and acted on the belief that states were abusing optional services to claim excessive amounts of federal funds. These rules threaten to create havoc in many states because for the first time they have clearly defined targeted case management services and outlined billing and reimbursement requirements. For example, case management

services must be billed in 15 minute units and there can be only one case manager per consumer. Montana's adult system spends over \$11M in case management services covered by the terms of this new rule.

In August, 2008 CMS also issued notices of proposed rulemaking on Coverage for Rehabilitative Services. These rules formalized the documentation and planning requirements for state agencies and provide guidance for the first time on the boundaries for rehabilitation services. The proposed rule clarifies the services definition and states that Medicaid Rehabilitative Services do not include services furnished by other programs that are focused on social or educational development goals. Examples of other programs include foster care, child welfare, education, child care, pre-vocational and vocational services, housing, parole and probation, juvenile justice, public guardianship and any other non-Medicaid services. Employees of the child welfare system are specifically excluded from case management billing. The new rules restrict the ability of states to provide inter-governmental transfers for these functions. Recognizing the scope of the changes for virtually every state, and in response to intense lobbying, Congress intervened and delayed the implementation of these regulations until April, 2009. It is not clear what will happen then.

Montana's adult and child mental health systems are in reasonably good shape compared to those of other states. Montana's billing procedures for Targeted Case Management are in 15 minute increments, consistent with new requirements. However in both the adult and child systems, TCM services are probably used more broadly in Montana than the new rules will allow. The new CMS rule restricts TCM services only to assessment, care planning, referral and linkage, and monitoring/follow-up on services received. Most case management staff also provide assistance in life skills coaching and para-professional counseling and supports. Others may provide transportation to assist clients in reaching their appointments. These services are generally critical to recovery and stabilizing families, but they are not allowable under the new TCM rules and may have to be billed under some other codes if they are to qualify for Medicaid. Montana's School Based Services are also reasonably safe from CMS recovery and compliance issues, at least at the system level, because they are billed in 15 minute increments. In addition, they are considered to be transfers outside of state government and are not subject to the same level of scrutiny by CMS auditors as transfers between state agencies would be.

Rehabilitation claims must be for services that are covered by an individual rehabilitation plan. Updates to the plan must document consumer progress in reaching their goals, and if no progress is noted the plan must be modified. This distinguishes between rehabilitation and habilitation services. Under the new rules rehabilitation services will also have to be unbundled (separated) from other services, and these services billed in 15 minute increments. This is a huge issue for many states that have created daily or monthly rates for programs that combine multiple service modalities. AMDD's definition of rehabilitation services in the approved state plan is exceedingly broad, historically allowing for wide latitude in defining eligible services. 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 this definition. It would open up almost \$18M in services (Group Home and Foster Care, Rehabilitation, and PACT) to be redefined under Medicaid.

The breadth and scope of changes that might have to occur upon final enactment of these regulations is enormous across the country. Montana's exposure is generally low. The scope of exposure for the reinterpretation of TCM services to adults and children is not clear at this time,

and greater clarity is needed from CMS on their final interpretations of rehabilitation option rules and what types of billing practices they will ultimately allow for services that don't lend themselves to 15 minute interval recording. Some of the exposure is at the state level for denial of services, and other elements of risk are for providers if compliance audits identify records that don't properly document the medical or rehabilitative necessity of services.

Recommendations.

- ▶ DPHHS should 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.
- ▶ It is recommended that Montana 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 changes should be implemented now and those that will need to occur once the direction of the new administration is clear.
- ▶ Montana should also actively monitor changes in federal rules and seek support from SAMHSA and NASMHD 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.

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

In what seems to be one of only two home and community based waivers for adults with mental illness in the country (the other being a combined 1915(b) and 1915(c) in Piedmont County, NC), Montana's waiver allows eligible adults to receive a range of rehabilitative services to support them in home and community settings. The objectives of the waiver program are rehabilitation and recovery. Individuals over 18 with SDMI are eligible for services if they meet nursing home level of care standards. A comprehensive array of services including case management, illness management and recovery, supported employment, personal assistance and health related services are available. Enrollment has been slow, with about 80 of an eventual 120 slots currently filled. We were not able to independently identify what factors have made enrollment slower than anticipated.

Recommendations.

- ▶ 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.
- ▶ It might also consider whether HCBS services could be used for some individuals currently served at the Montana Mental Health Nursing Care Center that might allow that program to be downsized.

e) Assist IHS to Maximize Medicaid Revenues.

While Montana is just a pass through for IHS Medicaid billing, the state can play a constructive role in assisting the tribes to maximize their Medicaid revenues. This releases more of their federal appropriation to pay for additional health services.

Recommendations.

- ▶ Montana should continue its efforts to assist IHS to enroll eligible Indians in Medicaid.
- ▶ Montana should share its information about incomplete data of IHS Medicaid mental health visits and provide any assistance they desire in better identifying these services on its claims. If the problems are indicative of possible under-billing, DPHHS should assist IHS to address these problems and monitor solutions.

D. Financing of Mental Health Programs for All Ages

1. What funding streams will support needed new services?

Compared to other states, Montana has done an excellent job of utilizing Medicaid revenue to fund 85% of community based service cost. Medicaid will support the growth of peer support services and this provides a critical element of service expansion. The pending HIFA waiver offers an exceedingly important opportunity to expand on the availability of health coverage and maximize federal revenues for several key population groups including adults with SDMI. At this time, the pursuit of a 1915i waiver is not recommended. The collaboration with the Department of Corrections offers the most promising avenue for braiding funding streams. Limited federal grant opportunities are available; those that seem most suitable include funding for homeless veterans, children affected by substance abuse, and training.

a) Comparison of Montana mental health revenues to those of other states

Overview. The three traditional sources of mental health service funding are Medicaid, state general fund for operation of state institutions and other mental health services, and the federal Mental Health Services Block Grant, which supports states and local governments to fund services in the community. Table IV-15 compares Montana's revenue sources for mental health to sources used by other western states and the U.S. average. Today additional sources of revenue are available to fund mental health systems and the specific sources used vary greatly from state to state. The National Association of State Mental Health Program Directors (NASMHPD) annually surveys state mental health agencies (e.g., AMDD) to gauge revenue and spending patterns and document the changes in revenue sources year to year. Each state

State *	State General Fund	Medicaid (Shared S and FMA)	Medicare (F)	CMHS Block Grant (F)	Other Federal	Local	Other Health Insurance	Misc.	Total
Arizona	14%	80%	0%	1%	0%	0%	5%	0%	100%
Idaho	59%	11%	0%	6%	23%	0%	1%	0%	100%
Oregon	13%	86%	0%	1%	0%	0%	0%	0%	100%
Montana	14%	85%	0%	1%	0%	0%	0%	0%	100%
No. Dakota	38%	27%	0%	3%	17%	0%	0%	15%	100%
So. Dakota	38%	54%	0%	4%	4%	0%	0%	0%	100%
Wyoming	68%	29%	0%	2%	2%	0%	0%	0%	100%
U.S. Avg.	37%	50%	1.3%	1.9%	2.1%	1.6%	1.4%	3.8%	100%

S = State / F = Federal
 *States with reporting 0% may equal 0% or > 1% of total spending. Totals may not add to 100% due to rounding.
 Source: NASMHPD/NRI, Inc., *State Mental Health Authority Profiles Systems and Revenue and Expenditure Study 2005*, Alexandria, Virginia, www.nri-inc.org, based on per capita spending percent by fund.

budgets differently for mental health services and rely on different funding sources to meet the needs of their citizenry. State criteria for Medicaid eligibility as well as for state programs vary significantly. We have chosen to present percentages rather than total spending in order to account for these differences.

Medicaid Funding. For many states, the Title XIX Medicaid program has become a larger and larger portion of overall revenue. From FY 2001 to FY 2005, total Medicaid expenditures grew by more than 10% at the federal level.²

A majority of states' mental health system revenues are made available from the states' general funds or from their Medicaid programs (approximately 87% of all funds). Montana (14%) is considerably below the U.S. average (37%) for general fund as a percent of total funds and is considerably above (85%) the U.S. average (50%) for Medicaid (state match and FMAP) as a percent of total funds. The revenue mix in Arizona and Oregon is similar to that of Montana. In stark contrast, Montana's neighbor to the south, Wyoming, funds its mental health programs primarily from the general fund (68%) and relies significantly less on the Medicaid program (29%).

Table IV-15 also suggests that some states are reaching beyond the general fund and Medicaid to other funding sources. The U.S. average of funding from these other sources, including Medicare, the CMHS Block Grant, other federal grants, local funds, other insurance, and miscellaneous funds, exceeds 12%. Montana has reported that only 1% of their mental health revenue is derived from revenue sources other than the general fund or Medicaid.

Findings.

- ▶ In 2005, 85% of Montana's revenue supporting mental health programs was derived from Medicaid, more than most Western states and the national average.
- ▶ In 2005, 14% of Montana's revenue was derived from the state general fund, less than most Western states and the national average.
- ▶ Montana's use of Medicaid to finance much of its mental health program reduces the financial burden on the state. However, the state share will increase as its match rate increases.

State	FY 2008 SAMSHA Grant Awards
Idaho	\$11.3 million
Montana	\$18.9 million
North Dakota	\$7.6 million
South Dakota	\$8.9 million
Wyoming	\$9.9 million

Source: SAMHSA

State	FY 2008 SAMSHA Grant Awards
Arizona	\$65.3 million
Colorado	\$59.5 million
Montana	\$18.9 million
New Mexico	\$27.4 million
Colorado	\$59.5 million

Source: SAMHSA

² National Association of State Mental Health Program Directors, State Mental Health Profiles Systems and Revenue and Expenditure Study 2005, Alexandria, Virginia, www.nri-inc.org.

Substance Abuse and Mental Health Services Administration (SAMHSA) Grants. After Medicaid, SAMHSA provides the largest number of dollars to states, in the form of government formula and discretionary grants for the planning of mental health programs and the treatment of mental health conditions. Formula grants are primarily population based while discretionary grants are competitively awarded, based on a state's program design that meets or exceeds the federal grant requirements. According to SAMHSA reports, in FY 2008, Montana state, local, and non-profit organizations received \$18.9 million in SAMHSA funding. Montana's neighboring states received much less than Montana did.

Other Western states – for example, Arizona, Colorado and New Mexico -- received a significantly greater amount of SAMSHA grant funding in FY 2008. However, these states' populations are much larger than Montana's.

Findings. Montana received \$18.9 million in SAMSHA Grants in FY 2008, exceeding its four neighboring states by as much as 100%. This is an indication that Montana has done well in making use of SAMHSA resources.

b) Additional Medicaid Options

Peer Services. Montana has a generally comprehensive set of rehabilitative services covered under its Medicaid State Plan. Currently, however, Montana has a limited number of peer providers. Montana should be able to use Medicaid to receive federal match for additional peer service development. In most instances, states use several funding streams to finance their Consumer Operated Service Programs (COSP) and peer providers working in traditional mental health agencies. Most states that fund COSP or peer providers use state general revenue or Mental Health Block Grant funds to develop and sustain them. However, states have used Medicaid to finance peer services. In these states, Medicaid is used to reimburse peer providers in COSP and traditional mental health agencies. Some states that have pursued Medicaid reimbursement for peer providers have included certified peer specialists or peer practitioners in their Medicaid state plan as an allowable practitioner. Other states have included a peer support service as a covered Medicaid benefit.

While the specific number of peer providers is not known, most of the Mental Health Centers in Montana reported using peer providers. They render an array of services, including rehabilitative and support services. There are limited efforts to certify peers. In FY 2007, AMDD provided a grant to –the Center for Mental Health Services in Great Falls to develop and implement a peer certification program.

In FY 2008 the AMDD provided funding for five half-time community liaison officer positions in AMDD. The liaisons will offer community support to individuals who have been discharged from Montana State Hospital. They will assist these individuals during the discharge process and re-integrate them into the community by identifying and helping them access needed services and resources in the community. In addition, AMDD recently funded four consumer drop-in centers and a virtual on-line drop-in center focused on providing a means for consumer communication and support for individuals who are not within reach of a physical drop-in setting.

While drop-in centers are not generally Medicaid reimbursable, positions such as the community liaison officers could be added to the Medicaid plan. As discussed previously, peer providers may be able to extend access to mental health supports in parts of the state with less

access to licensed mental health professionals. By supporting initial peer services with state and block grant funds, the state is developing experience with them and will be better able to design appropriate and effective expansions in the future.

Recommendations.

- ▶ Build on the peer certification program in Great Falls and extend this to several additional sites in frontier areas to help address provider shortages.
- ▶ Provide small seed grants to implement this in these areas and study the use and adequacy of Medicaid to support these services.
- ▶ Review and modify, if necessary, the state plan to allow Medicaid billing for peer specialists once the new administration's approach to State Plan Amendments is clear.

Health Insurance Flexibility and Accountability (HIFA) Waiver.

The State of Montana undertook an extensive planning process for several years to develop and submit an amendment to the state's existing Research and Demonstration (1115) Waiver. This waiver amendment seeks to expand eligibility for and coverage of health benefits and mental health benefits by Medicaid with a particular focus on uninsured adults with SDMI and young adults who were leaving state custody. The amended waiver was submitted as a part of a demonstration authorized by the Health Insurance Flexibility and Accountability Initiative (HIFA). It builds in the features and concept of HIFA by allowing Montana to modify its usual Medicaid benefits to provide coverage for an expansion population; in this case adults with SDMI up to 200% of poverty and youth ages 18 to 20 with SED who have been in the custody of the state and who require services to assist with their transition from custody. The savings from MHSP as a result of the added federal revenue will be reinvested in health benefits for people with SDMI and in providing services for uninsured youth with Serious Emotional Disturbance ages 18-20. There were no additional state costs anticipated from the HIFA waiver.

Should Montana's proposed HIFA waiver be granted, it would be a very significant benefit to Montana. This was discussed in our recommendations for expanding eligibility, but it would have a great benefit in financing as well by better leveraging current state investments for the covered population.

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

2. What funding sources are not being accessed by Montana and why?

We found that the Montana mental health system has explored and applied for virtually all the traditional revenue sources that support mental health services. A new source, created in the Deficit Reduction Act should be reviewed by state officials and tracked over the next one or two years. Other federal revenue opportunities and potential foundation sources are reviewed but the options for true programmatic support are quite limited.

a) Other Federal Revenue Opportunities

There are many grants that the State of Montana could apply for that, if received, would increase revenue available for mental health services. DMA Health Strategies has reviewed the *FY 2007 Montana Single Audit Report*, the Catalog of Federal Domestic Assistance (CFDA), and based on our own experiences in other states, we have compiled two tables that represent Montana Federal Funding Opportunities for Mental Health (please see Appendix E).

- ▶ *Appendix E, Table 1:* This table represents the list of federal funds in the CFDA that were expended by Montana state agencies for FY 2007 as published in the *FY 2007 Montana Single Audit Report* in the amount of \$622,567,444. This table and total spending does not represent the federal funds spent on mental health services and mental health administration in Montana; rather, it represents federal grants for which a) the primary purpose is specifically focused on mental health functions and services and the funds can be spent for services as well as administration of mental health programs (7 grants), or b) the funds may be spent on mental health services and functions or to support a person who needs mental health services, but the primary purpose is not solely focused on mental health (37 grants). If these grants are fully utilized for other allowable purposes, then other uses would have to be reduced in order to free up funds for mental health services. Montana may wish to review how these funds are being used and consider whether they should be reallocated.
- ▶ *Appendix E, Table 2:* This table represents a list of federal funds that have **potential** to become a revenue source for mental health services in Montana. These grants were not reported in the *FY 2007 Montana Single Audit Report*, yet that does not mean that an individual, non-profit or local government organization has not received a particular grant (and in some cases, only an individual or tribal government is eligible, leaving the state as an ineligible applicant). Table 2 provides a brief description of the grant as well as the most recent range and average financial assistance made by the granting agency.

According to our review, Montana received 44 grants or federal funding agreements in FY 2007 that can be used for mental health services. DMA Health Strategies has identified an additional 28 grants or federal funding opportunities for individuals, local governments, state agencies (including educational institutions), non-profits, and tribal governments. Many of these grants have multiple purposes but include mental health as a specific target. The range of funding last reported in the CFDA ranges from a low of \$2,470 (CFDA 93.923) to a high of \$1,722,872 (CFDA 93.441).

b) Potential for Research, Foundation, Philanthropic Support

The National Institute for Mental Health is increasingly moving into the areas of supporting services intervention research and uses of pooled data. A recent program announcement (currently closed) was entitled “Use of Pooled State Administrative Data for Policy Relevant Mental Health Services Research”. While Montana’s pooled data for Medicaid and people with serious and disabling mental illnesses would be ideal for this program, the focus would be on research to inform policy not on the efforts to actually develop new policy. The state should not independently pursue these sources of support but should be willing to find partnerships with researchers in special studies that might benefit the system indirectly.

Few national or regional foundations provide sources of support for mental health programs. This issue was recognized in 2004 in a Health Affairs article by Brousseau et al entitled “Are Foundations Overlooking Mental Health?” Since that time the situation has become more serious. The McArthur Foundation has pulled back much support for programming and focused instead on national policy and research. The Robert Wood Johnson Foundation has also dropped its significant commitment to substance abuse services and the key staff person in mental health left the foundation. The California Endowment and Texas’ Hogg Foundation are notable in their continued strong support for mental health programs, though those foundations are restricted to funding efforts in their states.

For children’s mental health services, the Annie E. Casey Foundation (AECF) has been a strong supporter of mental health services in past years, but their support has also declined and been replaced by a focus on community change, child welfare, and juvenile justice. In fact AECF funds three Juvenile Detention Alternatives programs in Hill, Cascade and Missoula counties.

In short, there are currently few if any national foundations that would be able provide resources to fund state program innovations in mental health for adults or children.

Finding. In general, Montana has done an admirable job of finding, applying for and receiving federal grants for the support of its mental health system. While there are some areas of opportunity that we turned up in our review of the Catalog of Federal Domestic Assistance, these opportunities are focused on specific niches such as homeless veterans. PRA has identified some grants specifically relevant to corrections and mental health, but there is little scope for other federal or foundation funding.

c) Section 1915i.

The Deficit Reduction Act (DRA), P.L. 109-171, was passed by Congress and signed by the President on February 8, 2006. The law creates new options under the Medicaid program that allow states greater flexibility to furnish community-based services while Section 6086 of the DRA gives states the ability to provide home and community-based services to elderly individuals and people with disabilities without requiring a waiver or demonstrating cost neutrality generally required under a 1915b or 1115 Waiver. Services approved under this option are intended to help individuals delay or avoid institutional stays or other high cost out-of-home placements. The initiative has become known as a 1915i State Plan Amendment.

Section 6086 gives states, at their option, the opportunity to offer home and community-based services (HCBS) to elderly individuals and people with disabilities who have incomes up to 150% of the federal poverty level; it does not require a waiver or a demonstration of cost neutrality. A state need only amend its Medicaid plan to provide any of the services now covered under HCBS waivers. Section 6086 expands on the populations not previously eligible for HCBS waivers; covered now are adults from ages 22 through 64 who have a mental disorder. This new program is referred to as a 1915i State Plan Amendment (SPA). Only Iowa has an approved 1915i SPA, under which it provides case management and habilitation services for adults with serious mental illness. At least four other states are looking closely at adopting a 1915i SPA.

Only one state, Iowa, has an approved 1915i program for individuals with mental illness. Iowa’s new benefit will provide statewide HCBS case management services and habilitation services at home or in day treatment programs that can include such things as support in the workplace.

Many other states have contemplated developing a 1915i. States see the 1915i as an opportunity to contain program expenditures by limiting the number of individuals that can participate. In addition, the 1915i also provides consumers with the opportunity to self direct their care—an opportunity that is not afforded for regular state plan services.

However, some states have expressed concerns regarding the 1915i program. One concern is the requirement that individuals must be Medicaid eligible and have incomes less than 150% of the FPL. States that have expanded their eligibility for children beyond 150% are particularly concerned that the 1915i will exclude many children that need these services. This would not be a concern for Montana.

Another concern is the limited benefit package available under a 1915i. Specifically, CMS will only allow a 1915i to cover the statutory services discussed above. States have indicated that the additional statutory services do not meet the needs of the target population that would be considered for the 1915i. For instance, many statutory services such as adult day health, personal care and homemaker services are not relevant for children. Other statutory services, such as rehabilitation, day treatment and clinic services can be included as regular state plan services and do not require 1915i. Another concern is the ability and the cost of developing an independent assessment and treatment planning process. A final concern is the ability to target the 1915i to the intended recipients. Unlike the 1915c Waiver, the eligibility criteria for the 1915i program cannot be based on specific diagnosis or illnesses.

The 1915i program may not be a useful tool for mental health services in Montana. While most youth and adults could meet the financial eligibility under a 1915i, it would not provide Montana with significant opportunities to expand service coverage or refinance services currently purchased through state only funds. For instance, Montana already covers many statutory services including rehabilitative services, case management, day treatment and services that may be considered as habilitative services such as adult mental health group home and adult foster care. In addition, the state would need to develop the necessary infrastructure (either by developing or building the capacity) for independent assessment and treatment plans. Even though the cost of these functions could be claimed under the Medicaid program it would be an additional cost to the state for operating a 1915i.

In addition, the submission of a 1915i application may “open up” the current state’s Medicaid plan for rehabilitative services. CMS is currently reviewing many states’ Medicaid rehabilitative services. Based on this review, CMS is requesting that certain services which do not appear to be rehabilitative (e.g. group home services) be removed from the plan. In addition, CMS is reviewing the states’ rate setting methodology for rehabilitative services and is requiring that all rates for rehabilitative services be reimbursed in 15 minute increments. This is hugely problematic for services that are priced on a monthly or per diem basis.

Recommendations. The needs for use of the 1915i are minimal given the comprehensiveness of rehabilitation services, the HCBS Waiver for adults, and the PRTF Demonstration grant. Furthermore the risks of opening up the State Plan right now are very high for the next year or more. Montana should monitor the use of the 1915i by other states and make a decision later. One area many states are considering is services to developmentally disabled people (particularly youth) who also have mental illness.

Recommendations.

- ▶ Several current grants stand out from the list in Appendix E, Table 2 as deserving of close review. These include several different grants for homeless veterans (Reintegration, Grant and Per Diem, and Adult Day Health), services to enhance the safety of children affected by adult methamphetamine or other substance use (could focus on treatment for attachment disorder and trauma) and several of the training programs.
- ▶ In the area of criminal justice, the state should monitor SAMHSA for any new funding in its collaboration with Bureau of Justice Assistance (BJA) for Mental Health and Justice, as well as new funding through the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) in 2009.

- ▶ DPHHS should review the remaining grant program requirements and consider whether they are a good fit for Montana’s goals, priorities, and resources.
- ▶ If DPHHS does not already do so, it should regularly review the Catalog of Federal Domestic Assistance and refer to the Federal agency websites for additional information on mental health granting opportunities. The on-line Catalog of Federal Domestic Assistance, <http://12.46.245.173/cfda/cfda.html>, provides access to the Federal Government’s database of programs authorized by Congress and available to U.S. territories, federally recognized Indian tribes, non-for-profit organizations, state governments and their political subdivisions. While many of the grants contained in the CFDA do not entail financial match requirements, federal agencies may file notice with the Federal Register that implements a financial match (either direct or in-kind) for a particular grant cycle. Montana should be made aware of these changes when planning on applying for grants, paying particular attention to the Request for Application (RFA) and changes filed with the Federal Register.

3. What is needed to blend or braid funds to improve efficiency?

To achieve a truly integrated system, restructuring of services must take place to ensure that there is a full continuum of services available in sufficient supply to serve all who need care. The primary requirement, however, for braided funding initiatives is an accounting system that can track expenditures properly; optimally this should be an information system that can be deployed to case workers. In the ideal world, this information system, based upon the eligibility of the consumer for various services, should track service utilization and assign the costs to the appropriate revenue stream. Such systems remain a long way from the ideal.

On a statewide basis, services are available across much of the needed continuum. They are not available everywhere, however. There are also some notable gaps. Data reporting across state agencies is inconsistent and does not allow for data matching outside of DPHHS agencies. Within DPHHS they have done a remarkable job at this data matching. The lack of inter-agency data makes it difficult to do the tracking necessary to braid or blend funds across these sources. For instance, CMHB Medicaid includes all child welfare mental health placements and certain juvenile justice placements. Currently there is duplication between the numbers reported by CMHB and Juvenile Justice for residential treatment services because half of the figures reported by Juvenile Justice are Medicaid enrollees included in CMHB.

A comprehensive accounting and reporting system that includes all mental health services to children and adults would facilitate coordination and collaboration to make best use of all agency resources to minimize stays and ensure successful community transition. Many of the barriers to data sharing agreements are in the perception but not the reality of barriers created by confidentiality regulations.

Improved data sharing and continued interagency planning are essential for any braided funding effort. Effective accounting for expenditures according to eligibility categories of youth or adults is not possible without a good IT system. Restructuring IT systems and administrative functions in the adult and child mental health systems can create the needed reporting to effectively “braid” the funding and allow Montana to achieve the optimal outcome; the choice of the most appropriate service occurs without being constrained by the funding stream. Unfortunately, virtually all systems across the country are a long way from this ideal.

V. How Can Montana's Mental Health System Be Organized Differently to Deliver Services More Efficiently?

Montana has accomplished a great deal over the last decade and continues to move in very positive directions. We have, however, identified some organizational changes that could improve service delivery. Greater integration for children's mental health services and co-location of CMHB with AMDD would be desirable. Other issues that should be addressed include data sharing, improved care coordination strategies and improvements in accountability and performance.

We have also developed recommendations for major system restructuring. We do not offer these recommendations lightly, but achieving some of the goals outlined in the President's New Freedom Commission requires this. In the system envisioned under the New Freedom Commission, Montanans would all understand that mental health is central to good health. Consumers would expect that services would be responsive to their needs and truly consumer driven. Mental health screening and early intervention would be common. Services would be evidence based and oriented toward recovery and resiliency. Disparities would be eliminated. To achieve this, many stakeholders argue, requires a fundamentally different way of doing business. It requires some form of Medicaid waiver for the needed flexibility and coordination, and it requires a reorganization of some aspects of DPHHS. While there are several different organizational approaches possible, we recommend that the state plan for and establish a quasi-public entity to coordinate care.

A. Approaches to Improving the Current Organization of Mental Health Service Delivery

Organizational changes in Montana's state agencies can address some of the issues we identified in our analysis. With multiple agencies involved in delivering mental health services, improved data sharing, local planning, improved care coordination and increased accountability are needed. Specifically:

1. Issue: Sharing Data & Information

State agencies routinely experience barriers to sharing information that occur because many of the information systems are separate, and privacy rules create both real and perceived barriers to data sharing. Even when the technical capacity exists and there is permission to share data, information is not routinely shared because of organizational boundaries and the lack of time. Data sharing is essential for continuity of care, transition planning and effective care coordination.

Currently information sharing among state agencies is limited. There is a lack of systematic reporting between state agencies and programs. For example, there were needs for data sharing identified for the following topics:

- ▶ Linking primary care with mental health treatment.
- ▶ Services to youth who are in transition to adulthood.
- ▶ Utilization of Medicaid specialty resources that can meet needs of foster children.

- ▶ Coordination of Medicaid services with other case services.
- ▶ Coordination of Home and Community Based Services Waiver slots.
- ▶ Development of vocational services and coordination of cases for people with serious mental illnesses.
- ▶ Jail diversion options and coordination.
- ▶ Mental health conditions of youth and adults entering and leaving correctional facilities.
- ▶ Development of affordable housing options.
- ▶ Coordination of housing and support services.

Findings. Our specific findings included the following:

- ▶ The Medicaid data system reports on AMDD, CMHSB and Other State Plan mental health services, but there is no systematic delivery of cross-division reports.
- ▶ Standard CHIP reports do not adequately address mental health services provided, and basic CHIP and Enhanced CHIP benefits for youth with SED are tracked with different data systems.
- ▶ DPHHS can un-duplicate mental health clients across all its mental health purchasing Divisions; however this is not done routinely and it has not been done for CHIP services.
- ▶ The Corrections system collects only limited information on prisoners' mental health needs.
- ▶ There are few systematic processes for sharing relevant clinical information between the judicial system and mental health providers.

Recommendations.

- ▶ Develop standard reporting formats to review MH service provision and expenditures across all DPHHS divisions on a periodic basis – at least every two years to inform the budget and planning process.
- ▶ Design standard reports on CHIP services that adequately cover the 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 cost but that also allows for reporting on clinical outcomes and other quality measures.

2. Care coordination

Multiple state agencies are involved in delivering services to adults and children with mental health problems. Survey respondents identified poor service coordination as a significant problem, and interviews confirmed this. DPHHS has developed a multi-agency review process for extraordinary cases that brings DPHHS divisions together to manage high cost cases involving services from more than one division. This is a promising approach that needs further expansion and dedicated staff support.

Other findings include:

- ▶ KMAs serve a very small number of youth and families (120 cases are currently enrolled). They have been difficult to start in some areas. It has not yet been determined how they will be sustained over time. Their relationship to LACs and SAAs is not clear, but they provide an important voice for children's service needs.
- ▶ KMAs are developing family leadership and attempting to implement wraparound planning. This approach to local planning and the development of wraparound service planning is important. However:
 - Funding for flexible services is currently very limited, and yet it appears that there are vehicles such as the System of Care Account that enable the Department to flexibly utilize the state portion of Medicaid savings; and
 - Funds to sustain the KMA infrastructure are not secured.
- ▶ The current KMA model is resource intensive for a small number of cases. The scarce resource is not necessarily funding, but rather people's time. Planning meetings and follow-up place huge demands on the schedules of many of the same people in case after case.
- ▶ On the adult side, the expanding network of providers for MHSP services will likely require additional attention to case coordination between them.
- ▶ Both MSH and community providers have noted that discharge planning for MSH can be problematic and often uncoordinated. They cite different reasons for this.
- ▶ Police, jails, courts and mental health providers are establishing innovative working relationships in a number of areas, but these are not system-wide.

Recommendations. Several of the most important recommendations for improving the coordination of care are summarized below. Many of these have been touched on in previous sections of the report.

- ▶ 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, at least from a reporting perspective.
- ▶ 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. Under a waiver option

some of these flexible funds could be covered through Medicaid savings; however most of the funds would have to be state or federal funds. Allocate a meaningful set of funds for each KMA to use. These could be allocated under the current authority given DPHHS and other agencies through the System of Care Account. A statewide total of at least \$250,000 may be sufficient to create meaningful regional pools of flex funds. As regions and local provider become better trained these funds could be expanded and more authority delegated to the provider level.

- ▶ Strengthen linkages between police, jails, prisons and crisis centers.
- ▶ 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. As a part of CCO implementation, or perhaps separately, a disease management type of approach could provide a framework for coordinating, supporting and improving mental health care provided by primary care physicians and other health practitioners. However, care should be taken in the design of the program. A recent Health Affairs article found improvement in quality at increased costs.³ The authors suggested that the design had a great deal to do with this. Montana officials should consider pharmacy consultation and outreach for certain diagnostic groups, e.g. anxiety and depression. It should also include statewide telephonic support for individuals not receiving case management but needing education, support, referral and follow up. Formal disease management programs are expensive to operate and the direct costs of the service will depend upon the numbers of cases identified and the scope of conditions to be covered.
- ▶ Strengthen linkages and care coordination activities with primary care – particularly to support primary care physicians for those individuals diagnosed with mental illness who are receiving prescriptions but no specialty services.

3. Opportunities for Improving Accountability

Survey respondents suggested system priorities that included improving quality, measuring and monitoring client outcomes and implementing evidence based practices. In fact, measuring outcomes of importance to consumers and to systems is an important form of monitoring and provides a basis for quality improvement. However, regulations governing the Medicaid fee for service system limit the ability to establish direct incentives for accountability and performance. Federal funds cannot be used to provide direct financial incentives to providers. Montana's limited provider network reduces competition that could foster performance and quality improvement.

AMDD's Recovery Markers Project is collecting data from case managers on the progress achieved by their consumers in recovery. This reinforces an emphasis on recovery principles in care by actively measuring relevant aspects of recovery. This is a national best practice. The Legislature should support its further expansion. The web based system that AMDD has set up for reporting recovery markers may be useful for children's mental health outcomes reporting also. The system also has the capabilities of providing pharmacy claims and other utilization data to case managers for them to review with their clients.

³ Bruce Fireman, Joan Bartlett, and Joe Selby "Can Disease Management Reduce Health Care Costs by Improving Quality?" *Health Affairs*, November/December 2004; 23(6): 63-75.

In addition, individual providers are initiating innovative service and quality improvement initiatives of their own. However, the state currently has had little focus on changing important aspects of provider performance, such as:

- ▶ Discharge planning for MSH
- ▶ Implementing person centered or wraparound planning
- ▶ Adoption of Evidence Based Practices

Recently, health systems and a limited number of mental health care purchasers have been seeking to improve the quality of care offered to their recipients or target population through pay for performance strategies. Pay for performance strategies also seek to control costs by reducing practice errors and/or inappropriate utilization. The most common approach to pay for performance is to set a single benchmark level of performance that represents “good” quality and pay a bonus to providers that meet or exceed this threshold.

Existing pay for performance initiatives are sponsored by government purchasers such as Medicare, Medicaid and some state mental health authorities, as well as private employers, coalitions of employers, and health plans. A recent study suggested that the majority of pay for performance programs generally target primary care physicians, specialists and hospitals. In addition, CMS has recently begun designing a nursing home pay for performance demonstration project. The Delaware Department of Health and Social Services has developed a pay for performance strategy to improve access and retention for individuals seeking addiction treatment. In addition, several state mental health authorities have developed incentive strategies to reduce the use of state inpatient hospital services. These strategies are often structured to allow counties or providers to keep all or a portion of funds that remain unexpended due to lower inpatient use for individuals who reside in their geographic area.

A state’s option to implement pay performance in its Medicaid program can vary greatly. These options are dependent on how a State administers its Medicaid and State Children’s Health Insurance Programs. If the pay for performance program is a part of a fee-for-service delivery system, a state may include its initiative in its State Plan. Paying an enhanced rate for the use of evidence based practices is one example of an approach the state could take. The state can use its Medicaid disproportionate share hospital payments⁴ for incentive payments to hospitals, or state general funds for incentive payments to the types of providers it designates. Other states have established their pay for performance initiatives through their managed care contracts, in which the managed care organizations may use a portion of their capitated payments for incentive payments.

Public purchasers of mental health care services have been slow to develop pay for performance plans. Traditionally, these purchasers have not developed clear or consistent outcome performance measures, which is true of public sector contracts in general. In addition, the information systems at both the purchaser and provider level may not have the capability to accurately track outcomes.

AMDD contracts currently contain some language that would allow the Division to either pay for performance or withhold payments if the “contractor is failing to perform its duties and responsibilities in accordance with the terms of the contract”. The AMDD contracts also allow

⁴ States receive disproportionate share payments based on a pre-set formula so that they can appropriately reimburse hospitals that serve a disproportionate number of low-income patients with special needs.

the Division to terminate a contract if a provider fails to perform the services or any requirement of the contract.

Most of the AMDD contracts do not specify any outcome expectations, with the exception of the contract for outreach services related to the federal Projects for Assistance in Transition from Homelessness (PATH). The PATH contract requires agencies to submit outcome data in several areas and tie payment to reporting outcomes, yet without defining any outcome threshold. The areas for which PATH providers must submit outcome information include primarily the change in the individual's stable housing and work status. The federal Substance Abuse and Mental Health Administration (SAMHSA) requires states to provide this information for the PATH program. However, only MHSP services are provided under contracts. To participate in AMDD's fee for service Medicaid programs, providers simply have to meet requirements to be enrolled as a Medicaid provider.

Currently, the Children's Mental Health Services Bureau is developing one example of a pay for performance approach. It is developing a new two-week assessment in a residential treatment program designed to stabilize a youth, evaluate them and prepare a plan for them to return to the community. This service is paid at a higher rate than the program's regular rate, and the program gets the extra payment only if the child actually returns to the community within the two-week period, and is able to be maintained in the community for at least 30 days. In this case, the provider gets a base payment of its regular daily rate, and the additional payment is made when the performance conditions have been met. This establishes an incentive for the residential provider to complete the assessment within the two weeks allowed and develop a realistic and practical plan for community care. It will be important for CMHB to closely monitor the effort as the payments may need to be adjusted to be more effective.

The state might also consider developing a pay for performance initiative that seeks in some way to reduce the utilization of Montana State Hospital. Providers, such as crisis stabilization providers operating under the 72 hour presumptive eligibility program, could receive an enhanced payment to divert certain types of consumers or facilitate a more timely discharge of individuals from MSH after their admission. Another example might be to increase the rate of annual primary care visits for Medicaid eligible individuals with severe disabling mental illness. Providers could receive a quarterly payment if they met or exceeded thresholds set by the state. DPHHS may use Medicaid disproportionate share funds for payments made to hospitals serving individuals with low income or enrolled in Medicaid. Payments for other individuals could be made using state or other federal funds.

Since pay for performance would be a new concept to purchasers and providers, the Department might consider phasing in such an initiative. For instance, the Department may want to pilot test the payment strategy in a limited geographic area, or may want to begin with voluntary participation of providers.

DPHHS may want to identify one or two simple benchmarks and raise the standards over time, or begin with rewarding data collection and reporting and introduce performance incentives over time. Establishing aggressive performance measures and targets make little sense, however, if the state or the providers have poor information and tracking systems.

Recommendations.

- ▶ Review and develop plans for pay for performance options in Medicaid and begin a planning process to implement them. This process will need to include key purchaser, consumer and ultimately provider stakeholders, and content experts in performance measurement and improvement. Develop a strategy for a small pilot.
- ▶ 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 Quality Improvement (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 service standards and performance requirements, and monitor provider performance more closely, with regular performance based contract reporting measures such as length of stay, re-admission rates, etc.

B. Options for Major System Reorganization

DMA has identified two major options for organizing the administration of public mental health services differently. One involves considering consolidation of many functions for CMHB, CHIP and AMDD services. The other involves the development of Medicaid waiver options for better coordination of care.

1. Options for Coordination among CMHB, CHIP and AMDD

Currently, AMDD is its own Division, with responsibility for adult mental health and substance abuse services. CMHB is a bureau within the Health Resources Division, and a sister to the Health Care Resources Bureau that includes CHIP. CHIP and CMHB frequently collaborate to assist in administering CHIP mental health services. For the implementation of the CHIP Extended Benefit, CHIP does not have mental health professionals on its staff, so CMHB clinical staff are available to CHIP for consultation when significant clinical issues arise. Children's Medicaid and the CHIP Basic and Extended Benefit Plan for children with SED are administered through three separate processes and personnel: CMHB, Blue Cross Blue Shield and the Health Care Resources Bureau that includes CHIP.

With similar benefits and serving some of the same families, there would be advantages to consolidating certain administrative aspects of CHIP and children's Medicaid mental health services. This could be accomplished by assigning responsibility for oversight of CHIP mental health directly to CMHB or making significant improvements in reporting that break out mental health utilization and spending. This would allow for greater attention to CHIP mental health services. Because children's mental health is a relatively small part of total health care, mental health gets relatively little attention in the general health world. This is part of the reason why the CHIP Extended benefit is administered by HRD staff, rather than Blue Cross. CMHB

experience with managing high cost services and experience with local systems of care can be helpful for the care of children receiving the Extended CHIP benefit.

In the past, adult and children's mental health were managed by the same Division. Operating as separate entities and in different locations cannot help but increase the division between child and adult services. While our analysis has shown that there are significant differences between the child and the adult systems in financing, scope of eligibility and provider networks, it is important for children to make an effective transition to the adult system at 18, and for both systems to work collaboratively to serve families that have both children and adults with mental health problems. A number of stakeholders identified the transition into the adult system as a problematic and difficult transition that should be improved. Shared administrative functions between AMDD and CMHB could lead to some savings and both divisions might end up functioning better. At the same time it is important that children's services not find themselves subsumed under the "weight" of the adult system, something that many state children's mental health agencies experience. Efficiencies and improvements could be realized in consolidated regional planning, contracting and quality improvement. This could create savings and benefit both the child and adult entities.

We considered the option of merging Children's Mental Health Bureau and AMDD again, which might increase efficiencies in certain administrative functions and facilitate the ability of both groups of staff to better plan for services to transition age youth. However, a disadvantage is that it would move CMHB away from CHIP which covers a large number of youth. Some of the advantages of a merger of CMHB and AMDD could be achieved simply by co-locating the staff and leadership, increasing the opportunity for more frequent communication, requiring joint local planning frameworks and approaches and creating a cross-agency effort to identify and better serve shared families. The creation of the CCO, even with separate Child and Adult divisions would accomplish these same objectives.

Recommendations. If the state does not decide to pursue the CCO or other managed care options

- ▶ Give CMHB more authority over the mental health benefit and the coordination of care within CHIP and for the CHIP extended benefit.
- ▶ Co-locate management staff and share administrative functions between AMDD and CMHB. These shared functions should include purchasing, network management, revenue and TPL functions, among other functions.

2. Care Coordination through Section 1915b Managed Care/Freedom of Choice and 1115 Research and Demonstration Waivers

The Center for Medicare and Medicaid Services (CMS) allows states to develop and operate waivers to implement delivery systems designed to better coordinate care, control costs, and limit individuals' choice of providers under Medicaid. States may request Section 1915b Waiver authority to operate programs that impact the delivery system for some or all of the individuals eligible for Medicaid in a state. Section 1915(b) Waiver programs may be implemented in regions; they do not have to be operated statewide. Recipient eligibility must be consistent with the approved state plan. States also have the option to use savings achieved by using managed care to provide additional services to Medicaid beneficiaries not typically provided under the state plan through the 1915(b)(3) Waiver. Some 1915(b) waivers are voluntary programs and some have the option for fee-for-service or managed care. There must be assurance that the Medicaid recipient has a choice of at least two providers.

There are nearly 100 1915b Waivers in operation with one or more in most states. Under a 1915b authority, States are permitted to waive "state wideness", comparability of services, and freedom of choice. There are four types of 1915b Freedom of Choice Waivers:

- ▶ 1915(b) (1) Mandates Medicaid enrollment into managed care.
- ▶ 1915(b)(2) Utilizes a "central broker".
- ▶ 1915(b)(3) Uses cost savings to provide additional services.
- ▶ 1915(b)(4) Limits the number of providers for services.

States that have implemented 1915b Waivers have generally had two sometimes competing goals: increasing the effectiveness of services, and controlling expenditures for behavioral health services. In their Waiver application, states must provide information to CMS on their goals to maintain or increase access to services, while maintaining or reducing costs. They must also outline their strategies to achieve these goals. The solution to this apparent conflict lies in increasing access to outpatient and support services while reducing the length of stay and use of high cost inpatient, residential and other costly services.

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas that show policy merit including all the options possible under the more limited 1915(b) waiver authority. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems. There are two types of Medicaid authority that may be requested under Section 1115:

- ▶ Section 1115(a)(1) – allows the Secretary to waive provisions of section 1902 to operate demonstration programs, and
- ▶ Section 1115(a)(2) – allows the Secretary to provide Federal Medicaid Assistance Percentage (FMAP) for costs that otherwise cannot be matched under Section 1903.

The differences between the 1915b and 1115 Waivers are significant. States have much more flexibility under a 1115 Waiver. The 1915b can only waive provisions of Section 1902 of the Social Security Act, including freedom of choice (1902(a)(23)), State wideness (1902(a)(1)), and

comparability of services (1902(a)(10)). Provisions of Title XIX other than 1902 provisions may not be waived. The 1115 Waiver can waive other sections of the Act. Both the 1915b and 1115 Waiver would allow the state to reinvest savings into the mental health system. However, under capitation rate⁵ setting rules for the 1915b, savings can only be reinvested in services that are part of the current state plan in order to be included in future capitation rates. This is an important distinction, while savings can be used to pay for services not typically provided under the state plan, this usage will lead to lower capitation rates in future years of the 1915b Waiver.

States that have 1915b or 1115 Waivers often contract with a Prepaid Inpatient Health Plan (PIHP) or a Prepaid Ambulatory Health Plan (PAHP) to implement and administer their managed care programs. A PIHP is an entity that provides, arranges for or otherwise has responsibility for the provision of any inpatient or institutional services for its enrollees. A PAHP does not provide or arrange for (and is not otherwise responsible for) the provision of any inpatient hospital or institutional services for its enrollees. PIHPs and PAHPs often receive pre-paid capitation payments or other payment arrangements to provide services to enrollees. PIHPs and PAHPs are generally private companies (profit and non-profit). However, some PIHPs and PAHPs are administered by state or local governments (e.g. Hawaii Child and Adolescent Mental Health Division and Philadelphia County).

From 1997 to 1999 the State of Montana used the 1915b Waiver authority for mental health services. The state no longer operates the mental health 1915b Waiver program. A number of factors led to the demise of the program, including but not limited to the following: multiple changes in ownership of the contractor, a poorly constructed contract which left far too much discretion to the contractor, weak contract oversight initially, provider and consumer resistance and lack of trust, and perhaps most importantly, rates that were set too low as a result of the state pulling funding from the program.

Montana does, however, currently perform certain “managed care functions” through its contract with First Health. Specifically, First Health provides Medicaid utilization review services for the State of Montana. This includes prior authorization, continued stay and retrospective review of the medical necessity of the following services:

- ▶ Adult and Children’s Outpatient Therapy Services
- ▶ Adult Acute Inpatient Services – Prior Authorization and Continued Stay for Out of State services only. (In state services are reimbursed with Diagnostic Related Groups)
- ▶ Adult Acute State Hospital Services for individuals under 21 and 65 years of age or older.
- ▶ Adult Intensive Outpatient services
- ▶ Adult Crisis Stabilization
- ▶ Youth Residential Treatment
- ▶ Therapeutic Home Visits
- ▶ Therapeutic Living Services
- ▶ Targeted Youth Case Management Services

In addition to the prior authorization and continuing stay review services, First Health also

⁵ Note that “capitation rates” refer to rates paid to a health insuring organization or similar entity to provide coverage for a set of defined services. In Medicaid, these are generally expressed as per member per month rates. As with personal health or other types of insurance, they are paid for everyone who is eligible in the rate category regardless of whether they need services or of the level of need. Rate categories can be established to break the population into subsets and to control the risk. For instance in Medicaid this is often done in categories for individuals eligible under Temporary Assistance for Needy Families (TANF) rules; aged, blind or disabled individuals (SSI) and perhaps children in state custody.

provides regional care coordination services for youth receiving Mental Health services under Medicaid. These staff facilitate treatment planning, communicate with the various parties involved in the care, and they provide liaison to First Health clinical reviewers, physicians and state and provider case managers.

Finally, First Health provides retrospective review services of selected providers, reviewing medical records and documentation for a range of Medicaid services provided by a sample of providers selected according to criteria determined by DPHHS.

Nationwide, Montana has one of only two 1915c Home and Community Based Services Waivers for adults covering a planned 120 people who would otherwise be receiving nursing home level of care. The waiver is unique and unusually broad in eligibility, covering a range of rehabilitative services, including respite and adult foster care among other services. In addition, Montana applied for and received a CMS PRTF Demonstration grant that serves up to 100 children per year. These are examples of the state's creativity and forward looking approach.

The sections below summarize our observations and recommendations on Organizational Structure and Reimbursement.

a) Organizational Structure.

Over the year and a half prior to this study, beginning in August 2006, a number of state officials and other interested parties met on at least four occasions to develop a set of recommendations for the state to consider in restructuring its operations to achieve the goals outlined by the President's New Freedom Commission (NFC). The major goals in this report were that:

- ▶ American understand that mental health is essential to overall health
- ▶ Mental health care is consumer and family driven
- ▶ Disparities in mental health services are eliminated
- ▶ Early mental health screening, assessment and referral to services are common practice
- ▶ Excellent mental health care is delivered and research is accelerated
- ▶ Technology is used to access mental health care and information

There was widespread agreement on these goals and a strong feeling that system reorganization was needed to accomplish some of the major goals of the NFC. Three different approaches were suggested. These include:

- ▶ Contracting with a specialized Managed Behavioral Healthcare Organization (MBHO) to provide managed care functions. This would be similar in some ways to the state's previous managed care initiative and its contract with Magellan Health Services. It could include features such as braided funding similar to the work in New Mexico⁶. Contract terms and conditions will need to be quite specific and detailed for it to address the likely fears and concerns of many other stakeholders based on Montana's earlier experience with managed mental health care.

⁶ Braided funding is an approach that a number of states have used to try to provide greater integration of services for consumers. New Mexico is the best example of the work nationally. In this approach, states use an intermediary organization (a managed care organization, a provider or the state or county itself) to provide open access to services across several different federal and state funding streams. The goal is to create a system where the restrictions and limits on a service associated with a funding stream are hidden from the consumer but the unique eligibility and reporting requirements are retained for reporting and accounting purposes.

- ▶ Developing a quasi-public Coordinated Care Organization (CCO) to administer a managed care program under a 1915b or 1115 Waiver authority. The CCO has been proposed as a quasi-public authority under the auspices of state government and would have a Board of Directors comprised of leadership from the various state agencies and stakeholders including consumers and providers. The CCO would hire a chief executive officer and authorize spending levels for the CEO, staff and infrastructure. The CCO would be responsible for purchasing and overseeing all mental health services. The CCO could be paid on a risk based, partially risk based or administrative fee contract. Under a risk arrangement, savings generated by the CCO would be reinvested in mental health services.
- ▶ Using existing or reorganized state agencies for the management of care. This approach is best suited to incremental improvements and retains many of the negative features of the current system, including annual financing, spending restrictions, hiring restrictions, etc. Under effective leadership and with a clear mandate, public agencies can transform themselves. Unfortunately leadership and mandates in the public sector are too often subject to changes in administrations and changing priorities to be effective in sustaining systems transformation over time.

Table V-1, below, summarizes potential advantages and disadvantages of different managed care organization structures.

Org. Structure	Advantages	Disadvantages
Private Contractor	<ul style="list-style-type: none"> • National managed care companies would compete for the services • May allow more rapid start up from organizations with experience in the field • Larger national firms can potentially bring more talented employees to Montana • Highly flexible in compensating employees • Profit motive spurs change • Potential to braid funds more easily and defragment the system 	<ul style="list-style-type: none"> • Increased administrative costs and profit • Procurement process is burdensome • Risk of appeal and litigation if process not run carefully • Still requires extensive oversight and public administrative support in agencies • May reduce access to services as less funding would likely be available for services • Easy to become politically charged • Montana history with managed care is traumatic • Changes the nature of the relationships with providers – more difficult to make the goal be about public benefit • Difficulty for the Legislature in directly impacting managed care decisions
Quasi-Public Authority or Non-Profit Corporation	<ul style="list-style-type: none"> • May offset concerns regarding previous managed care experience—it may be viewed as closer aligned with the mission of state agencies • Higher level of initial perceived public trust • Profit is reinvested back into system • Lower level of oversight needed for a “public” CCO • Several positive examples of public or quasi-public systems managing care (Philadelphia, Wraparound Milwaukee, Piedmont Behavioral Health (NC), and CAMHD (Hawaii)) • Can potentially by-pass public hiring and procurement rules to reduce costs • Would allow for more flexible financing and retained savings • Could have bonding authority to finance housing for mentally ill • Could develop a risk pool • Potential to braid funds more easily and defragment the system • “Authority” could contract for the technical expertise it needs. 	<ul style="list-style-type: none"> • Enabling legislation is required and negotiating the details will result in suboptimal decisions on many items • Separate bonding and financial authority is risky and requires separate oversight structures • Over time public “authorities” can become highly political and not necessarily more productive than state agencies. • Less legislative and executive branch control though some of this can be worked out in enabling legislation or through governance • Transition to quasi-public entity would be more difficult than people believe, though not more difficult than a private contractor • Difficulty in getting federal approval for some initiatives and the quasi-public nature of this may raise some questions • Requires legislative authority to retain revenue
Use Existing or Reorganized Public Agencies	<ul style="list-style-type: none"> • Marginal increases in costs • Known processes for administration • May be easier to create incremental change • Can be effective if there is a strong public mandate for change • Strong leadership is needed in any of the scenarios. Public agencies can be just as effective when the leadership is there, e.g. Goal 189 success and recent successes in reducing out of state placements for youth • Reorganizing staff within existing public agencies may help to initiate major change 	<ul style="list-style-type: none"> • Budgeting and hiring processes are restrictive • Little flexibility in compensation • Can be harder to accomplish transformative objectives • Political distractions • Status quo is often the path of least resistance • More difficult (though not impossible) to roll over savings

Any managed care plan in Medicaid requires a waiver. Whether delivered through a public or quasi-public agency or a contracted BHO, the waiver provides states with tools that are not available otherwise to control mental health care costs, coordinate care, and control utilization. These tools include the ability to implement:

- ▶ Selective contracting in the provider network rather than any willing and qualified provider;
- ▶ Assignment of recipients to providers for the coordination of care; and
- ▶ Capitated rate setting methods.

In addition, the use of an 1115 or 1915(b) waivers allow states to structure contracts with organizations to jointly administer Medicaid and state general funds. In Montana this would permit the consolidation of a number of administrative resources from several divisions that purchase and manage these services. The managed care entity can achieve this in many ways because it is a third party with a focus on implementation and execution. In our opinion, particularly in mental health services, the public purchaser should retain the responsibility of planning and responding to the public, other agencies and elected officials.

A risk based contract also provides an opportunity to obtain additional FMAP for administrative functions that may be currently funded with state general funds or that are reimbursed by Medicaid at the administrative match rate of 50%. Our review did not uncover any significant areas missing from the state's allocation and administrative cost plan for Medicaid. However, the added federal matching rate that would result from including administrative functions as a part of a capitation rate compared to the current administrative rate could conservatively amount to \$300,000 to \$400,000 in additional federal revenue. Calculation of this is as follows: The difference between the capitation rate (matched at 68%) compared to the current administrative rate (50% for most functions; higher for some functions such as IT and Quality which are matched at 90% and 75% respectively) is approximately 18%. Multiplying this 18% difference in FMAP rate times an estimated \$2M in eligible administrative costs equals roughly \$300K -\$400K. This estimate may understate the administrative costs for both adult and child divisions.

The CCO model assumes that a quasi-public organization would have many of the reimbursement and financing related advantages of a contractor, but that public trust would be higher, transition to the new entity would be easier and a lesser degree of oversight would be required of the public authority. The CCO model also assumes that most if not all of the functions performed by AMDD and CMHB would transition over to the new entity. This is a significant undertaking that will require detailed planning for both state staff and contractors (such as First Health).

There are a number of examples of quasi-public authorities that have been quite successful in administering mental health services. These include Philadelphia Community Behavioral Health (CBH), Hawaii's Child and Adolescent Mental Health Division, and Wraparound Milwaukee. In Philadelphia's case, the city created a non-profit organization, CBH, to manage the behavioral (mental health and substance abuse treatment services) health benefit for the city. Wraparound Milwaukee and Hawaii are both run by a county or state division. There are also several California counties that manage capitated mental health services as integrated delivery systems. All of these organizations have been in existence for five or more years; a decade in the case of Wraparound Milwaukee. None of them have chosen to contract out administrative functions to a managed care organization. They all have developed their own claims and IT

solutions. While all of them had challenges in their implementation, as a group they have been surprisingly free of problems.

New Mexico has undertaken a compelling approach in many ways, attempting to consolidate the administration of mental health and substance abuse funding streams across all state agencies. However, we do not recommend the governance and oversight strategy that New Mexico has established, because it has resulted in oversight by committee. The state created a large purchasing group (the “Behavioral Health Purchasing Collaborative”), a statewide Behavioral Health Planning Council and disparate local advisory groups called “Local Collaboratives”. Decision making and staffing of these groups have been very resource intensive and overly time-consuming, and the quality and timing of decision making has been sub-optimal.

In any managed care scenario, the state must structure payment incentives so that they are aligned with its goals, which must be clearly specified as part of the contract or enabling language for the CCO. For instance, will the state use a risk based contract to achieve its goals of increased access, or will the state consider an administrative services-only contract with performance incentives to manage enrollees’ services? Risk based contracts use capitation or case rate payments to provide incentives to an organization to maximize efficiency of services, yet these are not always the best ways to improve effectiveness. Administrative service contracts generally use an administrative fee with some form of incentive payment to meet goals and objectives of increased access and improved outcomes.

b) Reimbursement.

The table below presents a framework for considering reimbursement options for a managed care organization under a 1915b or 1115 Waiver authority in Montana. It outlines advantages and disadvantages of each approach and should be viewed independently from the organizational or contracting design.

Reimbursement Options	Advantages	Disadvantages
Non-Risk, Administrative Services Organization Contract	<ul style="list-style-type: none"> • Matching federal funds for administrative services would be included in ASO contract (50% of all administrative costs) • The PIHP or PAHP may need less financial reserves for a risk pool 	<ul style="list-style-type: none"> • State of Montana would continue to hold the risk for all service expenditures • State may have to expend additional resources to develop or contract for needed managed care functions
Risk Based Managed Care Contract	<ul style="list-style-type: none"> • Matching federal funds for administrative services would be included in the risk based managed care contract (68% of all administrative costs). This marginal increase might result in \$300-400K in additional revenue. • State of Montana would have less risk for service expenditures. • Can negotiate rates that differ from Medicaid rates. Could pay a premium for services in underserved areas. 	<ul style="list-style-type: none"> • Managed care administrative costs come out of service funding unless the state makes up the difference • State will still need to maintain oversight functions • There will be rate setting difficulties and likely added costs of incorporating the HCBS waiver and the PRTF Demonstration

Managed care initiatives are often undertaken when a state believes that the patterns of care being used are unnecessarily intensive and expensive. Utilization management controls, selective contracting, and resetting prices of service can all be implemented by a managed care contractor to drive changes that keep care closer to the community whenever possible. Montana already has a utilization review organization (First Health) to help reduce use of residential facilities for children and to manage authorization for some of the more intensive adult services. These same “controls” are not possible under current admission and commitment rules for Montana State Hospital. The state resources for the PRTF Demonstration and the Home and Community Based Services Waivers are explicitly focused on substituting community resources for residential and nursing home levels of care wherever possible. These waivers provide considerable flexibility in using Medicaid funds in non-traditional ways. It would be challenging (though not impossible) to incorporate these services in the managed care approach; alternatively these waivers could be terminated.

On both the child and adult side, Montana lacks enough current providers to benefit from selective contracting or from increased competition. As a result, Montana’s strategy should be to build and maintain effective partnerships with its “suppliers”. This partnership should find effective ways to foster a focus on recovery among its provider network and to ensure that providers make the changes in practice necessary to implement it. That are sorely needed, according to many of the comments we received from stakeholders.

An optimal strategy for Montana depends upon a number of factors including the perceived capacity of the public organization to effect change, whether authority for the needed financing strategies can be obtained in the public agency (e.g. retention of reserves for reinvestment), contracting and hiring flexibility, and ultimately the availability of leadership and experience. Public sector compensations levels are often the barrier to these last two attributes.

Recommendations. DPHHS should develop and have a public review process of a detailed plan for a public Care Coordination Organization (CCO) to manage mental health services to children and adults under a 1915(b) or 1115 Waiver. A detailed design and plan for the waiver and ultimately procurement will require considerable effort by the state and is beyond the scope of this paper. An 1115 Research and Demonstration Waiver would allow the state to consolidate its HIFA Waiver terms into the managed care approach. The CCO should consolidate all children’s and adult mental health services and administrative activities. The state should consider whether to include substance abuse services also.

Montana agencies have demonstrated their abilities to accomplish needed system changes through their various efforts over the past years. Reducing out of state residential placements for youth and reducing the Montana State Hospital census are examples of agency capabilities. The challenge for these agencies is to maintain their attention and focus on transformation and cost management. This takes sustained leadership and cooperation throughout the administration. The use of a third party to manage care can change the dynamics of the system markedly. Splitting planning and implementation functions up between the state and the managed care entity, consolidating administrative functions across the several agencies, and creating an effective non-profit governance strategy for a statewide quasi-public entity are important elements of success. The added federal revenue will permit the state to fund certain needed administrative functions.

If the state ultimately does not decide to pursue this plan, many of the same goals can be achieved by AMDD and CMHB with effective leadership, new financing rules and other changes. This will require a firm commitment by the administration and strong project management and leadership within the state agencies.

c) Implementation Plan

While the state should continue its many current efforts to improve the existing service system during the implementation process, the following activities are essential to plan for and implement the CCO:

- ▶ Create an internal working group to undertake the detailed planning and analysis needed to implement the effort.
- ▶ Develop and seek input on a detailed workplan. Ensure that there are some dedicated resources to the efforts and a realistic timeline developed for start up. It is not likely that anything could happen sooner than 2012 despite the best wishes of many in the system.
- ▶ Study the current mental health positions in AMDD, CMHB, and Extended CHIP. Identify the functions, current staffing and costs of all subcontractors including ACS (the Medicaid claims payment subcontractor), Blue Cross and First Health. This should include an assessment of capacity of existing staff.
- ▶ Collect data on other mental health administrative costs in AMDD, CMHB, First Health Services and the CHIP contract with Blue Cross. Evaluate where there may be savings or efficiencies in consolidating staff and contractor functions into a quasi-public CCO. To minimize disruption during the transition, the state should ensure that current employees will continue to have a job either in the new entity or will be placed in a comparable position. There needs to be an overlap in the start up and wind down of the work of any contractor. This will incur start up costs.
- ▶ Review the options for governance and legal organization of the CCO. The basic options include: 1) establishing a non-profit corporation (subject to IRS approval) with shared governance similar to what Philadelphia has established; 2) creating a public authority as a separate governmental entity; or 3) designating a division within one of the agencies, similar to what Hawaii or Wrap Around Milwaukee have established at the state and county levels. The central issues will revolve around the flow of funds from the Medicaid agency and the legal, governance and reporting relationship between the new entity, DPHHS and the Legislature. Care should be taken to avoid the appearance of inter-governmental transfers since those have been under scrutiny at CMS. With respect to non-profit governance issues, the details of the board composition and oversight functions in Philadelphia and in other sites can provide some guidance for Montana officials. However, there is no template for Montana to follow. This will require considerable discussion and negotiation and it should include public hearings, since the concerns about any form of managed care are likely to be strong. If the state's plans call for a separate non-profit, it will require IRS approval for federal tax exemption. Legislative authorization and clear enabling language about the public purposes and mission of the new entity may be necessary to ensure that IRS approval or tax-exempt status is received.⁷
- ▶ Develop a plan to identify and define the scope of services to be included in the CCO. We have assumed that it would include all AMDD contracted services; however, there will surely be a debate over how to handle Montana State Hospital and the Montana Mental

⁷ In the late 1990's the IRS was concerned about the legitimacy of tax exempt status of many non-profit managed care organizations. While the concerns of attorneys and others seem to have relaxed on this in recent years, the public benefit and purpose of the organization needs to be very clear.

Health Nursing Care Center costs. The choices are that the cost of MSH and MMHNCC be either 1) excluded from the CCO benefit; 2) paid for on a capacity, grant type basis with annual capacity; 3) covered through some form of risk adjusted case rate; or 4) purchased on a fee for service basis.

- ▶ Develop financial estimates for the costs of the transition including estimation (based upon existing expenditures) of capitated rates or premiums, any additional cash flow requirements for fee for service claims incurred but not reported, the potentially overlapping capitation payments, and other one-time expenses.
- ▶ Develop publicly accountable and responsible procedures to retain revenue in the CCO. These would be used initially to fund needed risk reserves within the CCO, and second be reinvested in services. Initially, the state would have to retain risk. Over the first several years of CCO operation, however, savings must be retained to build the required reserves. Once an appropriate level of reserves is achieved (consider one or two months of operations and service expenses at a minimum), the savings would be captured by the state. These should be reserves based upon a full accrual method of accounting (after an allowance is made for claims incurred but not yet reported and pending but not yet paid).
- ▶ Review the HIFA application and other changes needed for the design of a more comprehensive 1115 Waiver that incorporates the adult eligibility expansion in the current HIFA Waiver and brings the administration of existing children's mental health benefits and substance abuse services into a more comprehensive and coordinated Medicaid initiative. At a minimum, the waiver document should incorporate the plans for a capitated benefit and CCO administration.
- ▶ Draft and submit the waiver for approval to the new administration.
- ▶ Develop legal documents including any needed organizational papers and memoranda of understanding.
- ▶ Establish financial mechanisms, including banking arrangements for cash management, billing and claims processing procedures. DPHHS' contract with ACS will likely need modification to ensure that reporting for mental health utilization and expenditures is discrete and separate, both organizationally and financially. There are at least three acceptable ways to handle this: 1) Establishing separate check runs and using separate bank accounts; 2) Establishing completely separate check runs for the CCO as a separate legal entity or Org. Code (accounting code); and 3) Processing a consolidated check run with separate Org. Code financial accounting for all MH checks. The check registers and claims reports should be accessible for the CCO independently of DPHHS. To ensure appropriate separation of powers and internal controls, CCO checks should not be run without explicit authorization of the CCO leadership. As a result, Options 1 or 2 are likely the preferred approach.
- ▶ Develop a comprehensive organizational plan for the new entity with positions and reporting structure clearly laid out.
- ▶ Develop and implement a detailed plan for the transfer all existing contracts and provider relationships.
- ▶ Establish and hold initial meetings of the Board.
- ▶ Implement a formal hiring process, particularly for the senior staff positions. Ensure that some key positions are hired prior to the transition in order to focus on some of the critical project tasks.

Additional steps will become clearer as the planning process expands to involve others, and after the strategy and direction has been set by the Legislature and administration. Leadership on the planning teams and within the administration will be key to success. With several recent

and future retirements, this may be a factor that needs to be considered. Strong project management skills will be needed as will strong group facilitation skills. A transparent planning process will be critically important to build and maintain trust. We hope that this study has set a tone which will be helpful going forward.

d) Potential Costs of the CCO

In implementing managed care approaches, there is a general assumption that the staff and services needed to accomplish the care coordination goals will come from restructuring existing staff, efficiencies achieved by eliminating redundancy, and possibly increased revenue from increased federal match for administrative costs. While increasing resources for the better coordination of services can improve consumer outcomes, given the gaps in services that we have documented the state of Montana should not develop a plan that seeks to reduce overall service costs. In our experience, any savings from these areas are often/usually offset by the costs of the additional functions needed to achieve the improvement, increased capital outlays for new technology, one-time costs for the transition, risk reserves and what economists call risk premiums (the additional percentage point or more to cover the “costs” of taking on risk), and profits. Advocates and others always fear that reductions in services to consumers and families will finance profits for the managed care entity. The CCO proposal, using either a non-profit Montana corporation or organized within a state agency, avoids some of these concerns about profit making.

There will be certain one-time costs associated with the transition. These may include actuarial and consulting costs, legal costs, costs of moving staff and changing functions between agencies. With a conservative approach, assuming that the waiver application can be completed by DPHHS staff, these functions can be accomplished for \$250,000 to 300,000. In addition to one-time costs, there are certain new or incremental functions that can and should be performed by the CCO. These include increased activities in contract management and oversight for providers, added staff for provider reporting and new technology investments in reporting and internet functionality. These are likely to cost \$300,000 for 3-4 FTEs (salaries, benefits and some allowance for increased overhead) and the technology.

The costs of most other administrative functions can be addressed as the state consolidates staff from AMDD, CMHB, those staff from CHIP Extended Benefit, and First Health Services. If the final decision is that the CCO should be a separate non-profit organization, some level of administrative oversight will need to be retained in DPHHS. At its simplest level, an individual in the administration must be designated as the Single State Agency Director for SAMHSA Block Grant planning and oversight. Similarly, a clear designation should be made of the unit or staff responsible for oversight of mental health services and expenditures in Medicaid. Philadelphia and Wraparound Milwaukee have addressed this by separating the planning functions and keeping them in the County agency. The implementation and care coordination functions were moved to CBH. This separation of functions may have some cost implications for Montana although there may be some creative ways to handle these requirements.

Total first year costs incremental costs are likely to be from \$550,000 to \$600,000. Subsequent additional costs are estimated at \$300,000. These can be offset by the savings from the added federal match that we have estimated for a shift from administrative to service match rates. We have not projected savings in service premiums, since we believe that all savings should be reinvested in filling service gaps and making other system improvements.

We are cognizant that we are making these projections and assumption at a time of potentially dramatic changes in state revenues given the national financial crisis. If state revenues are going to be dramatically affected and cuts will be needed, it is important that the cuts take place before any of the restructuring. Great care should be taken that the two issues are not confused in the minds of providers or consumers and families.