

Report to the State of Montana: Legislative Mental Health Study

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Report to the State of Montana: Legislative Mental Health Study

I. Introduction

DMA Health Strategies is pleased to present the State of Montana with this Final Report on the Legislative Mental Health Study. Over the past six months DMA and our contractors for this project, Policy Research Associates, Leslie Schwalbe and John O'Brien, have conducted site visits to Montana; interviewed individuals, primarily in person but also by telephone when necessary or appropriate; and made presentations to Montana legislators. In addition we disseminated a survey both on-line and on paper to a wide variety of stakeholders. DMA also requested and analyzed data on mental health service utilization and costs from a variety of sources. Based on this effort, we have developed answers to the twelve study questions with which we began.

A. Goals of the Project

The goal of the Montana Legislature in initiating this project was for its contractor to assess mental health needs, identify gaps in services, recommend a best-practices model of services, and identify potential new funding sources in the state of Montana. More specifically, the goal of this study was to evaluate mental health services in the state to determine the extent to which Montana's publicly funded system is fully using existing state and federal resources and whether additional services are needed and/or new resources may be found. The availability of resources relates directly to the adequacy of the mental health service array and the capacity of the mental health providers in the state to provide the necessary services in a timely manner to all residents, regardless of where they live.

B. Purpose of this Report

This report summarizes key findings, options for improvement, and recommendations for short, medium and long term activities for system change and improvement. It builds on and follows our presentations to Montana legislators and other stakeholders, incorporating feedback from them and from state agency staff. We describe financial and organizational options for the state, including opportunities for new revenue and the costs and benefits of new organizational approaches. Our recommendations are consistent with the opportunities for additional funding, and the Legislature's preferences for system development overall, including within the criminal justice system. The recommendations build upon and strengthen Montana's current system and its current initiatives and outline a process for improvement and transformation that is systematic, achievable, and that allows measurement of progress.

The report addresses the public mental health system for children and for adults. It also includes a chapter specific to the mental health needs in the criminal justice system. Our analysis and recommendations are in keeping with the goals of the President's New Freedom Commission on Mental Health's recommendations for a consumer- and family-driven system of care and the further development of a comprehensive, statewide public mental health system.

C. Study Questions

To guide our investigation and analysis, DMA worked with the Montana Legislature's, Children, Families, Health, and Human Services Interim Committee (the Committee) and the Department of Public Health and Human Services (DPHHS) staff to formulate twelve study questions. They are:

1. How many people need mental health services and where are they located?
2. What services does Montana have in place?
3. Where are services being delivered? And by whom?
4. How can the system be organized differently to deliver services more efficiently?
5. What services do the citizens of Montana need that currently do not exist?
6. How are services funded?
7. Have Montana's funding streams changed significantly over the past few years? If so, which ones and why?
8. How does the consumer pay? Should consumers pay more?
9. How can Montana make better use of current funding streams and funding levels? What is needed in order to blend or braid funds to improve efficiency?
10. What funding sources are not being accessed by Montana and why?
11. What funding streams will support needed new services, and which of them are potentially available or unavailable to Montana?
12. How can the sequential intercept model be used to improve services to persons in the criminal justice system?

II. Methodology

To complete this study, numerous individuals and organizations cooperated to meet with our consultant team in Montana. We also gathered, reviewed and analyzed large quantities of qualitative and quantitative data.

A. Site Visits and Interviews

Richard H. Dougherty, Ph.D., Leslie Schwalbe, Wendy Holt, Dan Abreu and Henry Steadman visited Montana a total of six times. They conducted interviews with representatives of state agencies, consumer organizations, members of Montana's local and regional planning groups, and other stakeholders; made presentations to the Committee and one to the Mental Health Oversight Advisory Council (MHOAC). In addition, we disseminated a survey using a Web application and on paper that yielded over 700 responses from stakeholders in the state.

B. Quantitative Data on Need for and Utilization of Services

This project required that we estimate the need for mental health services in Montana, and inventory the services available to meet that need, in order to identify the strengths of Montana's mental health system, the gaps in that system and the barriers affecting access to care and optimal functionality of the service system. To meet this requirement we collected and worked with state staff to develop, and subsequently analyze, four types of information about Montana's mental health system:

- Data on prevalence of mental health problems;
- Data on service and utilization;
- Information about eligibility standards and other relevant state agency policies that affect access to and use of mental health services; and
- Information about the experiences and concerns of Montana's mental health service providers and the perceptions and experiences of Montana's consumers of mental health services and other mental health system stakeholders.

To provide a context for our analysis we also sought data from other Western states with significant rural populations.

1. County Based Prevalence Estimates

DMA purchased prevalence estimates developed by Dr. Charles Holzer of the University of Texas Medical Branch based on 2006 Census data. Dr. Holzer uses the National Institute of Mental Health's Collaborative Psychiatric Epidemiology Surveys (CPES) as the basis for his estimates. CPES provides data on the distributions, correlates, and risk factors of mental disorders among the general population, with special emphasis on minority groups. This project joins together three nationally representative surveys: the National Comorbidity Survey Replication (NCS-R), the National Survey of American Life (NSAL), and the National Latino and Asian American Study (NLAAS). While the estimates have some limitations in terms of poverty data (only reporting for 200% of federal poverty), this data set is the most widely accepted and most comprehensive prevalence data available in the US; it builds on the foundation laid by all the major national studies of prevalence. Dr. Holzer develops estimates for specified sectors of the population, and extrapolates to develop estimates for sectors for which robust prevalence studies have not yet

been conducted. These data are stratified by county, which enabled us to account for differences in prevalence that stem from race, ethnic, age and economic differences in county adult populations.¹ See Appendix A for more detailed notes on prevalence estimates, and county and regional data.

2. DPHHS Data

Montana's Department of Public Health and Human Services (DPHHS) completed a comprehensive utilization and spending matrix (spreadsheet) that summarized Medicaid and all other mental health service utilization and spending data (by service type) and by county across multiple funding streams. With these data, DMA was able to compare service use to need, measured by the prevalence data, and identify geographically, by age, whether some groups have a relatively greater unmet need than others. In our experience, few, if any, other states have the capacity to generate a report with this scope of data. Appendices B, C and D provide more detailed information on these data and county and regional rates of service use in comparison to population under 200% of poverty.

DMA sought data on Medicaid mental health services for Medicaid eligible American Indians provided by Indian Health Service (IHS) Facilities from DPHHS and data on all mental health services provided directly from IHS. We received a report from DPHHS on claims filed with the mental health revenue code 915 and from IHS on total mental health visits to Montana facilities. DPHHS believes the report it provided to be incomplete, and our analysis of the data suggests this to be the case. This report provides information about the nature of the problems with the data and analyzes how its absence may affect the understanding of service gaps in the regions served by IHS facilities.

An Important Note about the Limitations of Our Data

Our data request captured an extensive menu of mental health services, including those that are only used as mental health treatment or rehabilitation, and other medical services, like personal care services, labs, medications, and physician evaluation, that may be provided in connection with assessing or treating a mental health diagnosis or for other health problems. A high proportion of individuals in Medicaid, 9095 adults - virtually half of those served by AMDD, and 4695 children, over half of those served by CMHB, receive what we have reported as "miscellaneous" services. This broad definition of mental health services, combined with our inclusion of individuals receiving psychotropic medications gives Montana an indication of the extent and cost of the treatment of mental health conditions both through traditional mental health services, and by other practitioners. However, this broad definition also contributes to the high rates we have found for Medicaid recipients to get mental health services. The definition may in fact overstate the rates at which individuals receive mental health treatment. For example, because we included psychotropic medications we may be reporting on individuals who are using these medications to treat non-mental health conditions. Our figures also may have included tests or physician examinations that ruled out a mental health condition as the cause of a presenting problem that was eventually determined to be a physical health condition. It may be helpful for Montana to further evaluate both the numbers of individuals served and the types of services they receive in order to establish a working definition for receiving mental health services that may be somewhat more helpful in setting policy and monitoring program performance.

3. Utilization Data from Other States

DMA sought data from other western states and received data from Alaska, New Mexico and Arizona. We also used published data from Minnesota. To better match the rural and frontier

¹ Note: In 2006, Montana commissioned a report from the Western Interstate Commission for Higher Education (WICHE) entitled *The Status of Mental Health in Montana: Prevalence, Service Utilization, Penetration Rates and Unmet Need*. This study also used estimates developed by Dr. Holzer using similar methodologies but based solely on the National Comorbidity Survey Replication (NCS-R).

nature of Montana, we selected data only from Minnesota counties that are considered frontier or had population densities no higher than those of Montana's most densely populated county. Arizona provided use with data that excluded its most urbanized county, Maricopa County which includes the city of Phoenix. Appendix E provides detailed information on these data and how we used them.

C. Department of Labor and Industry: Health Care Licensing Bureau

DMA requested data from Montana's Health Care Licensing Bureau on licensed mental health practitioners in order to analyze their distribution across the state. Detailed lists of these providers by region and city are provided in Appendix F.

D. Juvenile and Adult Justice System

Policy Research Associates (PRA) operates the National GAINS Center, which has served since 1995 as a locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system. Two representatives of PRA and the GAINS Center conducted a Needs Assessment of mental health services in the adult and juvenile criminal justice systems, including institutional justice facilities and facilities that transition individuals from prisons to community services. Dr. Henry J. Steadman, President of Policy Research Associates (PRA) and Director of the National GAINS Center, and Dan Abreu, M.S. CRC, LMHC, Associate Director of the National GAINS Center, visited seven facilities, interviewed individuals who could provide relevant information and reviewed a variety of state documents in preparation of this report.

Dr. Steadman and Mr. Abreu visited the following facilities:

- May 12, 2008 – Passages Assessment and Sanction Center
- May 13, 2008 – Yellowstone County Detention Center
- May 13, 2008 – Montana State Women's Prison
- May 13, 2008 – Pine Hills Youth Correctional Facility
- May 15, 2008 – Lewis and Clark County Detention Center
- May 15, 2008 – Montana State Hospital Forensic Unit
- May 15, 2008 – Montana State Prison

On May 14, 2008, the PRA team met with key criminal justice and mental health stakeholders and on May 15, 2008, they held a dinner meeting with the Missoula Mental Health Court Team.

In addition to conducting site visits and interviews, PRA reviewed several reports and audits, including:

- Mental Health Oversight Advisory Council letter relating to mental health care in the justice system(August 21, 2006)
- Technical Assistance Collaborative Report Recommendations Progress/Updates (November, 2007)
- Strategic Plan Collaboration of DOC/DPHSS (December 1, 2006)
- Criminal Justice/Mental Health Intercept Model Adult Offenders (February 28, 2008)
- Predicting and Reducing Recidivism: Factors Contributing to Recidivism in the State of Montana Pre-Release Center Population & the Issue of Measurement. University of Montana. (2006).

PRA's recommendations for Montana reference a number of relevant resources. A list of these resources is provided in Appendix G, and they can be obtained upon request from the Legislative Services Division.

E. Survey

DMA used a web application, Survey Monkey, to distribute and administer a survey to Montana stakeholders. The survey was developed in consultation with Committee staff and distributed to the contact lists of the CFHHS and the Law and Justice Interim Committee, as well as through Montana advocacy groups and state agencies. This method does not result in a sample that is statistically representative of state stakeholders; however it did allow us to generate significantly broader input to our work. The survey generated 706 responses. Twenty-five percent were consumers and families, 25% were providers, and 17% were advocates. The remaining one-third of responses were from "other" categories. Geographically, Missoula and Lewis and Clark counties had the highest response rates, and there were no respondents from the following eight counties: Blaine, Carter, Glacier, Judith Basin, Liberty, Prairie, Wheatland and Wibaux.

Appendix H contains a summary of survey responses.

F. Glossary

Appendix I contains a glossary of terms and definitions.

III. Findings on the DPHHS Mental Health System

A. Child Mental Health Services

DMA has gathered data from a number of sources in order to develop a clear understanding of the number of adults and children in Montana who need and receive mental health services and where they live within the state.

1. How many children need mental health services and where are they located?

Approximately 30,000 children in Montana between the ages of 9 and 17 are estimated to have a diagnosable mental health condition during the year. An estimated 16,500 children of all ages were estimated to have a Serious Emotional Disturbance (SED) in 2006. Of that group, 8,900 were estimated to be in households whose incomes were under 200% of poverty. The estimated rate of SED among children in households with incomes under 200% of poverty, the group most likely to be eligible for and in need of public mental health services varies relatively little across the regions of the state, but varies as much as 15% between the highest and lowest prevalence counties. This is primarily due to economic and ethnic differences in county populations.

a) Estimates of Children in Need of Mental Health Services

There are different levels of need for mental health services. The most expansive definition of need for mental health services is children who experience a mental health problem that meets the criteria for a mental health diagnosis. This group will include children who may experience a one-time problem, such as depression after a major loss, as well as those who have complex and on-going mental health problems that are serious enough to interfere with their functioning at home or school.

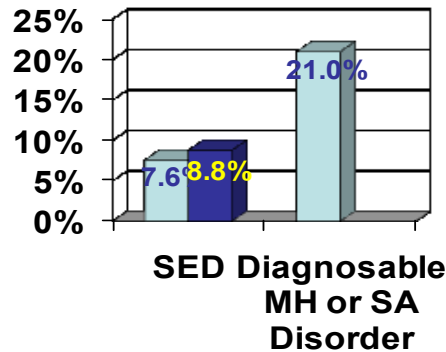
The major epidemiological studies of children have found rates of mental disorders of 20% among a rural sample of 9 to 13 year olds² and of 18.9% in a sample of 9 to 17 year olds.³ We will use a rate of 19% as a benchmark for children with a mental disorder associated with at least a minimum effect on their ability to function. However, it is important to remember that this rate may be somewhat high for children ages 0 to 17, since younger children have a lower prevalence. If that rate is applied to estimates of Montana's population in 2006, this amounts to somewhat less than 30,000 children. In our survey of stakeholders, survey respondents rated children with less serious mental health needs, those with mental health problems not meeting SED criteria, as among those with the most unmet service needs.

² Costello, A.J., Angold, A., Burns, B.J., Stangl, D.K., Tweed, D.L., Erkanli, A., Worthman, C.M. The Great Smoky Mountains Study of Youth. Goals, design, methods, and the prevalence of DSM-III-R disorders. *Archives of General Psychiatry*. Vol. 53 No12, December 1996. Access 10/6/2008 <http://archpsyc.ama-assn.org/>

³ Shaffer, D., Fisher, P., Dulcan, M.K., Davies, M., Piacentini, J., Schwab-Stone, M.E., Lahey, B.B., Bourdon, K., Jensen, P.S., Bird, H.R., Canino, G., & Regier, D.A. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA Study. *Methods for the Epidemiology of Child and Adolescent Mental Disorders Study*. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 865-877.

The most common standard used to identify children with more serious forms of mental illness is serious emotional disturbance (SED). To meet criteria for SED, children must not only have a mental health diagnosis, but the problem must substantially impair their functioning at home, at school, or in the community, and must have persisted, or be likely to persist for 6 months or more. Montana has established a legal definition for SED (see below) which is used as an eligibility criterion for getting certain more intensive mental health services.

**Figure III-1
Estimated 2006 Prevalence of
Children's Mental Health Needs
by Family Income**



Legend: ■ Total* Population ■ Under 200% Poverty**

* Population includes children in households, institutions and group settings

** Population includes only children in households

Source: Estimates by Holzer based on CPES and Census Estimates

The most reliable prevalence studies of children found that in any given year, 5% to 9% of children aged 9 to 17 have an SED.⁴ Dr Charles Holzer has developed estimates of SED prevalence based on these national epidemiological surveys and studies, and taking into account the family income demographics of each Montana county. He estimates that in 2006 7.6% of Montana children (16,500 individuals) had SED. Of that number, 8,900 children were from households with incomes under 200% of poverty. Poverty is a factor that tends to increase risk for mental health disorders. Therefore, we find that the prevalence rate for children with household incomes under 200% of poverty is somewhat higher than for children as a whole, 8.8% (see figure III-1). Throughout our analysis, we will use the SED prevalence rates for children under 200% of poverty as our standard because it provides an indicator that is closest to the population that the state has targeted for provision of public mental health services. Unfortunately, the prevalence estimates are not available for income levels lower than 200% of poverty.

Montana's SED Definition

Under administrative rule, a child aged 6 to 17 meets the SED criteria if the child:

- 1) has a moderate to severe presentation of any one of 20 mood, psychotic, or personality disorders; and
- 2) as a result of the diagnosis, has consistently and persistently demonstrated a significant degree of behavioral abnormality in any two of the following areas:
 - ▶ Failure to establish or maintain relationships with adult caregivers or authority figures;
 - ▶ Failure to demonstrate or maintain appropriate peer relationships;
 - ▶ Failure to demonstrate appropriate range and expression of emotion or mood;
 - ▶ Disruptive behavior that leads to isolation in or from school, home, therapeutic, or recreational settings;
 - ▶ Behavior harmful to the child's growth, safety, or welfare or the welfare or safety of others;
 - ▶ Behavior that results in substantial documented disruption to the family.

A child under the age of 6 meets the SED criteria if the child exhibits one of six behavioral abnormalities that cannot be attributed to intellectual, sensory, or health factors and that results in a substantial impairment in functioning for at least six months and is likely to continue for at least six months.

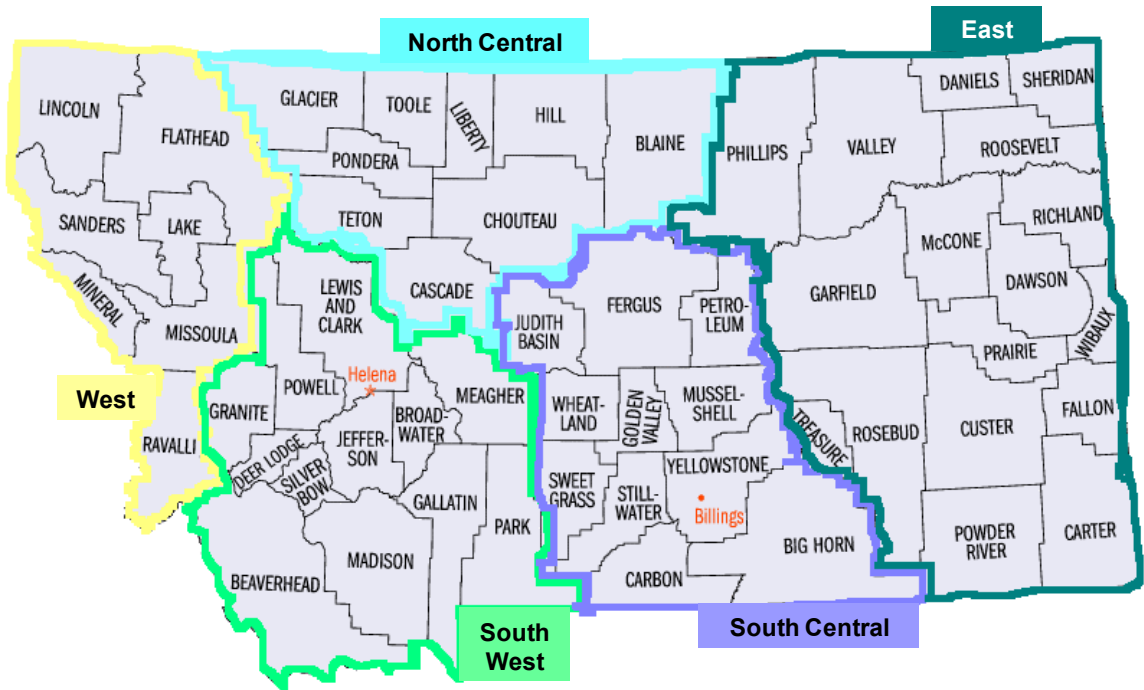
⁴ Ibid.

As we compare the number of children Montana reaches through its mental health programs to these numbers and percentages, it will be important to remember that – because its income standards for publicly funded healthcare do not reach 200% of poverty, Montana should not be expected to match that standard.

b) Estimates of SED prevalence under 200% of poverty by region and county

We collected prevalence, utilization and expenditure data by county across Montana. The county data, because of the small population in many Montana counties, showed wide disparities. In addition, statistical estimates for small populations are not as accurate as those for larger populations. As a result, it was important to group the counties into regions for our analysis. After consultation with Legislative Services Division staff, DMA used five regional breakdowns to analyze the variation within the state. These regions correspond to those used by the Children’s Mental Health Bureau.

**Figure III-2
Children’s Mental Health Service Bureau Regions**



Prevalence rates for SED in children from households under 200% or poverty vary relatively little between regions. Table III-1 shows that rates of SED for poor children vary by from 8.7% to 8.9% between the highest and lowest prevalence regions. County rates show significantly greater variation. Table III-2 presents differences in prevalence of SED by county for children. Rates for children range from a low of 8.2% in Treasure County to a high of 9.4% in Petroleum County. That is, there was a 15% difference between the highest and lowest prevalence counties for children.

Table III-1
Estimated 2006 Prevalence of Children with Serious Mental Health Problems in Households under 200% of Poverty In Montana by Region

Region	SED
Eastern	8.9%
North Central	8.8%
South Central	8.8%
South West	8.7%
Western	8.8%
State	8.8%

Source: Estimates by Holzer based on CPES and Census Estimates

Table III-2
Counties with the Highest and Lowest Estimated Prevalence of Children with Serious Mental Health Problems in Households Under 200% of Poverty

Lowest prevalence rates		Highest prevalence rates	
Treasure	8.2%	Musselshell	9.2%
Broadwater	8.5%	Roosevelt	9.3%
Jefferson	8.5%	Prairie	9.3%
Stillwater	8.6%	Meagher	9.3%
McCone	8.6%	Petroleum	9.4%

Source: Estimates by Holzer based on CPES and Census Estimates

c) Children in Need of Public Mental Health Services

Another dimension of relevance to Montana is how many children in need of mental health services must rely on public programs to get them. In Montana, poor children up to 175% of poverty have access to mental health services through either Medicaid or CHIP. Montana children have eligibility for Medicaid at the federal statutory minimum, which is 133% of poverty for children under 6 and 100% of poverty for children ages 6 and older. In addition, children in the custody of the state are enrolled into Medicaid, and children who are found to be disabled can be enrolled into Medicaid. Table III-3 shows income levels for a family of four as an indication of where these income limits fall at the current time, as well as where 200% of poverty is.

Table III-3
2008 Federal Poverty Guidelines Relevant to Children’s Programs

% of 2008 Federal Poverty Guidelines	Family of 4
100%	\$21,200
133%	\$28,300
175%	\$37,100
200%	\$42,400

Source: <http://aspe.hhs.gov/poverty/08Poverty.shtml> and <http://aspe.hhs.gov/poverty/faq.shtml#chart>

Under Medicaid, basic mental health outpatient services, such as a mental health assessment, outpatient therapy and psychotropic medications, are available to any Medicaid eligible child with a diagnosable mental health problem. Children who meet criteria for serious emotional disturbance (SED) have access to a set of more intensive services under Medicaid.

Montana’s Children’s Health Insurance Program (CHIP) offers insurance coverage for children up to 175% of poverty and covers basic outpatient mental health services for any diagnosable mental health problem. There is also an extended CHIP benefit for children with SED. Children with SED and incomes up to 160% of poverty who are not eligible for Medicaid or CHIP can access some intensive mental health services through the Children’s Mental Health Services Plan to the extent that funds are available. Details of benefits provided are described in the following section.

In FY2007, almost 55,000 children were enrolled in Medicaid for some part of the year, over 19,000 were enrolled in CHIP, and 59 received services through the Children’s Mental Health Services Plan. Together, the enrollment in these programs is similar to the Current Population

Survey estimates of children below 175% of poverty in 2006, suggesting that most children eligible for these programs are enrolled in them.

Children who exceed the income standards for Medicaid and CHIP must rely on private insurance for mental health coverage. In Montana, according to 2004/2005 Current Population Survey data and prior to raising the income limits for CHIP, 17% of children across all income groups were uninsured. Since the rate of uninsurance falls with income, it is likely that fewer than 17% of children above 175% of poverty are uninsured. For those who are insured, private insurance policies generally cover some degree of mental health services, but there may be limits on the amount of services covered and the providers included in the plan's network. Private insurance benefits are often not sufficient to cover the full expenses or the specialized services that a child with SED might need.

2. What children's services does Montana have in place?

To answer this question in the context of Montana's public mental health system, we considered the services provided in its three children's mental health programs: Medicaid, the Children's Health Insurance Program (CHIP) and the Children's Mental Health Services Plan (CMHSP) for uninsured children whose families have incomes up to 160% of poverty. Medicaid and CHIP cover basic mental health services for children who have a diagnosable mental health condition, and an extensive set of services that constitute a comprehensive continuum of care for children with SED. A Medicaid demonstration allows even broader services for up to 100 children annually who are at risk of admission to residential placements. CMHSP provides more limited benefits for children under 160% of poverty who have SED and are not enrolled in Medicaid or CHIP. A comprehensive school and community based services program administered by the Office of Public Instruction is a Medicaid benefit and has grown significantly in recent years. The Youth Services Division of the Department of Corrections also provides some community based and residential services for youth under its supervision.

An effective mental health system includes a comprehensive continuum of services and supports that offer individuals care as close to home as possible. Table III-4 below lists the services covered by Montana's public mental health programs. As the table shows, Montana Medicaid covers a generally comprehensive set of mental health services.

	Medicaid - Child	SCHIP		Children's Mental Health Services Plan (SED only)
		Basic	Extended	
Outpatient Services				
Basic outpatient services	24 visits	20* visits		24 visits
Intensive Outpatient			Visits 21-50	
Evaluation & Mgmt. (physicians, PA, and Nurse Practitioners)	Y	Y		
Psychiatry/Medication				
Medication Management	Y			
Psychotropic Drugs	Y	Y		

Table III-4, cont.				
Montana Covered Mental Health Services by Plan Type				
	Medicaid - Child	SCHIP		Children's Mental Health Services Plan (SED only)
		Basic	Extended	
Crisis Intervention				
Hospital or MHC Crisis Management	Y			
23 HR Observ. - Hosp.	Y			
Intensive Community Services and Supports				
Targeted Case Management	Y			
Comprehensive school & community treatment	Y			
Com-based psych rehab. & support (CBPRS) Psych. Aide	Y		120 hrs	
Behavior Mgmt Skills Dev Scvs	Y			
Day Treatment Services	Y		120 hrs	
Partial Hospitalization	28 Acute or sub-acute days	42* days		
Respite Care Services (State only funds)	12 hrs/mo		144 hrs	12 hrs/mo
Community Residential				
Group Home	3 levels of Therapeutic	Therapeutic*		
Therapeutic Foster Care	Y	Y	+ 30 days	
Inpatient and Residential				
Psychiatric Residential Treat. Fac.	Y	Y		
Acute Inpatient	Y	21* days		
*No limits apply to children with schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder and autism. Sources: Medicaid Mental Health Manual, CHIP Benefit Plan, Presumptive Eligibility Rate Sheet, Billings Indian Health Service Website				

a) Services important for all children with mental health problems

Outpatient mental health services, medication management, and psychotropic medications are available to any child with a diagnosable mental health problem in Medicaid and CHIP. These children may also receive evaluation and management services for mental health problems from a primary care or other health practitioner. These services are often sufficient to treat children with less serious mental health problems, but are also important as a basic service for many children with SED. The remaining Medicaid and CHIP services, including intensive outpatient, are authorized for children with SED.

b) Services important for children with SED

- ▶ Only Medicaid covers targeted case management, a service that assists people with complex service needs to coordinate and manage them. As such, it is of particular importance for children with SED. CMHB reports that there has been considerable growth in the use of this service. As a result, starting in January 2008, limitations were put on the amount of this service available to each child without prior authorization. After study, they were somewhat relaxed, but a higher limit for prior authorization remains in place. Center for Medicare and Medicaid Services (CMS) regulations modified by the DRA have tightened the definition of allowable case management activities and specifically prohibit the direct delivery of an underlying medical, educational, social, or foster care service. This may require the state to review the practice of this service to ensure it complies with the regulations.

- ▶ School and community based mental health services is a behavior management service provided in schools to children with Serious Emotional Disturbance. It is helpful in assisting schools and families to work with children's behaviors in consistent and proven ways. The Office of Public Instruction has been instrumental in encouraging the expansion of this service, which has been well accepted in the schools where it is provided.
- ▶ Other community based services for children with SED covered by Medicaid, CHIP or extended CHIP include: community-based psychiatric rehabilitation and support (CBPRS) which provides the services of a trained psychiatric aide to assist a child and family to address the functional problems caused by a mental health condition in order to assist the child to participate in school and community activities; Behavior Management Skills Development services focus specifically on behavior management techniques. Day treatment services provide a group treatment milieu afterschool. Partial hospitalization provides hospital level of care for relatively short periods of time for children who are able to be at home for the rest of the day and overnight. It can be used as a transition from residential care. Respite Care Services are available only to Medicaid eligibles, but are paid for by state funds. These services provide care for a child with SED so that caregivers can take a break or care for their other children.
- ▶ Crisis intervention services are available in both Medicaid and CHIP. They can be provided by a hospital emergency room or a mental health clinic. They assist families to manage a child's psychiatric crisis. When a child requires more intensive services to address the problems, crisis intervention services can keep the child safe while a respite or residential placement is located. Many of Medicaid's covered services, like outpatient mental health, medication management, etc. can be provided as crisis interventions. Only one service, 23 hour observation, is provided strictly as a crisis service.

c) Out- of-home children services

- ▶ Group homes and foster care provide home settings that are usually based in the community (though some group homes are out of state). They may be needed to provide a level of care that parents cannot provide, or they may be needed when a child with mental health needs does not have a safe home. Medicaid pays for only the clinical portion of such programs. Other state and federal funds cover room and board if the child is in state custody. Parents may bear the cost of room and board if they retain custody and their child needs this level of care.
- ▶ Psychiatric residential treatment facilities (PRTFs) are a more intensive level of care and active clinical treatment near to that provided by inpatient facilities. Medicaid pays the full cost of both PRTFs and inpatient care. A very small proportion of children need this level of care.

d) Psychiatric Residential Treatment Facility (PRTF) Demonstration - Child

CMHB has secured a federal grant from CMS that will allow it to use Medicaid resources flexibly for up to 100 Medicaid children and youth annually who are in or at risk of PRTF level of care and have family incomes up to 150% of poverty. Targeted on the five communities with the highest admission rates, this five year grant and state match provides administrative support to implement and evaluate the project. It will focus on using a system-of-care planning process to develop a plan of community based services that will support a child to return from a PRTF or prevent a PRTF admission. In addition to the administrative support, the state is able to use Medicaid for services that would not otherwise be allowed. These include the provision of respite services (currently available only through state funds); non-medical transportation; a special blood test that provides information about the efficacy of psychotropic medications; and

flexible funding that can be spent for other non-medical needs that are critical to help a child and family cope with the demands of a serious mental health problem. At the end of the five year grant, the state hopes to submit a 1915i waiver application that would allow it to operate such a program on an ongoing basis.

We identified only four mental health services that are not currently covered under children's regular Medicaid benefits. They are respite services, homemaker services, personal care services, and peer support services. Respite services are available to Medicaid beneficiaries, but are fully funded by the state and are not a true Medicaid service. Homemaker and personal care services are most relevant for Medicaid enrollees with physical limitations and disabilities, but are generally not significant for the majority of children with serious mental health problems. Peer services such as support services delivered by peers who are parents of children with SED can assist individuals to recover, manage their illnesses, develop community support systems and build a satisfying and stable life in the community.

e) Children's Mental Health Services Plan.

CMHSP currently covers only outpatient services and respite. Until recently, it also covered day treatment and community based rehabilitation and support. These services were removed to manage within a reduced appropriation.

f) Child and Family Services Division.

CFSD provides assessments and outpatient therapy from providers with specialized qualifications who are not willing or able to participate in the Medicaid program when the complexity or urgency of a child's condition requires this level of expertise.

g) Youth Division, Department of Corrections.

The Youth Division provides mental health residential services for youth in their custody who need that level of care when Medicaid cannot be accessed. The Division also provides certain community based services. However, these services are not a benefit plan, so are not included in the table.

3. Where are children's services being delivered? And by whom? Is additional outreach needed?

Where are children services being delivered, and by whom?

In Medicaid, a high proportion of children are receiving services outside of CMHB's well developed continuum of services provided by mental health specialists. These are services provided by primary care practitioners and advanced practice registered nurses (APRNs) and services in the schools. With only 17 child psychiatrists in the state, and none located in the North Central or Eastern regions, the significance of general health providers in providing mental health services is clear.

Many children are receiving services through Medicaid in schools, but this service is unevenly distributed across the state. Twenty one counties have no such services, with the South Central region having the lowest penetration rate. Intensive community services and supports, which have the potential to successfully maintain children with SED in their homes and communities, are not evenly available across the state. North Central has the lowest penetration and South West has almost twice the penetration of the other regions.

Is additional outreach needed?

In general, Montana seems to be doing a good job of providing access to services for eligible children. Statewide, Montana delivers mental health services to children largely through its Department of Public Health and Human Services (DPHHS), and through a DPHHS collaboration with the Office of Public Instruction. In FY2007, the DPHHS Children's Mental Health Bureau administered Medicaid mental health services for 8,760 children and Children's Mental Health Services Plan services for 59 children. Data on the number of children receiving services through the CHIP program were not available; 19,000 were enrolled. The Child and Family Services Division provided mental health services for 1,152 children in its custody who had the most complex needs. School mental health services, administered by the Office of Public Instruction and billed through DPHHS, served 1,802 children. A total of 5,676 children enrolled in Medicaid and six enrolled in CMHSP received psychotropic medications, most of them in combination with other mental health services. The Department of Corrections provided residential mental health treatment for 26 youth, half of whom are counted by Medicaid since it paid for all or part of the cost. DOC provided community services to an undetermined number.

Our analysis of Medicaid penetration showed that Montana Medicaid is coming close to reaching the number of enrollees estimated to need basic mental health services. Addition of accurate IHS services data is also important to provide a more complete picture of unmet needs in Medicaid. It is also important for the state to better understand how well CHIP is serving Montana children with mental health needs and with SED enrolled in that program.

Based on consultation with DPHHS, DMA used a conservative method to estimate the number of children with SED served through DPHHS programs. This method, based on the number of children receiving targeted case management services, results in a minimum estimate of at least 3,285 SED children receiving DPHHS services, or 6% of those enrolled. While this estimate understates the number of SED children getting services, it does suggest that additional outreach may be needed for this group. Utilization data for specific services of importance to this group at a state and regional level also suggest gaps in access and availability.

This section will address the utilization of services by children at a state level, describing the state divisions involved in delivering public mental health services and evaluating how well they are meeting the need on an overall basis. Then it will address the question in more detail, analyzing use of different service modalities and the relative access in different regions of the state. (Please note the data limitations that are outlined in Section II, page 4)

a) Department of Public Health and Human Services Children's Mental Health Programs

Montana's Department of Public Health and Human Services (DPHHS) is largely responsible for the delivery of public mental health services. In response to a data request, DPHHS compiled a data matrix for this project that summarized all the mental health services provided by the agency and eliminated any duplication of clients served by more than one division. Because data for the CHIP program is administered by a subcontractor, children receiving only CHIP services were not included, and due to incomplete data, people receiving mental health services only through Indian Health Services (IHS) facilities were not included.

DPHHS served an unduplicated total of 11,591 children through four major program areas depicted in Figure III-3, Medicaid, the Children's Mental Health Services Plan and the Child and

Family services Division (CFSD). This figure excludes the CHIP program, a significant fifth source of children's mental health services, for which FY 2007 service data was not available.

- ▶ Children's Mental Health Bureau (CMHB) administers the children's Medicaid mental health benefit, which served 8,760 children or 78% of the unduplicated DPHHS total in 2007.

- ▶ CMHB also administers the Children's Mental Health Services Program.

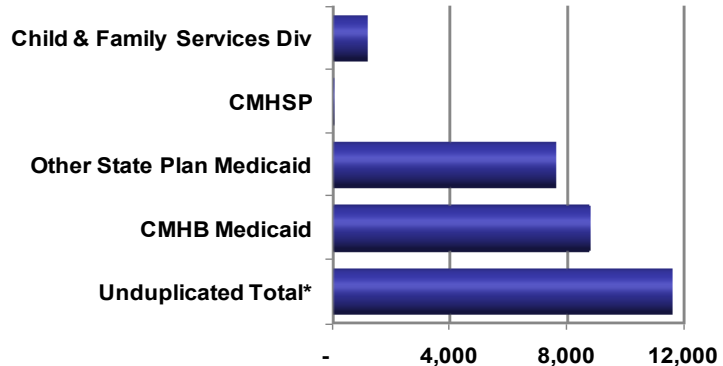
CMHS served 59 children enrolled in the program in FY2007.

- ▶ Seven thousand children, two-thirds of the DPHHS total, are served through several components of Montana's Medicaid program for children that are administered by the Health Resources Division (HRD) or the Office of Public Instruction (OPI). These include the pharmacy benefit and the school mental health services program. OPI has an important role in the administration and expansion of school mental health services, for which local school systems contribute the state match portion. The claims are paid through HRD's Medicaid claims payment system as a part of Other Medicaid. From here on, we refer to this as Other Medicaid, or Other State Plan Medicaid.

- ▶ The Child and Family Services Division (CFSD), Montana's child welfare agency, purchases specialized assessment and outpatient treatment for children who have complex mental health problems and who are not able to receive this service through a Medicaid provider. Over a thousand children, or about 10% of the DPHHS unduplicated total, receive mental health services purchased by CFSD. Foster children get the remainder of their mental health services through Medicaid.

- ▶ Many children - close to 40% - receive services through more than one of these four programs. This is a positive sign that outreach is occurring by each of the programs. Children in CFSD custody are Medicaid eligible and get most of their services through CMHB Medicaid. Children getting mental health services and psychotropic medication will be counted in both CMHB and Other Medicaid. Children eligible for services in schools because of serious emotional disturbance may be in CFSD custody and may be getting CMHB services. In addition, children in the community may lose or gain Medicaid eligibility during the year. If it were possible to include data on children receiving CHIP services, we would undoubtedly find that children move between Medicaid and CHIP, and perhaps between CHIP and other programs.

**Figure III-3
Children Receiving DPHHS MH Services
and/or Medications in FY07**



* Excludes CHIP recipients and recipients receiving mental health services only from IHS facilities

Sources: DPHHS Special Report Montana Mental Health Study

b) Meeting Children's Mental Health Needs - Statewide

To evaluate how well Montana is meeting the needs of its children with mental health problems, we compared the number of children served to the estimate of need. We used two approaches to understanding need; the estimated 2006 8.8% statewide prevalence for children

with SED in households under 200% of poverty and 19% as the estimated prevalence for children with a mental health problem during the year. It is important to remember that both benchmarks include children that are not eligible and could not be served by Montana's public mental health programs under their current eligibility rules. Both benchmarks are rough standards, since they exclude children under 9. While these benchmarks aren't an exact match for Montana's programs, they are a helpful marker in evaluating Montana's success in reaching children who need mental health services at different levels. They are the best available and the most widely accepted estimates of needs.

Penetration in Medicaid. The proportion of children in the population who have received at least one health service during a specified period of time is called penetration, and is a general indicator of access to healthcare. The most robust measure of penetration we can calculate from available data is for Medicaid. We have compared the number of Medicaid enrollees who access mental health services to those who were enrolled in Medicaid at some point during the year. Our data shows that 11,341 unduplicated children were served through HRD Medicaid and CMHSP. Penetration for Medicaid enrolled children was 21%, exceeding the 19% benchmark, the prevalence rate expected for children over 9 with a mental health or substance abuse problem during the year. This calculation suggests that Montana has done very well in reaching children enrolled in Medicaid with some kind of mental health treatment. We remind the reader that our data exclude recipients receiving mental health services from Indian Health Service (IHS) or tribal facilities. These data were excluded because DPHHS staff decided that they were incomplete.

Montana's Medicaid penetration rate compared favorably to that of Alaska, whose penetration rate for children's mental health services (not psychotropic medications) was only 8%. Other comparison states did not submit data in a form that allowed for calculation of Medicaid penetration.

Service Access for Children with SED.

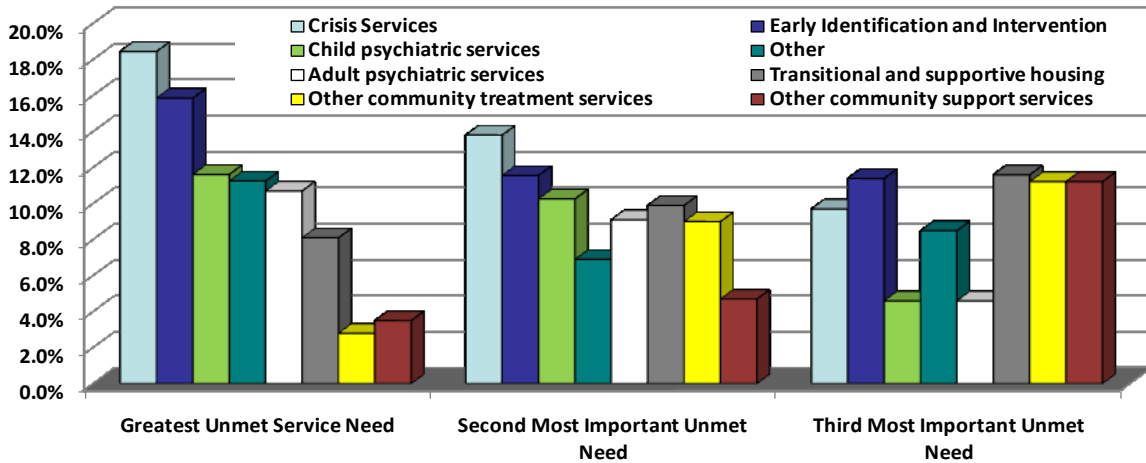
We would have liked to make an estimate of the children receiving services primarily directed towards those with SED. However, to do so, we would have needed to identify those children who used the CMHB Medicaid services that are restricted to children with SED, and remove any duplications. The data that we requested and received did not allow us to perform this type of calculation. Instead, we looked at the SED service with the largest number of users, targeted case management. A total of 3,285 children, or 6.0% of children enrolled in Medicaid, received targeted case management. This is less than the 8.8% of children estimated to have SED. However, since there are likely additional children receiving other SED services, but not using targeted case management, we know that the true penetration rate for SED services would be higher than 6%; the exact amount cannot be determined from our data set. DPHHS's claims system is capable of developing reports that calculate the unduplicated number of children receiving SED-only services. We urge the department to periodically calculate this measure in order to allow it to evaluate the level of access for this group of children.

CHIP is administered by a subcontractor whose reporting differs from Montana's Medicaid system, and we were unable to receive data on the number of children receiving mental health services. However, it is important for the state to get the utilization data for CHIP needed to assess how well the mental health needs of the 19,000 children enrolled in this program are being met.

c) Statewide Availability of Specific Service Modalities

DMA used a variety of methods to measure the availability of services in Montana. In addition to DPHHS’ detailed report, DMA disseminated a comprehensive survey to Montanans interested in commenting on the availability of services and unmet service needs of persons with mental health conditions. Out of 706 respondents, more than 500 respondents to the survey rated the three most needed types of services in the state (see Figure III-4). The most frequently identified services needed were crisis intervention, early identification and treatment, psychiatry for both children and adults, and housing.

**Figure III-4
Survey Responses: What is the greatest service need in Montana?**



N = 542 for the Greatest, 536 for the Second and 517 for the Third Most Important Unmet Need

In addition, we analyzed the number of children receiving key services as an indication of the relative frequency of service use. We have not attempted to show every service type that Montana delivers because the detail would be overwhelming and hard to interpret. However, by excluding some services, the reader may get the impression that fewer people are being reached for services. To evaluate overall access, please consider our analysis in the prior section which did include all the children who are reached by the DPHHS programs.

Figure III-5 (next page) shows the number of children getting certain specific Medicaid services, those receiving CMHSP services, and those served in CFSD.

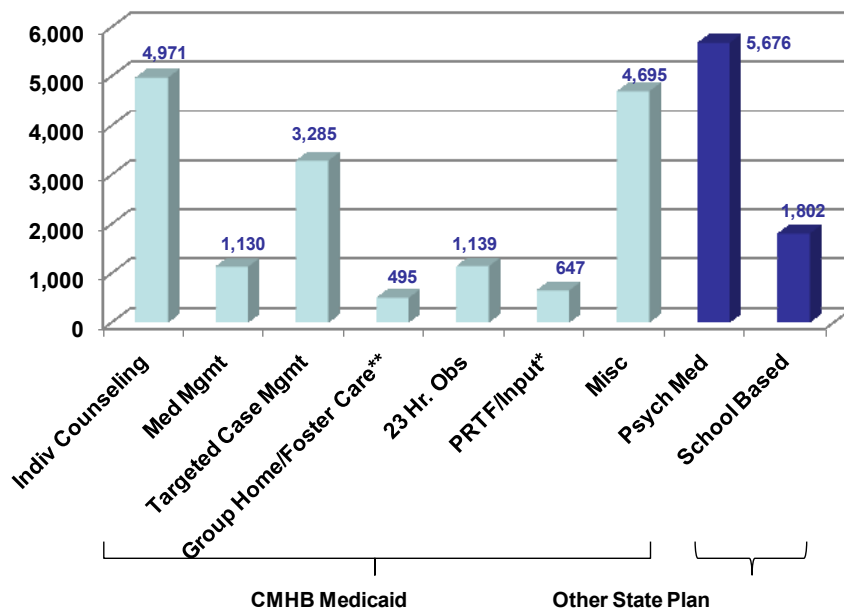
Medicaid services important for all children with mental health problems

- ▶ Outpatient counseling is available for both children with SED and those with much less severe conditions. The modality of individual counseling is most frequently used, accessed by almost 5,000 children, 9% of Medicaid enrollees.
- ▶ Almost as many children as those receiving outpatient counseling, 4,695 or 8.6%, receive miscellaneous services. Miscellaneous services are all those services provided for a mental health diagnosis that are not included in CMHB’s menu of specialized mental health services. As such, they can cover a broad spectrum from very limited services, such as a lab test for medication levels, to ongoing medication management from a primary care physician. The state may wish to better understand who is being served in this

category, and what kinds of services they are getting to better evaluate the significance of the services included in this broad category.

- ▶ Psychotropic medications were prescribed for 5676 Medicaid children, 10% of enrollees, most often in combination with mental health services of other kinds.
- ▶ Only 1,166 Medicaid enrolled children get medication management provided by psychiatric specialists. These are the 1,130 who receive it under CMHB Medicaid, and 36 who receive it under Other State Plan Medicaid (not shown on the chart). These children represent only about 20% of the 5,676 children who used psychotropic medications.
- ▶ The discrepancy between use of psychotropic medications and medication management services suggests that primary care physicians and mid-level practitioners (e.g., APRNs) are prescribing and managing these medications. This likelihood points to the significance of primary care providers as an important part of the mental health service delivery network.

**Figure III-5
SFY 2007 Unduplicated Medicaid Enrolled
Children Receiving Selected Service Types**



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

* Excludes people receiving services in IHS facilities

** May double count children receiving both types of service in the year

Source: DPHHS Special Report

Medicaid services important for children with SED

- ▶ Targeted case management is a service that assists people with complex service needs to coordinate and manage them. As such, it is of particular importance for children with SED. This service is provided to 3,285 children enrolled in Medicaid. CMHB reports that there has been considerable growth in the use of this service. As a result, starting in January 2008, limitations were put on the amount of the service available to each child without prior authorization. After study, the limitations were somewhat relaxed, but a higher limit for prior authorization remains in place. CMS regulations modified by the Deficit

Reduction Act (DRA) have tightened the definition of allowable case management activities and specifically prohibit the direct delivery of an underlying medical, educational, social, or foster care service. This may require the state to review the practice of this service to ensure it complies with these regulations.

- ▶ School based mental health services, behavior management provided in schools to children with Serious Emotional Disturbance, is another fast growing service as it becomes available in more schools. The Office of Public Instruction has been instrumental in encouraging the expansion of this service, which has been well accepted in the schools where it is provided. In FY 2007 it reached approximately 1,802 children and youth.
- ▶ CMHB's menu of other community services targeted towards supporting children with and their families in living a full life in the community are used at much lower rates than targeted case management. Community based rehabilitation and support is used by 1,346, close to the number receiving school based services. Less than 1,000 children use the other intensive community based services.
- ▶ Crisis intervention services are represented only by 23 Hour Observation, a hospital service, which was used by 1,139 Medicaid children. The rate of use for this service exceeds that of Inpatient and PRTFs and is fairly close to the number of children served in group and foster care. This service may perform an important function in preventing longer residential stays. Unfortunately, this is only one crisis modality. We are unable to see crisis services provided on an outpatient basis or through other program types because services provided on a crisis basis are not distinguished from routine service provision.

Medicaid out of home services for children

- ▶ Services like therapeutic foster care, group homes, and psychiatric residential facilities or inpatient care are needed and used by far fewer children. Foster care is the most used residential modality, for 793 children, while 495 are in group homes at some point during the year. PRTF care is used by 635 and only 12 were served in an inpatient hospital.

Cross State Comparisons. One way to compare Montana's relative use of services of different intensities to other states is to compare the utilization rates per thousand population for different levels of care. The table below shows these rates for inpatient and residential services as compared to non-residential community based services. State mental health systems differ in how they organize their services, what services they cover, and who is eligible for services. While all of these issues make such comparisons inexact, the comparisons can be helpful in identifying whether one is an outlier in comparison to other states.

We were able to get comparison data from four other states:

- ▶ Alaska contributed data on its Medicaid mental health services.
- ▶ Arizona contributed data from its managed mental health programs, excluding Maricopa County, the county including Phoenix, its largest city.
- ▶ New Mexico contributed data from its Mental Health purchasing collaborative.
- ▶ From public mental health data reported by Minnesota, we selected only those counties who were frontier or had a population density that did not exceed Montana's most densely populated county.

Table III-5 shows that Montana ranks toward the top in terms of overall mental health utilization rates per thousand, with rates close to Minnesota and New Mexico and exceeding Alaska's rates for Medicaid services substantially.

	MT Medicaid and CMHSP*	AK Medicaid	AZ (excl. Maricopa Cty)	NM*	MN R/F Counties*+
Children's Penetration					
Inpatient and Residential	3.0			5.9	9.8
Group Home and Foster Care	5.9			3.4	
Residential Subtotal	8.9	9.7	2.2	9.3	9.8
Community Only	39.3	30.3	44.3	43.7	43.0^
Total	48.2	40.0	46.4	52.9	52.8
Source: DPHHS Special Report, 2000 Census and submissions from other states – see Appendix E					
*May include some duplications of children served at both inpatient and residential in the same year.					
** May show duplication of children served in more than one county in the same year.					
^May overstate community only utilization rate because group home and foster care use not separately reported.					

Montana's use of inpatient and residential services is much lower than that of New Mexico, and Minnesota. Montana and New Mexico are almost opposite in their relative use of the more restrictive forms of residential care and group home and foster care, which are more likely to be community based. This is a favorable indication that Montana is able to serve children closer to home. In comparing residential use overall, Montana has similar, but slightly lower rates as 3 of the other 4 states. However, Arizona's lower rates for residential and inpatient care may demonstrate that additional reductions in use of this level of care can be achieved.

d) Regional Service Availability

One of the important barriers identified by survey respondents was an insufficient number of providers or services. This section describes the availability of programs and providers, and explains what our analysis of DPHHS and other service data suggests about the availability of services across the major regions of the state.

Service Location and Capacity. As of May 2008, only 17 Montana licensed physicians were board certified as Child and Adolescent Psychiatrists. They were located in only 5 cities, and none were located in the North Central or Eastern regions. The number is low to meet the need, and the limited locations create a transportation burden or barrier for those living at a distance from them.

Other mental health professionals are also less available in the Eastern and to some degree, the Northern parts of the state. (See our analysis in the adult section.) There is no indicator in the data we received that would allow us to distinguish those specializing in adults or children.

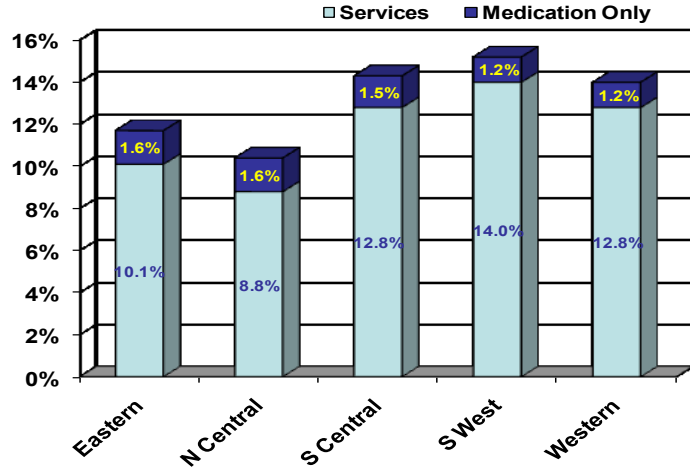
City of Residence	# of MDs
Billings	6
Bozeman	4
Helena/Clancy	4
Kalispell/Marion	2
Missoula	1
Grand Total	17

We also looked at the distribution of specialized programs across regions. There are no children's inpatient psychiatric units in the state of Montana, though children are sometimes admitted to pediatric units with a primary mental health diagnosis.

Children's Utilization By Region.

Figure III-6 provides an overall picture of access to services for children across the regions, showing the unduplicated number of DPHHS mental health service recipients by region. There was a 59% difference between regions on mental health service utilization rates for children, and almost a 10-fold difference between the counties with the highest and lowest penetration. The North Central Region had the lowest penetration rate, followed by the Eastern. The remaining three regions were higher, and both Western regions had somewhat lower proportions of children receiving only psychotropic medications. These differentials did not correspond to differences in need as measured by estimates of the rate of SED among children in households under 200% of poverty. In fact, the South West had the lowest SED prevalence, but the highest service penetration.

**Figure III-6
FY2007 DPHHS Child MH Service & Medication Users* as a Percent of Population Under 200% of Poverty**



* Excludes recipients receiving CHIP services and those receiving mental health services only from IHS facilities

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

Table III-7 shows weighted averages for each region of major service categories for children. In our calculations, we weighted each county by its number of service users, so that small counties were not rated equally with larger counties. Because the numbers involved are so small, we have transitioned to using a calculation of users per thousand population. (This essentially is equivalent to multiplying a percentage by 10.) We have provided the same calculations for

	Misc	Medication	Outpatient Services [^] *	Medication Mgmt. [^]	School	Crisis	Intensive Community Services. & Supports [^] *	Community Residential [*]	PRTF/ Inpatient [*]
Eastern	33	51	24	7	21	13	10	7	4
North Central	33	52	23	4	17	6	7	4	3
South Central	73	71	33	16	6	25	12	8	4
South West	56	68	39	10	25	22	21	12	4
Western	32	56	34	17	25	12	11	6	3
Percent difference highest to lowest	227%	138%	170%	402%	404%	400%	300%	297%	137%

+ May include duplications of children receiving services in the same category in more than one county during the year.
[^]May include duplications of children served in both Medicaid and CMHSP during the year.
^{*} Average of more than one service modality. Excludes multiple family therapy, a little used modality.
 Source: DPHHS Special Report and Census Estimates

each county in Appendix B. We also calculated the difference between the highest and lowest utilization regions. By this measure, there is considerable variation in the utilization of most service types. Medication and Inpatient/PRTF services are the most evenly distributed, with all other service categories varying two-fold or more between the highest and lowest region. Medication management, school and crisis services were the most variable, with a four-fold difference between the lowest and highest rates.

- ▶ North Central had the lowest utilization for medication management and crisis services and fell at the bottom or was lowest for all other services except school services, where it was not dramatically different from higher counties. This suggests that school services may substitute to some degree for other community based services in North Central.
- ▶ South Central showed more reliance on outpatient than on school services. It had the lowest utilization in school services, falling considerably below all other regions, but had the highest rate for miscellaneous services and medication, and was close to the highest in outpatient services and psychiatry.
- ▶ The Western region was relatively high on outpatient services, psychiatry and school services, but was relatively low on the more intensive levels of care, both community and residential.
- ▶ The South West region stood out in having intensive community supports that are considerably better developed than any of the other regions. Further developing this level of care in the rest of the state represents an opportunity to develop more services and possibly prevent disruptive out-of-home placements.

Our data do not allow us to easily distinguish inpatient services from services in Psychiatric Residential Treatment Facilities (PRTF), so we have combined these two most intensive and restrictive types of psychiatric treatment. During 2007, 2,264 youth were placed in out of home services at some point during the year.

Service type	Total Out of State	Total Instate	Percent Out of State
Inpatient/PRTF	142	801	18%
Therapeutic Foster Care	0	804	100%
Group Homes	60	457	12%
Total	202	2,062	10%
<i>Source: DPHHS Special Report and HRD Medicaid SED Youths Receiving Out of State Placements Services (2/29/08)</i>			

It is important to note that children’s lengths of stay in this level of care is highly varied, ranging from a matter of weeks to considerably longer.

Approximately 10% of children in 24 hour placements were placed out of state. Almost a fifth (18%) of children in the PRTF level of care were sent out of state in FY 2007. A lesser, but still significant 12 % of children placed in group homes were out of state in the same year. Using out of state facilities can allow Montana to better meet a child’s need for a specialized service. However, sending a child far from family, friends and community makes it more difficult to engage those adults in supporting and participating in the child’s treatment, and to plan for discharge and arrange for community based services. Distances are so great within Montana that some of these difficulties can also apply regarding in-state placements, and if out-of- state placements are closer to the child’s home than within-state placements, they may be preferable to the latter. However, scrutiny reveals that a number of children are sent as far as Texas, creating a significant transportation barrier.

CMHB has been focusing considerable attention on bringing children back to Montana from out-of-state and strengthening community services for high need children in order to prevent residential placements. In addition to its initiation of the PRTF waiver demonstration, these efforts include the implementation of Children's System of Care and the use of a flexible System of Care account for services.

4. Children's System of Care

a) Background

Montana has been moving toward systems of care planning for children with complex needs since 2001, creating a multi-agency planning committee in 2001, a System of Care planning committee in 2003, and receiving a SAMHSA system of care grant in 2004, which is now beginning its fifth year. The grant helped the state to carry out the Legislature's directive to develop a system of care.

Systems of care is a way of planning and delivering services that enhances each family's role in identifying the services their child needs and developing and continuously adapting a service plan. System of care is targeted toward children with the most serious mental health problems, and those whose complex needs require services from more than one state agency. In addition to identifying and planning for a comprehensive set of state services, system of care focuses on identifying and further developing natural community resources that can be an ongoing source of support for the youth and family, and enhance their participation in community activities. In general, system of care projects include some limited form of flexible funding which is not required to meet standard reimbursement requirements, like those for Medicaid and Title IVE. This allows it to be used for non-traditional services that can complete service plans or allow a family to make best use of services. For example, funding a car repair may be the least expensive way to support a family's access to services. Paying for a swim program may allow a child access to a form of exercise and community participation that would not otherwise be available. Systems of care have been extensively researched and have often generated cost savings, reductions in out of home placements, and improved outcomes for youth and families.

b) SAMHSA Grant

Montana's system of care grant has involved five sites where local staff have been hired to develop local advisory committees, known as Kids Management Agencies (KMAs), and develop system of care planning processes. To date, 120 youth have been enrolled and approximately 70 meet the requirements for the federal evaluation. Although, flexible funds are quite limited, there has been considerable training of system of care staff, parents, and providers in the principles and practices of system of care, providing a necessary foundation for further implementation. However, Montana's current system of care delivery model is not well financed, and it will be challenging to find ways to sustain it in its current form.

In 2007, the Legislature established a System of Care account that allows state agencies to deposit the state share of any excess Medicaid match or other general fund dollars into the account. These funds can be used to purchase services on a flexible basis on behalf of high risk seriously emotionally disturbed children who have multi-agency service needs. Spending authority for the current biennium is set at a maximum of \$500,000. In FY 2008, \$46,000 was channeled through the account on behalf of 11 children. Nine of them would have required PRTF level of care without the ability to make these flexible expenditures. Another child was at risk of a disrupted adoption, and one would have been sent to an out of state group home.

Overall, the State's efforts have reduced the number of children in residential care in FY 2008 considerably. In May of 2008, there were only 48 children in inpatient and residential treatment facilities. While this is a point in time count that is not strictly comparable to the FY 2007 count of children in treatment at some point during the year, it does appear that there has been a decrease in use of this level of care. In addition, as of July 2008, there were only 42 youth served out of state, 17 of whom were in PRTFs and 22 of whom were in group homes. Again, though comparing full year utilization to a point in time, it does appear that meaningful progress has been made in serving youth in state.

5. What services do the children of Montana need that currently do not exist?

Priority needs in Montana's children's mental health system include: expansion of services for children in the North Central region; expanding systems of care which will assist in encouraging further development of community based services for children with SED; and the continued expansion of school based services.

- ▶ Overall, the North Central region needs improved access for most service types.
- ▶ While school based services are expanding quickly, they do not yet cover the state. Twenty one counties showed no utilization of school based services in FY 2007. In the North Central region, relatively higher utilization of school services may be compensating for lower utilization of standard outpatient services.
- ▶ A severe shortage of trained child psychiatrists, with none located in the North Central or Eastern regions puts children with more serious conditions at risk of being inaccurately diagnosed and not treated optimally. Primary care physicians and mid-level practitioners (for example, physician assistants and APRNs) play an important role in the children's mental health system as providers of mental health prescribing services.
- ▶ Systems of care and local planning efforts can play an important role in encouraging the further development and use of intensive community services. The primary challenge for the state will be to find ways to finance the creative and non-traditional approaches likely to come out of these efforts.
- ▶ CFSD has addressed the needs of its more complex cases to get a specialized assessment and treatment on a timely basis by paying for services outside of Medicaid.
- ▶ CMHB, through the PRTF demonstration grant and the use of flexible funds has some powerful tools for encouraging care of children with the most intensive needs within their communities and use of residential care and out-of-state residential services has begun to show a decline.

Recommendations

- ▶ Conduct more aggressive recruitment efforts for child psychiatrists in accordance with methods suggested in our discussion of workforce issues at the end of this chapter and rate increases recommended in Chapter IV.
- ▶ Develop a strategy for increasing training in the treatment of very young children and continue efforts to identify problems through primary care screening.
- ▶ Strengthen crisis services for children
 - CMHB should work with LACs and SAAs to more systematically assess the needs for children's crisis intervention and how capacity can best be created.
 - Develop a plan for funding crisis response and stabilization services that is consistent with and aligned with AMDD's 72 hour presumptive eligibility services.

- ▶ Make plans to further develop family support and peer providers to conduct outreach, facilitate service planning, coordinate care and deliver support services. Work with KMAs and LACs to develop peer service models that can compensate for some of the gaps in the frontier workforce.
- ▶ Define a Medicaid procedure with a rate that adequately reimburses the assessment and treatment of certain complex CFSD cases which will increase access to providers and to timely services while drawing down federal match.
- ▶ Work with LACs and tribes to identify priorities for local service development and develop plans for expanding those services. Pay particular attention to North Central Montana and frontier locations. Find or fund small grants that can finance collaborative approaches with primary care and family support programs.
- ▶ Continue to provide flexible fund support to CMHB in order to reduce the use of residential care and maintain youth with SED in their homes and communities.

B. Adult Mental Health Services

This section addresses questions related to Montana’s adult mental health services.

1. How many adults need mental health services and where are they located?

In 2006, over 121,000 adults in Montana were estimated to have a mental health condition that caused them to lose at least a week of work. An estimated 38,500 adults met the criteria for serious mental illness that are similar to, but not quite as strict as, Montana’s standard for severe disabling mental illness (SDMI). Of that group, about 22,000 are from households with incomes below 200% of poverty. The prevalence rate for adults in households under 200% of poverty is 9.2%. Prevalence rates across Montana’s regions range from a low of 8.8% to a high of 9.4% for adults in poor households. County rates show significantly greater variation, with a 40% difference between the highest and lowest prevalence counties.

In FY 2007, almost 66,000 adults were enrolled in Montana’s adult public mental health programs. Eligibility for adult mental health services is complex, and varies for individuals with different family statuses, disabilities and presence or absence of SDMI. These eligibility criteria leave significant numbers of poor uninsured adults without access to mental health services.

Special populations with unique needs include Indians, whose estimated rate of serious mental illness of 10.9% among households under 200% of poverty exceeds the statewide estimate. IHS and other tribal facilities provide basic mental health services but lack the capacity to provide services for people with SDMI. Veterans returning from combat are at elevated risk for post-traumatic stress and related conditions. While enlisted, they have access to military health and employee assistance services, but they may encounter gaps in coverage when they leave the military, from delays either in establishing eligibility for Veterans Administration services or in establishing private health insurance.

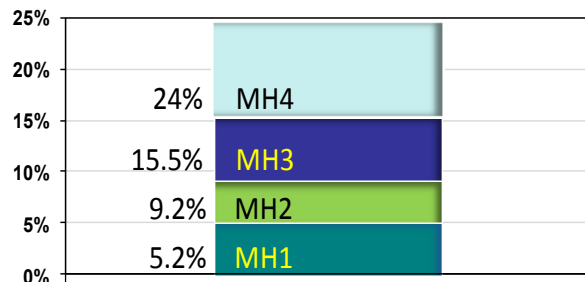
a) Estimates of Adults in Need of Mental Health Services

As with children, adults’ mental health needs cover a considerable span of intensity. The National Institute of Mental Health’s Collaborative Psychiatric Epidemiology Surveys (CPES) provide highly detailed information about the prevalence and severity of adult mental health problems. Dr. Holzer has used this survey data as the basis for developing estimates of four levels of mental health problems in adults. Figure III-7 illustrates the four levels of need defined by Holzer as they are estimated to occur among Montana’s 238,263 adults in households with incomes below 200% of poverty. Need level is defined by:

- ▶ Diagnosis,
- ▶ Days off work and
- ▶ Impairment.

Impairment is defined by the Sheehan Disability Scale which measures the extent a mental disorder interferes with home management (like cleaning, shopping and taking care of the house), a person’s ability to work, a person’s ability to form or maintain close relationships with other people, and a person’s social life. This self-rating scale ranges from zero to ten, and it is scored by taking the average of the four areas assessed.

**Figure III-7
Percent of Montana Adult Population
In Households Under 200% of Poverty
by Level of Mental Health Need**



Source: Estimates by Holzer based on CPES and Census Estimates

MH1 represents the most impaired individuals and MH4 the least impaired. MH1 is comparable to Serious and Persistent Mental Illness (SPMI), a standard representing the most severe forms of mental illness. The criteria for MH1 are a chronic major mental health diagnosis; average impairment ≥ 7 on a scale of 10, where 10 is most impaired; and more than 4 months off work due to the mental health problem. Criteria for MH2 require a chronic mental health diagnosis; average impairment ≥ 7 ; and more than 4 months off work. Individuals, who meet criteria for MH1, are included in the percentages for MH2, and so on up the scale.

Criteria for MH3 involve a current mental health diagnosis; average impairment ≥ 5 and more than 1 month off work. Criteria for MH4 require any current mental health need, average impairment ≥ 3 and more than 1 week off work. Since many people who benefit from mental health treatment do not miss work because of their condition, this lowest standard still represents a significant level of need. We will be using MH4 as our standard for people needing less intensive mental health services. A larger number of people have a need for services but have not missed work; however, we do not have data for that group. Our standard includes the individuals captured by the more severe standards in MH1 through MH3, but also incorporates the additional individuals who meet the criteria for the lesser level of severity defined by MH4.

Montana sets a standard of Severe Disabling Mental Illness (SDMI) for access to most of its public mental health services. SDMI is generally considered to fall between the more commonly used standards of SPMI and SMI. We compared Montana’s definition of SDMI to Holzer’s levels, acknowledging that this is imperfect since they are based on different criteria. We have chosen to use MH2, a conservative definition of SMI, believing it to provide the closest estimate to Montana’s SDMI eligibility standard. By using MH2, our estimates of need will slightly exceed the number of Montanans who would qualify for SDMI. When we are referring to Holzer’s

utilization, we will refer to SDMI, the standard used to set eligibility for many of Montana’s adult mental health services.

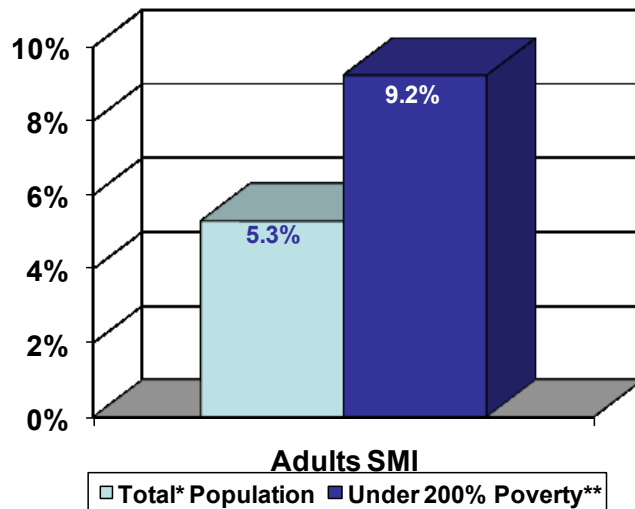
Montana’s SDMI Definition

Under Montana administrative rules, a person has a severe disabling mental illness if he or she:

- has been involuntarily hospitalized for at least 30 consecutive days at Montana State Hospital at least once OR
- has a moderate to severe mood, psychotic, or personality disorder; AND
- has an ongoing functional impairment. A person meeting at least two of the following criteria is considered to have an ongoing functional impairment:
 - ▶ Must be on medication to control the symptoms of mental illness;
 - ▶ Is unable to work in a full-time competitive situation because of the mental illness;
 - ▶ Is determined by the Social Security Administration to be disabled because of mental illness;
 - ▶ Is able to maintain a living arrangement only with ongoing supervision or is homeless or at risk of homelessness because of the mental illness; or
 - ▶ Has had or will predictably have repeated episodes in which the mental illness worsens.

In Montana, Holzer estimates that in 2006 approximately 5.3% of the total adult population, or 38,500 individuals met the criteria for MH2. Among the 238,263 Montana adults in households with incomes under 200% of poverty, the rate is considerably higher, 9.2%, resulting in an estimate of 22,000 adults in this group meeting criteria for MH2. As with children, we will use the rate for adults from households under 200% of poverty as our standard. While it considerably exceeds the income levels at which most adults become eligible for services in Montana, this type of estimate, taking into account Montana’s specific demographic makeup, is not available for income levels lower than 200% of poverty. (See Figure III-8.)

**Figure III-8
Estimated 2006 Prevalence of
Adult Mental Health Needs
by Family Income**



Source: Estimates by Holzer based on CPES and Census Estimates
 *Population includes households, institutions and group settings
 **Includes households only

b) Special Populations - Adults

Dually diagnosed. Adults who have both SMI and a substance abuse problem are said to have “dual diagnosis.” According to Dr. Holzer’s estimates, about 12% of all Montana adults meeting MH2 criteria are estimated to have experienced a substance abuse problem during the past 12 months. Other studies and Montana stakeholder feedback suggest that higher rates are present. For example, the Epidemiological Catchment Area study found a life-time prevalence of abuse of alcohol or drugs of 29% among people with mental illness.⁵ Similarly, the 2007 National Survey on Drug Use and Health (NSDUH) reported that past year illicit drug use in 2007 was 28% among adults with Serious Psychological Distress (SPD), considerably higher than use

⁵ Office of Applied Studies (2008) Results from the 2007 National Survey on Drug Use and Health: National Findings. DHHS, SAMHSA, September 2008, p. 70. <http://www.oas.samhsa.gov/NSDUH/2k7NSDUH/2k7results.cfm#TOC>. Accessed 9/18/08.

among adults without SPD (12.2 percent). SPD is yet another standard for mental illness. It identifies people who would be considered to have a mental health diagnosis.

American Indians. American Indians constitute about 6.4% of Montana's population or more than 60,000 individuals. Holzer's estimates found that Native American adults from households under 200% of poverty had a higher rate of MH2, 10.9%, than all Montana adults under 200% of poverty. Data from a national study found that Indian male and female adults and adolescents are significantly more likely to commit suicide than non-Hispanic Whites (percentages vary by age and gender); and that Indian adults are less likely to receive mental health treatment (12.7% versus 14%) or prescription medications (10.7% versus 11.8%) than Whites.⁶

Veterans. As of 2004, Montana had the highest per capita rate of enlistment in the armed forces among the states. In addition to its armed forces members, it also has close to 4000 active full-time members of the National Guard. Several studies have documented the mental health needs of veterans returning from combat duty. A 1983 study found that approximately 30% of men and 27% of women had PTSD at some point in their life following service in Vietnam. Studies examining the mental health of Persian Gulf War veterans found that rates of PTSD stemming from the war range from almost 9% to about 24%. Because the conflicts in Iraq and Afghanistan are ongoing, their full impact on the mental health of soldiers is not yet known. One study looked at members of four United States combat infantry units who had served in Iraq and Afghanistan. After deployment, approximately 12.5% had PTSD, a greater rate than had been found among these soldiers before deployment.⁷

c) Estimates of MH2 Prevalence by Region and County

We conducted the same kind of regional analysis for adults as for children, using the five children's regions because they provided more detail than the three adult regions.

Prevalence rates vary relatively little among regions. Table III-9 shows that rates of SMI vary by from a low of 8.8% to a high of 9.4% between the highest and lowest prevalence regions in Montana. County rates show significantly greater variation (Table III-10). County prevalence rates for adults range from a low of 7.4% in Sheridan County to a high of 10.4% in Roosevelt County, a 40% difference. However, we caution that small area estimates are statistically less robust than are those for larger populations. Estimates of dual mental health and substance abuse disorders also vary by region. The Eastern region of the state has a lower incidence of co-occurring disorders than the average, and the Southwest had the highest incidence. Appendix A contains prevalence estimates for each county.

⁶ U.S. DHHS, The Office of Minority Health, "Mental Health and American Indians/Alaska Natives," <http://www.omhrc.gov/templates/content.aspx?vl=3&vlID=9&ID=6475>

⁷ Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R.L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351, 13-22. (from: <http://ptsd.about.com/od/prevalence/a/MilitaryPTSD.htm>)

Table III-9
Estimated 2006 Prevalence of Adults with Serious Mental Health Problems in Households under 200% of Poverty In Montana by Region

Region	SMI
Eastern	8.8%
North Central	9.2%
South Central	9.4%
South West	9.1%
Western	9.3%
State	9.2%

Source: Estimates by Holzer based on CPES and Census Estimates

Table III-10
Counties with the Highest and Lowest Estimated Prevalence of Adults with Serious Mental Health Problems in Households under 200% of Poverty

Lowest prevalence rates		Highest prevalence rates	
Sheridan	7.4%	Silver Bow	9.7%
Prairie	7.6%	Granite	9.7%
Treasure	7.8%	Glacier	9.8%
McCone	7.9%	Big Horn	10.0%
Garfield	8.0%	Roosevelt	10.4%

Source: Estimates by Holzer based on CPES and Census Estimates

d) Adults in Need of Public Mental Health Services

Another dimension of relevance to this discussion is how many adults in need of mental health services must rely on Montana’s public programs. Low income adults in Montana have much less access to mental health services than low income children and adolescents, as a result of the lower income cap on Medicaid eligibility. Montana Medicaid excludes the majority of poor adults who are without dependent children, high medical expenses or disabilities. While pregnant women are eligible for Medicaid to 133% of poverty, other adults with dependent children are eligible only to 40% of the poverty level, and in 2001, medically needy adults were eligible to 73% of poverty.

This coverage is lower than many states provide for adults. According to the Kaiser Family Foundation’s “Medicaid Program at a Glance”⁸:

- ▶ In 2006 Montana ranked 38th in eligibility levels for non-working parents.
- ▶ Among Western states only Nevada and Idaho ranked lower. More than half of states set the limit at 100% of poverty or above.
- ▶ According to the Kaiser Family Foundation Health Facts, in 2005, 12% of Montanans were enrolled in Medicaid, a lower percentage than in 38 other states.

Adults who are disabled, whether by reason of mental illness or other conditions, can also get eligibility for Medicaid up to 74% of poverty. Most states use this or a similar income standard; there is little variation in the income eligibility standard across the states, or in their rates of enrollment in the disability category. We have provided a table showing the relevant income levels and how they compare to 200% of poverty.

Montana’s adult Medicaid mental health benefit is commonly described as being restricted to people with SDMI. In fact, there is a set of mental health services available to any adult with a diagnosable mental illness. They may receive basic mental health services from providers that don’t specialize in mental health, such as primary care physicians, mid-level practitioners, and Federally Qualified Health Centers or hospital outpatient departments. They can also receive psychotropic medications. However, most specialized mental health services, including those

⁸ Kaiser Family Foundation’s “Medicaid Program at a Glance”, <http://www.kff.org/medicaid/7235.cfm> accessed 9/10/2008.

provided by Community Mental Health Centers and independent practitioners such as psychologists, social workers and psychiatric counselors, are restricted to serving adults who meet criteria for SDMI.

% of 2008 Federal Poverty Guidelines	Family of 1	Family of 4
40%	\$4,160	\$8,480
73%	\$7,488	\$15,300
74%	\$7,696	\$15,700
150%	\$15,600	\$31,800
200%	\$20,800	\$42,400

Source: <http://aspe.hhs.gov/poverty/08Poverty.shtml> and <http://aspe.hhs.gov/poverty/faq.shtml#chart>

Mental Health Services Plan (MHSP) Eligibility.

The state offers a Mental Health Services Plan (MHSP) with a more limited benefit than Medicaid to provide coverage for adults with SDMI whose incomes exceed the Medicaid poverty level. Currently this benefit is offered up to 150% of poverty, but AMDD has statutory authorization to raise the rate to 160% subject to the availability of funds. Initial eligibility for this program is coordinated with Medicaid to maximize enrollment into Medicaid and ensure that Medicaid resources are used whenever they are available, since the state is fully responsible for MHSP.

Indian Health Service Eligibility.

The Indian Health Service is a federal agency providing a range of prevention, health and behavioral health services to Indian people. Two of Montana’s tribal reservations, Rocky Boy and Flathead, operate their own health facilities. A total of 11 facilities, ranging from clinics to hospitals, operate on seven reservations. In addition, six Urban Indian clinics operate in five communities. The facilities bill the state for services provided to Medicaid eligible Indians, and the state is then fully reimbursed by the Federal government; no state match is required. The facilities can also bill private insurance and Medicare. Indians without health insurance are served from IHS resources. IHS reported that reservation based health facilities delivered 58,000 outpatient mental health visits in FY 2007; however, we do not know how many individuals were served.

72 Hour Presumptive Eligibility.

Recently, the state created a new eligibility category, 72 hour presumptive eligibility, which provides eligibility for all uninsured Montana citizens for crisis assessment and intervention services for up to 72 hours. Begun on a pilot basis in specified communities, services under this eligibility status have now become available from any qualified provider willing to contract with the state to provide them.

State Institution Eligibility.

The state provides hospital and nursing home care for psychiatric illnesses through the Montana State Hospital (MSH) and the Montana Mental Health Nursing Care Center (MMHNCC). According to Montana State Statute, a commitment (or admission) to MSH can accomplish the goal of care and treatment suited to the needs of a person suffering from a mental disorder only when a less restrictive alternative is unavailable or inadequate. The MMHNCC primarily serves individuals who have both mental illness and chronic medical needs that make them particularly complex to care for.

There are ten commitment and detention statuses that govern admission to MSH; five are considered civil commitments for individuals committed by the courts because of need for hospital level treatment, four are considered forensic commitments for individuals involved with the correctional system and in need of hospital level services, and one is administrative - an inter-departmental offender transfer from the Department of Corrections for individuals who need services offered by the State Hospital (also considered forensic for purposes of census

management). One of the forensic commitment statuses, “Not Guilty by Reason of Mental Illness”, is no longer used, yet there remain a number of patients at MSH who were originally committed under this status.

Involuntary admissions are almost two-thirds of all MSH admissions, with court ordered detentions accounting for an additional 19% of admissions but a dramatically lower number of bed days. Reducing the length of stay of these involuntary admissions is probably the area on which to focus attention in order to reduce MSH bed utilization.

Table III-12											
FY 2007 Montana State Hospital Census Totals by Commitment Status											
FY 2007 Commitment Status →	ED (CC)	COD (CC)	INVOL (CC)	I H S (CC)	VOL (CC)	ITT (FC)	COE (FC)	UTP (FC)	GBMI (FC)	NGMI (FC)	Total
Number of Discharges	21	131	447	15	10	1	11	22	20	3	681
Avg. Length of Stay in days	3	5	110	37	573	7	92	152	481	775	n/a
Median Length of Stay in days	3	4	57	38	105	7	85	172	487	996	n/a
Patients Hospitalized for 365 days or more	n/a	n/a	22	0	3	0	0	0	0	9	61
Legend:											
CC – Civil Commitment						FC – Forensic Commitment					
ED – Emergency Detention						ITT - Inter-Institutional Transfer					
COD – Court Ordered Detention						COE – Competency to Stand Trial Evaluation					
I H S – Tribal Court Commitment						UTP – Unfit to Proceed					
VOL – Voluntary Commitment						GBMI – Guilty but Mentally Ill					
INVOL – Civil Involuntary Commitment						NGMI – Not Guilty by Reason of Mental Illness (no longer a commitment type)					
<i>Source: Montana State Hospital Reports</i>											

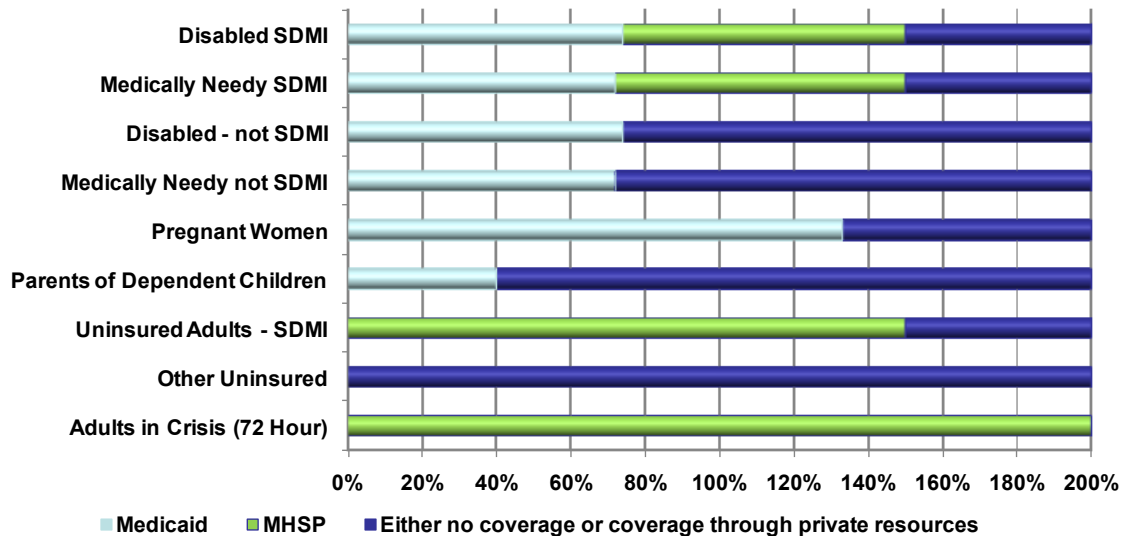
Veterans’ Services. Responsibility for serving military Veterans is shared between the Montana National Guard and the Veterans Administration. The Montana National Guard, which is jointly funded by the state and federal government, oversees the almost 4000 Air and Army guard troops in Montana. National Guard members are eligible for armed forces health insurance and Employee Assistance Services. The Veterans Administration (VA) is a federal service for which military and national guard who meet certain eligibility criteria are eligible post-discharge. Both the armed forces and the Montana National Guard have strengthened their procedures for timely application for VA services for those likely to qualify for them.

Discussion. Consistent with Montana’s relatively low Medicaid income eligibility standards, the 65,691 adults enrolled in Medicaid or receiving MHSP services constituted approximately 74% of adults under 100% of poverty and 43% of adults under 150% of poverty. The other forms of coverage Montana offers are specific to either crisis or institutional care, and do not indicate access to full mental health coverage.

Montana has constructed its adult mental health benefits to meet priority needs within the available resources of the state but the result is a complex system that differs for adults with different family status, disabilities and presence or absence of SDMI. The covered mental health services are comprehensive for Medicaid eligible adults with SDMI, but mental health service coverage is incomplete for non-SDMI Medicaid eligibles and also incomplete in different ways for MHSP eligibles. This patchwork of adult programs leaves important groups of poor

uninsured adults without access to mental health services. Figure III-9 shows the categories of adults that have full or partial mental health coverage by income level. It is challenging for children with ongoing mental health problems to make the transition from the more comprehensive benefits of the children’s system to the more complex and limited benefits of the adult system as they turn 18.

**Figure III-9
Coverage for Montana Medicaid and MHSP MH Services
of Adults Under 200% of Poverty by Selected Eligibility Category**



Since most Medicaid and MHSP mental health services are limited to the category of adults with SDMI, many adults with significant, but less serious, mental health problems are not able to get mental health services unless they have a mental health crisis and can access presumptive eligibility services or are committed to the state hospital. Many such problems co-occur with substance abuse, which exacerbates their effects for individuals, their families and their communities. Many of these individuals behave in ways that involve them with the police or lead to incarceration.

The significance of eligibility limitations is recognized by many stakeholders in the state.

- ▶ Seventy percent of survey respondents indicated that Medicaid eligibility requirements were a barrier affecting many or most people seeking services.
- ▶ Survey respondents rated adults with mental health problems not meeting SDMI criteria as least likely to get the mental health services and supports they need.

e) Health Insurance Flexibility and Accountability (HIFA) Waiver

In 2006, DPHHS submitted an 1115 Medicaid waiver application to the Centers for Medicare and Medicaid Services (CMS) for approval. Submitted as a Health Insurance Flexibility and Accountability (HIFA) Waiver, it would allow Montana to provide health-care coverage to several thousand uninsured low-income Montanans not currently eligible for Medicaid. This would allow DPHHS to enroll current MHSP participants into a Medicaid financed mental health services program. In addition, the proposal would cover a number of young adults, ages 18-22 with SED, who are no longer eligible for Medicaid though they continue to struggle with

significant mental health problems. The waiver also includes provisions to support a small business insurance pool and could cover children eligible for CHIP if a wait list develops. The target date for implementing the waiver was July 2007, but the proposal has been stalled at CMS and has neither been approved nor denied.

Recommendations

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

2. What adult services does Montana have in place?

To answer this question in the context of Montana's public mental health system, we considered the services provided in Medicaid, the Mental Health Services Plan for adults through 150% of poverty, and 72 Hour Presumptive Eligibility. We also considered services that could be available through an IHS facility. While adults with SDMI who qualify for Medicaid have access to a comprehensive continuum of mental health services, Medicaid eligible adults with less severe mental health problems are restricted with regard to the providers and services they can access, and adults with SDMI who do not qualify for Medicaid have access solely to community based services, with some significant limitations. This coverage - which offers only limited services for problems before they become serious - contributes to the pattern of individuals coming into public mental health services through admission to Montana State Hospital. Continued development of the resources to provide crisis intervention and stabilization services for individuals under 72 hour presumptive eligibility status will help to address this problem, but still requires individuals to reach a crisis state before they qualify for services.

An effective mental health system includes a comprehensive continuum of services and supports that offer individuals care as close to home as possible. Table III-13 below lists the services covered by Montana's public mental health programs. It indicates that Montana Medicaid covers a generally comprehensive set of mental health services. MHSP covers most of the continuum of community based services, while presumptive eligibility covers only crisis services. Indian Health Services are not provided by the state of Montana, but are available to Montana Indians through Urban Indian Health Clinics and IHS or tribal facilities on each reservation. They provide psychiatry, mental health counseling and social services to the degree allowed by their funding and ability to fill staff positions.

Table III-13 Montana Covered Mental Health Services by Plan Type				
	Medicaid - Adult	Mental Health Services Plan (SDMI Only)	72 Hour Presumptive Eligibility	Indian Health Service (IHS)
Outpatient Services				
Basic outpatient services	24 visits for SDMI	24 visits	Y	Y
Evaluation & Management (physicians, PA, & Nurse Practitioners)	Y for all (Not restricted to SDMI)		1/ day per service type	Y
Comprehensive school and community treatment	For 18-22 with SED	N/A	N/A	N/A
Psychiatry/Medication				Y
Medication Management	Y for all (Not restricted to SDMI)			
Psychotropic Drugs	Y for all (Not restricted to SDMI)	\$425/mo		Y
Other Miscellaneous Services**	Y for all (Not restricted to SDMI)			Y
Crisis Intervention				Y
Care Coordination			Y	
Crisis Intervention Facility	Y for SDMI		Y	
Hospital or MHC Crisis Management	Y for all (Not restricted to SDMI)		Y	
23 HR Observ. - Hosp.	Y for all (Not restricted to SDMI)			
Intensive Community Services and Supports				
Targeted Case Management	Y for SDMI	4 hr/mo		
Com-based psych rehab. & support (CBPRS) Psych. Aide	Y for SDMI	Y	Y	
Behavior Mgmt Skills Dev Services	Y for SDMI			
Dialectical Behavioral Therapy – Skill Development (Intensive Outpatient)	Y for SDMI	Y		
Day Treatment Services	Y for SDMI	Y		
Partial Hospitalization	28 days for SDMI			
Program in Assertive Com. Treat.	Y for SDMI	Y		
Respite Care Services (State only funds)	Y for SDMI			
Community Residential				
Group Home	Y for SDMI	Y		
Adult Foster Care	Y for SDMI			
Intensive Community Based Rehabilitation (residential)	Y for SDMI			
Inpatient and Residential				
Psychiatric Residential Treat. Fac.	Y for SDMI Ages 18-20			
Acute Inpatient	Y for all (Not restricted to SDMI)			

a) Services Important for all Adults with Mental Health Problems

Basic mental health services are available for all Medicaid recipients through Evaluation and Management services provided by non-mental health providers. They are also able to get hospital services, not only outpatient and emergency services, but also observation and inpatient care. A broad range of miscellaneous services that can include lab testing and personal care services when provided for mental health diagnoses are also available to all

Medicaid eligibles. Psychotropic medications are also available to all Medicaid enrollees, as well as psychiatric medication management. However, individuals without SDMI who are covered by Medicaid are limited to these services and the providers that offer them, and do not have access to the broader range of intensive community based service available to SDMI Medicaid recipients.

b) Outpatient Services for Adults

Individuals with SDMI have access to outpatient counseling from Mental Health Centers that specialize in services for the most seriously ill, as well as from mental health specialists in independent practice.

c) Crisis Intervention for Adults

Adults have a number of service types that provide crisis intervention services. In addition to 23 hour observation, Mental Health Centers (MHCs) can provide crisis services and specialized crisis facilities can do so also.

d) Community Services important for Adults with SDMI

Targeted case management to assist individuals to develop a service plan that meets their needs and coordinate them is also offered by MHCs. A number of other services are specialized to meet a variety of needs. These include psychiatric aides who can provide one to one support in participating in community activities and undertaking daily living activities, behavioral management services to address behavior problems that interfere with functioning, and an intensive evidence based outpatient service, dialectical behavioral therapy (which is effective in teaching skills related to regulation of emotions, and tolerance of distress for people with certain diagnoses). Day treatment provides day-time rehabilitative services, mostly in a group setting. Partial hospitalization provides hospital level of care which can allow some individuals to prevent a full hospitalization or serve as a transition after a hospital stay. The Program of Assertive Community Treatment (PACT) is an intensive service provided by a multi-disciplinary team for a small number of individuals in the community who need a very intensive level of treatment and support. Respite care services, provided primarily through state funds, allow the caregiver of an adult with SDMI to be freed from care giving duties for a specified period to have a break or handle other responsibilities.

e) Out-of-Home Services - Adults

Group Homes and adult foster care offer community residential settings where there is a considerable degree of supervision and support. Acute inpatient care is available from community hospitals and Montana State Hospital. Only the state hospital provides long term hospital care.

f) Home and Community Based Services Waiver- Adults

Montana has a Home and Community Based Services Waiver that allows it to provide a very flexible mix of community services for individuals with mental illness who are in or at risk of nursing home care. This mix includes services not otherwise covered under Montana's state plan, including respite services, and personal care services (which assist individuals with tasks such as bathing if they are not able to do them safely alone). Of the services not otherwise covered under the state plan, respite services are available to all Medicaid beneficiaries, but are fully funded by the state and are not a true Medicaid service. Homemaker services and personal care services are most relevant for Medicaid enrollees with physical limitations and disabilities. However, they are generally not a significant need for the majority of individuals with SDMI.

g) Peer Services - Adults

Montana has a rapidly developing set of peer services, though they are not financed through Medicaid. These services are available to individuals with SDMI in Medicaid and MHSP. Peer services known as Consumer Operated Service Programs (COSP) include drop-in centers and club houses where consumers have a considerable say in governing and operating the services and activities. The environment that is created fosters growth, leadership and peer support. Peer services can also include support services delivered by trained consumers employed by either a COSP or a traditional provider. Adults who have lived with SDMI can offer important supports that assist individuals to recover, manage their illnesses, develop community support systems and build a satisfying and stable life in the community. This year the state funded four drop-in centers which offer peer support, vocational services and opportunities for socializing, and a virtual drop-in center on-line. AMDD has also funded five half-time community liaison positions to be filled by mental health consumers. They are located in Butte, Helena and Missoula to assist individuals as they transition from the state hospital back to the community. AMDD providers are able and encouraged to hire consumers, who meet education and training requirements, into positions as psychiatric aides.

h) Services for Veterans

The National Guard has an important role in conducting post-discharge assessments, in outreach to Guard members who are not keeping in touch, and in assisting members and their families to access needed services. In response to a task force on the needs of guard members returning from overseas combat deployments, the Guard has greatly strengthened the mental health component of its assessment program and initiated outreach to members who fail to attend required events. As of October 2007, 98% of returning Guardsmen had completed their initial post-discharge assessment, including screening for mental health problems. The Guard has sought funds to support its new standard of conducting additional assessments every six months for the first two years post-deployment. It has also developed two multi-disciplinary crisis response teams to take immediate action when a guardsman experiences a crisis. Though the team does not include a mental health professional, it is trained in the signs of PTSD and traumatic brain injury and is able to consult with a mental health professional when needed. The Guard has also developed information about resources available to guardsmen and their families that include several avenues for seeking mental health services. It has sponsored trainings by mental health professionals on meeting the mental health needs of returning soldiers. The Guard identified additional resources needed to fully implement these changes, indicating that they would be sought from federal sources, and – if that was not sufficient – from the state.

The VA also has geared up to meet the increasing mental health needs of returning veterans. They do outreach by appearing during pre-discharge events to explain benefits and how to access them. In addition, a new position of Transition Coordinator is responsible for facilitating transitions of new vets who are in active treatment in out-of-state facilities and need to continue treatment upon their return to Montana. Once enrolled in the VA, service members are screened for mental health problems and traumatic brain injury during their initial primary care visits, and can be evaluated by an expanded cadre of mental health clinicians if a possible problem is identified. The VA has increased the number of mental health clinicians at its 11 service sites around the state; it also has contracts with the four Community Mental Health Centers in the state, and can pay independent clinicians when those resources are not sufficient. An Access to Care Unit is responsible for making linkages to mental health services within whatever timeframe is appropriate given the veteran's level of acuity.

While mental health clinicians are posted at each VA facility, the VA's three full-time psychiatrists are all located at Fort Harrison in Helena. When veterans need inpatient mental health treatment, they may go to Sheridan Hospital in Wyoming or the VA may pay for service from one of Montana's psychiatric inpatient facilities. On occasion, but relatively infrequently, a veteran may be referred to the Montana State Hospital, in which case the state pays for the care. The VA has received permission to create its own psychiatric inpatient facility at Fort Harrison, and this is expected to be completed within about four years.

The VA would like more veterans to be aware of the services available to them, and how to receive them. They feel that they are well organized and have sufficient resources to effectively address veterans' needs once they access the system. One gap identified is mental health treatment for the families of veterans. Couples counseling is available when it is focused on the problems of the veteran, but no children's counseling is available at all. Unfortunately, many military families cannot immediately meet criteria for Medicaid upon discharge because their last six months of military pay puts them over the income limit. The VA will explore whether such families might qualify for CHIP, which would at least cover their children.

Another opportunity for improvement lies in the area of training. VA health care personnel and clinicians are getting training in the mental health problems most frequently experienced by returning veterans, but the contracted and independent mental health clinicians that serve some veterans are not able to participate in the specialized two week training programs offered by the military. Though the military would cover the training costs, they are not able to pay for travel out of state and two weeks of per diem costs.

Discussion

Montana's adult public mental health programs are considerably more fragmented than are those for children, with limits on available providers, amount of service, and dollar values of medications that affect different groups. While some basic mental health services are available to all adult Medicaid enrollees with a diagnosable mental health problem, they are only available from physicians, mid-level practitioners (e.g., physician assistants or advanced practice registered nurses (APRNs)), health centers and hospitals, and not from Community Mental Health Centers or independent mental health professionals. The scope of our study did not identify how well the options for adults to receive mental health services from non-specialty providers are understood or utilized. In fact, in our conversations, mental health benefits were commonly discussed as being limited to SDMI.

Since early intervention in mental health problems is optimal in terms of enhancing outcomes, lessening the negative impact of mental health problems, preventing crises, and making use of less intensive and lower cost services, it is important for Montana Medicaid recipients and Medicaid providers to ensure that these mental health services are well used. To achieve this goal, enrollees and providers must be made aware that mental health services from a primary care physician, a Federally Qualified Health Center or a hospital outpatient department are available to all Medicaid recipients with a diagnosable mental health problem. Given the significance of these service providers in helping to provide early attention to mental health problems, it is important to support them in providing mental health services. While a number of physicians prescribe psychotropic medications and have developed some expertise in treating mental health conditions, physicians have limited training in mental health. With the limited pool of psychiatrists in Montana, most physicians will not have easy access to psychiatric

consultation to support them in diagnosing and treating mental health conditions. Further support could strengthen the quality and capacity of these providers to deliver mental health services.

Medicaid enrollees with SDMI are able to access the comprehensive continuum of mental health services covered by Montana, with the option to use both mental health specialty providers and general health providers who offer mental health treatment. Adults with SDMI and incomes under 150% of poverty, who don't qualify for Medicaid, have access to a broad range of community based and crisis services funded by MHSP. However, their coverage has some limits not present in Medicaid on case management and medications. The medication benefit, in particular, can be insufficient to cover certain needed medications or combinations of medications. Residential and inpatient care are also excluded in the MHSP benefit. Exclusion of or limitations to these significant services makes it more likely that persons eligible for MHSP services will end up in Montana State Hospital (MSH) if they experience a crisis. Presumptive eligibility for crisis services is beginning to fill one gap in the continuum, but it has not yet been fully implemented. Its limitation of services to 72 hours may not be sufficient to truly stabilize all crises and prevent problems from worsening, particularly for individuals who have significant mental health and/or co-occurring mental health and substance abuse problems, but do not meet criteria for SDMI or income that would qualify them for ongoing community care.

Findings

Montana has developed a comprehensive Medicaid mental health benefit which covers multiple forms of treatment, rehabilitation and support for adults with SDMI. Peer services is one service not currently covered which would be a significant addition to Montana's continuum of care. While adults with SDMI who qualify for Medicaid have a comprehensive continuum of services, Medicaid adults with less severe mental health problems are restricted in the providers and services they can access, and adults with SDMI who do not qualify for Medicaid have access solely to community based services, with some significant limitations. This coverage - which offers only limited services for problems before they become serious - contributes to the pattern of individuals entering public mental health services through admission to Montana State Hospital. Continued development of the resources to provide crisis intervention and stabilization services for individuals under 72 hour presumptive eligibility status will help to address this problem, but still requires individuals to reach a crisis state before qualifying for services. The HIFA Waiver continues to offer the most attractive means of better addressing the needs of adults with SDMI, but its likelihood of being approved is uncertain.

3. What adult services are being provided and by whom? Is additional outreach needed?

What adult services are being provided and by whom?

The Eastern region falls behind the others in penetration for many categories of SDMI mental health services, though North Central has the lowest penetration for medication management. The Southwest has the highest penetration rates for many SDMI service categories. Non-mental health specialists and certain specialists providing services under "miscellaneous" are a significant source of care for many Medicaid eligibles. There appears to be potential for increasing access to intensive community services and supports, which may help reduce use of crisis and hospital care.

Is Additional Outreach Needed?

AMDD served 13,209 people through Medicaid and 5,041 adults with SDMI through MHSP. Almost 15,000 were served through other state plan Medicaid, and 2,148 received vocational services from the Disabilities Division. The Department of Corrections provides mental health services for an undetermined number of people in its correctional facilities and also through its community corrections programs.

Within Medicaid, penetration rates are high for individuals receiving any mental health service or medication. However, because relatively few adults are enrolled in Medicaid, they represent a small percentage of the estimated number of poor adults likely to need mental health services. These poor adults are not likely to have other forms of health insurance.

MHSP services are restricted to adults with SDMI, and reach 3.3% of the population in households under 150% of poverty, equivalent to about a third of the 9.2% of poor adults estimated to meet MH2 criteria. Based on consultation with DPHHS and their additional analysis of the database, we developed two estimation methods for the number of Medicaid eligibles with SDMI receiving Medicaid services. Our minimum estimate showed that AMDD mental health services for SDMI are reaching many, but not all, of Medicaid enrollees likely to need them, while our maximum method indicated that DPHHS is reaching a group that considerably exceeds the number of enrollees estimated to meet MH2 and MH3 criteria. Additional work to understand service patterns and reporting conventions are needed to test assumptions underlying each estimate and develop a robust methodology for making a more meaningful estimate of adults receiving SDMI services and to determine the degree to which additional outreach is needed for this group.

We lack specific data on need and access to services for veterans and Indians. However, the National Guard has improved its capacity for identification of mental health problems, outreach, and crisis intervention, while the Veteran's Administration has expanded its mental health resources and is facilitating linkage to services. Coordination and outreach to veterans and their families can help ensure that they have access to the services for which they qualify. IHS reports difficulties in recruiting and maintaining mental health staff and there appears to be considerable room for strengthening communication and collaboration with IHS, which would help to improve Indians' access to the specialized services the state provides for SDMI.

To address questions regarding services and outreach, we compared people receiving services with those estimated to be in need at the state level. We then looked in more detail at providers delivering different modalities, and the relative access to services in different regions of the state. (Please note the data limitations that are outlined in Section II, page 4)

a) Department of Public Health and Human Services - Adults

DPHHS serves almost 25,500 unduplicated adults annually through Medicaid, the Mental Health Services Plan and the Disabilities Services Division (DSD). Only people served solely by IHS facilities are excluded from this count.

We note that the Department of Corrections also provides mental health services. An indication of some of the numbers served is provided in Chapter VI.

Adult Serving Divisions

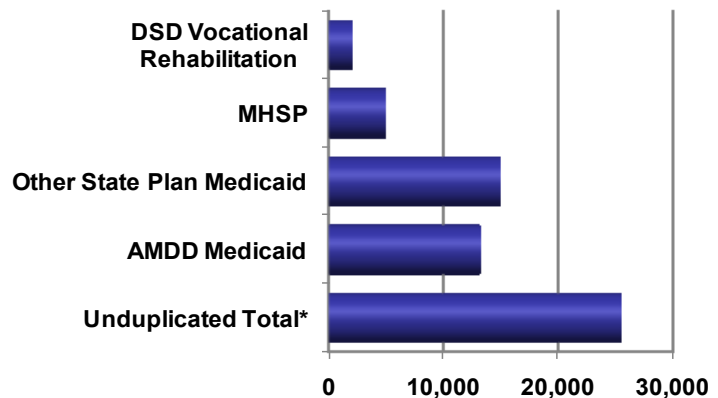
- ▶ The Addictive and Mental Disorders Division (AMDD) administers adult Medicaid mental health services for over 13,000 adults, representing 52% of DPHHS’ unduplicated total.
- ▶ AMDD also administers the Mental Health Services Plan which served over 5000 people, representing 20% of DPHHS’ unduplicated total.
- ▶ HRD serves almost 15,000 adults through the Other State Plan Medicaid, which primarily covers the costs of psychotropic medications. This means that almost 60% of the unduplicated adults served were getting psychotropic medications. There were also at least 1,100 who received some form of mental health services through HRD.
- ▶ The Disability Services Division (DSD) provides vocational services for over a thousand individuals with mental illness, or about 5% of the unduplicated total.
- ▶ Adding together the numbers served by each distinct program and comparing them to the unduplicated total indicates that over half of adults served by DPHHS receive services through more than one of these four programs. It is likely that most adults getting vocational services through DSD are also eligible for services through Medicaid or MHSP. As mentioned above, use of medication often overlaps with use of some form of AMDD mental health services. As with children, adults may gain or lose Medicaid eligibility and move between MHSP and Medicaid during the year. The remaining 50% of adults are receiving services from just one of the four programs.

b) Meeting Adult Service Needs – Statewide

Penetration in Medicaid.

The total number of adults eligible for Medicaid for all or part of FY2007 was 60,650. The data we requested did not allow us to determine the actual number of unduplicated Medicaid recipients. As a result, we have developed an estimate. We do know that the unduplicated total of individuals receiving Medicaid or MHSP services is 23,672. If we subtract the 5,041 unduplicated MHSP recipients from this amount, we can be sure that at least 18,631 individuals received mental health services or medications under Medicaid. If some MHSP recipients were enrolled in Medicaid during that year and received mental health services, then the number could be higher. These 18,631 individuals constituted 31% of total Medicaid enrollees. This penetration rate considerably exceeds the 24% prevalence estimate for people who have a mental health diagnosis sufficient to cause them to lose days of work (MH4).⁹

**Figure III-10
Adults Receiving DPHHS MH Services
and/or Medications in FY07**



* Excludes Montana State Hospital and Montana Nursing Care Center recipients, and recipients receiving mental health services only from IHS facilities

Sources: DPHHS Special Report Montana Mental Health Study

⁹ We note that these rates are not directly comparable to the rates reported by other states because few of those states include psychotropic medications in their utilization figures.

Service Access for Poor Adults. The 25,446 unduplicated individuals¹⁰ receiving DPHHS mental health services constitute 16.6% of the estimated 153,525 adults below 150% of poverty in 2006. This is well below the 24% rate of individuals experiencing a mental health problem serious enough to cause them to lose days of work. Thus, while individuals who have Medicaid have healthy rates of access to services, Medicaid mental health services reach a much smaller proportion of likely need among adults under 150% of poverty. Many of these individuals would not have access to private coverage; Montanans under 100% of poverty experienced an almost 40% rate of uninsurance in 2004/2005, and those between 100 and 150% of poverty had a 33% rate of uninsurance¹¹.

Service Access for Individuals with SDMI.

Individuals with SDMI are served in MHSP and Medicaid. MHSP services are restricted to adults with SDMI, and reach 3.3% of the population in households under 150% of poverty, equivalent to about a third of the 9.2% of poor adults estimated to meet MH2 criteria.

We developed two estimates of the SDMI individuals receiving Medicaid mental health services that represent the minimum and maximum possibilities. The minimum estimate was based on looking at the number of individuals served in the most frequently used service restricted to people with SDMI, outpatient therapy. Between AMDD and Other State Plan Medicaid, a (possibly duplicated) total of 6585 or 10.9% of Medicaid enrolled adults received this service, somewhat more than the 9.2% MH2 prevalence rate. The maximum estimate assumed that all the unduplicated 13,209 adults served by AMDD had SDMI. This constituted 21.8% of the 60,650 adults enrolled in Medicaid in FY2007. This maximum estimate far exceeds the 9.2% prevalence rate for MH2, and even the 15.5% prevalence rate for the more expansive definition of MH3.

We also analyzed how these two estimates would affect our calculation of the numbers of adults under 150% of poverty receiving services for SDMI. Adding our minimum Medicaid estimate to MHSP, we find that Montana is reaching at least 7.6% of the population in households under 150% of poverty, less than the expected 9.2% prevalence for MH2. According to our maximum estimate, it is reaching 11.9%, exceeding the MH2 prevalence rate.

Obviously, there is a considerable variation between the two estimates, leading to very different assessments of the need for additional outreach. The method for developing the minimum estimate is simple and robust, though we know that it is not a complete count since it excludes individuals with SDMI who receive SDMI services other than individual counseling. A number of ambiguities in adult Medicaid mental health claims make it difficult to construct a more solid maximum estimate of adults with SDMI. Though Montana's adult Medicaid benefit is commonly described as restricted to individuals with SDMI, certain mental health services, such as those provided by physicians and federally qualified health centers, do not carry this restriction, and are likely used by individuals with less intensive needs. To develop an estimate of individuals with SDMI it would be necessary to identify and exclude individuals with lower level needs.

The reports we received identified some of these lower need individuals, but likely not all of them. They showed 6233 adult Medicaid recipients who received only psychotropic medications, and had no service claim with a mental health diagnosis. It is likely these

¹⁰ This figure includes individuals receiving vocational rehabilitation services from the Disabilities Services Division that were not included in the unduplicated count of Medicaid and MHSP cited above.

¹¹ 2004/2005 Current Population Survey – Annual Social and Economic Supplement.

individuals are served in primary care settings¹². They constitute 10% of the total adult Medicaid enrollment and a quarter of all adults receiving Medicaid mental health services or medications.

Claims for mental health services provided in primary care settings are reported in the “miscellaneous” service category in AMDD Medicaid. Miscellaneous services can also include personal care services, a lab test for medication levels, or psychiatry services not covered by AMDD’s service menu. Though the dollar value of miscellaneous services is not great, it is the category of service with the greatest number of unduplicated service users, over 9,000, constituting almost 70% of the AMDD Medicaid unduplicated total, and exceeding the over 5,000 adults receiving the next most common service type, outpatient services. This would be consistent with a significant number of individuals with less serious conditions receiving services through primary care or Federally Qualified Health Centers. However, a DPHHS analysis of individuals receiving a miscellaneous service found that virtually all also received a service that is restricted to individuals with SDMI, suggesting the opposite conclusion, that virtually all had more serious conditions.

Another aspect of the data on adult mental health services that was hard to interpret was that data on Other State Plan Medicaid services reported almost 1,000 individuals to be receiving one or more mental health services that were not adjudicated to AMDD. These services ranged from outpatient to inpatient care and all are normally reserved for people with SDMI. The degree of overlap between individuals included in AMDD Medicaid and those reported in Other State Plan Medicaid is unknown. DPHHS should review these kinds of claims in future years to determine whether they are being reported properly.

Given the unanswered questions about the level of need of adults being served and the broad range of possible SDMI estimates, we encourage DPHHS to review its Other State Medicaid and Miscellaneous claims to better understand the individuals being served, their level of access to services and their patterns of care.

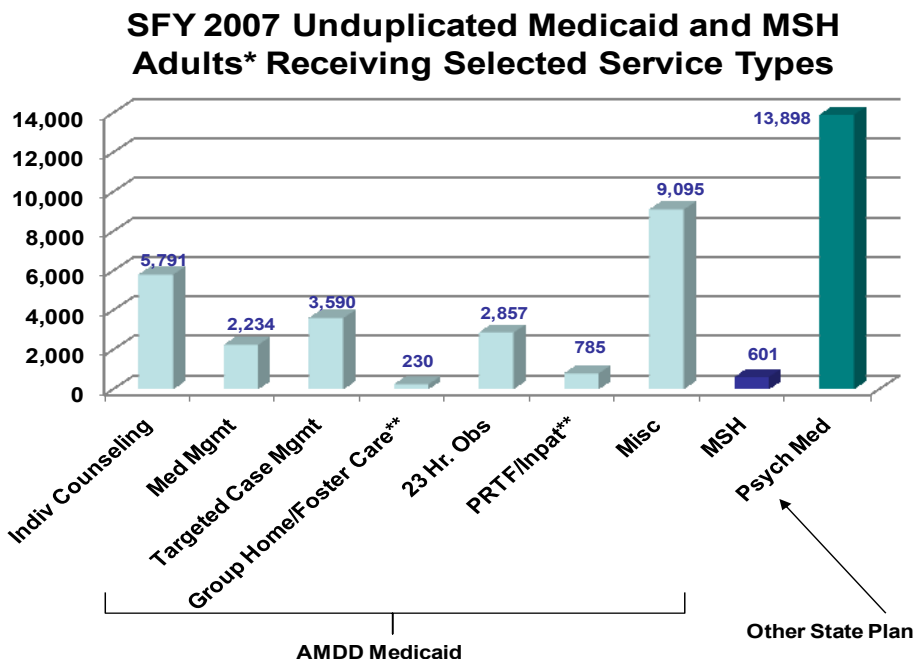
Though our estimates of the overall level of service to individuals with SDMI are inconclusive, our findings on the utilization rates of specific services on a statewide and a regional basis which follow, provide evidence on the relative access to specific services for adults with SDMI that allow for additional consideration of service availability.

c) Statewide Availability of Specific Service Modalities - Adults

We analyzed the penetration rates for some of the most used adult services to provide further indication of service need, summarized in Figure III-11.

¹² According to Surgeon General, “The general medical sector has long been identified as the initial point of contact for many adults with mental disorders; for some, these providers may be their only source of mental health services.” The National Institute of Mental Health Epidemiologic Catchment Area Program found that, in a 12 month period, “More than 6 percent of the adult U.S. population use the general medical sector for mental health care...” They represented 40% of all adults who sought mental health services from any possible provider. (U.S. Department of Health and Human Services, 2001)

Figure III-11



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

* Excludes people receiving services in IHS facilities

** May double count adults receiving both types of service in the year

Source: DPHHS Special Report

Services important for adults with less serious mental health problems. For adults, miscellaneous services and psychotropic medications have the highest penetration rates. Medications and miscellaneous services are not restricted to adults with SDMI, but both are used by adults with SDMI. Over 50% of unduplicated adults receiving DPHHS mental health services or medications used a psychotropic medication. Most use medications in conjunction with some other service; twenty-four percent of adults receiving psychotropic medications receive them without any other public mental health service. Only 16% of adults using psychotropic medications saw a psychiatric practitioner during the year. It is possible that a number of adults are having their medications managed by a primary care physician or mid-level practitioner.

Medicaid Services Important for Adults with SDMI

- ▶ Individual counseling from a Mental Health Center or mental health specialist is the most frequently used modality, used by 5,791 Medicaid enrolled adults. Not shown in the chart are another 794 enrollees (possibly duplicated) who receive this service under Other State Medicaid.
- ▶ Targeted case management was used by 3,590 AMDD Medicaid enrollees, and another 424 received this service under Other State Plan Medicaid.

Medicaid Crisis Services

These data are incomplete in their counts of crisis services, but we see that 2,857 individuals experienced observation stays, and another 350 (not shown) received crisis intervention services.

Medicaid Out of Home Services

- ▶ Relatively few adults are accessing supported housing programs through DPHHS; 230 were in group homes and 113 were in an adult form of foster care.
- ▶ Provision of inpatient and residential levels of care is almost equally split between Montana State Hospital, which served 601 unduplicated clients; inpatient, which served 238; and PRTFs, which served 547. This suggests that there is room to develop more community based capacity and allow adults to be treated closer to home.

Cross State Comparisons. One way to put Montana’s relative use of services of different intensities in context with other states is to compare the proportion of adults served at different levels of care. The Table III-14 below shows the percentage of total adults served who received inpatient and residential services as compared to non-residential community based services.

Table III-14					
Adult Penetration Rates – Montana Compared to Other States					
(Utilizers per Thousand Population)					
	MT Medicaid and MHSP*^	AK Medicaid	AZ (excl. Maricopa Cty)	NM*	MN R/F Counties*+
Adult Penetration					
Inpatient and Residential	1.7			1.5	3.6
Group Home and Foster Care	0.6			.05	
Subtotal Residential	2.3	0.2	6.1	1.55	3.6
Community Only	24.1	10.9	34.6	20.45	33.3
Total	26.4	11.1	40.7	22.0	36.9
*May include some duplications of adults served at more than one residential modality in one year.					
^May show duplication of adults served in more than one plan (AMDD Medicaid, Other State Plan Medicaid, MHSP or DSD) in the same service category.					
+May show duplication of children served in more than one county in the same year					
Source: DPHHS Special Report, 2000 US Census, and submissions from other states – see Appendix E					

Montana’s overall adult penetration rate falls in the middle of a broad range of rates, with the least urbanized states at the low end, and the more urbanized states (even though their most densely populated counties were excluded) at the top end. Montana’s overall residential utilization also falls in the middle of a broad range with the less urbanized states showing the lower rates, and the more urbanized states showing higher rates. Overall this analysis suggests that Montana can improve access to community services. A more qualitative and detailed analysis would be needed to determine whether Montana’s mid-range use of residential services is at the most appropriate level.

d) Regional Service Availability - Adults

One of the important barriers to access identified by survey respondents was an insufficient number of providers or services. This section describes the availability of programs and providers, and explains what our analysis of DPHHS and other service data suggests about the availability of services across the major regions of the state.

Service Location and Capacity.

The 83 psychiatrists who are not Board Certified as Child and Adolescent Psychiatrists and who presumably serve primarily adults, are unevenly distributed. (See Table III-15) The South West region has the highest penetration of psychiatry, while the Eastern region has no resident psychiatrist. Since this is the workforce that serves the entire state, we have calculated their penetration based on the whole population rather than just those under 200% of poverty. A listing of psychiatrists by city is available in Appendix F.

Region	Adult Psychiatrists	Per Thousand
Eastern	0	0
North Central	7	7
South Central	21	14
South West	31	17
Western	24	11
Statewide	83	11

**Excludes those licensed as child and adolescent psychiatrists
Source: Department of Labor and Industry: Health Care Licensing Bureau as of 5/5/08. Census 2006 Total Population estimates.*

Other mental health professionals are also less available in the Eastern and to some degree, the Northern parts of the state. There is no indicator on the data we received that would allow us to distinguish those specializing in adults or children. The Eastern region has the lowest

	Psychologists per 10,000	Social Workers/ Professional Counselors per 10,000	Licensed Alcohol Counselors per 10,000
Eastern	1.1	7.5	5.1
North Central	2.1	14.5	7.6
South Central	1.6	18.2	8.1
South West	3.1	21.9	8.5
Western	3.8	18.2	6.6

Source: Department of Labor and Industry: Health Care Licensing Bureau as of 5/5/08. Census 2006 Total Population estimates

rate of psychologists, social workers/professional counselors and licensed alcohol counselors per population. The two western regions tend to be on the high side, particularly for the mental health professions. South Central is mixed, low on psychologists, but high on social workers. City listings are available in the Appendix F.

The following table shows AMDD’s listing of the services available for adults. Of the services listed in the table below, only group home beds are present in every region. The distribution of remaining programs is similar to that of adult psychiatrists; the four psychiatric units are in the central and western part of the state, as are most of the crisis stabilization programs and PACT teams. The Eastern region is particularly lacking in services, with no psychiatric unit, Dialectical Behavior Therapy (DBT) team, Program of Assertive Community Treatment (PACT) team, or access to Home and Community Based Services (HCBS) waiver services.

	Dialectical Behavioral Therapy Team	Adult Foster Care Beds	Adult Group Home Beds	Crisis Stabilization	Intensive Community Based Rehabilitation Beds	Program of Assertive Community Treatment Teams	Acute Psych Unit	Home and Community Based Services Waiver	72-Hour Presumptive Eligibility Program
Eastern	No	8	8	0	8	0	0	No	Yes
N Central	Yes	19	18	0	8	1	0	Yes	Yes
S Central	Yes	0	12	14	6	1	1	Yes	Yes
S West	Yes	14	7	15	8	2	1	Yes	Yes
Western	Yes	8	18	17	0	2	2	No	Yes

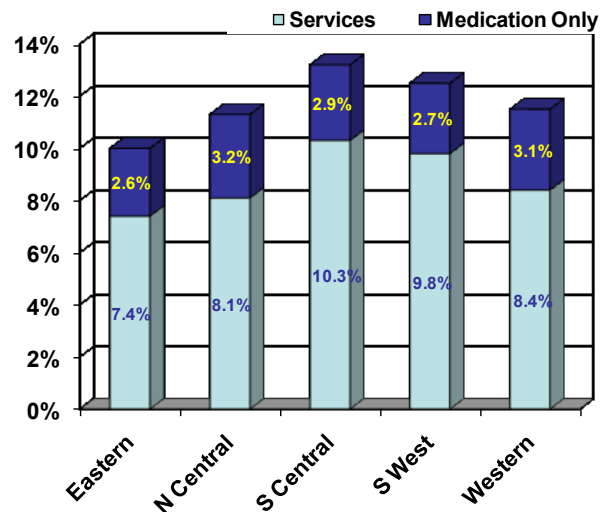
Source: AMDD Report, Service Capacity by County

Telemedicine. Montana providers have been active in building and using telemedicine, and Montana has a widespread telemedicine infrastructure. It is covered by three telehealth networks and one which will be built by 2010. Together they cover most of the state. Our data does not provide any indication of whether services were provided through telemedicine or conventionally. Therefore, we were unable to evaluate how it is being used across the state.

Regional Penetration Rates.

Figure III-12 shows penetration calculated for unduplicated AMDD mental health service users as a percent of population in households under 200% of poverty by region. We found a 39% difference between the highest and lowest mental health service penetration regions, and more than an eight-fold difference between the highest and lowest penetration counties. These differentials considerably exceed those for prevalence. However, the direction of the differences does correspond to variation in prevalence. The Eastern region had the lowest prevalence rate for SMI for adults in households under 200% of poverty and also had the lowest penetration rate. South Central had the highest prevalence rate for SMI for adults in households under 200% of poverty and also has the highest penetration rate for mental health services and medications.

**Figure III-12
FY2007 DPHHS Adult MH Service & Medication Users* as a Percent of Population in Households Under 200% of Poverty**



* Excludes recipients receiving only state hospital or nursing home services and those receiving mental health services only from IHS facilities

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

Table III-18 presents our analysis of penetration for service categories, measuring number of service users per thousand population in households under 200% of poverty. The modality

closest to being evenly distributed was medication, followed by outpatient services and intensive community services and supports. The Eastern region fell at the bottom for medication and outpatient, though South Central was lowest in penetration of intensive community services and supports.

	Misc.	Medication	Outpatient Services ^{^*}	Medication Management [^]	Crisis ^{^**}	Intensive Community Services and Supports ^{^*}	Community Residential ^{^*}	PRTF/ Inpatient ^{^*}
Eastern	29	59	11	19	6	6	0.9	1.2
North Central	35	72	15	2	4	6	0.8	2.4
South Central	65	81	15	12	10	4	0.8	3.7
South West	42	73	18	18	10	8	1.6	1.2
Western	40	73	14	20	8	6	0.7	1.5
Percent difference highest to lowest	219%	137%	165%	990%	245%	170%	248%	299%

+ May include duplications of adults receiving services in the same category in more than one county during the year.
[^]May include duplications of adults served in more than one of the following categories: AMDD Medicaid, Other State Plan Medicaid, MHSP or DSD during the year.
^{*} Average of more than one service modality
^{**}Report predates implementation of Presumptive Eligibility
Source: DPHHS Special Report and Census estimates of 2006 household population in poverty

The largest variation was found in medication management penetration rates, where there was a dramatic 10-fold difference between North Central and the rates in virtually all other regions. However, this disparity doesn't seem to affect use of medications in North Central, which is similar to two other regions. The other services had differentials of between two-fold and three-fold across the regions.

- ▶ The Eastern region, containing the 17 eastern-most counties, had relatively low penetration across the board, with the exception of psychiatry (where penetration was high) and intensive community services and supports and community residential (where it fell in the middle). It was similar to South West in its relatively low penetration of inpatient/PRTF services.
- ▶ North Central is low in psychiatry and crisis services, but relatively high in psychotropic medication penetration. It was second lowest in access to miscellaneous services, but relatively high in use of inpatient care.
- ▶ South Central was highest in its use of the less intensive forms of care, miscellaneous and medication, as well as in use of crisis and inpatient services to meet acute mental health needs. It was low in penetration of intensive community services and supports, and somewhat low in psychiatry.
- ▶ South West was relatively high in most service categories, and had the highest penetration of intensive community services and supports and community based residential services. It shared the low hospitalization rate of Eastern Montana.
- ▶ Western had relatively high penetration rates for most services, with the highest psychiatry penetration. However, it had the lowest penetration of community residential. Its inpatient/PRTF rates were toward the low side.

The Role of the Indian Health Service in Mental Health. We added the counts we received from our special report on IHS facility services¹³ to the miscellaneous category, where services of IHS facilities are categorized, and compared the results to the same category excluding IHS. "Miscellaneous services" includes services for mental health diagnoses provided by non-MH providers, including Personal Care Agencies, FQHCs, physicians and labs. It also includes certain psychiatry services not included in standard mental health procedure codes. These services do not require that the client meet criteria for SDMI, but are available to any individual with a diagnosable mental health problem.

Table III-19 shows how these services are distributed across the regions. We have provided the same calculations for each county in Appendix C. The Eastern and North Central Regions have the lowest penetration of this type of service, with South Central considerably higher, and the two western regions close to the statewide average. Addition of our IHS data, which is likely partial, considerably raises the rates for the two lowest regions. Despite a 30% increase, the Eastern region still remains the lowest, but is

Region	Misc.	Misc. including Partial IHS	Percent Difference
Eastern	29	38	30%
North Central	35	42	20%
South Central	65	66	2%
South West	42	42	0%
Western	40	40	1%
State Total	43	46	5%

Source: DPHHS Special Report and DPHHS Report on Revenue Code 915 Visits to IHS Facilities, 2006 Census Estimates

considerably closer to the next lowest regions. North Central actually exceeds the Western region in this calculation. However, in the Salish/Kootenai facility on the Flathead reservation, whose reservation in the 2000 census included over 40% of Montana’s total reservation population, showed only 79 Medicaid members served. This appears likely to be a significant undercount of actual mental health services provided. Should actual level of services provided from that service center be correctly identified, it is likely that the relative ranking would look different.

While accurate accounting for IHS facility services may reduce the disparity between regions in access to mental health services provided for individuals with a diagnosable mental health disorder, IHS facilities do not provide the kinds of specialized mental health services targeted toward meeting the special needs of individuals with SED or SDMI. Therefore, our conclusions about access to these targeted services would not be affected, and the regional disparities in these services would be expected to apply equally to Indians with SDMI as to any other resident of the region.

According to the IHS consultant responsible for managing the mental health services in the IHS operated facilities, IHS faces the same challenges as the rest of the State in recruiting mental health professionals to provide services in its more remote locations. They pay a premium when it is necessary to fly a psychiatrist to an IHS site to provide services, and also utilize telemedicine when on-site personnel can’t be found. However, they also have some Indian professionals who represent an important, culturally competent resource for serving their communities. Because of limited resources and staff vacancies, IHS reports that they must too often work to resolve

¹³ This discussion concerns IHS and tribal health facilities operating on reservations. Any mental health services provided by Urban Indian Health Centers were included in the DPHHS Special Report.

immediate crises, rather than being able to provide the proactive and preventive services they would like to emphasize.

4. What services do the adults of Montana need that currently do not exist?

The Eastern region stands out with lower rates of service utilization, programs and mental health professionals than the other regions. While inclusion of IHS mental health services available in the region significantly raised the penetration rates for miscellaneous mental health services, the rates remained low relative to other regions. In addition, the IHS does not deliver the specialized services needed by individuals with SDMI, so would not change the penetration rates for other service types.

Psychiatry is notable for its poor distribution across the state, with no psychiatrists in the Eastern region, and most clustering in only a few cities. While the availability of Psychiatric APRNs and of telemedicine may extend the range of psychiatric prescribers, the overall resource is quite low.

With only five hospital sites (including MSH), inpatient level of care is not readily accessible for many Montanans. The regions with the most hospital resources, South West and South Central, have the highest rates of hospital use. Inpatient care stands out as a service not readily accessible in the Eastern part of the state.

Our data do not reflect the implementation of presumptive eligibility and the expansion of crisis intervention services. Full implementation of this capacity across the state will meet a need emphasized by Montana stakeholders and recognized as a factor in preventing the criminalization of people experiencing mental health crises.

We also note that intensive community services and supports tend to be used by fewer people than other service categories. There appears to be room to expand the capacity of community services to meet the needs of individuals with more serious conditions within their own communities, and potentially reduce the use of out-of-home levels of care.

Recommendations

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

Native Americans.

- ▶ Develop a long-term strategy to enhance collaborations with IHS and independent tribes to better understand their needs, enhance cultural competency, and make best use of combined mental health resources.
- ▶ Work with IHS to assess reasons why bills don't consistently identify mental health visits and collaborate to assess service needs of Indian tribes.

- ▶ Continue joint efforts with IHS to increase Indian enrollment in Medicaid to maximize Medicaid reimbursement for IHS services and free IHS appropriations to serve more of the uninsured.

Veterans.

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

5. Presumptive Eligibility and Crisis Services for Adults

This and following sections address high priority issues in the adult service system in more detail.

Crisis intervention is considered a necessary component of any comprehensive mental health system. Without this capacity, individuals in crisis are more likely to end up in police or court custody or in MSH. Montana’s recent creation of presumptive eligibility is a targeted effort to fill one of the significant gaps in Montana’s adult coverage. However, there is currently limited crisis and acute treatment capacity in many Montana communities. Survey respondents overwhelmingly identified crisis care as the most needed or second most needed service in the state; there are only 2 crisis programs in the state. The presumptive eligibility status creates a broad range of services that will be reimbursed when rendered on a crisis basis to eligible individuals. This does create a funding stream that has the potential to support the existing crisis services and perhaps allow other providers to expand their crisis intervention capacity. However, it is not clear that this is sufficient to ensure a robust crisis intervention capacity for the state.

- ▶ Presumptive eligibility expansion rolled out slowly because it required significant planning and implementation time.
- ▶ Hospitals have been slow to use the new presumptive eligibility option, and may need psychiatric back-up to be willing to participate.
- ▶ Existing crisis services serve a high proportion of dually diagnosed (mental health and substance abuse) clients. Their assessments and mental health interventions are covered, but any addiction treatment they need is not. Crisis providers need to be able to intervene with either or both conditions.

Recommendations

- ▶ Build telemedicine capacity at MSH to support local crisis management.

- Implement more aggressive recruitment of new psychiatrists at MSH. This might involve reissuing a procurement document based on more market research.
- Pilot and implement linkage to hospital emergency rooms.
- Add clinicians trained in forensic psychology and offer psychiatric consultation to police and sheriffs similar to Billings Crisis Center’s tele-health consultation to jails.
- ▶ The Legislature should request a formal one year review of implementation and utilization of crisis stabilization services under presumptive eligibility including a review of populations denied presumptive eligibility or referred elsewhere
- ▶ Strengthen and expand financing for crisis services
 - Expand resources available for the next biennium in order to allow crisis providers to bill Medicaid for substance abuse interventions.
 - DPHHS should review Medicaid and MHSP funding mechanisms for crisis services to ensure that they can appropriately reimburse the full costs of the service. Consider:
 - ~ Simplifying the rate structure;
 - ~ Grant or deficit funding mechanisms to purchase capacity
 - ~ To maximize resources, consider ways to limit providers to one designated organization per geographic area as the service expands further across the state
 - Explore options for developing local partnerships like Billings Crisis Clinic
 - Hospitals benefit from reduced costs for detoxification of uninsured individuals and may need to contribute to crisis service costs

6. Montana State Hospital and Other Inpatient Care - Adults

The census at Montana State Hospital (MSH) is felt by many to be the barometer for the well-being of the adult mental health system. Census management at MSH is a daily challenge for hospital administrators. When the census is high, it increases state costs and removes people from both their communities and opportunities for recovery. Exceeding licensed capacity places the Hospital in jeopardy of losing federal reimbursement for Medicaid¹⁴ and Medicare eligible patients and non-compliance with licensing regulations. The current licensed capacity at MSH is 189 and includes 174 hospital beds and 15 adult group home beds. The volatility in the census is demonstrated by the following statistics:

- ▶ In the 36 months that made up FY 2006 - FY 2008, the Hospital exceeded its licensed bed capacity 26 times (72%);
- ▶ The average census for the first month of FY 2009 was 177, well within the hospital’s licensed capacity;
- ▶ On September 25, 2008, MSH census was 185, within the licensed capacity.

There have been close to 700 admissions to the MSH per year for each of the past three years, with the projection that there will be 720 admissions in the current fiscal year. Most admissions are a result of a referral from other psychiatric hospitals, residential treatment facilities, general hospitals and the criminal justice system. Very few people admitted to the state hospital are there because a family member, friend, mental health or primary care provider made a referral. With the five civil and five forensic commitment statuses, the hospital must care for individuals with widely varying needs, including those with lengths of stay between a few days and two weeks and those who remain for years. For example, among those committed as not guilty but

¹⁴ The state is prohibited from billing Medicaid for State Hospital Services for adults between 18 and 64, but there are often a few patients that are younger or older and can be billed.

mentally ill, nine have been hospitalized a year or more, contributing to an average length of stay for this status in 2007 of 775 days.

In FY 2008, emergency detentions accounted for 45% of admissions and were responsible for the greatest number of admissions each month. Emergency detention at the hospital is used when there is no bed available for psychiatric use in the county where the detention took place. These admissions often result in a status change to involuntary commitment.

From discussions with State Hospital staff and other research, we concluded that the hospital lacks the requisite authority to exercise a gate-keeping function to control admissions, and only has limited ability to take proactive steps to prevent overcrowding and a breach of hospital licensed capacity. Instead, court decisions regarding civil and forensic commitment status determine who gets admitted to MSH.

Table III-20 shows data pertaining to inpatient levels of care. Most admissions to MSH come from the South West, where MSH is located, and Western regions. We added MSH total admissions per thousand to PRTF¹⁵ and Other Inpatient clients per thousand to get a sense of total penetration for this intensive level of care. The table is titled a “duplicated” total because it includes an unknown number of users who are counted twice, either because they had multiple admissions to MSH, or because they had admissions to more than one of the three kinds of services. With all inpatient level services considered, South Central stood out with the highest inpatient penetration, but its greater use of PRTFs was paired with lowest reliance on MSH. The South West had the second highest overall rate of inpatient utilization, seeming to rely heavily on MSH, and to make less use than most other regions of other facilities. The Eastern region stood out as having the lowest combined penetration rate at this intensive level of care, with relatively low penetration for all options. North Central and Western used overall inpatient at close to the state average with North Central relying more on community options and Western relying more on MSH. These regional differences suggest that patterns of use that rely less on MSH are possible. The challenge will be to site facilities not only where they are needed, but also where there is sufficient volume for them to be viable. Other considerations may also play into these patterns, including preferences and common practices of different courts.

Table III-20					
Total (Duplicated) FY 2007 Mental Health Hospital Utilization					
	MSH Admissions		PRTF	Other Inpatient	Duplicated Total
Region	#	Per Thousand < 200% Poverty	Clients Per Thousand < 200% Poverty		
Eastern	32	1.5	1.6	0.8	4.0
North Central	71	1.9	2.8	2.0	6.6
South Central	62	1.4	6.8	0.6	8.8
South West	286	5.1	1.2	1.2	7.5
Western	231	3	2.1	1.0	6.1
Total	682	2.9	2.9	1.1	6.9

Source: MT 2007 MSH Admissions and DPHHS Special Report, 2006 Census estimates for households

¹⁵ For adults, PRTF is a billing designation used by some psychiatric inpatient facilities. It is not a separate level of care.

a) Legislative and Executive Efforts to Reduce MSH Census

Over the past 18 months, Montana has invested significant resources in mental health services, including:

- ▶ At the hospital, to ensure adequate staffing and support of the licensed capacity (supplemental appropriation for staff and operations);
- ▶ In the community, funding for services that could have a direct impact on hospital admissions (i.e., 72-hour crisis stabilization);
- ▶ In the community, funding to improve the amount of support services in the community that have a negligible impact on hospital admissions (mental health drop in-centers); and
- ▶ In the community, flexible funding for housing, medication, and other services and supports to overcome barriers for a person ready for discharge to return to the community.

While the average daily census at the state hospital has been below capacity for the past three months, the current initiatives at their currently funded level may not have a long-term impact on ensuring that the hospital's census remains within its licensed capacity. Some of the funding, such as that available to be used flexibly, relies on one-time resources which are not necessarily available in the long run.

b) Other States' Practices for Managing State Hospital Census

Other states have put in place measures that statutorily or administratively help manage their state hospitals' census. They fall into two general categories: controlling admissions and managing discharges.

Strategies for Controlling Admissions

- ▶ Limited (or no) emergency admissions
- ▶ The establishment of community crisis services including crisis line, mobile teams, and other intervention services in areas that have high state hospital admission rates
- ▶ Require that local treatment options be exhausted prior to admission to the state hospital. This mandatory local treatment could occur in a general or psychiatric hospital.
- ▶ Some states have given statutory authority to the state hospital CEO. The CEO establishes the annual capacity for each program (forensic, civil, geriatric, adolescent), and notifies State and County political leadership of the bed capacity. When the capacity has been reached or there is a potential for the capacity to be breached, the CEO is required to notify referring agencies (local hospitals, managed care agencies, courts, etc.) Patients are then admitted based on the date of their court order.
- ▶ Some states have further refined admission policy by region. In Arizona, each geographic service area, managed by a regional behavioral health authority, is given a bed allocation for the counties they serve. One of the largest counties in Arizona, Maricopa, has an established bed capacity of 55 civil beds for a population base of more than 3.7 million people. This procedure is established by agreement between the hospital the regional behavioral health authority.
- ▶ In managed care states, the managed care organizations (MCOs) assume the risk for the cost of their members' care in the state hospital.

Strategies for Managing the Discharges

- ▶ Require joint patient discharge planning by hospital and community.

- ▶ Require community providers to actively participate in developing their clients' hospital treatment plans and discharge plans.
- ▶ Establish community liaison positions to the regions with highest admission rates.

Montana's efforts to reduce MSH census have been effective so far. However, there are likely to be continued challenges in controlling census at MSH because Montana relies heavily on the law to regulate admissions to the Montana State Hospital. There is not equal weight given to the medical necessity of the placement when determining admission. When courts, other hospitals, and community providers know that MSH cannot say no to an admission, they have less incentive to work out alternative arrangements. While there is certainly a continued need for a facility of last resort, MSH needs to be able to establish a balance that maintains appropriate admission criteria and controls its census. Additional community psychiatric inpatient capacity can help relieve the stress on MSH and treat many Montanans closer to home. In siting additional units, it may be helpful to better understand causes of regional variation in overall inpatient penetration and reliance on MSH.

Recommendations

Until recent efforts, MSH census was rising significantly. In addition to continuing its successful efforts, and strengthening crisis capacity, the following steps would support census management.

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

C. Cross Cutting Issues

1. Workforce Limitations

Workforce limitations affect both children's and adults' services, and have the biggest impact on the rural and frontier parts of the state, including Indian reservations. The least well served areas are North Central for children and Eastern for adults, suggesting that it is possible to serve each area better. The state has a number of options that can be used to help address the need for a better trained and deployed workforce. In addition, setting attractive rates is necessary. Our analysis of Montana's rates appears in Chapter V.

a) Telemedicine.

While Montana providers have been effective in getting grants to establish infrastructure, there can still be operating challenges. Montana Medicaid will pay for services provided by telemedicine at the same rate as a service provided face to face, but these payments do not necessarily cover operating costs for telemedicine capacity. Providers have actively sought assistance from the Rural Utilities Service of the United States Department of Agriculture (USDA), which can provide assistance for operating costs of the communication services. Even with that support, costs can still be high for a small provider.

Medicaid does allow payment for line charges, use of equipment, and technical support, but many states do not reimburse these expenses. Where telemedicine can enhance local resources in a responsible and efficient way, Montana may wish to consider funding a portion of operating costs. Doing so on a pilot basis and assessing the potential for reducing Medicaid transportation may demonstrate that additional costs are at least partially offset by savings.

b) Recruiting professionals.

The time to recruit a psychiatrist to rural practice averages 32 months across the nation and the cost may be \$20,000-\$30,000.¹⁶ The reasons are common to rural and frontier areas: the geographical area covered is vast, the number of colleagues low, the reimbursement rate generally low and the responsibility to provide on-call coverage unsustainable for an individual practitioner.¹⁷ The strategies employed to respond to the challenge, from Alaska to Vermont, involve collaborative approaches, usually with educational, legislative and healthcare partners, of three types - none of which has been found to be sufficient on its own:

- ▶ *Support trainees.* Grow-your-own strategies include identifying and supporting native residents in obtaining training, with financial support throughout training and financial incentives to remain in or return to the home area.
- ▶ *Increase retention.* Develop strategies to retain existing psychiatrists (e.g., creating support networks, ensuring effective and supportive supervision). Those actions that help with Retention also help with Recruitment, as they make the package more attractive.
- ▶ *Improve recruitment.* Recruit new psychiatrists by using financial incentives and incentives related to quality of professional life. Loan repayment programs in particular are a common incentive, used for example in Kentucky, Minnesota, North Carolina, North Dakota, New York, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah and Washington.

¹⁶Rural Behavioral Health Workforce Development, Presentation by Dennis Mohatt
http://www.nasmhpd.org/general_files/meeting_presentations/07%20Hospital%20Summit/DennisMohatt.pdf

¹⁷"Stress of Practicing in Rural Area Takes Toll on Psychiatrist" Aaron Levin, Psychiatric News May 5, 2006
Volume 41, Number 9, page 4© 2006 American Psychiatric Association.

According to a December 2006 summit in Nebraska¹⁸, New Mexico has one of the most extensive sets of behavioral health recruiting strategies, including the following additional techniques:

- ▶ Financial Incentives - NM provides the following financial incentives:
 - Different Medicaid reimbursement for providers in rural areas
 - Tax incentives for establishing and maintaining practices in specific areas
 - Low/no cost capital financing for new practices
 - Loans for service, loan repayment and stipend programs made available for multiple professions, including psychiatrists.
- ▶ Professional Support and Recruiting Center: The Rural and Community Psychiatric Network of New Mexico provides a professional support network and a recruitment center. This is a collaborative project of the Psychiatric Medical Association of New Mexico, the NM Behavioral Health Purchasing Collaborative, the NM Department of Health/Behavioral Health Services Division, and the UNM Psychiatry Department.

Although Montana does not have a medical school to help meet its needs for physicians and psychiatrists, it does participate in the WWAMI Medical Education Program¹⁹, a partnership among Washington, Wyoming, Alaska, Montana, Idaho, which sends students from Western states without medical schools to the University of Washington. This could be an ideal source from which to recruit. In addition, Montana does train Advanced Practice Registered Nurses. APRNs in Montana are already providing psychiatric services, and expansion of the program could further address the gap in psychiatry. Consider creating a University Collaboration even if not with a Medical School; examples include New Hampshire, Virginia, Oregon and Louisiana. For all mental health professions, it is important to tie into general workforce marketing efforts in the state, such as economic development commissions. The North Dakota Health Workforce summit in December 2006²⁰ included this step, as have most other behavioral workforce development efforts.

A strongly recommended general resource is The Western Interstate Commission for Higher Education Mental Health Program²¹ which among other activities served as the expert source on Rural Substance Abuse Behavioral Workforce issues for the Annapolis Coalition²² on the Behavioral Health Workforce.

c) Peer services.

Montana has made a strong beginning in developing peer services. The State should assess its current models and seek consumer and provider feedback on how such services can be built in the frontier and remote parts of the state. Careful focus will be needed on training, defining roles and responsibilities, and providing supervision and support. Further attention is given to this recommendation in Section V.

¹⁸ Health Care Workforce Pipeline: A Matrix of selected Workforce Strategies from States Across the Nation. December 5, 2006. http://ruralhealth.und.edu/projects/workforcesummit/pdf/HCWS_pipeline.pdf. See generally, the Center for Rural Health <http://medicine.nodak.edu/crh>

¹⁹ <http://www.montana.edu/wwwami/>

²⁰ <http://ruralhealth.und.edu/projects/workforcesummit/>

²¹ <http://www.wiche.edu/mentalhealth/>

²² An Action Plan for Behavioral Health Workforce Development, 2007, prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by The Annapolis Coalition on the Behavioral Health Workforce (Cincinnati, Ohio) under Contract Number 280-02-0302 with SAMHSA, US Department of Health and Human Services DHHS)

Recommendations

- ▶ Evaluate use of telemedicine services and consider using Medicaid to cover reimbursement for operating costs if that would enhance its utilization.
- ▶ Conduct a more comprehensive and systematic recruiting effort for psychiatry and other professions including participation in conferences and recruiting fairs, incentives for relocation and retention policies and practices.
- ▶ Expand funding for Montana's Advance Practice Nurse Practitioners (APRN) program to train more practitioners qualified to prescribe psychotropic medications.
- ▶ Work with LACs and SAAs to pilot peer service models that are appropriate for frontier and rural areas.

2. Primary Care and Mental Health Integration

Strategies to improve the long term health of persons with serious mental illness are often dependent upon practitioners' efforts to collaboratively identify, assess and treat both physical and psychological impairments. Studies show that people with serious mental illness die 25 years earlier on average than the general population, and that 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary, and infectious diseases.

Montana has not targeted the SDMI population as one that could benefit from collaboration between primary care and the mental health system. DPHHS has, however, piloted a screening tool for children ages 0-3, and is considering expanding the DPHHS Medicaid disease management program to cover mental health conditions.

a) Current DPHHS Efforts

Montana has recognized the potential of primary care providers to serve an important role in improving early identification of children's mental health problems. Research has conclusively demonstrated that very young children can show signs of social and emotional problems that can be effectively addressed to prevent or minimize additional problems. As part of a national study, DPHHS implemented a pilot project directed at primary care and pediatric physicians for the screening and identification of developmental concerns in young children from birth to 3 years old. Known as the Ages and Stages Questionnaire, or ASQ, this parent-report screening tool helps physicians, caregivers and parents identify children who should be referred to specialty providers for further evaluation. The DPHHS pilot included 1,230 children who were screened using the ASQ tool; 4.39% of these children were referred for additional evaluation. The challenge with this age group is to develop the needed services. Relatively few practitioners are trained to treat mental health problems in very young children, which generally involves teaching parents and other caregivers how to address these problems in the child's day to day life.

For adult Medicaid enrollees, DPHHS does have a disease management (DM) program that targets people with chronic pain, heart failure, and asthma, among other diseases. DPHHS is considering expanding the program to all chronic illnesses, which would include mental illness. Risk stratification, predictive modeling, and other analysis techniques would be used to identify individual Medicaid enrollees to be enrolled in the Montana Medicaid Health Improvement Plan.

Recommendations

We encourage DPHHS to continue its current efforts in screening of young children and in the expansion of disease management initiatives to include mental health conditions. As an example, DM efforts could identify and follow up on individuals receiving psychotropic medications but not receiving treatment to better understand the care they are receiving and to provide support to their primary care clinicians and prescribers.

3. Issue: Local Planning

Local Advisory Councils, Service Area Authorities and the Mental Health Oversight and Advisory Council have made progress in involving a broad group of consumers, family members and other stakeholders in planning, but further definition and development are needed. KMAs add another layer of organization in the community, planning for services at the individual case level. Often these are the same people who are serving on LACs and SAAs, and the boundary confusion is likely to be significant. In addition, boundaries are geographically inconsistent between adult and youth regions.

The Montana Legislature created Local Advisory Councils (or Committees) (LACs), Service Area Authorities (SAAs), and the Mental Health Oversight Advisory Council (MHOAC) to work with AMDD and CMHB. The majority of the members of MHOAC and the majority of the board of directors of the SAAs must be consumers or family members. People in each county are encouraged to participate in or form these councils to determine needs and suggest solutions to their SAA. In turn the SAA is to provide input to MHOAC. The process is cumbersome and the communication difficult. As a result there are many questions about roles and responsibilities.

Relatively few survey respondents identified LACs or SAAs as one of the strong features of Montana's mental health system. Approximately 3% to 6% ranked Local Advisory Councils an important strength, and 2% to 4% rated Service Area Authorities an important strength. Our interviews found that LACs and SAAs are still figuring out what they should do and how they should work together and with other entities.

The local planning functions are truly central to building responsive local systems of care for children and adults. Communities must take ownership of developing solutions to help and support their citizens. To achieve this, the LAC and SAA structures need more support and more emphasis on communities. It would help if child and adult regions were aligned; the different regional boundaries dilute the resources available to work with specific towns. Local officials need information to help them plan. This report and the detailed appendices should help them better understand the service utilization of their counties; more information should be developed annually to support them. Furthermore, regional staff from AMDD and CMHB need to learn effective organizing skills to empower these councils and facilitate their planning and problem solving.

According to stakeholders, the areas to be further defined include:

- ▶ The role of the state agency representatives who attend meetings.
- ▶ Support when co-leaders of LACs or SAAs have disagreements about agendas.
- ▶ Methods for consumer participants to engage effectively.
- ▶ The ability of the LAC and SAA to speak out publicly. Can they take public positions and advocate for them outside of the LAC/SAA process?

LACs don't explicitly include members of local courts and law enforcement. Their input would benefit planning for the mental health needs of individuals involved with the criminal justice system.

To reach their full promise, Local Advisory Councils need to be able to combine their experiential perspective with relevant data on service needs and service utilization in their area. Regular reporting can help them plan and evaluate the effectiveness of additions to the service network.

Recommendations

- ▶ Develop broader consensus on the vision, mission and goals of LAC and SAA community oversight. Clarify relationships and responsibilities between planning groups, councils and authorities – Do they operate on parallel but independent tracks? Do they review the same priorities? What is their relationship to DPHHS/AMDD? To the MHOAC?
- ▶ Make the geographic boundaries for planning areas consistent for adults and youth system so that resources can be consolidated to work more closely with communities.
- ▶ Modify LAC membership to include law enforcement representatives from local authorities and state offices.
- ▶ Improve flow of information to LACs and SAAs needed for their planning and monitoring functions. Develop standard reports that provide prevalence, program access, utilization and outcomes data for LACs and SAA areas and region in formats that allow comparison to regional and state averages. Consider building on the reporting framework laid out in this report for utilization and costs data by funding stream, service and county.