SCOPE AND PROVISION OF SERVICES

1.0 INTRODUCTION

The Department of Public Health and Human Services (DPHHS) is seeking a Request for Information (RFI) from individuals, advocates, provider networks or associations, independent providers, hospital organizations, and other interested parties regarding near-term and long-term strategies toward improving behavioral health and developmental disabilities services in Montana.

1.1 PURPOSE

The purpose of this RFI is to solicit specific information to assist the DPHHS in developing short and mid range strategies to strengthen the continuum of behavioral health and developmental disabilities services to Montanans.

This RFI seeks input on actions that could be taken in calendar years 2023, 2024, and 2025 that would provide stabilization, improvement, or increases in quality services available to individuals with a behavioral health and/or developmental disability diagnosis.

1.2 BACKGROUND

Governor Greg Gianforte signed House Bill 872 into law on May 22, 2023, providing a generational investment to reform and improve Montana's behavioral health and developmental disabilities service systems. A central component of the governor's Budget for Montana Families, the $300 million investment will expand intensive and community-based behavioral health care and developmental disabilities services across Montana.

Pursuant to HB 872, eligible uses of the $300 million include:

- Medicaid and CHIP matching funds for payments made to behavioral health settings;
- Medicaid and CHIP matching funds for payments made to intermediate care facilities for individuals with intellectual disabilities;
- statewide community-based investments to stabilize behavioral health and developmental disabilities service providers and delivery, increase and strengthen the behavioral health and developmental disabilities workforce, increase service capacity to meet identified behavioral health and developmental disabilities services demands, and increase opportunities for Montanans to receive integrated physical and behavioral health care;
- acquisition of new or remodeling of existing infrastructure or property to support the establishment of behavioral health settings and intermediate care facilities for individuals with intellectual disabilities;
- planning, operation, or other contract expenses associated with intermediate care facilities for individuals with intellectual disabilities; and planning, operation, or other contract expenses associated with behavioral health settings.

House Bill 872 establishes a commission to make recommendations on investments to the governor. A summary report of the responses to this RFI will be provided to the commission in the fall/winter of 2023.

1.3 SCOPE OF WORK

To better understand challenges and opportunities and to develop strategies to improve service delivery systems for behavioral health and developmental disability populations, please respond to any or all of the following questions.

Tell us who you are. Check all that apply:
☐ Behavioral health service provider
☐ Developmental disability service provider
☐ Consumer/client
☐ Advocate
X☐ Behavioral health association
☐ Hospital organization
☐ Other interested party

Please answer the following questions that are applicable to your situation regarding behavioral health services, developmental disabilities services, workforce, and access.

Where possible, please include examples such as infrastructure investments, workflow and practice improvement support strategies, service expansion (or re-instatement) grants, or other innovations that the department should consider implementing in the next three years to promote comprehensive, integrated behavioral health and developmental disabilities services. Where possible, please provide relevant examples of evidence-based models and/or promising state and local approaches.

Please answer the following questions regarding behavioral healthcare services:

1) What are the top three challenges with outpatient (including intensive outpatient) behavioral health service delivery in Montana today?

1. **Recreating the behavioral health system decimated by the 2017 budget cuts and the pandemic through statewide community-based investments to stabilize behavioral health providers and delivery.**
2. Expand and reopen existing facilities to increase service capacity to meet identified behavioral health services demands.
3. Implement innovative Montana-based recruitment and retention plan to increase and strengthen the behavioral health and developmental disabilities workforce.

2) What are the top three challenges with inpatient behavioral health service delivery in Montana today?

1. Lack of community-based provider care to care for patients prior to admission into an acute setting or accept after discharge from an acute setting.
2. Being forced to act as crisis response facilities in lieu of behavioral health crisis facilities being available.

3. Workforce and retention of healthcare staff across the continuum of care.

3) In addition to Medicaid provider rate increases currently being impleted by DPHHS, what do you see as the greatest opportunity to rapidly impact behavioral health services in Montana?

Reopening programs that have either closed or been severely curtailed since 2017 such as Home Support Services, Targeted Case Management for children and adults, and coordinated crisis response and stabilization across Montana.

4) How can investments in the following play a role in improving behavioral health in Montana:
   a. peer support specialists,
   b. community health workers, and
   c. direct care workers

Please see BHAM's detailed strategy suggestions attached.

5) Provide any additional comments about what is needed to benefit behavioral health service delivery in Montana.

Please see BHAM's detailed strategy suggestions attached.

<u>Please answer the following questions regarding services for individuals with developmental disabilities</u>:

Perhaps the only thing the Developmentally Disabled and Behavioral Health systems have in common is that they have both been tremendously underfunded in Montana. If the two systems are conflated, both systems will be done a disservice. Care for the DD population vs care for the BH population (both mental health and substance use disorder (SUD)) is dramatically different. Although some DD clients also have a co-occurring mental health diagnosis, the mental health treatment is different due to the primary DD diagnosis. A co-occurring diagnosis in behavioral health refers to a client who has both a mental health and SUD diagnosis. Although the terminology is the same, the clients require vastly different treatment modalities. Just as the DD system requires the input of providers in the DD system, the behavioral health providers need to provide expert input in the behavioral health system. The two must have different strategies for their different challenges.

1) What are the top three challenges with developmental disabilities service delivery in Montana today?

2) In addition to the provider rate increases currently being implemented by DPHHS, what do you see as the greatest opportunities to rapidly impact developmental disabilities services in Montana?

3) How can investments in the following play a role in improving developmental disabilities services in Montana:
   a. peer support specialists;
   b. community health workers;
   c. direct care workers

4) Provide any additional comments about what is needed to benefit developmental disabilities service delivery in Montana.

Please answer the following questions regarding workforce and consumer/client access:

Please see BHAM's detailed strategy suggestions attached.

1) What policies or process changes would encourage greater behavioral health and/or developmental disabilities service provider participation in Medicaid and CHIP?

2) What policies would best incentivize behavioral health and/or developmental disabilities service providers to train and practice in rural and other underserved areas?

3) What policies could improve and ensure equitable access to and quality of care in behavioral health and/or developmental disabilities services for minority populations and geographically underserved communities?

4) Provide any additional comments about what is needed to improve workforce and access in the behavioral health and/or developmental disabilities service system in Montana.

Behavioral Health
Alliance of Montana

BHAM STRATEGY FOR BEHAVIORAL HEALTH FOR FUTURE GENERATIONS
August 2023

The Behavioral Health System for Future Generations Fund makes a historic $300M available for the creation of a sustainable behavioral health continuum of care in Montana. We recognize that while this amount is substantial, investments in healthcare can quickly deplete the fund. Therefore, we have focused on proposals that provide the greatest 'bang for the buck' in establishing a continuum of care.

Our proposals fall into three categories related to return on investment:

1. Small investment with return on investment in a short amount of time (less than one year).
2. Mid-sized investment with return on investment in a medium amount of time (between 1-2 years).
3. Large investment with return on investment for future generations (2+ years and ongoing).

I. SMALL INVESTMENT WITH RETURN ON INVESTMENT IN A SHORT AMOUNT OF TIME

For this first category of investment, we suggest reinvigorating evidence-based, community-based programs that were closed or greatly curtailed in the 2017 budget cuts.

1. Home Support Services (HSS):
Home Support Services provide a therapist and behavioral health worker to work with children and families at risk in the home to prevent children from being removed to therapeutic group homes, psychiatric residential treatment facilities, or foster care. This is an extremely cost-effective program that keeps kids at home with their families with the help of the team to address behavioral or parenting issues within the family. HSS diverts kids from higher-cost, more traumatic residential care.

Most of the HSS teams were disbanded after the budget cuts. The rates were raised two years ago after a BHAM and DPHHS taskforce, but providers were in the midst of the pandemic and lacked resources for start up costs. The most recent Provider Rate Increases have a considerable increase to HHS[i] which will make the teams financially viable, but the providers still lack start-up costs. Experience and training are key for effective HSS teams. Inexperienced therapists and behavioral health workers are not effective in at-risk homes teams require experienced, well-trained staff for these teams.

We are developing a proforma that will show twelve months of ramp up costs vs the rate reimbursement for each HSS team.

PLAN: Providers receive twelve months of ramp up costs for each team offset by increasing reimbursement to reestablish HSS teams doing this invaluable work.

2. Targeted Case Management for Youth and Adults

Target Case Management (TCM) was another behavioral health "primary care" program that was largely shuttered after the 2017 budget cuts where low rates made it unsustainable. TCM is a cost-effective, community-based program that keeps kids with their families and adults able to function in the community. After the budget cuts of 2017, many adults lost their TCM, and 30% more clients were involuntarily committed in Missoula County[ii] alone. Most of these people were left without their TCM, access to their therapist and medication provider, and often without the ability to fill out their housing vouchers and many became homeless. This loss of TCM started the revolving door at the Montana State Hospital (MSH) and overwhelmed the acute care system and hospital emergency departments.

With the implementation of Certified Community Behavioral Health Centers (CCBHCs)[iii] in Montana, care coordination again becomes a cornerstone of behavioral health care. However, it will be several years before the CCBHCs have been implemented across the state. Until then, BHAM proposes that we reinstitute TCM for children and adults to prevent the utilization of higher cost, higher acuity care in hospitals and the MSH. We are developing a proforma that will show nine months of ramp up costs vs the rate reimbursement for each TCM hired for children and adults.

PLAN: Providers receive nine months of ramp up costs to hire case management and reinvigorate the limited case management system to keep adults and children at risk at home, in their communities, and with family and friends and reduce the cost of acute and emergency department care.

3. Proposed Pilot Project for Dual Licensure of Shelter Facilities for Youth.

Licensed Shelter Care Facilities serve youth and families in need of shelter but are not covered by Medicaid. Although Shelter Care Facilities were included in the Governor's Provider Rate Study, the rates proposed for FY2024 and FY2025 are well below the benchmarks recommended by the rate study. There are only three providers currently providing Shelter Care in Montana. Youth Homes alone will lose $230,000 per year at the proposed rate because the proposed rate is below the cost of care. Without shelter, youth are either left in an unsafe or unhealthy placement or placed out of community or out-of-state at a greater expense to DPHHS. Children have spent the night in CFSD offices due to the lack of available placement.

PLAN: BHAM proposes a pilot project that allows for a dual licensed model allowing shelters to provide care for short stays of 14 days or less as recommended

in the Families First guidelines. This pilot would include Youth Homes and Providence St. Patrick in Missoula.

This pilot project has the support of:

- Children and Families Services Division (CFSD): Nikki Grossberg, Administrator, and Kate Larcom Regional Administrator Region V.
- Missoula Youth Court: Christine Kowalski, Chief Probation Officer.
- Saint Patrick Hospital: Jeremy Williams Director, Psychiatric Services, and Sandy Cummins, LCSW, MHP, Facilitator and Youth Crisis Diversion Project.
- Behavioral Health Alliance of Montana (BHAM).

Youth in both shelters and in therapeutic group care receive services that are trauma-informed and clinically focused. Adherence to the rules of therapeutic group homes meets the clinical needs of youth in crisis and for longer therapeutic placements.

Providence St. Patrick acute care needs short-term treatment care for stabilized youth awaiting long-term options (out of state or in-state). This efficiency of care will free up beds for youth in need of acute care and save the state money in the long run. Shelter homes could mirror the care that is delivered in acute behavioral health hospitals where youth stay for as little as one night and for up to 90 days and would receive a daily rate from Medicaid that covers costs. The first 14 days would be covered by the placing agency as happens now and youth pending Medicaid authorization could stay longer if appropriate. If a youth is found not to be Medicaid eligible, a case plan would be completed with a discharge plan.

4. **Re-Open Closed Adult, Children's Behavioral Health Group Homes and Shelters.** BHAM suggests re-opening closed facilities for adult and children's congregant living as well as the closed children's shelter in Missoula with start up funding. There will be costs associated with hiring and training staff, re-opening closed homes, and agencies do not have the cash reserves to finance those costs until the increased reimbursement has enough volume to sustain the programs.

5. **Expand SUD Intensive Outpatient Program**
   Many of the SUD IOP programs have closed due to insufficient reimbursement. The ASAM levels of reimbursement were set after the provider rate study last fall. The acuity of the patients and the bundled reimbursement is making many of these ASAM programs unsustainable, including SUD IOP. Adequately reimbursed, SUD IOP allows for an individual to seek recovery when they are ready, rather than waiting for an inpatient recovery bed. By incentivizing these lower cost programs, the state can save substantial money and reduce the recidivism rate if clients are referred to IOP before or after inpatient SUD recovery.

II. MID-SIZED INVESTMENT WITH RETURN ON INVESTMENT IN A MEDIUM AMOUNT OF TIME.

1. Implement Crisis Now System across Montana[iv]

Montana does not have a crisis system, but rather a disparate group of limited crisis response teams. Until a few years ago, Western Montana Mental Health Center (WMMHC) had crisis facilities that offered crisis stabilization in Polson, Missoula, Hamilton, Butte, and Bozeman. The Community Crisis Center in Billings also offers 23-hour, 59-minute crisis stabilization. Currently, WMMHC only has Missoula and Hamilton crisis stabilization facilities still operating. [v]

Historically, crisis stabilization has been underfunded and the state has paid facilities for empty beds to ensure that staff were available when the beds were needed. Like in hospital emergency departments, staff must be available 24/7/365 in the event of a crisis even though there are times when there are no patients.

Six mobile crisis response teams are available in communities across Montana currently. Mobile crisis response teams employ mental health professionals to respond to calls, often without law enforcement, to stabilize the situation and prevent "policing mental health" and taking the person to jail. The mobile crisis response teams in Montana are currently available only a portion of the daytime hours and rarely during the night or weekends due to funding.

In January 2023, new rates were implemented for mobile crisis response teams and crisis stabilization that includes more service requirements but does not increase the rate to cover those costs[vi].

CCBHCs[vii] require that services span the continuum of crisis services, from prevention to post-crisis care, making them an essential component of a crisis response system. This, again, will take several years to implement across the large state of Montana.

While the CCBHC crisis continuum of care is being created and implemented, BHAM proposes reopening the existing crisis facilities at a much lower cost than building new facilities. National Council on Mental Wellbeing provides a "Roadmap to the Ideal Crisis System for the state to follow in implementing a Crisis Now model.[viii]

Currently, the WMMHC crisis facilities in Polson, Butte, and Bozeman are being used as adult behavioral health group homes. These can be repurposed to their original mission for far less than building new stabilization facilities or mini-state hospitals.

The crisis facilities are staffed with onsite, awake staff 24/7, with two people on each shift. Clients also must have access to a therapist, medication management, and nursing 24/7. Involuntary beds have additional staff when a client is present and need access to a

Mental Health Professional for the commitment hearings. Providers of crisis beds are also paid $500 for empty involuntary beds by the county where the facility is located.

Frequently, the clients do not have Medicaid and there is a process for the presumptive eligibility. This requires a full-time billing staff person to handle the Medicaid and the presumptive process, as well as the continued stay authorizations.

This financial proforma details the difficulty of keeping crisis facilities open and staffed with the proposed reimbursement (See Attachment A). We propose changing the reimbursement around crisis facilities so that they are financially viable and can take the pressure off Montana State Hospital.

III. LARGE INVESTMENT WITH RETURN ON INVESTMENT FOR FUTURE GENERATIONS.

1. Proposal to establish a quality Medicaid behavioral health workforce in Montana.

Montana Medicaid insures a full one-third of Montanans[ix]. Mental health and substance use disorder treatment (behavioral health) agencies are primarily reimbursed by Montana Medicaid. These agencies treat the most acute people with mental illness or substance use disorders; adults with a Seriously Mentally Ill (SMI) diagnosis or children with a Seriously Emotionally Disturbed (SED) diagnosis. The reimbursement for these services has historically been below the cost of delivering the care. The Governor's Provider Rate Study and the 2023 Legislature's allocation of funds to raise the Medicaid rates to the rate study benchmarks are a tremendous step forward in fixing the broken system. However, costs will continue to grow, and the rates will soon be again below the cost of providing the care. It will be a constant balancing act to raise rates to cover costs in our fee-for-service system. In reality, salaries in behavioral health will never match salaries in medical health care.

As behavioral health programs have been expanded to hospitals and federally qualified health centers that are reimbursed at much higher levels, the competition for qualified employees has increased. Agencies reimbursed by Medicaid have been unable to recruit and retain qualified staff to treat the most acutely ill in our communities. Medicaid state-approved agencies will never be able to compete on a purely financial basis with medical providers.

BHAM proposes a Montana compensation package be made available to people who choose to work in Medicaid state-approved, safety net agencies that serve at least 70% Medicaid clients. This plan will build and grow a quality and dedicated workforce for the SMI/SED populations. These benefits would help to retain and recruit a high-quality workforce that would benefit Montanans for generations to come.

1. **Health Insurance Group Coverage:**

BHAM proposed a health insurance benefit that could be provided to individuals who work in Medicaid-funded agencies (at least 70% Medicaid reimbursement) at a lower cost to the individual. Medicaid-funded agencies struggle with providing low-cost plans to their employees and typically the plans are high cost with high deductibles for the employees.

Eligible workers could be allowed to participate in the Montana state employee self-funded insurance plan and pay premiums into that system. The insurance pool is large enough to absorb the risk of additional members without a substantial cost to the state. This benefit would be substantial in helping to recruit and retain quality employees into the Medicaid safety net agencies.

2. **Loan Repayment Program for Eligible Employees**

BHAM suggest two options for solutions:
1. The National Health Service Corps (NHSC)[x] from HRSA is available to all tribal and FQHC employees automatically. However, mental health and SUD clinics are not automatically enrolled and are required to fill out annual applications for this program. Many agencies simply do not have the capacity to enroll in this program. The state could offer administrative help to mental health agencies and substance use clinics to enroll in the NHSC program.

OR

2. A Montana loan repayment program that allows eligible employees (at least 70% Medicaid reimbursement) to receive Montana loan forgiveness after a five-year commitment that includes a loan repayment forfeiture if the five-year commitment is not met (only loans for Montana tuition would qualify). This would benefit the licensed professional staff, key to a quality behavioral health care system.

3. **Best Beginnings Daycare Scholarships:**

Allow employees working in Medicaid-funded agencies (at least 70% Medicaid reimbursement) and earning below 300% of Federal Poverty Level to receive Best Beginnings Daycare Scholarships to ensure that employees working in the safety net agencies can receive high-quality, licensed childcare. This would be particularly valuable in recruiting and retaining direct service workers who receive the lower end of the pay scale.

4. **Housing Stipends:**

BHAM proposed that rental/mortgage assistance be made available to behavioral

health workers if they have a household income at 80% of median county income and work at a state-approved Medicaid agency (at least 70% Medicaid reimbursement) that has at least a 50% Medicaid payor mix. This would benefit both licensed professional and direct care workers who are unable to live in many cities across Montana now due to the skyrocketing housing costs. This would create a stable workforce for future generations.

PLAN: Implement the Montana LEADS Program, "Long-Term Employment Accessing Disbursement for Success."[xi]

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[i] MT DPHHS Proposed Fee Schedule:
https://medicaidprovider.mt.gov/menuetest/ProposedJuly2023YouthMentalHealthFeeSchedule.pdf, P.4

[ii] Missoula County Attorney, Involuntary Commitment Tracking Spreadsheet 2018 vs 2019.

[iii] https://www.samhsa.gov/certified-community-behavioral-health-clinics/section-223/care-coordination

[iv] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[v] https://crisisnow.com/

[vi] https://medicaidprovider.mt.gov/docs/feeschedules/2023/January2023Proposed/ProposedJanuary2023NonMedicaidMHCrisisServicesREVISED12052022.pdf

[vii] https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/ccbhcs-and-crisis-response-systems/

[viii] file:///C:/Users/mwindecker/Downloads/042721_GAP_CrisisReport.pdf

[ix] https://www.medicaid.gov/state-overviews/stateprofile.html?state=Montana

[x] https://nhsc.hrsa.gov/loan-repayment

[xi] Or any other catchy title you guys come up with because I'm tapped out!

Crisis Facility Pro Forma

Assumptions:

Capacity payment: 21 ED bed days per month @ $500/bed

Average daily census: 2.13

Medicaid rate: $390.69/occupied bed/day

	July	Aug	Sep	Oct	Nov	Dec	Jan
Number of days	31	31	30	31	30	31	31
REVENUE							
ED beds	$10,500	$10,500	$10,500	$10,500	$10,500	$10,500	$10,500
Medicaid	$25,797	$25,797	$24,965	$25,797	$24,965	$25,797	$25,797
TOTAL REVENUE	$36,297	$36,297	$35,465	$36,297	$35,465	$36,297	$36,297
EXPENSES							
Total Salaries	$42,961	$42,961	$42,961	$42,961	$42,961	$42,961	$42,961
Benefits @ 32%	$13,748	$13,748	$13,748	$13,748	$13,748	$13,748	$13,748
Total Personal Services	$56,709	$56,709	$56,709	$56,709	$56,709	$56,709	$56,709
Operating Expenses	$1,752	$1,752	$1,752	$1,752	$1,752	$1,752	$1,752
Total direct expenses	$58,461	$58,461	$58,461	$58,461	$58,461	$58,461	$58,461
Overhead @ 18%	$10,523	$10,523	$10,523	$10,523	$10,523	$10,523	$10,523
TOTAL EXPENSES	$68,983	$68,983	$68,983	$68,983	$68,983	$68,983	$68,983
NET INCOME/(LOSS)	($32,686)	($32,686)	($33,518)	($32,686)	($33,518)	($32,686)	($32,686)

Feb	Mar	Apr	May	June	**TOTAL**
28	31	30	31	30	
$10,500	$10,500	$10,500	$10,500	$10,500	$126,000
$23,301	$25,797	$24,965	$25,797	$24,965	$303,742
$33,801	$36,297	$35,465	$36,297	$35,465	$429,742
$42,961	$42,961	$42,961	$42,961	$42,961	$515,532
$13,748	$13,748	$13,748	$13,748	$13,748	$164,970
$56,709	$56,709	$56,709	$56,709	$56,709	$680,502
$1,752	$1,752	$1,752	$1,752	$1,752	$21,024
$58,461	$58,461	$58,461	$58,461	$58,461	$701,526
$10,523	$10,523	$10,523	$10,523	$10,523	$126,275
$68,983	$68,983	$68,983	$68,983	$68,983	$827,801
($35,183)	($32,686)	($33,518)	($32,686)	($33,518)	($398,059)