Behavioral Health System for Future Generations (BHSFG) Commission Report

Recommendations to Reform and Improve Montana's Behavioral Health and Developmental Disabilities Service Systems

September 2024

MONTANA DPHHS
DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

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Introductory Letter

Letter from Chair Bob Keenan and Vice-Chair Charlie Brereton

We are proud to present the final report of the Behavioral Health System for Future Generations (BHSFG) Commission. As required by House Bill (HB) 872, the report comprises detailed recommendations on how to make historic investments in Montana's behavioral health (BH) and developmental disabilities (DD) service systems. We are confident these recommendations lay a strong foundation for the future and will ensure every Montanan has access to, and benefits from, the care they need. This is not another strategic report for the bookshelf, but instead our comprehensive, vetted, and actionable roadmap for future generations.

Nearly a year in the making, the report draws from many sources. These include Commissioners, public commenters, individuals with lived experience, community stakeholders, health care providers, subject matter experts, including those who work at the Department of Public Health and Human Services (DPHHS), and data-driven reports and analyses, such as the Alternative Settings reports. The Commission has held 12 public meetings across Montana over the last 12 months, each with extensive testimony from Montanans, which further informed the report's recommendations and contributed to our consensus-driven approach.

The Commission's work was guided by priorities established in its first few months. These include building a comprehensive statewide crisis system, investing in clinically appropriate state-run health care settings and a functional commitment system, expanding the capacity of the adult and children's BH service delivery systems, expanding the capacity of the DD service delivery system, expanding the capacity of the co-occurring populations' service delivery system, and enhancing family and caretaker supports. These priorities were our "North Star" and are strategically woven throughout the recommendations in our final report.

There are many people we would like to thank, some of which are listed in the Acknowledgements section of the report. We would be remiss, however, if we did not specifically mention Governor Gianforte for his vision and commitment; Senator John Esp for his help in designing and passing HB 872; our fellow Commissioners for their focus and dedication over many months; and the staff of DPHHS for their tireless work, trust in the process, passion to improve systems for those whom they serve, and belief that better is always possible.

Our focus now turns to making these recommendations a reality in Montana over the coming years, which will be no small feat and require the partnership of the Executive Branch, Legislature, health care providers, advocates, and others. We look forward to this critical next chapter.

Sincerely,

Representative Bob Keenan, Chair

Director Charlie Brereton, Vice-Chair

Commission Background and Purpose

HB 872

The BHSFG Commission was established through the passage of HB 872. Along with an historic investment of $300 million (M), the Commission was charged with providing recommendations to reform and improve Montana's BH and DD service systems. This legislation makes $225M available for recommendations made by the Commission, subject to legislative appropriation, including $70M during the 2024-2025 biennium. It also appropriates an additional $75M specifically for certain types of capital projects.

Background and Purpose

The Montana DPHHS is responsible for administering the statewide Medicaid program that serves the medical, economic, and community-based needs of nearly 240,000 Montanans. Montana's Medicaid system serves a diverse population, providing access to services that support individuals of all ages with a wide variety of medical and other needs; included in this critical service system are the BH and DD programs. These two special populations have some of the most complex service needs and, together, comprise approximately 22% of the total annual $1.2 billion (B) Medicaid spending for the program, equal to the total hospital spend. The complexity of needs covered within these two populations, while often grouped together, is categorically different. However, a common thread that links them is the growing demand for services from these populations and a growing expectation of community-based service choices to meet the needs of the roughly 85,000 people accessing these services.

Governor Greg Gianforte signed HB 872 into law on May 22, 2023, providing a generational investment to reform and improve Montana's BH and DD service systems. A central component of the Governor's Budget for Montana Families, the $300M investment was made to expand intensive and community-based BH and DD services across Montana. Key to HB 872 was the establishment of the BHSFG Commission to serve as a governing body and collect stakeholder input and feedback, evaluate system challenges, and formalize recommendations to be supported by historic one-time-only (OTO) investments and other long-term funding sources.

Seven core priorities[1] established by the BHSFG Commission serve as the cornerstone of this report's recommendations:

1. **Comprehensive statewide crisis system**
2. **Clinically appropriate state-run health care settings and a functional commitment system**
3. **Capacity of adult behavioral health service delivery system**
4. **Capacity of children's mental health service delivery system**
5. **Capacity of developmental disabilities service delivery system**
6. **Capacity of co-occurring populations service delivery system**
7. **Family and caretaker supports (BH and DD)**

> ***"Across all parts of the Commission's work, since the bill passed, I observed things that I believe would have helped me personally… I just believe that with some of the initiatives that are already done and more that will come, we have the ability to impact lives and change what's happening."*** *– Montanan with lived experience*

[1] Some references to specific priorities are abbreviated within the recommendation detail for ease of presentation.

Executive Summary

The following is a summary of the Commission process, emerging themes, and recommendations:

1. Beginning in July 2023, public Commission meetings were held every six to eight weeks across Montana to consider reforms and gather feedback through scheduled panels from community stakeholders representing families, BH and DD staff, hospitals, judges, tribal officials, county leaders, prevention experts, and mobile crisis responders, among others. The Commission also issued a request for information (RFI) and received dozens of detailed responses from community stakeholders around Montana. These responses included a wide range of compelling ideas, many of which informed the Commission's recommendations.

2. Concurrent with its meetings across the state, the Commission also oversaw the development of two Alternative Settings reports which focused on identifying the need for additional facilities or services to address the BH and DD needs of Montanans. The Alternative Settings Steering Committee (and its working subcommittees focused on access, the care continuum, and workforce) met extensively throughout 2023 and 2024 with diverse stakeholders, ultimately culminating in the development of the two reports. These reports are a key input to the Commission's recommendations.

3. The Commission's work was guided throughout this time by its key priorities, which were unanimously adopted at the October 13, 2023, Commission meeting. These include building a comprehensive statewide crisis system, investing in clinically appropriate state-run health care settings and a functional commitment system, expanding the capacity of the adult and children's BH service delivery systems, expanding the capacity of the DD service delivery system, expanding the capacity of the co-occurring populations' service delivery system, and enhancing family and caretaker supports.

4. Following community meetings and Commissioner input, three themes emerged as the primary "gaps" that need to be addressed to strengthen Montana's BH and DD systems (as seen in Figure 1 below): (1) workforce; (2) case management; and (3) continuum capacity. While each of these themes is individually impactful, none are mutually exclusive. Each theme serves as a critical component of system effectiveness and efficiencies.[2]

5. The Commission then developed **22** recommendations that aim to improve and better integrate the BH and DD systems. These recommendations span the three themes that emerged from the Commission process and align with the Commission's priorities.[3]

6. The Commission recommended **11**[4] Near-Term Initiatives (NTIs), supported by the Governor and launched by the Department, aimed at immediately addressing systemic issues raised through

[2] On behalf of the Commission, the Department also engaged Alvarez and Marsal (A&M) to support its HB 872 workstreams by providing project management and health and human services policy and operational expertise.
[3] See Themes below (page 6).
[4] The number of NTIs is not yet final and subject to change, pending Commission recommendation and the Governor's approval of additional NTIs.

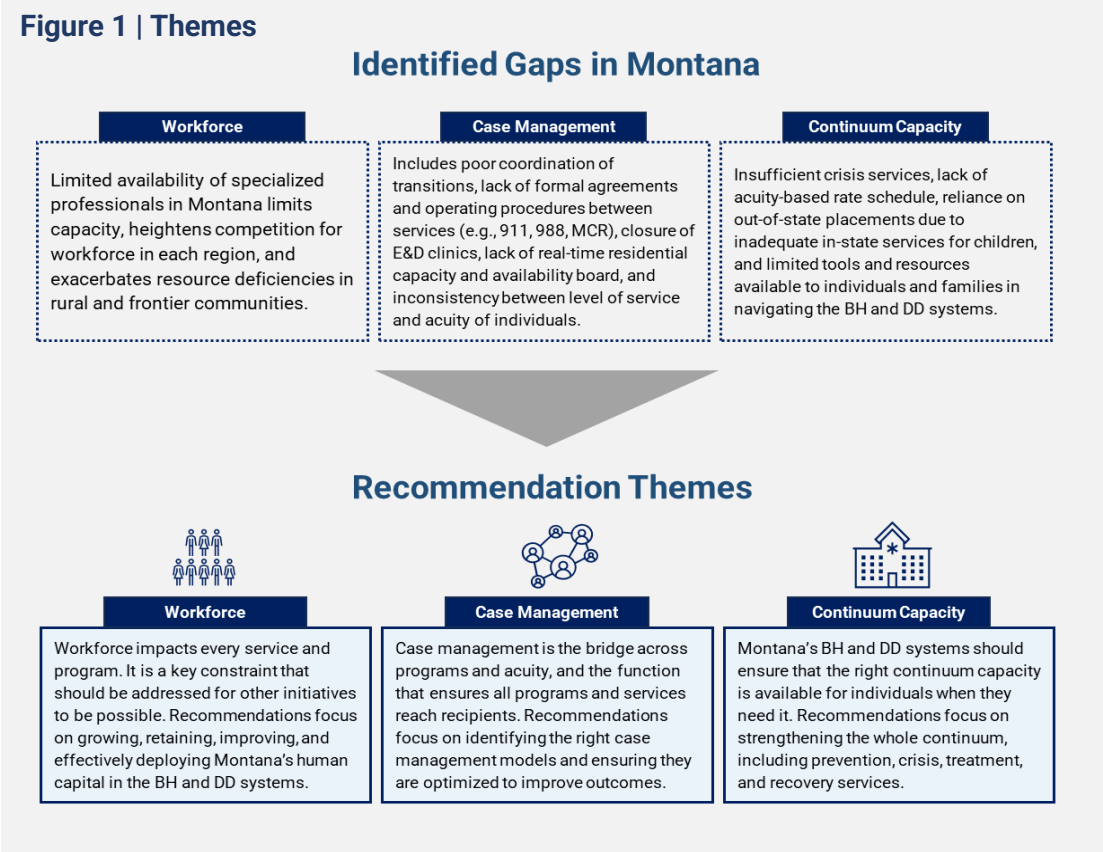
the Commission process. To date, these initiatives have up to **$47M** in funding available to implement them.

7. The Commission has estimated a funding level of **$103M**[5] required to initiate and operationalize the recommendations related to improving programmatic outcomes and service delivery. Recommendation cost estimate details in this report consider long-term sustainability and associated strategies to ensure continued success and fiscal viability. Due to resource, fiscal, and other operational and political constraints, the Commission does not expect DPHHS to implement all the recommendations immediately.

8. Finally, the Commission has directed DPHHS to issue two RFIs to assist with its determination of how to invest **$75M** in appropriated capital project funds. One RFI solicited information regarding projects to enhance the continuum of care for the BH system; the other solicited information regarding projects to enhance the residential capacity of the DD system. At the time of submission of this report to the Governor, the Commission does not have final recommendations for use of the funds allocated for the Long-Range Building Program (LRBP) but may provide an addendum to this report in the future. The Commission intends to reconvene in October 2024 to consider a capital projects framework.

Themes

Figure 1 | Themes



[5] See the Budget Summary portion of the Recommendations section for details (pages 13-15). Cost estimates contained in this report are subject to change.

Summary of Recommendations and Near-Term Initiatives

This report includes **22 recommendations and 11 NTIs** that aim to improve Montana's BH and DD systems. Recommendations span the entire continuum of care and aim to improve the state's long-term capacity to meet the needs of individuals with BH and DD challenges. The DD recommendations are organized into the continuum capacity and case management categories. The BH recommendations are organized into three categories: case management, continuum capacity, and workforce. Separately, NTIs reflect common sense, actionable ideas to address known and worsening gaps in Montana's BH and DD systems.

Figure 2 | Summary of Recommendations and NTIs

Recommendations: *Aim to improve Montana's BH and DD systems over the long term. These recommendations span the entire continuum of care and aim to improve the state's capacity to meet the needs of people with BH and DD challenges.*

Developmental Disabilities

1. Refine and Reconfigure the Current 0208 Comprehensive Waiver Services Rates
2. Expand Access to Waiver Services Through a §1915(c) Supports Waiver
3. Expand the Service Delivery System to Support Individuals with Complex Needs
4. Redefine and Reopen Evaluation and Diagnostic Clinics to Support Families More Effectively
5. Conduct an In-Depth Study of the Current DDP Waitlist Management Process

Behavioral Health

6. Enhance the Targeted Case Management Program
7. Develop a Targeted Case Management Training Program
8. Implement a Care Transitions Program
9. Adopt Electronic Bed Registry and Enhance 988
10. Expand Mobile Crisis Response to Additional Regions
11. Introduce New Crisis Stabilization and Receiving Center Services
12. Expand Scope of the Certified Adult Peer Support Program
13. Increase Support for Individuals with SMI and/or SUD Experiencing Homelessness
14. Launch a Media Campaign to Raise Awareness and Reduce Stigma
15. Reduce Transportation-Related Barriers to Care
16. Expand the Family Peer Support Program for Parents and Caregivers
17. Redesign Rates to Improve In-State Youth Residential Services
18. Invest in School-Based Behavioral Health Initiatives
19. Incentivize Providers to Join the BH and DD Workforce
20. Expand Training Content Available to BH and DD Workforce
21. Enhance Behavioral Health Integration Efforts
22. Expand and Sustain Certified Community Behavioral Health Clinics

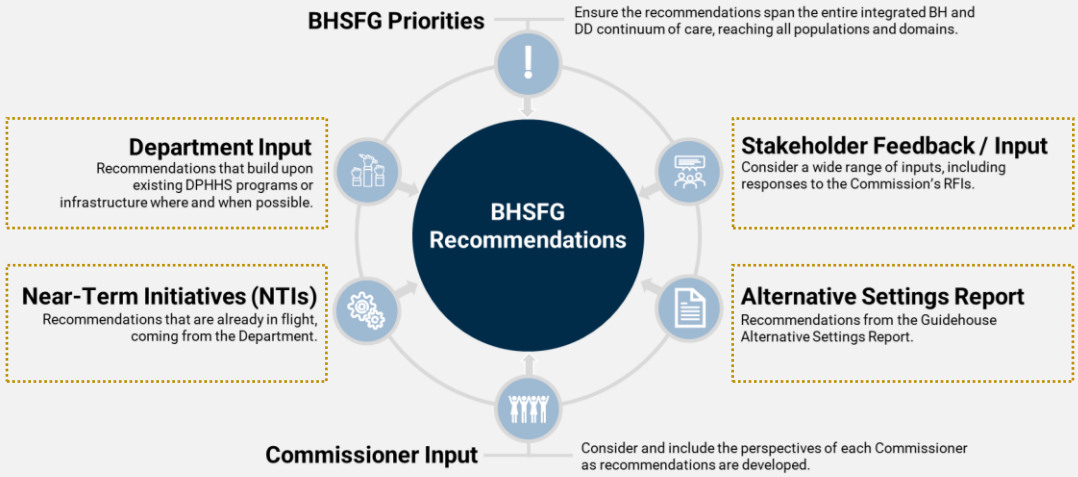
Near-Term Initiatives: *Initiatives the Commission recommended, and the Governor passed, throughout the Commission's tenure. NTIs reflect common sense, actionable ideas to address known and worsening gaps in Montana's BH and DD systems. NTIs were specifically designed to address problems that could be alleviated via short-term initiatives utilizing one-time-only funding. NTIs are separately categorized from this report's recommendations, which are longer term in nature, but are fundamental actions DPHHS has taken, under Commission guidance, to improve the BH and DD systems.*

1. Incentivize Community-Based Court Ordered Evaluations
2. Increase Residential Bed Capacity
3. Support Mobile Crisis Response and Crisis Receiving and Stabilization Services
4. Development and Deployment of a Comprehensive Crisis Worker Curriculum and Certificate Course
5. Health Care and DD Workforce Training and Certification
6. Family Peer Supports Pilot Program
7. Support for Tribal and Urban Indian Organizations to Expand BH and DD Capacity
8. Fair Market Rent Re-evaluation Study
9. Access to Naloxone and Fentanyl Test Strips
10. Funding to Launch Occupational Therapy Doctorate and Physician Assistant Programs
11. Grants for Local Innovation Pilot Programs

Overview of the Commission Process

The Commission implemented a "hub and spoke" model to accept and evaluate inputs from many diverse sources and views this report as the central hub, coalescing feedback as depicted below.

Figure 3 | BHSFG Recommendations Inputs



The following outlines the Commission's approach to addressing each source of input:

- **Stakeholder Feedback / Input:** DPHHS collected information from Montana stakeholders, including individuals with lived experience, families, advocates, and providers, through various channels, including RFIs and public comment. This feedback informed the Department and the BHSFG Commission as they collaboratively developed NTIs and recommendations. Stakeholders shared insights by completing online forms, e-mailing the Department directly, speaking on panels, and participating in public comment during Commission meetings.
- **Alternative Settings Report:** DPHHS contracted with Guidehouse to conduct an independent study of the current capacity and subsequent gaps in physical capacity to support individuals with BH needs. In addition to the initial BH study, subsequent sub-studies were also conducted on workforce issues, DD service system needs, and housing. Guidehouse submitted and presented final reports to the Commission in April 2024.
- **Department Input:** DPHHS and the Commission reviewed extensive historical data to inform the systemic review of Montana's BH and DD systems. The multifaceted environmental scan included a review of the systems through existing and relevant departmental work products such as reports, memos, analyses, and studies. This work also included benchmarking the Montana system with peer states and national trends to identify best practices, as well as leveraging existing Department data sources and datasets to conduct relevant analyses and identify past, current, and projected trends.

To immediately address identified needs in the BH and DD service systems, the Commission voted on and recommended a series of NTIs to Governor Gianforte. Upon his approval, funding was quickly allocated, and programs were launched by DPHHS in advance of the issuance of the final report.

BH and DD Systems Overview

Behavioral Health

Within DPHHS, the Behavioral Health and Developmental Disabilities Division (BHDD) works to implement and improve a statewide system of prevention, treatment, care, and rehabilitation for Montanans with mental disorders, addictions to drugs or alcohol, or developmental disabilities. Public mental health, substance use disorder, and DD services are coordinated through the Treatment Bureau, the Prevention Bureau, the Children's Mental Health Bureau (CMHB), and the Developmental Disabilities Program (DDP). CMHB supports and strengthens services for Montana youth and families through Medicaid-funded mental health treatment services. In 2022, CMHB provided 21,895 youth with mental health services, with 99.9% receiving community-based supports.[6]

The 2024-2025 Montana DPHHS biennial budget proposed $970M for BH (mental health and substance use) and DD services.[7] This investment provided access to screening, services, and treatment for Montana children, adolescents, and adults. The public BH system includes services paid for by Medicaid, the Children's Health Insurance Program (CHIP), the state-funded Mental Health Services Program (MHSP), state general funds allocated for substance abuse treatment or mental health services, federal block grants, and other revenue sources. Indian Health Services, tribal health programs, and the Veterans Administration also provide BH services to meet the needs of Montana's residents.

The Montana Medicaid benefit plan covers outpatient psychotherapy services to any Medicaid-eligible adult or child diagnosed with a mental health disorder. Additionally, more comprehensive services are available to Medicaid-eligible adults with severe and disabling mental illness (SDMI) and youth with serious emotional disturbance (SED). Montana Medicaid provides reimbursement for an array of mental health services, from community-based services to inpatient and residential levels of care. Montana has a federal Home and Community-Based Services (HCBS) waiver that allows adults with SDMI to receive mental health services and supports needed to live in home settings. Montana offers extended mental health benefits to Medicaid and CHIP recipients who meet eligibility criteria. These benefits include home support services, therapeutic family care, respite, and a variety of therapies (inpatient, outpatient, residential, individual, family and group).

Montana's expansion of Medicaid has resulted in steadily increased access to mental health and substance use disorder services, including alcohol and drug services, psychotherapy, and other services.[8] In 2021, the state provided rehabilitative mental health services to over 50,000 adults and 21,000 youth enrolled in Medicaid.[9] While Montana's overall Medicaid spending increased from approximately $2B in 2019 to $2.2B in 2021, overall state spending decreased (from $460M to $430M), with the federal government picking up the difference.[10]

[6] Montana 2022 Biennial Report. Available at: BHDD - Presentation to the 2023 HHS Joint Appropriation Subcommittee (mt.gov).
[7] Department of Public Health and Human Services 2024-2025 Biennium Budget. Available at: leg.mt.gov/content/Publications/fiscal/2025-Biennium/2025-Biennium-Budget-Analysis/Section-B/Section-B-All.pdf.
[8] Medicaid Expansion in Montana & Nationwide Financial Modernization & Risk Analysis (MARA) Study Committee 2025 Biennium January 9, 2024 Available at: PowerPoint Presentation (mt.gov).
[9] Montana Healthcare Foundation 2022 Annual Report. Available at: Medicaid-in-MT-2022_4.12.22-FINAL.pdf (mthcf.org).
[10] Ibid.

Access to BH services has long been a challenge in Montana, with a severe and ongoing shortage of providers exacerbated by the impact of COVID-19, particularly in remote, rural, and frontier areas; such shortages severely impact individuals' ability to obtain necessary services. Montana also has among the highest rates of mental illness in the country. In 2023, 34% of adults in Montana reported symptoms of anxiety and/or depressive disorder, compared to 32.3% in the United States.[11] BH needs are particularly acute among Medicaid enrollees; in 2021, nearly one-third of Medicaid expansion enrollees (36,949) had one or more BH diagnoses recorded on a Medicaid claim.[12]

Despite these challenges, BHDD, providers, community partners, and advocates have continuously worked to enhance the state's BH system, through initiatives that strengthen prevention, treatment, and recovery services. This includes investing in each component of Montana's BH system to ensure a "no wrong door" approach and providing high-quality services to meet an individual's needs. In 2023, Montana was selected as one of 15 states for a $1M federal grant to support a 12-month planning process for the implementation of Certified Community Behavioral Health Clinics (CCBHCs) and has advanced a subsequent demonstration grant application. Although Montana was not selected to receive a demonstration program award for an October 2024 start, the Department plans to resubmit its application for the opportunity to join the next round of states.

In 2024, Montana received approval from the Centers for Medicare and Medicaid Services (CMS) for an enhanced Medicaid reimbursement rate for qualifying mobile crisis response services. Montana established crisis receiving and stabilization centers to provide 24/7 drop-off and walk-in rapid assessments and supports for adults experiencing a BH crisis. Critical access hospitals (CAHs) are a key component of the Montana health care delivery system, particularly in rural and frontier regions. Montana's CAHs are often the sole health care provider in underserved areas and offer access to BH services, including inpatient beds and the ability to operate psychiatric and/or rehabilitation units of up to 10 beds.

Separate from the BHSFG effort, the Department has taken several proactive steps to transform the BH system. This includes collaboration with providers, stakeholders, advocates, tribal partners, and policymakers to identify recommendations aimed at enhancing the system. In July 2022, Montana received approval for the Medicaid 1115 Healing and Ending Addiction Through Recovery and Treatment (HEART) demonstration waiver to add contingency management, tenancy support services, and pre-release services for qualifying incarcerated beneficiaries, in addition to seeking Institutions for Mental Diseases (IMD) reimbursement exclusion waivers for both adult and youth populations. In 2023, the Montana Legislature passed a $339M provider rate increase package over SFY 2024 and 2025 aimed at stabilizing Medicaid providers and increasing access to appropriate services for Medicaid beneficiaries.

[11] Kaiser Family Foundation Montana State Fact Sheet, 2023. Available at: Mental Health and Substance Use State Fact Sheets: Montana | KFF.
[12] Medicaid in Montana: Montana Healthcare Foundation 2023-Medicaid-in-Montana-Report_FINAL.pdf (mthcf.org).

Developmental Disabilities

The Developmental Disabilities Program (DDP) manages an active service array to meet the support needs of individuals with DD, from birth to death (*see Appendix B – Developmental Disabilities Continuum of Care*). Developmental disabilities[13] are lifelong, and often require comprehensive supports to assist individuals with activities related to health and safety as well as achieving quality-of-life outcomes. While DPHHS is ultimately responsible for providing access to services, key federal and state statutes and regulations also guide system eligibility, system access, and service quality. Federal requirements like the Olmstead Decision, the Home and Community-Based Services Settings Rule, and the newly published Access Rule, provide further direction to program operations and direct systems to focus on promoting community-based care and moving away from institutionalized care. Additionally, Montana has made steps to align the service system toward a community-based model by closing the Montana Developmental Center.

Community-based supports for individuals with DD are provided through a §1915(c) HCBS waiver for individuals eligible for services, managed by DDP and approved by CMS. Through this waiver (known as the 0208 Comprehensive Waiver) DDP offers a comprehensive service array including over 30 services ranging from Residential Habilitation (including group home supports and supported living services), Day Supports and Supported Employment, and other support services (including Personal Care, Companion, and Respite). The waiver serves approximately 2,500 individuals at an average cost of $55K per person per year. The waiver includes a schedule of reimbursement rates to obtain services from a network of approximately 70 community-based service provider organizations across the state. Notably, DPHHS did undergo a rate study to update reimbursement rates across programs (including DDP) in 2021 and subsequently increased service rates on July 1, 2023. In addition to waiver services, DPHHS also manages a series of State Plan services for individuals with DD, including Targeted Case Management (TCM) and Applied Behavior Analysis, and a 12-bed residential facility for individuals with complex needs, the Intensive Behavior Center (IBC) in Boulder.

While the current services provide an array of options, DDP manages a waitlist of approximately 2,100 individuals waiting for waiver services. People waiting for services enroll in the waiver through (1) chronological selection when waiver slots open; (2) reserved capacity for individuals who enter a defined crisis; or (3) reserved capacity for individuals transitioning from an institutional setting (e.g., IBC). Individuals and families waiting for service can remain on the waitlist for many years. Once selected, however, shortages in the direct care workforce may lead to further delays.

Overall, DPHHS operates a strong service system that works to meet the needs of Montanans with DD. Further refining the service system infrastructure and expanding service options will strengthen the system for generations to come.

[13] Montana Code Annotated 53-20-202: "Developmental Disabilities" means disabilities attributable to intellectual disability, cerebral palsy, epilepsy, autism, or any other neurologically disabling condition closely related to intellectual disability and requiring treatment similar to that required by intellectually disabled individuals if the disability originated before the person attained age 18, has continued or can be expected to continue indefinitely, and results in the person having a substantial disability.

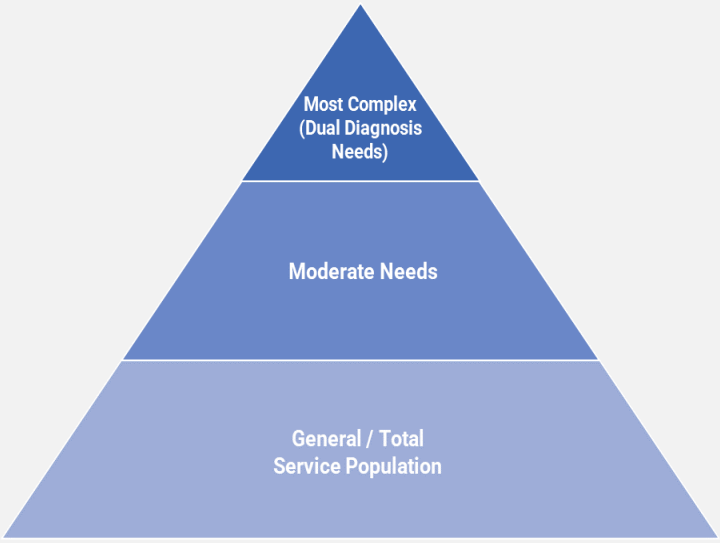
Recommendations

How the Recommendations Address Montana's BH and DD Systems

This report includes seventeen recommendations focused on improving Montana's BH system and five recommendations focused on improving Montana's DD system. These recommendations touch every aspect of the BH and DD continuum of care, address the Commission's stated priorities, incorporate input from a diverse range of stakeholders, and serve every population within the systems.

While the DD service system has a largely functional service array and operating structure, recommendations in this report focus on refining and targeting enhancements at key points in the service continuum for the BH and DD systems. As outlined in Figure 4, these recommendations address the three fundamental aspects of a service pyramid: working to secure the foundation of the service system (i.e., broad impact) while more specifically meeting the needs of those at the top of the pyramid (i.e., those with the most complex needs). The recommendations work closely together for impact, in totality, across the service continuum.

Figure 4 | Service System Pyramid



In all, the DD recommendations are generally centered around the following goals:

1. Expand **access points** to the service system to better support the needs of families.
2. Modernize the funding of services to support more **person-centered services** while supporting service provider flexibilities and sustainability.
3. Expand the **array of services** available to provide more options that better align with the needs of individuals with DD.

In parallel, the BH recommendations generally aim to:

1. Improve **case management**, enhancing a person's ability to navigate the continuum and get the right care, at the right time, and in the right place.
2. Expand the number and kinds of services offered **across the continuum** to better serve the needs of Montanans.
3. Incentivize people to join and stay in the **BH workforce**, ensuring greater stability and higher quality of services.

Recommendations Budget Summary

Based on this approach, DPHHS and the Commission have developed OTO cost estimates totaling **$41M,** and an additional **$62M** to fund the initial operational budget impact. DPHHS and the Commission have also developed a strategy for long-term sustainability, with an emphasis on the expected impact on the state budget, for each recommendation.

The Commission has already identified a significant level of funding to implement the recommendations provided in this report but understands the importance of outlining a long-term budget strategy to ensure that (1) Commission funds are leveraged appropriately and efficiently to launch each recommendation, and (2) the state budget can sustain these investments into the future.

Approach

This report includes cost estimates broken down into the components necessary to (1) fund initial investments required to launch the recommendation (One-Time-Only); (2) fund the initial operational costs for the recommendation once launched (Operational); and (3) sustain the recommendation into the future as part of the state's "base budget" (Total Recurring, Federal Share, and State Share).

Critically, as recommendations are implemented, and prior to their inclusion in the state budget as recurring line items, the Commission's funding provides a financial bridge to operationalize recommendations following their launch and implementation. The level of funding required for this operational component will depend heavily on the planning, sequence, and timing to launch of each recommendation. Leveraging the well-established fiscal note development process, DPHHS and the Commission have determined cost estimates for each recommendation that are derived from an annual estimate and funding strategy and then adjusted based on the potential expected duration of time anticipated to elapse prior to an eventual transition into the state's base budget.

Initial cost estimates to launch and operationalize each recommendation are included in this report and can be broken down into the following components:

BHSFG Funding		**Long Term Sustainability**		
One-Time-Only	**Operational***	**Total Recurring**	**Federal Share**	**State Share**
BHSFG funded grants, contract RFPs, or other initial investments to stand up and launch the recommendation. ***Includes capital cost estimates for relevant recommendations.***	BHSFG funding available to finance the initial operational needs for the recommendation prior to inclusion in the "base budget." ***Figures will vary depending on the timing to launch each recommendation.***	Total recurring costs included in the "base budget", on an ongoing annual basis, funded through both state and federal sources. ***The total annual recurring costs going forward.***	The share of total recurring costs funded through federal sources, such as Medicaid match or federal grants. ***The amount of total recurring costs offset by federal funds.***	The share of total recurring costs funded through state sources, such as the general fund. ***The amount of total recurring costs that impact the state's budget going forward.***

**These figures are subject to change based on executive branch processes and/or detailed implementation planning to refine project resource needs.*

The cost estimates provided below are preliminary and are subject to change. The numbers are based on assumptions outlined in the recommendations and supported by available data. Actual expenditures are ultimately subject to approval by the Governor's Office and appropriation by the Legislature.

Figure 5 | BHSFG Cost Estimates Build Up Summary

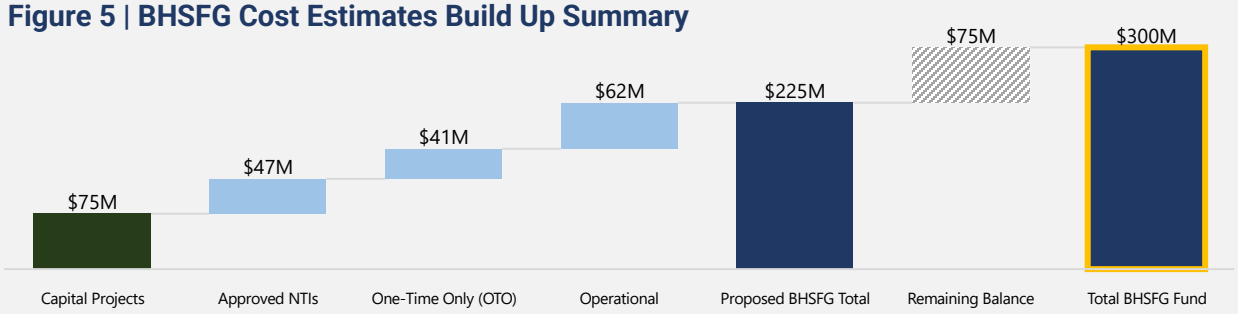


Figure 6 | Breakdown of Cost Estimates by Recommendation (1 of 2)

	Recommendation	Domain	BHSFG Funding Amount OTO	BHSFG Funding Amount Operational
1.	Refine and Reconfigure the Current 0208 Comprehensive Waiver Services Rates	DD	$1.3M	$300K
2.	Expand Access to Waiver Services Through a §1915(c) Supports Waiver	DD	$250K	$66K
3.	Expand the Service Delivery System to Support Individuals with Complex Needs	DD	$1.9M	$8.8M
4.	Redefine and Reopen E&D Clinics to Support Families More Effectively	DD	$50K	$2M
5.	Conduct an In-Depth Study of the Current DDP Waitlist Management Process	DD	$625K	$100K
6.	Enhance the Targeted Case Management Program	BH	$586K	$1.5M
7.	Develop a Targeted Case Management Training Program	BH	$1M	$200K
8.	Implement a Care Transitions Program	BH	$248K	$2M
9.	Adopt Electronic Bed Registry and Enhance 988	BH	$1.2M	$9.0M
10.	Expand Mobile Crisis Response to Additional Regions	BH	$2.8M	$771K
11.	Introduce New Crisis Stabilization and Receiving Center Services	BH	$13.8M	$3.8M
12.	Expand Scope of the Certified Adult Peer Support Program	BH	$300K	-
13.	Increase Support for Individuals with SMI and/or SUD Experiencing Homelessness	BH	$1.1M	$781K
14.	Launch a Media Campaign to Raise Awareness and Reduce Stigma	BH	$1M	-
15.	Reduce Transportation-Related Barriers to Care	BH	-	$1.7M
16.	Expand the Family Peer Support Program for Parents and Caregivers	BH	$525K	-
17.	Redesign Rates to Improve In-State Youth Residential Services	BH	$75K	-
18.	Invest in School-Based Behavioral Health Initiatives	BH	$200K	$6.1M
19.	Incentivize Providers to Join the BH and DD Workforce	BH	$7.8M	$500K
20.	Expand Training Content Available to BH and DD Workforce	BH	$2M	-
21.	Enhance Behavioral Health Integration Efforts	BH	$3.9M	-
22.	Expand and Sustain Certified Community Behavioral Health Clinics	BH	-	$24.6M
		Total:	**$40.6M**	**$62.2M**

*Long-term sustainability is reflected on an **annual recurring basis**. The total recurring numbers represent the sum of the federal and state shares. The cost estimates provided below are preliminary and are subject to change. The numbers are based on assumptions outlined in the recommendations and supported by available data. Actual expenditures are ultimately subject to approval by the Governor's Office and appropriation by the Legislature.*

Figure 6 | Breakdown of Cost Estimates by Recommendation (2 of 2)

			Long Term Sustainability		
	Recommendation	**Domain**	**Total Recurring**	**Federal Share**	**State Share**
1.	Refine and Reconfigure the Current 0208 Comprehensive Waiver Services Rates*	DD	$7.5M	$4.6M	$2.8M
2.	Expand Access to Waiver Services Through a §1915(c) Supports Waiver*	DD	$21.1M	$13.1M	$7.9M
3.	Expand the Service Delivery System to Support Individuals with Complex Needs*	DD	$8.8M	$5.5M	$3.3M
4.	Redefine and Reopen E&D Clinics to Support Families More Effectively*	DD	$1M	$500K	$500K
5.	Conduct an In-Depth Study of the Current DDP Waitlist Management Process*	DD	$100K	$75K	$25K
6.	Enhance the Targeted Case Management Program*	BH	$2.8M	$2M	$793K
7.	Develop a Targeted Case Management Training Program	BH	$100K	-	$100K
8.	Implement a Care Transitions Program*	BH	$1M	$714K	$278K
9.	Adopt Electronic Bed Registry and Enhance 988 *	BH	$3.9M	$1.9M	$1.9M
10.	Expand Mobile Crisis Response to Additional Regions*	BH	$1.4M	$991K	$385K
11.	Introduce New Crisis Stabilization and Receiving Center Services*	BH	$8.7M	$6.3M	$2.4M
12.	Expand Scope of the Certified Adult Peer Support Program*	BH	$1.3M	$958K	$373K
13.	Increase Support for Individuals with SMI and/or SUD Experiencing Homelessness	BH	-	-	-
14.	Launch a Media Campaign to Raise Awareness and Reduce Stigma	BH	-	-	-
15.	Reduce Transportation-Related Barriers to Care	BH	$1.7M	$860K	$860K
16.	Expand the Family Peer Support Program for Parents and Caregivers*	BH	$1.8M	$1.1M	$626K
17.	Redesign Rates to Improve In-State Youth Residential Services*	BH	$6.5M	$4.8M	$1.7M
18.	Invest in School-Based Behavioral Health Initiatives*	BH	$7.2M	$2.8M	$4.5M
19.	Incentivize Providers to Join the BH and DD Workforce	BH	$250K	-	$250K
20.	Expand Training Content Available to BH and DD Workforce	BH	-	-	-
21.	Enhance Behavioral Health Integration Efforts*	BH	$1.9M	$1.2M	$714K
22.	Expand and Sustain Certified Community Behavioral Health Clinics*	BH	$53.6M	$41.2M	$12.4M
		Total:	**$131M**	**$89M**	**$42M**

(*) = indicates recommendations eligible for a federal match

Recommendation #1: Refine and Reconfigure the Current 0208 Comprehensive Waiver Services Rates

- Implement a standardized assessment tool that can measure level and complexity of support needs.
- Re-engineer the reimbursement model for Residential Habilitation, Day Habilitation, and other Personal Support services to account for the level of acuity and support needs.

Background

Current DDP practices do not utilize a standardized, valid assessment tool to measure the level of need or acuity of individuals being served. While the current reimbursement model does include service tiers, these tiers are only differentiated by number of hours of support, and do not take into consideration altered staffing ratios, enhanced support needs, or other provider operating costs to support people with more complex needs. Selecting and implementing a standardized assessment tool and refining the rate schedule to account for level of need and setting size will improve funding alignment, support state budgeting and tracking activities, and have a broad-ranging impact across the service system (Figure 4).

Summary

Theme:	Continuum Capacity
Population Impacted:	DD — Adults
Place in Continuum of Care:	Supports/Services
BHSFG Priority # (1-7):	5. Capacity of DD service delivery system 6. Capacity of co-occurring populations service delivery system
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings – Panels and Public Comment

Intended Outputs

- More expansive rate methodology with tiered rates set by level of acuity across service domains.
- DDP provider cost reporting at a set cadence to support ongoing rate maintenance.

Intended Outcomes

- Providers are more appropriately incentivized to support individuals with complex needs.
- The needs of individuals with DD are better met by service reimbursement rates that are more aligned with their unique needs.

Performance Measures

(see Appendix C for additional details on performance measures)

- Decrease emergency department (ED) utilization.
- Decrease out-of-state placements.
- Decrease reliance on state-operated facilities.
- Decrease waitlist.
- Increase access to community-based services.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$1.3M	**$300K**	**$7.5M**	**$4.6M**	**$2.8M**

Recommendation #2: Expand Access to Waiver Services Through a §1915(c) Supports Waiver

- Implement a new §1915(c) Supports Waiver focused on in-home support services.
- Expand the service reimbursement rates to include services under the new Supports Waiver.

Background

Under current DDP operations, eligible individuals and families on the current waitlist access State Plan service options which are limited in type, scope, and duration, and focused primarily on Targeted Case Management and therapy-based services. These individuals and families on the waitlist lack a more robust service array, placing greater unfunded demand on them which may increase crisis situations. This recommendation would enable DDP to offer more cost-effective services upstream which in turn reduces the reliance on 24/7 care.

Summary

Theme:	Continuum Capacity
Population Impacted:	DD — Adults and Children
Place in Continuum of Care:	Supports/Services
BHSFG Priority # (1-7):	5. Capacity of DD service delivery system 6. Capacity of co-occurring populations service delivery system 7. Family and caretaker supports (BH and DD)
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings – Public Comment (Families)

Intended Outputs

- Expanded service options and improved access to services for families at a lower cost.

Intended Outcomes

- More timely access for individuals and families to a limited-service array, reducing crisis points.
- Increase in service options and choices for individuals that better align with their unique needs.
- Earlier access to services that reduce reliance on more costly options.

Performance Measures

- Decrease ED utilization.
- Decrease out-of-state placements.
- Decrease reliance on state-operated facilities.
- Decrease waitlist.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$250K	**$66K**	**$21.1M**	**$13.1M**	**$7.9M**

> ***A better system for enrollment and coverage needs to be considered…especially the most cost-effective insurance for the disabled.*** *– Montanan with lived experience*

Recommendation #3: Expand the Service Delivery System to Support Individuals with Complex Needs

- Pilot the START Program to test a more comprehensive support model for those with the most complex needs.
- Procure training through a specialized vendor to provide comprehensive training and on-demand technical assistance for supporting people with complex needs across the current provider network.
- Develop an Enhanced Community Living service in the 0208 Waiver to provide specialized Residential Habilitation for people with complex medical and/or behavioral health needs; the service would be limited to no more than 4-person homes with higher staffing qualifications, lower staffing ratios, and specialized reimbursement rates.

Background

Traditional services like Residential Habilitation use a consistent reimbursement structure regardless of levels of support. While this approach is appropriate for the general population of people utilizing the service, individuals with complex behavioral and/or medical support needs often require higher staffing ratios and higher staffing qualifications that may not be met in a standard group home model. Additionally, the current crisis response system does not specifically target supporting individuals with developmental disabilities given their unique needs. This leads to individuals continuing to be served at IBC, other state-run facilities, or through out-of-state placements. While developing acuity-based rates (as outlined in Recommendation #1) would help circumvent this, establishing this three-pronged approach (START Program, Intensive On-Site Provider Support, and Enhanced Community Living Service) would provide DDP with a more comprehensive array of specialized service capacity to support those in the top and middle tiers of the service continuum triangle (see Figure 4). Building this community capacity also provides an opportunity to evaluate how IBC interfaces with the system and consider changes in scope or location, in alignment with the Alternative Settings recommendations.

Summary

Theme:	Continuum Capacity
Population Impacted:	DD — Adult and Children
Place in Continuum of Care:	Supports/Services
BHSFG Priority # (1-7):	5. Capacity of DD service delivery system 6. Capacity of co-occurring populations service delivery system 7. Family and caretaker supports (BH and DD)
Stakeholder Input:	Alt. Settings Report

Intended Outputs

- Reduced out-of-state placements.
- Increased severability of people with complex needs from providers.

Intended Outcomes

- Increased ability for people with complex support needs to remain in their local communities, leverage natural supports, and receive adequate services and resources to meet their needs.

Performance Measures

- Decrease out-of-state placements.
- Decrease reliance on state-operated facilities.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$1.9M	**$8.8M**	**$8.8M**	**$5.5M**	**$3.3M**

> ***Having more locations that can handle behavioral disorders [is important]. They just didn't have the kind of support for someone or the training to support those kinds of needs… biggest need is training and personnel.*** *– Montanan with lived experience*

Recommendation #4: Redefine and Reopen Evaluation and Diagnostic Clinics to Support Families More Effectively

- Engage with stakeholders (families, medical professionals, and service providers) to redefine the intent and scope of Evaluation and Diagnostic (E&D) clinics to better meet family and state needs.
- Launch a pilot of E&D clinics operating under the newly defined role to evaluate effectiveness.

Background

Due to budget cuts during SFY 2017/2018, three previously operating E&D clinics were discontinued. The closure of these clinics has caused a significant bottleneck for families seeking evaluations to gain access to DDP services. The decrease in availability of these services has driven an extended waitlist for screening, further extending the time families spend waiting for services. Conversely, DD programs nationally have worked to establish a more robust "No Wrong Door" system by expanding access to service eligibility screening. The intent of this approach is to reduce the frequency of scenarios wherein individuals otherwise unknown to the service system come forward at points of crisis. Earlier interactions can also serve as an opportunity to engage individuals and families with peer networks, unfunded services, and/or state-plan services that may reduce or delay the need for waiver-funded services.

Summary

Theme:	Case Management
Population Impacted:	DD — Children
Place in Continuum of Care:	Supports/Services
BHSFG Priority # (1-7):	5. Capacity of DD service delivery system 7. Family and caretaker supports (BH and DD)
Stakeholder Input:	BHSFG Commission Meetings – Panels and Public Comment

Intended Outputs

- Increased effectiveness and efficiencies in screening for service eligibility.
- Expanded opportunities for family peer connection.
- Increased coordination between early childhood services and DDP programs.
- Establishment of a No Wrong Door-like system.

Intended Outcomes

- Increased access to and reduced wait times for screening services for individuals and families, and increased efficacy in identifying appropriate/eligible services.

Performance Measures

- Decrease waitlist.
- Increase access to community-based services.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$50K	**$2M**	**$1M**	**$500K**	**$500K**

Recommendation #5: Conduct an In-Depth Study of the Current DDP Waitlist Management Process

- Identify process changes to collect more robust information about individuals waiting for service (including priority of need, type of services needed, and level of support needed).
- Identify opportunities to modify current information technology systems to modernize and centralize data input, tracking, and reporting support operations.
- Identify and secure federal funding options for long-term program sustainability.

Background

DDP currently manages a waitlist of approximately 2,100 individuals (almost equal to the number of people receiving funded waiver services). However, the current process collects limited data that, due to staffing and operating systems constraints, is not updated consistently or frequently. Lacking key information on waitlist participants hinders DDP in its ability to forecast service demand and provider capacity, and to provide legislative appropriation requests that meet the needs of those waiting for services.

Summary

Theme:	Case Management
Population Impacted:	DD — Adults and Children
Place in Continuum of Care:	Supports/Services
BHSFG Priority # (1-7):	5. Capacity of DD service delivery system 7. Family and caretaker supports (BH and DD)
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings – Public Comment

Intended Outputs

- Improved ability to project current and future service needs for supporting capacity development and budget planning.

Intended Outcomes

- Improved access and reduced wait times for individuals and families eligible to receive services.

Performance Measures

- Increase access to community-based services.
- Decrease waitlist.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$625K	**$100K**	**$100K**	**$75K**	**$25K**

Recommendation #6: Enhance the Targeted Case Management Program

- Re-evaluate the current TCM reimbursement model (e.g., by population, quality, intensity, and outcomes) for all TCM services.
- Expand the TCM program, service availability, and current met and unmet service needs.
- Support and incentivize providers to measure outcomes on a path toward more value-based models.

Background

Montana's long-term vision is to provide robust care coordination, case management, and discharge planning to successfully transition individuals with BH and DD needs from higher levels of care to home and community settings. In SFY23, TCM was delivered to approximately 8,000 Medicaid members, accounting for 2% of the Medicaid population. This recommendation would update the Targeted Case Management model for individuals with severe disabling mental illness and/or substance use disorder, and children with SED and developmental disabilities.

Summary

Theme:	Case Management
Population Impacted:	All
Place in Continuum of Care:	All
BHSFG Priority # (1-7):	3. Capacity of adult BH service delivery system 4. Capacity of children's mental health service delivery system 5. Capacity of DD service delivery system 6. Capacity of co-occurring populations service delivery system 7. Family and caretaker supports (BH and DD)
Stakeholder Input:	BHSFG Commission Meetings - AMH, CMH

Intended Outputs

- New reimbursement model that considers TCM eligibility requirements, acuity, health-related social needs, and clinical presentation.
- Specific requirements by intensity for level of effort and subsequent rates.

Intended Outcomes

- Decreased utilization of avoidable, high-cost services (e.g., inpatient psychiatric) for people receiving TCM.
- Increased utilization of preventive care for people receiving TCM.

Performance Measures

- Decrease ED utilization.
- Increase access to community-based services.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$585K	**$1.5M**	**$2.8M**	**$2M**	**$793K**

Recommendation #7: Develop a Targeted Case Management Training Program

- Develop a training curriculum that provides tools and skills for targeted case managers that (1) promotes understanding of best practices, service planning, and treatment options, (2) ensures fidelity to the TCM model, and (3) ensures delivery of TCM with a focus on outcomes.
- Improve the quality and consistency of TCM delivery, qualification standards, and workforce stability through a prescribed learning path with a certification.

Background

A new TCM curriculum would ensure (1) program compliance, (2) the employment of effective case management practices, (3) the capacity to effectively deliver a revised TCM model (recommended in this report), and (4) fidelity to the model. There are several states (e.g., AL, KY, MN) that offer TCM training programs as well as existing national training programs that Montana could leverage for training curriculum, some with certification. The proposed TCM training curriculum would focus on population-specific interventions, engagement strategies, use of assessment tools, compliance with TCM rules (eligibility, services, and staffing), and model fidelity approaches and considerations.

Summary

Theme:	Case Management
Population Impacted:	All
Place in Continuum of Care:	All
BHSFG Priority # (1-7):	3. Capacity of adult BH service delivery system 4. Capacity of children's mental health service delivery system 5. Capacity of DD service delivery system 6. Capacity of co-occurring populations service delivery system
Stakeholder Input:	BHSFG Commission Meetings

Intended Outputs

- TCM teams more effectively identify the level of need and assign case managers more systematically, with caseloads considering service intensity.
- All TCM staff members receive the training.

Intended Outcomes

- Increased skill among targeted case managers as measured through competency-based surveys (e.g., pre-and post-tests).
- Increased speed and efficacy of targeted case management services, as measured by post-event (ED, mobile crisis response) tracking.

Performance Measures

- Increase workforce training and capacity.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$1M	**$200K**	**$100K**	**-**	**$100K**

Recommendation #8: Implement a Care Transitions Program

- Design and implement a care transitions service for individuals discharged from institutions that facilitates reintegration back into their communities.
- Identify and secure federal funding options for long-term program sustainability.

Background

Hospital and inpatient readmissions represent poor social outcomes for patients, increase state inpatient costs, and add to the pressure on already-strained hospital systems. The causes of these readmissions are varied but often share a common thread: little to no intensive support of patients as they leave the hospital and reintegrate into their communities. Case management is a dynamic, person-centered approach, occurring in a variety of settings where medical care, behavioral health care, and social supports are delivered. Montana offers several case management services for eligible individuals with complex needs that aim to improve transitions from higher levels of care (e.g., inpatient hospitals and correctional settings). This recommendation aims to enhance existing TCM programs and initiate a new case management program (e.g., Critical Time Intervention) for people transitioning from specific settings.

Summary

Theme:	Case Management
Population Impacted:	BH – Adults
Place in Continuum of Care:	Recovery
BHSFG Priority # (1-7):	2. Clinically appropriate state-run health care 3. Capacity of adult BH service delivery system
Stakeholder Input:	BHSFG Commission Meetings – AMH

Intended Outputs

- People discharged from psychiatric hospitals with care transitions support have a tailored discharge/reintegration plan and community connections.
- Increase post-acute appointment attendance.

Intended Outcomes

- Reduced readmissions for people discharged from inpatient psychiatric care.
- Reduced length of stay for individuals readmitted to a hospital.

Performance Measures

- Decrease reliance on state-operated facilities.
- Follow-up after ED visit for mental illness.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$248K	**$2M**	**$1M**	**$714K**	**$278K**

> ***What happened was unbelievable. [My brother] slowly came back to life when I thought he'd never be here today… and the reason for that was [my brother] was finally properly treated, instead of penalized. He was given structure, safety, and accountability and treated as a human, not an inmate #8.*** *– Montanan with lived experience*

Recommendation #9: Adopt Electronic Bed Registry and Enhance 988

- Support a web-based system that monitors real-time BH bed availability and maintains an updated inventory of statewide and community resources.
- Formalize agreements with Public Safety Answering Points (PSAPs) to appropriately respond to individuals in crisis.
- Support 988 call centers' capacity to support real-time virtual coordination with first responders for de-escalation when mobile crisis response services are not locally available.
- Support virtual technology solutions for first responders and mobile crisis teams.

Background

The Department has identified a need to make further investments in information technology (IT) for its behavioral health system of care. Montana, like many other states, seeks to improve its coordination of behavioral health services by making a web-based electronic bed registry accessible to public and private psychiatric hospitals, psychiatric units in critical access hospitals, crisis stabilization and receiving centers, residential settings, and withdrawal management centers. This also includes providing additional funding to enhance the 988 call center IT systems and virtual technology for mobile crisis and first responders. Other rural states have invested in innovative virtual technology solutions to connect first responders to BH professionals when people are experiencing a crisis.

Summary

Theme:	Continuum Capacity
Population Impacted:	All
Place in Continuum of Care:	Crisis
BHSFG Priority # (1-7):	1. Comprehensive statewide crisis system
Stakeholder Input:	BHSFG Commission Meetings

Intended Outputs

- Implement a formal dispatch protocol for crisis responders.
- Provide first responders with technology to coordinate with BH providers during crisis calls.
- Enhance access to BH crisis services in rural areas.
- Implement an electronic bed registry for behavioral health providers.

Intended Outcomes

- Decrease the number of calls that require emergency department or higher levels of intervention.
- Decrease the number of people with a BH crisis who are arrested.
- Increase the number of service connections made through 988.
- Increase registry participation by having a minimum of 25 providers join in the first year.

Performance Measures

- Decrease reliance on state-operated facilities.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$1.2M	**$9.0M**	**$3.9M**	**$1.9M**	**$1.9M**

Recommendation #10: Expand Mobile Crisis Response to Additional Regions

- Offer grant funding to providers for 1) start-up and 2) non-billable service costs, to expand access to Medicaid-covered mobile crisis response (MCR) in densely populated regions where MCR is not currently delivered.
- Issue an RFP for new rural approaches to MCR services in areas with extreme staffing shortages and low forecasted utilization rates. Models may include leveraging existing providers (e.g., CMHCs) to virtually support local MCR teams, first responders, and/or available providers to respond rapidly in person.
- Assess potential adjustments to the MCR rate to consider regional differences (e.g., additional response time in rural areas).

Background

Montana has 6 mobile crisis teams, none of which are located in the eastern part of the state. There is concern that mobile crisis teams may not have the utilization in underserved areas to sustain their operating costs. Innovative solutions should be leveraged, such as a hub and spoke model that includes a central "hub" of staff (e.g., BH professionals, CMHCs) virtually connecting with the "spoke" — e.g., peers, Community Health Workers, Emergency Medical Technicians, and MCR teams – deployed in the community to assist people in crisis.

Summary

Theme:	Continuum Capacity
Population Impacted:	All
Place in Continuum of Care:	Crisis
BHSFG Priority # (1-7):	1. Comprehensive statewide crisis system 3. Capacity of adult BH service delivery system
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings

Intended Outputs

- Increased MCR reach to cover underserved regions.
- Increased capacity of MCR teams to provide access to 24/7 crisis services.

Intended Outcomes

- Reduced number of BH emergencies resulting in jail or emergency department (ED) interaction.
- Improved MCR team response time (within one hour of dispatch in urban areas, two hours for rural communities, and three hours for remote communities).
- Increased number of individuals receiving MCR support.

Performance Measures

- Increase access to community-based services.
- Follow-up after ED visit for mental illness.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$2.8M	**$771K**	**$1.4M**	**$991K**	**$385K**

Recommendation #11: Introduce New Crisis Stabilization and Receiving Center Services

- Provide one-time grant funding to fund new Crisis Stabilization Services for adults in high-priority need areas with service gaps, severe staffing shortages, and low forecasted utilization rates.
- Release an RFP to fund new child and adolescent pilot programs for individuals (1) experiencing a behavioral health crisis who need immediate stabilization services, and (2) with emerging behavioral health conditions that need services and supports who do not present as an imminent threat of harm to self or others.
- Assess the long-term costs, sustainability, and development of new Medicaid services and rates for crisis stabilization service models for children and adolescents.

Background

Montana has multiple crisis stabilization and receiving centers for adults that operate in select regions throughout the state. Crisis receiving and stabilization services offer the community no-wrong-door access to provide critical triage, assessment, and services to people experiencing a crisis. However, many people live hours from these existing centers, and they do not offer services to children and adolescents.

The Commission heard from stakeholders who shared support for providing crisis services to children and adolescents. Establishing crisis stabilization centers for children and adolescents will allow those experiencing a mental health crisis immediate, rapid triage, and assessment of level of care. This should assist in keeping them out of emergency departments and other facilities and ensure referrals and access to specialized mental health treatment for stabilization support and recovery services. This recommendation proposes to fund construction and start-up costs for between 4-8 crisis stabilization and receiving centers or BH urgent care facilities throughout the state, based on need and demand. Provider types include behavioral health providers, FQHCs, critical access hospitals, and other identified entities.

Summary

Theme:	Continuum Capacity
Population Impacted:	All
Place in Continuum of Care:	Crisis
BHSFG Priority # (1-7):	1. Comprehensive statewide crisis system 3. Capacity of adult BH service delivery system 4. Capacity of children's mental health service delivery system
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings

Intended Outputs

- Increased access to rapid stabilization services for children and adolescents.
- Increased access to crisis services in high-priority/need areas.

Intended Outcomes

- Decreased emergency department (ED) visits related to BH crises.
- Decreased utilization of psychiatric hospitalization.

Performance Measures

- Decrease ED utilization.
- Decrease out-of-state placements.
- Increase access to community-based services.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$13.8M	**$3.8M**	**$8.7M**	**$6.3M**	**$2.4M**

Recommendation #12: Expand Scope of the Certified Adult Peer Support Program

- Amend the certified peer support Medicaid benefit to include (1) non-Severe Disabling Mental Illness (i.e., individuals with moderate behavioral health conditions), and (2) settings designated as "licensed agencies" in the State Plan.
- Encourage the recruitment and hiring of additional certified peer support specialists through new start-up and incentive funding.

Background

Peer support services reduce stigma, connect people to services, and minimize dependence on more disruptive emergency treatment. In SFY23, 33 providers (8 Mental Health Centers, 21 SUD providers, and 4 FQHCs) provided peer support services. Certified adult behavioral health peer support services are currently available to individuals with (1) a severe disabling mental illness, and/or (2) a substance use disorder diagnosis. Non-SDMI members are currently not eligible. Current eligible settings include (1) agencies licensed to operate as mental health centers, and (2) agencies which are both state-approved and licensed as an SUD residential or outpatient facility.

Summary

Theme:	Continuum Capacity
Population Impacted:	BH — Adults
Place in Continuum of Care:	Prevention, Treatment
BHSFG Priority # (1-7):	3. Capacity of adult BH service delivery system
Stakeholder Input:	Alt. Settings Report, RFI

Intended Outputs

- Peer support services offered to people with moderate mental health diagnoses.
- Increased number of individuals reached by peer support specialists by adding eligible settings.

Intended Outcomes

- Increased preventive service utilization.
- Increased retention in mental health treatment.

Performance Measures

- Decrease ED utilization.
- Increase workforce training and capacity.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$300K	**-**	**$1.3M**	**$958K**	**$373K**

Recommendation #13: Increase Support for People with Serious Mental Illness and/or Substance Use Disorder Experiencing Homelessness

- Provide funding for tenancy support specialists to assist adults with qualifying substance use disorder and/or serious mental illness who are also experiencing or are at risk of homelessness.

Background

Montana, like many states, is struggling to address a growing number of people experiencing homelessness. Many of these individuals often also experience mental illness and/or substance use issues. There are nearly 2,200 Montanans experiencing homelessness, with an estimated 460 with a serious mental illness. According to the National Alliance to End Homelessness, Montana's homeless population increased by 38% between 2007 and 2022. The state's rate of homelessness was 14.1 per 10,000 in 2022, the 18th highest in the nation. A lack of reliable housing can compound behavioral health issues, leading to adverse outcomes.

Funding tenancy support specialists would help individuals with SUD and/or SMI at risk of homelessness access personalized assistance, prevent homelessness barrier resolution, and enable early intervention.

Summary

Theme:	Continuum Capacity
Population Impacted:	All
Place in Continuum of Care:	Prevention
BHSFG Priority # (1-7):	3. Capacity of adult BH service delivery system
Stakeholder Input:	BHSFG Commission Meetings – CMH, Montana Coalition to Solve Homelessness

Intended Outputs

- Expanded coverage of tenancy support services.

Intended Outcomes

- Increased number of people with SMI/SUD experiencing homelessness receiving BH services.
- Reduced ED utilization for people with SMI/SUD experiencing homelessness.

Performance Measures

- Increase access to community-based services.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$1.1M	**$781K**	**-**	**-**	**-**

> ***Now she drives around Missoula and sees many of the people who are homeless or living on the streets… and she's like 'That was my roommate at Warm Springs or when I was in the group home, they lived in the group home.' That's kind of traumatic for her because those are people she really cares about.*** *– Montanan with lived experience*

Recommendation #14: Launch a Media Campaign to Raise Awareness and Reduce Stigma

- Communicate consistent messaging to all communities about ways to connect to and access BH supports and services.
- Offer clear "How do I engage with DPHHS providers?" guidance to anyone in need of behavioral health care.

Background

Montana's frontier nature can be challenging and for many may contribute to a sense of isolation, misunderstanding of symptoms, and disconnect from potential life-saving services. All states face unique issues related to engagement and stigma. Some have created campaigns that incorporate their state's identity. Montana can borrow applicable ideas from other state campaigns. The BHSFG Commission is expanding services and improving access, which a statewide campaign could highlight to raise awareness of existing and new opportunities for people to access help, especially for high-need services like 988 crisis call centers.

Summary

Theme:	Continuum Capacity
Population Impacted:	All
Place in Continuum of Care:	Prevention
BHSFG Priority # (1-7):	All
Stakeholder Input:	Alt. Settings Report, RFI

Intended Outputs

- Delivery of the BHSFG Commission's message to defined target populations statewide; channels may include: (a) TV/radio, (b) billboards, bulletins, posters, (c) news publications, and (d) digital programming (e.g., social media).

Intended Outcomes

- Increased use of mental health and SUD services among people in need.
- Decreased use of mental health and SUD services provided by emergency departments and law enforcement (when avoidable).

Performance Measures

- Increase access to community-based services.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$1M	-	-	-	-

Recommendation #15: Reduce Transportation-Related Barriers to Care

- Reduce administrative barriers to member claiming and reimbursement through a mileage pre-pay program.
- Reassess current NEMT supply and explore options that may include contracting with NEMT broker companies.

Background

For non-emergency medical transportation (NEMT), Montanans overwhelmingly use private vehicles (70%), predominantly due to the lack of public transport options. Reimbursement lags are a reason stated for lower rates of "kept" appointments. Montana has limited public transportation options, especially in rural communities. Efficient selection of transportation options (e.g., hired taxi or van) may be improved through active management. Montana previously sought an NEMT broker through an RFI, with no responses. States use NEMT broker-led models to improve access, efficiency, and client experience.

Summary

Theme:	Continuum Capacity
Population Impacted:	BH – Adults and Children
Place in Continuum of Care:	Prevention, Treatment
BHSFG Priority # (1-7):	3. Capacity of adult BH service delivery system 4. Capacity of children's mental health service delivery system
Stakeholder Input:	RFI

Intended Outputs

- Increased access to safe, reliable transportation.

Intended Outcomes

- Increased number of completed non-emergency transports to appointments.
- Decreased use of ambulances or law enforcement for transport.

Performance Measures

- Increase access to community-based services.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
-	**$1.7M**	**$1.7M**	**$860K**	**$860K**

Recommendation #16: Expand the Family Peer Support Program for Parents and Caregivers

- Offer start-up grants to provider agencies seeking to hire a family peer supporter.
- Add family peer support to the State Plan as a Medicaid-reimbursable service.

Background

While certified BH peer support for SED, SDMI, and SUD is growing, family peer support (FPS) is minimally offered in Montana and is not yet certified. It is therefore not yet Medicaid billable. In SFY23, 33 providers (8 Mental Health Centers, 21 SUD providers, and 4 FQHCs) provided peer support services. Peer support is an evidence-based program supported by CMS that reduces stigma and delivers help to people who may not seek it. The Commission approved an NTI to extend and expand current FPS grants; this recommendation complements that effort.

Summary

Theme:	Continuum Capacity
Population Impacted:	BH and DD — Children
Place in Continuum of Care:	Prevention, Recovery
BHSFG Priority # (1-7):	3. Capacity of adult BH service delivery system 4. Capacity of children's mental health service delivery system 5. Capacity of DD service delivery system 7. Family and caretaker supports (BH and DD)
Stakeholder Input:	BHSFG Commission Meetings – CMH, MT's Peer Network

Intended Outputs

- Increased number of family peer support workers in Montana.
- Formalized path to certification for family peer support workers.

Intended Outcomes

- Reduction in interactions with law enforcement and DPHHS due to violence or neglect in the home.
- Increased use of supportive services like respite, family counseling, and therapy.

Performance Measures

- Decrease ED utilization.
- Increase workforce training and capacity.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$525K	**-**	**$1.8M**	**$1.1M**	**$626K**

"Having someone come alongside you during difficult situations like ours offers hope and courage for each day. I hope that sharing a part of our story shows the value of funding and support for family peer support specialists to help future families like ours." *– Montanan with lived experience*

Recommendation #17: Redesign Rates to Improve In-State Youth Residential Services

- Design an acuity-based rate structure to assist providers in meeting the resource-intensive needs of high-acuity youth.
- Support smaller residences for higher acuity youth, as part of the proposed acuity-based model.

Background

In SFY23, according to DPHHS, 174 youth received out-of-state placement in a Psychiatric Residential Treatment Facility (PRTF), and 65 received out-of-state placement in a Therapeutic Group Home (TGH). The Department has acted previously on recommendations to address PRTF rates. TGHs also serve youth with challenging behaviors, however, and have a rate less than half of PRTFs. The introduction of an acuity-based rate or payment modifier better aligns reimbursement with clinical and behavioral presentation.

Summary

Theme:	Continuum Capacity
Population Impacted:	BH — Children
Place in Continuum of Care:	Treatment
BHSFG Priority # (1-7):	4. Capacity of children's mental health service delivery system
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings - CMH

Intended Outputs

- The design of a tiered rate methodology that aligns levels of acuity with levels of service.
- The secured buy-in of providers and other stakeholders to the adjusted rate methodology.

Intended Outcomes

- Reduced out-of-state residential placements.
- Unique needs of individuals in this population are addressed through improved service alignment.

Performance Measures

- Decrease out-of-state placements.
- Decrease reliance on state-operated facilities.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$75K	**-**	**$6.5M**	**$4.8M**	**$1.7M**

Recommendation #18: Invest in School-Based Behavioral Health Initiatives

- Identify priority communities for continued investments in existing school-based programs and release funding for one-time investments in school-based Multi-Tiered System of Support (MTSS), to include universal screening, referrals, and evidence-based interventions that support youth wellbeing.
- Enhance the supportive environment of schools through interprofessional training for school counselors, nurses, psychologists, social workers, administrators, and other professionals.
- Determine (1) the right policies in partnership with the Office of Public Instruction (OPI), and (2) funding sources to ensure sustainability, i.e., options like the reversal of the Medicaid free care rule.

Background

Montana offers universal behavioral health screening in select schools to identify at-risk youth. This screening, combined with access and referral to the right services, can improve youth mental health and reduce adverse outcomes (e.g., crisis, ED visits, etc.). Montana provides the Comprehensive School and Community Treatment (CSCT) model. Montana's Office of Public Instruction has also invested in the Multi-Tiered System of Support (MTSS) in schools. Under this recommendation, additional support will be provided to schools for the expansion of universal screening and the implementation of additional evidence-based practices.

Summary

Theme:	Continuum Capacity
Population Impacted:	BH – Children
Place in Continuum of Care:	Prevention, Treatment
BHSFG Priority # (1-7):	4. Capacity of children's mental health service delivery system
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings - CMH, RFI

Intended Outputs

- Advancement of the implementation of MTSS through comprehensive school-based mental health services for Montana youth.
- Increased availability of youth mental health training and consultation for school personnel (e.g., counselors, guidance, social workers, teachers).

Intended Outcomes

- Increased utilization of Medicaid BH services billed by school districts.
- Increase in preventive and supportive BH services by youth, especially those at risk.

Performance Measures

- Decrease waitlist.
- Increase workforce training and capacity.
- Increase access to community-based services.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$200K	**$6.1M**	**$7.2M**	**$2.8M**	**$4.5M**

> ***To implement integrated behavioral health services to expand into our school systems, we have to figure out how we're going to do that and how we're going to deliver that in an equitable fashion.*** *– Todd Wilson, Helena Indian Alliance*

Recommendation #19: Incentivize Providers to Join the Behavioral Health and Developmental Disabilities Workforce

- Develop a tuition reimbursement program that encourages BH workers to practice in Montana. This program targets workers who are (1) essential to BHSFG initiatives, and (2) underrepresented in currently available tuition reimbursement programs.
- Create dual enrollment programs to offer tuition-free college-level courses to Montana high school students that prepare students to enter BH and DD professions.

Background

Workforce shortages have significantly impacted Montana's BH and DD systems, impeding the delivery of services due to a lack of appropriate staff. This has a "ripple effect" throughout these systems. Without appropriate staff, BH and DD providers are unable to deliver services they otherwise could, which then exacerbates the various BH and DD challenges experienced by Montana residents and communities. Economic factors, including the high cost of tuition for relevant education and credentials, further complicate efforts to alleviate workforce shortages.

While tuition reimbursement programs exist for various health care professions, this recommendation specifically targets providing tuition reimbursement opportunities for the BH and DD workforce, including less credentialed members, such as case management staff and direct care workers.

This recommendation would also create dual enrollment courses in conjunction with OPI and the Montana University System so Montana high school students can earn college-level credits in BH and DD professions, tuition-free before they graduate from high school. This program would allow students to stack credentials as they move through their career path. Tuition-free courses can expose high school students to BH and DD professions and help them earn college credit and build subject matter expertise, enabling Montana to improve its ability to recruit individuals to work in these critical positions.

Summary

Theme:	Workforce
Population Impacted:	All
Place in Continuum of Care:	All
BHSFG Priority # (1-7):	All
Stakeholder Input:	BHSFG Commission Meetings – CMH, AMH, RFI

Intended Outputs

- Increased number and geographic coverage of BH and DD workers.
- Increased number of workers in targeted program types and regions with enhanced payments to cover high-need areas and/or populations.
- Increased number of individuals in the pipeline for BH and DD professions for years to come.

Intended Outcomes

- Increased access for people seeking services impacted by workforce shortages.
- Improved participant satisfaction with access to services.
- Increased number of high school students enrolled in BH and DD-focused college courses.

Performance Measures

- Decrease waitlist.
- Increase workforce capacity and training.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$7.8M	**$500K**	**$250K**	**-**	**$250K**

Recommendation #20: Expand Training Content Available to Behavioral Health and Developmental Disabilities Workforce

- Partner with a university to develop a learning platform that hosts and tracks training programs for the behavioral health and developmental disabilities workforce.
- Design and launch impactful training courses for middle managers, case managers, peers, community health workers (CHWs), and other BH workers on topics such as evidence-based interventions, harm reduction, and standards of cultural competence and diversity.

Background

A variety of factors impact Montana's ability to recruit and retain behavioral health workers. A workforce survey conducted by the University of Montana in 2023 predicted a 25% turnover over a six-month period, with emotional exhaustion by far the highest driver. Key strategies for decreasing burnout include professional development, leadership development, and supervisor/coaching programs. Training fulfills the dual role of imparting knowledge and bringing workers together to form a community, creating a sense of belonging that has a substantial impact on employee well-being.

Summary

Theme:	Workforce
Population Impacted:	All
Place in Continuum of Care:	All
BHSFG Priority # (1-7):	All
Stakeholder Input:	BHSFG Commission Meetings – CMH, AMH, RFI

Intended Outputs

- Additional training content for the workforce, targeting high attendance rates.
- Increased number of workers in targeted program types and regions, with enhanced payments to cover high-need areas and/or populations.

Intended Outcomes

- Decreased workforce turnover (by helping providers retain staff).
- Improved workforce self-reported satisfaction scores (measured by survey).

Performance Measures

- Increase workforce training and capacity.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$2M	**-**	**-**	**-**	**-**

> ***As urbans we can specialize in different areas to enhance the services [that we deliver] to our Native American people both from the reservation and in urban areas.*** *– Leonard Smith, Assiniboine and Sioux tribal member of the Fort Peck Tribes*

Recommendation #21: Enhance Behavioral Health Integration Efforts

- Identify ways that optimize reimbursement for primary care practices using the Integrated Behavioral Health model.
- Develop a CHW pilot program for Montana providers currently providing services, to (1) provide short-term "bridge" funding as needed, (2) collect data (e.g., cost reports; services such as screenings, assessments, and referrals), and (3) assess outcomes (e.g., remission of symptoms, 7 and 30 day follow up, decreased ED utilization).
- Use results from the pilot to define the scope of practice for CHWs in Montana, in coordination with the Montana CHW Committee, with a focus on specific population(s) and services.
- Evaluate the outcomes from the pilot to assess the potential of a Medicaid benefit for CHW services, including eligibility (i.e., groups served, services, program costs) and actuarially sound reimbursement rate.

Background

The Montana Healthcare Foundation has invested significant funding into primary care practices for the Integrated Behavioral Health model to help reduce the demands on specialty care providers. This work includes identifying sustainable reimbursement options for integrated behavioral health models in primary care. Montana State University's "Montana Paraprofessional Workforce Report" (January 2022) estimates 108 CHWs were active in Montana in 2020, with 121 workers having completed the AHEC CHW training program. Current estimates suggest there are now over 200 active CHWs. Montana currently has a CHW program funded through the CDC, with funding set to expire in May 2025. 29 states allow Medicaid payment for CHWs. Nine (California, Indiana, Louisiana, Minnesota, North Dakota, Nevada, Oregon, Rhode Island, and South Dakota) allow payment for a specific set of services through the State Plan. CHWs in Montana are a growing workforce with the training and community connections needed to impact health outcomes. A targeted CHW pilot may enable insights into the most appropriate scope of practice for CHWs in Montana and how they may complement other services.

Summary

Theme:	Workforce
Population Impacted:	BH – Adults and Children
Place in Continuum of Care:	Prevention
BHSFG Priority # (1-7):	3. Capacity of adult BH service delivery system 4. Capacity of children's mental health service delivery system
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings – AMH, RFI, Primary Care Association

Intended Outputs

- Identification of ongoing sustainable funding for integrated behavioral health models.
- Extension of existing CHW pilot programs to continue capacity building in Montana.

Intended Outcomes

- Increased number of primary care practices with sustainable integrated behavioral health models.
- Increased provision of preventive health services, e.g., wellness checks, annual physical examinations, and outpatient therapy.

Performance Measures

- Decrease ED utilization.
- Follow-up after ED visit for mental illness.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
$3.9M	**-**	**$1.9M**	**$1.2M**	**$714K**

Recommendation #22: Expand and Sustain Certified Community Behavioral Health Clinics

- Enhance the capacity and infrastructure of Montana's BH system to adopt and sustain the Certified Community Behavioral Health (CCBHC) model statewide.
- Provide funding to CCBHC providers to support data, technology, and training capabilities that adhere to the SAMHSA CCBHC requirements.

Background

Montana has taken significant steps to address its BH challenges by increasing access to an integrated BH system. The Department identified CCBHCs, a model with specially designated clinics that provide access to coordinated BH care, as a key component of its approach to building a more integrated system. CCBHCs are required to serve anyone who needs mental health or substance use services, regardless of their ability to pay, place of residence, age, or diagnosis. In 2023, DPHHS received a SAMHSA state planning grant that supported a needs assessment and the development of a reimbursement methodology to inform the design and implementation of a future statewide CCBHC model. There are four providers that have been recipients of two or more years of the SAMHSA CCBHC community grants. Currently, these providers are actively working with the Department to meet the full CCBHC certification requirements. The Department plans to submit its application in SFY25 to SAMHSA to become a CCBHC Medicaid demonstration state in SFY26.

Summary

Theme:	Continuum Capacity
Population Impacted:	BH – Adults and Children
Place in Continuum of Care:	All
BHSFG Priority # (1-7):	3. Capacity of adult BH service delivery system 4. Capacity of children's mental health service delivery system 6. Capacity of co-occurring populations service delivery system
Stakeholder Input:	BHSFG Commission Meetings – CMH, AMH

Intended Outputs

- Enhanced state infrastructure and capacity to support oversight and monitoring of a future Montana CCBHC network.
- Increased access to integrated CCBHC services.
- Increased capacity of Montana's CCBHC providers to meet the core SAMHSA requirements.

Intended Outcomes

- Decreased avoidable, high-cost service utilization.
- Increased capacity of CCBHCs to deliver integrated BH services.

Performance Measures

- Decrease ED utilization.
- Increase workforce training and capacity.
- Follow-up after ED visit for mental illness.

Proposed Funding

BHSFG Funding		Long Term Sustainability		
OTO	**Operational**	**Total Recurring**	**Federal Share**	**State Share**
-	**$24.6M**	**$53.6M**	**$41.2M**	**$12.4M**

Near-Term Initiatives

Summary

NTIs recommended by the Commission and approved by Governor Gianforte were either already implemented or in the planning stages for implementation by DPHHS prior to the development of this report. While NTIs are separately categorized from this report's recommendations, they are fundamental and immediate actions DPHHS has taken, under Commission guidance, to improve the BH and DD systems. The Commission used the following criteria to identify NTIs that:

1. Focus on solving specific, known, and worsening problems in the BH and DD systems.
2. Deploy funding to address those problems while identifying a path towards sustainability.
3. Are achievable within the current resource constraints of DPHHS.
4. Build upon existing DPHHS programs or infrastructure where and when possible.
5. Consider a wide range of inputs, including responses to the Commission's RFIs and public input.

The following table includes NTI funding and progress to date:

#	NTI	Launch Date	Funding Amount	Goal	Progress to Date
1	Incentivize Community-Based Court Ordered Evaluations (COE)	3/8/24	$7.5M	HB 872 funds are available for providers to use for community-based COE and/or stabilization services.	Successfully launched NTI on 3/8/24. Completed and paid for multiple COEs in community settings.
2	Increase Residential Bed Capacity	2/5/24	$15.8M	HB 872 funds are awarded to residential setting providers to increase capacity.	Received 136 applications totaling $30M. Reviewed applications using Department priorities. Expanded funding amount from $10M to $15.8M.
3	Support Mobile Crisis Response / Crisis Receiving and Stabilization Services	5/31/24	$7.5M	HB 872 funds are awarded to existing mobile crisis providers to enhance financial stability, and to crisis receiving and stabilization providers to expand capacity.	Shared contracts with mobile crisis providers. Released RFP to provide resources to crisis receiving and stabilization providers.
4	Development and Deployment of a Comprehensive Crisis Worker Curriculum and Certification Course	8/1/24	$500K	HB 872 funds are awarded to a university partner to develop (with DPHHS) and host a crisis curriculum for all crisis workers.	Finalizing contract language with the University of Montana to co-develop and host course.
5	Health Care and DD Workforce Training and Certification	4/19/24	$600K	HB 872 funds are awarded to providers to train their workforce to support individuals with DD and to help DSPs obtain certification in providing services to individuals with DD.	Successfully launched DD Workforce training on 4/19/24 and Health Care Workforce training on 5/10/24.
6	Family Peer Supports Pilot Program	7/30/24	$700K	HB 872 funds are awarded to organizations with a proven track record of providing family peer support services in Montana.	Successfully launched application on 7/30/24.

#	NTI	Launch Date	Funding Amount	Goal	Progress to Date
7	Support for Tribal and Urban Indian Organizations to Expand BH and DD Capacity	8/30/24	$6.5M	HB 872 funds are awarded to Tribes and Urban Indian Organizations to stabilize or improve their capacity to meet the BH and DD needs of the people they serve.	Successfully launched application on 8/30/24.
8	Fair Market Rent Re-evaluation Study	9/13/24	$1M	HB 872 funds are awarded to the Montana Department of Commerce to conduct a statewide reevaluation study.	Executed MOU with the Department of Commerce to conduct rate study on 8/1/24.
9	Access to Naloxone and Fentanyl Test Strips	TBD	$400K	HB 872 funds are awarded to providers to build 24 naloxone and fentanyl test strip vending "kiosks" in communities across the state.	The Governor approved this NTI on 8/16/24. DPHHS is currently developing a work plan and timeline and aims to launch a grant program later this fall.
10	Funding to Launch Occupational Therapy (OT) Doctorate and Physician Assistant (PA) Programs	TBD	$4M	HB 872 funds are awarded to the universities in Montana to cover start-up costs to launch OT and PA programs.	The Governor approved this NTI on 8/26/24. DPHHS is currently developing a work plan and timeline and aims to launch the program later this fall.
11	Grants for Local Innovation Pilots	TBD	$2.5M	HB 872 funds are available to rural and frontier counties and Tribes to pilot select innovative behavioral health models in their communities.	The Governor approved this NTI on 9/25/24. DPHHS is currently developing a work plan and timeline and aims to launch the program later this fall.

Initiative #1: Incentivize Community-Based Court Ordered Evaluations

Purpose: There are very few options to perform court-ordered forensic fitness evaluations (COEs) in Montana, with most conducted by one psychiatrist at the Montana State Hospital Forensic Mental Health Facility (FMHF, also known as Galen). This has led to a backlog of ordered yet uncompleted evaluations. To address this, this NTI makes available $7.5M of HB 872 funding to compensate providers to conduct local, community-based COEs and related stabilization services.

Implementation Progress to Date

Date Approved by Commission:	10/13/23
Date Approved by Governor:	12/19/23
Funding Level:	$7.5M
Place in Continuum:	Treatment
Population Served:	BH – Adult
Next Steps:	Continue outreach efforts to increase utilization of this NTI

Initiative #2: Increase Residential Bed Capacity

Purpose: Montana lacks the residential bed capacity to meet the state's needs. To address this, this NTI will provide $15.8M worth of one-time grants to congregate community living providers who serve individuals with a serious mental health or developmental disability diagnosis. The goal of this NTI is to stabilize or increase residential service provision across the state, and to build sustainable capacity so that more Montanans can be served in clinically appropriate settings closer to home.

Implementation Progress to Date

Date Approved by Commission:	10/13/23
Date Approved by Governor:	12/19/23
Funding Level:	$15.8M
Place in Continuum:	Treatment, Recovery
Population Served:	BH – Adults, DD – Adults
Next Steps:	DPHHS will begin accepting invoices on 9/16/24 and funds will be made available soon after

Initiative #3: Support Mobile Crisis Response and Crisis Receiving and Stabilization Services

Purpose: Montana's crisis providers have limited resources to meet the state's needs. To help address this, this initiative will provide one-time grants to existing MCR and new crisis receiving and stabilization providers to 1) stabilize MCR programs and 2) increase crisis receiving and stabilization service capacity across Montana.

Implementation Progress to Date

Date Approved by Commission:	11/30/23
Date Approved by Governor:	01/22/24
Funding Level:	$7.5M
Place in Continuum:	Crisis Intervention
Population Served:	BH – Adults
Next Steps:	Distribute funds to MCR contracts; finalize award amounts for crisis receiving and stabilization submissions.

Initiative #4: Development and Deployment of a Comprehensive Crisis Worker Curriculum and Certificate Course

Purpose: Montana's health system has substantial workforce shortages that limit its capacity to respond to crises. To alleviate this problem, this NTI will create a Crisis Worker Certification Course, in partnership with a university experienced in curriculum development, that will be available to providers delivering crisis services.

Implementation Progress to Date

Date Approved by Commission:	12/01/23
Date Approved by Governor:	01/22/24
Funding Level:	$500K
Place in Continuum:	Crisis Intervention
Population Served:	BH - Adults
Next Steps:	Finalize contract with University of Montana to create and administer course; engage with crisis system stakeholders

Initiative #5: Health Care and DD Workforce Training and Certification

Purpose: The developmental disabilities workforce faces significant constraints that limit its ability to provide people with needed services. To help offset that, this initiative will provide up to $350K to pilot a direct support professionals (DSP) credentialing structure to help stabilize the DSP workforce and will provide up to $250K to enhance training opportunities for health care professionals to better support individuals with DD.

Implementation Progress to Date

Date Approved by Commission:	01/11/24
Date Approved by Governor:	01/30/24
Funding Level:	$600K
Place in Continuum:	All
Population Served:	DD – Adults and Children
Next Steps:	DSP credentialing initiative is live, and providers are actively enrolling DSPs in the program and DPHHS is engaged in office hours with NADSP and providers.

Initiative #6: Family Peer Supports Pilot Program

Purpose: Montana families raising children with BH challenges too often have unmet emotional support needs that can exacerbate the BH needs of their children and can negatively impact the health and well-being of families, parents, and caregivers. To help address this, this initiative will create a family peer support pilot program to provide one-time grants to up to five organizations with a proven track record of providing family peer support services in Montana. This will provide Montana families with needed access to a cost-effective solution to help meet family and caretaker needs.

Implementation Progress to Date

Date Approved by Commission:	3/29/24
Date Approved by Governor:	6/10/24
Funding Level:	$700K
Place in Continuum:	Prevention, Recovery
Population Served:	BH - Children
Next Steps:	Select awardees

Initiative #7: Support for Tribal and Urban Indian Organizations to Expand BH and DD Capacity

Purpose: The Tribal Nations and Urban Indian Organizations of Montana face significant barriers to providing care and often lack resources to address community needs (which include disproportionately high rates of mental health disorders, suicide, and substance abuse). This initiative will provide one-time grants to Tribal Nations and Urban Indian Organizations to stabilize or improve their capacity to meet the needs of the people they serve. Allowable uses of funds include improving, repairing, or expanding existing BH facilities; starting, improving, or repairing MCR teams; expanding transportation options to relevant facilities for people with BH needs; and other potential uses to address urgent BH needs.

Implementation Progress to Date

Date Approved by Commission:	5/20/24
Date Approved by Governor:	7/17/24
Funding Level:	$6.5M
Place in Continuum:	All
Population Served:	All
Next Steps:	Application closes 9/30; DPHHS will review applications and notify awardees after applications close.

Initiative #8: Fair Market Rent Reevaluation Study

Purpose: A lack of affordable housing creates and exacerbates BH challenges and crises for vulnerable individuals. Montana's market rents have increased substantially over the last several years, and current Fair Market Rent (FMR) rates do not provide Montanans with enough resources to afford housing. To address this, this initiative will provide up to $1M to the Montana Department of Commerce to conduct a statewide FMR reevaluation project.

Implementation Progress to Date

Date Approved by Commission:	5/20/24
Date Approved by Governor:	7/31/24
Funding Level:	$1M
Place in Continuum:	Prevention
Population Served:	BH – Adults and Children
Next Steps:	Application is currently live

Initiative #9: Access to Naloxone and Fentanyl Test Strips

Purpose: The opioid epidemic is a statewide crisis as overdose deaths continue to increase at alarming rates. Naloxone, a medication that can reverse opioid overdose, is a critical tool in addressing this issue, as are fentanyl test strips that can detect the presence of fentanyl in different kinds of drugs and drug forms. This initiative provides funding to build 24 naloxone and fentanyl test strip vending "kiosks" in communities across the state. These kiosks will provide communities with cost-effective tools to help reduce the number of overdose fatalities across Montana.

Implementation Progress to Date

Date Approved by Commission:	05/20/24
Date Approved by Governor:	8/16/24
Funding Level:	$400K
Place in Continuum:	Prevention, Treatment
Population Served:	BH – Adult
Next Steps:	TBD

Initiative #10: Funding to Launch Occupational Therapy Doctorate and Physician Assistant Programs

Purpose: Physician assistants and occupational therapists fill critical roles in Montana's BH and DD continuums of care, particularly in rural and frontier areas. However, Montana has significant workforce shortages of both PAs and OTs, in large part due to a lack of affordable, accessible degree programs in these fields. To help address these shortages, this initiative will provide one-time funding to support start-up costs for PA and OT doctorate programs at the University of Montana College of Health. This will allow the University of Montana to launch each program within the next two years to address critical BH and DD workforce shortages. This NTI also expands the eligibility criteria associated so that any institution of higher education authorized to issue degrees in Montana by the Board of Regents per MCA-20-25-106.

Implementation Progress to Date

Date Approved by Commission:	5/20/24
Date Approved by Governor:	8/26/24
Funding Level:	$4M
Place in Continuum:	All
Population Served:	BH – Adults and Children, DD – Adults and Children
Next Steps:	TBD

Initiative #11: Grants for Local Innovation Pilot Programs

Purpose: Rural and frontier counties and Tribes across Montana have heightened BH needs and often lack resources to address them. Given that rural and frontier counties and Tribes have a diversity of complex challenges, there is no "one-size-fits-all" approach to improving their BH outcomes. This NTI will provide grants to up to 10 rural and/or frontier counties and Tribes to pilot innovative behavioral health solutions designed to meet the unique needs of their communities.

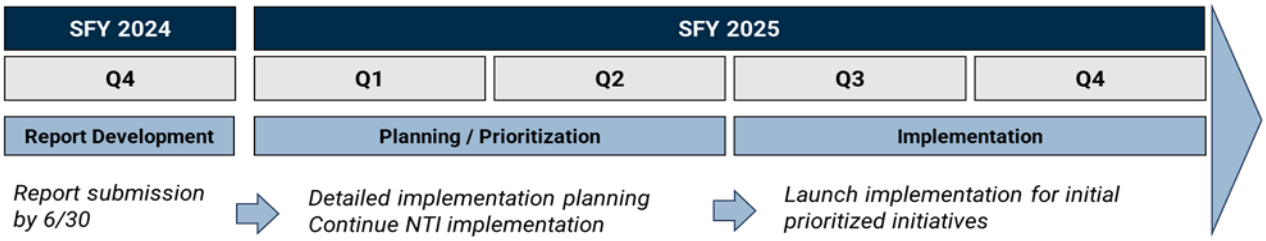
Implementation Progress to Date

Date Approved by Commission:	06/28/24
Date Approved by Governor:	09/25/24
Funding Level:	$2.5M
Place in Continuum:	All
Population Served:	BH – Adults and Children
Next Steps:	TBD

Implementation Planning

Following the submission of this report, the Commission and DPHHS will shift focus to implementation planning. The planning period between report submission and approval is critical, as it enables the Commission and DPHHS to strategize how recommendations become initiatives. This planning phase will coincide with the continued execution of NTIs and the potential launch of additional approved NTIs. The timeline below (Figure 7) depicts the planning phase preceding implementation.[14]

Figure 7 | Implementation Planning Timeline



The Commission will build upon its successful project management approach applied to the launch and implementation of the NTIs by assessing each recommendation based on key considerations or requirements, as shown in Figure 8, below. This enables DPHHS to organize recommendation leads, subject matter experts, and other necessary support to engage with key stakeholders and plan for the launch of a recommendation. The output of this phase includes a detailed implementation plan that will inform a specific timeline to launch and complete each recommendation.

Figure 8 | Implementation Planning Requirements

Requirements	Project Needs
Staffing	Assessing the available workforce and determining any additional staffing needs or skill requirements to implement the recommendation effectively.
System / Infrastructure	Evaluating the existing technological infrastructure and identifying any upgrades or changes necessary to support the implementation of the recommendation.
Legislative / Regulatory	Reviewing relevant laws, regulations, policies, and manuals to ensure compliance and identifying any legal or regulatory requirements that may need addressing, updating, or amending.
Finance / Sustainability	Analyzing the financial implications of the recommendation, including initial investment requirements and long-term sustainability strategies to ensure continued success.
Project Implementation Timeline	Developing a comprehensive timeline outlining key milestones and deadlines for executing each recommendation, ensuring efficient progress tracking.
Risks	Identifying potential risks and challenges associated with the implementation of the recommendation, such as operational or financial risks, and developing mitigation plans to address them effectively and proactively.

[14] Note that currently anticipated continued implementation occurring in SFY 2026 is not reflected in the visual.

A preliminary requirements assessment for the recommendations included in this report yields a breakdown of three tiers or levels of complexity: High, Medium, and Low. Each complexity tier also reflects a level of risk. This tiering does not reflect a prioritization of recommendations, but rather an initial grouping of them in advance of conducting a more thorough and detailed planning process.

Recommendation Tiering[15]	
Complexity Tier	**Description**
High *# of Recs = 10 (45%)*	Require multiple launch steps such as the issuance of an RFP for the engagement of contracted services, legislative and/or regulatory compliance applications (e.g., waiver amendment), and significant provider and other key stakeholder engagement including advocates and individuals with lived experience. System impact is expected to be broad and sustained. **Timeline to launch is expected to be 12+ months.** **Recommendations:** Enhancing TCM, Expanding the Peer Supports Program, Redesigning In-State Youth Residential Rates, Investments in School-Based Initiatives, Reconfiguring Rates for DD Waiver Services, Expanding Services to Individuals with Complex DD Needs, Care Transitions, Access to Stabilization Services, and Certified Community Behavioral Health Clinics (1, 2, 3, 6, 8, 11, 16, 17, 18, 22). ***Risks generally include Department resourcing, coordination with stakeholders, and the time needed to address the various systems, rate, and program changes required (including seeking federal approvals); a fiscal sustainability plan is also critical for each of these recommendations.***
Medium *# of Recs = 5 (23%)*	Require fewer steps to implement than the High tier recommendations with fewer risks associated, but still require up to 12 months to implement and a significant amount of funding. These stand to have a broad impact on the system. **Recommendations:** Developing a Targeted Case Management Training Program, Expanding Mobile Crisis, Expanding the Scope of the Peer Support Program, and Addressing the DD Waitlist Management Process (5, 7, 10, 12, 21). ***Risks generally include balancing Department resourcing with efforts dedicated to the higher complexity initiatives, engagement with providers, and fiscal sustainability plans.***
Low *# of recs = 7 (32%)*	Require steps to implement such as a provider contract amendment or issuance of an RFP, as well as Department oversight and project management; complexity levels are similar to that of the NTIs though in many cases will require a longer timeline to implement. **Recommendations**: Adopt Electronic Bed Registry and Enhance 988, Funding the Reopening of Evaluation and Diagnostic Clinics, Increasing Support for People w/ SMI Experiencing Homelessness, Launching a Media Campaign, Reducing Barriers to Transportation, Expanding Training Content, and Incentivizing Providers to Join the Workforce (4, 9, 13, 14, 15, 19, 20). ***Risks generally include balancing Department resourcing with efforts dedicated to initiatives in the High and Medium tiers.***

In addition to considering the complexity and resource needs for implementation, the Commission has also worked to assess recommendation impact (i.e. the degree to which a recommendation improves service options for people accessing services), Commission member input to account for constituent voices and/or Commission member expertise, and recommendation sequencing (i.e. identifying how

[15] Recommendation tiering is based on a preliminary assessment of each recommendation and does not reflect the more detailed planning exercise to occur during the next phase described throughout this section of the report.

recommendations may impact others to inform a phased implementation plan - see Appendix E). While the implementation planning phase is necessary to develop detailed requirements and timelines for all recommendations, the following section of the report captures initial and illustrative requirements for five of the high-complexity recommendations.

Recommendation Implementation Examples

Below are implementation examples for five of the higher complexity recommendations. Please note that these examples are illustrative. Implementation planning involves evaluating the complete project scope, considering the current context of ongoing initiatives, and addressing specific planning requirements. This includes assessing project complexity, identifying target milestones, and estimating the duration of each project. Projected staffing increases are for state staff; note that these figures are preliminary and subject to change based on ultimate project requirements and resource availability.

Recommendation #3: Expand the Service Delivery System to Support Individuals with Complex Needs	
Overview: This recommendation proposes a more comprehensive support system, introducing three models of care (START program, increased provider capacity, and a new Enhanced Community Living residential habilitation option) to best support individuals with DD who have complex, dual diagnosis needs. The START program is foundational to this recommendation and is a critical step in building the needed capacity to serve individuals with complex needs. This helps establish a stronger continuum of care. This program will serve as a critical stopgap to supporting people in restrictive settings.	
Implementation Requirements	
Staffing:	• 0.5 FTE Project Manager
System / Infrastructure:	• Procure National Center for Start Services (NCSS) contract for certification process • Issue Request for Proposal for Qualified Service Provider(s) • Identify pilot location • Identify pilot scope – Clinical Team vs Clinical Team Plus model • Add MMIS service codes / modifiers • Revise Personal Support Planning Process
Legislative / Regulatory:	• Review and update ARMs • Establish and update DDP Operating Policies / Provider Manual
Finance / Sustainability:	• Identify Medicaid finance / reimbursement options – 0208 Waiver Amendment or Alt Waiver Structure • Determine reimbursement structure and rate
Project Implementation Timeline:	• Years 1-5: start-up and program operations • Year 5: pilot evaluation and planning
Risks:	• The START model requires a team of highly skilled clinical staff that may be challenging to find given already low staff availability. • Ongoing, sustained funding will be needed to maintain and grow the pilot. If funding is not available, the overall impact of the program may be limited. • The pilot will be established in a more populated region of the state to support staffing needs, which may limit immediate support availability to individuals with complex needs in more frontier regions and/or who require extended travel to receive services.

Recommendation #6: Enhance the Targeted Case Management Program	
Overview: Under this recommendation, Montana would update the TCM model for individuals with SDMI and/or SUD, children with SED, and individuals with DD. This work would evaluate the reimbursement model to determine a need for future reimbursement changes. This recommendation also proposes to examine TCM utilization across current service providers to identify service availability (supply) and current met and unmet service needs (demand) to better understand system capacity development needs. Additionally, this recommendation seeks to explore alternative payment models by piloting an incentive program for providers who meet certain metrics as established by the Department.	
Implementation Requirements	
Staffing:	• 1 FTE TCM Program Manager
System / Infrastructure:	• Procure vendor to develop VBP and reimbursement model • Establish metrics for the VBP pilot • Develop VBP pilot program standards for TCM providers that meet eligibility requirements
Legislative / Regulatory:	• Review and update Montana State Plan • Update the provider manuals to reflect VBP model, reimbursement
Finance / Sustainability:	• Determine reimbursement structure • Determine VBP criteria for VBP incentive program, quality metrics, and total costs
Project Implementation Timeline:	• Years 1-2: start-up, VBP program analysis • Years 3-5: new reimbursement model and VBP rollout
Risks:	• Ongoing funding to potentially support new reimbursement model may not be budget neutral. • Obtaining the necessary data to establish the reimbursement model due to lack of availability or completeness. • Adequate staffing to oversee monitoring and compliance. • Providers' ability to manage the administration of new assessments and reimbursement model.

Recommendation #8: Implement a Care Transitions Program	
Overview: Under this recommendation, Montana would expand its existing case management services for eligible individuals with complex needs to improve transitions from higher levels of care (e.g., inpatient hospitals, correctional settings, and state institutions). This recommendation would initiate and fund start-up costs for a new case management program for people transitioning from specific settings. One model for consideration is Critical Time Intervention (CTI), an evidence-based time-limited transition model backed by decades of rigorous research. Under CTI, a discharged patient receives intensive, community-based support that helps them through vulnerable periods of transition; guidance on "linking" to the services they need in their community; and assistance in developing the independence they need to live sustainably in the community.	
Implementation Requirements	
Staffing:	• Identify DPHHS lead for care transitions program
System / Infrastructure:	• Identify the population(s) and applicable settings (e.g., inpatient, correctional, etc.) • Determine the case management model • Identify the number of teams • Establish outcome metrics • Establish the contracting vehicles (e.g., RFP, sole source) • Establish necessary MOUs with agencies
Legislative / Regulatory:	• Update regulations and provider manual
Finance / Sustainability:	• Determine total start-up costs • Assess feasibility of submitting a SPA to bill Medicaid long-term
Project Implementation Timeline:	• Years 1-2: start-up • Years 3-5: determine settings and long-term sustainability strategy
Risks:	• Delayed implementation of new service. • Coordination with other agencies and facilities. • Workforce shortages. • Medicaid approval of model as a billable service.

Recommendation #18: Invest in School Based Behavioral Health Initiatives	
Overview: Under this recommendation, Montana would identify priority communities for sustained investments in existing school-based programs and allocate one-time funding to launch a school-based Multi-Tiered System of Support (MTSS). MTSS investments encompass universal screening, referrals, and evidence-based interventions aimed at enhancing youth well-being. This recommendation also invests in infrastructure for training and coaching for selected evidence-based practices implemented by school districts. Additionally, the supportive environment of schools will be bolstered through interprofessional training for school counselors, nurses, psychologists, social workers, administrators, and other professionals. This would also include determining appropriate policies in collaboration with OPI and identifying funding sources to ensure sustainability, such as Medicaid due to the reversal of the Medicaid free care rule.	
Implementation Requirements	
Staffing:	• Identify existing state staff for oversight, monitoring
System / Infrastructure:	• Identify contracting mechanism for school mental health services • Update rules, regulations, and systems for Medicaid billing for school mental health services • Identify performance measures, reporting, quality metrics • Identify contracting mechanism for PROJECT ECHO or interprofessional training of school staff • Support existing infrastructure of training and coaching models for school-based evidence-based practices
Legislative / Regulatory:	• Identify necessary legislation and regulatory changes • Draft SPA for reversal of free care
Finance / Sustainability:	• Assess fiscal note for the state match of Medicaid-covered services • Identify the funding source for ongoing interprofessional training for school staff • Identify ongoing sources of funding for long-term sustainability (e.g., Medicaid, grants, state-county funds, local education agency funds)
Project Implementation Timeline:	• Year 1: Contract with an entity to deliver a PROJECT ECHO or interprofessional training of school staff, develop partnership and MOU with OPI, and determine priority schools • Year 1: Identify contracting for school-based services • Years 1-2: Determine feasibility of reversal of free care
Risks:	• Obtaining parental consent to provide BH services delivered in schools may be challenging. • Ensuring evidence-based programs are implemented with fidelity. • SPA development, submission, and approval may be subject to change and elongated timelines. • Securing funding source(s) for interprofessional training of school staff may be difficult. • A successful partnership with OPI is critical to avoiding delays in project implementation.

Recommendation #19: Incentivize Providers to Join the BH and DD Workforce	
Overview: Under this recommendation, Montana would offer additional tuition reimbursement for less credentialed members of the BH and DD workforce, including case management staff and direct care workers. This recommendation proposes to incentivize providers to join the BH and DD workforce in Montana by enhancing the existing State Loan Repayment Program (SLRP) that encourages behavioral health workers to practice in Montana. This program would aim to target workers who are (1) essential to BHSFG initiatives and (2) underrepresented in currently available tuition reimbursement programs. Additionally, this recommendation would establish dual enrollment courses so that Montana high school students could earn college-level credits in BH and DD profession fields, free of charge, while still in high school. This would involve coordination between the Department, OPI, the Montana University System, and the Montana Office of the Commissioner of Higher Education (OCHE).	
Implementation Requirements	
Staffing:	• 1 FTE Program Coordinator
System / Infrastructure:	• Identify the eligible BH and DD providers for tuition reimbursement • Crosswalk to existing tuition reimbursement programs • Establish tuition reimbursement program standards • Create formal partnership between DPHHS, OPI, and OCHE to develop and establish tuition-free dual enrollment courses in BH and DD professions
Legislative / Regulatory:	• Assess need to develop new regulations to align with additional funding
Finance / Sustainability:	• Establish the total funding availability and annual amount
Project Implementation Timeline:	• Year 1: Develop application and program requirements, partner with eligible providers to discuss program and receive their input on applicant eligibility requirements, partner with OCHE and OPI to develop dual enrollment courses, decide funding disbursement amounts and mechanism, launch application, launch messaging campaign to socialize application, choose initial cohort. • Year 2: Award funding to initial cohort, maintain oversight, plan long-term sustainability, offer dual enrollment courses.
Risks:	• Lack of interest from BH and DD workers. • Lack of buy-in from providers. • Lack of interest from students. • Lack of buy-in from OCHE, OPI, and other education partners. • Limited ability to receive long-term funding.

Conclusion

In the months ahead, the BHSFG Commission[16] will continue its diligent work to transform Montana's BH and DD systems to ensure that those in need of care have access to the appropriate level of service at the right time. As part of this effort, DPHHS will carry on with implementing NTIs, the Commission will continue to meet as needed, and both the Executive and Legislative branches will proceed with discussions surrounding critical funding needed to sustain long-term recommendations.

The Commission and DPHHS will also plan for implementation of the foundational recommendations contained in this report while remaining cognizant of the various dependencies, such as a requirement for multi-year budget authority, associated with the implementation of certain recommendations. Specifically, the Commission will ensure implementation plans and timelines align with both BHSFG budget considerations and the Executive Planning Process for the 2027 biennium.

The Commission is confident that the historic opportunity afforded by HB 872 is a major first step in ensuring sustainable, high-quality BH and DD service systems for generations of Montanans to come but acknowledges that transformation is an iterative process. The recommendations put forth in this report provide a solid foundation for Montana, assuming lawmakers and other state decision-makers, both current and future, continue making necessary and prudent investments to ensure long-lasting reform.

Throughout 2023 and 2024, stakeholders in Montana have poured time, energy, and expertise into the Commission process. The Commission is deeply grateful for their participation and the investment of these stakeholders does not go unnoticed. The ideas brought forward through Commission meetings, Alternative Settings Steering Committee and subcommittee meetings, public comment, and other stakeholder activities have been cataloged and will continue to be evaluated by both the Commission and DPHHS.

The Commission sincerely thanks the people of Montana for their trust and the opportunity to serve.

[16] HB 872 sunsets the BHSFG Commission on July 1, 2025.

Acknowledgments

This report presents findings and recommendations collaboratively developed by the Department and the Commission. The Commission extends its sincere gratitude to all contributors, including individuals and families with lived experience, panelists, and subject matter experts, for their invaluable support and expertise in this endeavor. Their input has been instrumental in shaping these recommendations.

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Legislator

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Director, DPHHS

Senator John Esp
Legislator

Senator Ellie Boldman
Legislator

Representative Michele Binkley
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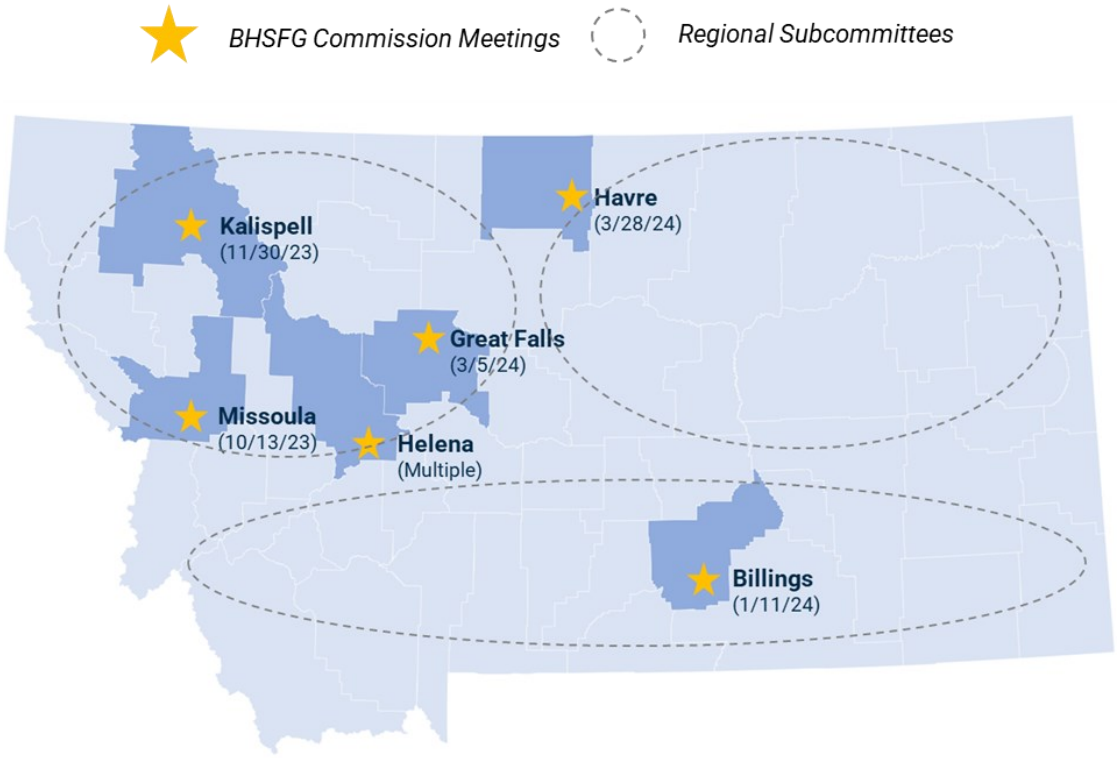
[17] Rural Behavioral Health Institute

Appendices

Appendix A: BHSFG Commission Meetings

BHSFG Commission Meeting Date	BHSFG Commission Meeting Links
July 20, 2023	BHSFG Meeting #1: Overview and Discussion of Guiding Priorities
September 8, 2023	BHSFG Meeting #2: Civil and Forensic Commitments
October 13, 2023	BHSFG Meeting #3: Crisis Now Model
November 30 – December 1, 2023	BHSFG Meeting #4: Developmental Disabilities Overview
January 11 – January 12, 2024	BHSFG Meeting #5: Children's Mental Health Overview
March 5, 2024	BHSFG Meeting #6: Tribes and UIOs Introductions
March 28 – March 29, 2024	BHSFG Meeting #7: Adult Mental Health/SUD Overview
April 22 – 23, 2024	BHSFG Meeting #8: Guidehouse Report and Commission Recs
May 20, 2024	BHSFG Meeting #9: Commission Report Summary
June 28, 2024	BHSFG Meeting #10: Recommendation Prioritization
July 23, 2024	BHSFG Meeting #11: Joint Legislative Committee
August 26, 2024	BHSFG Meeting #12: NTI and Recommendation Updates

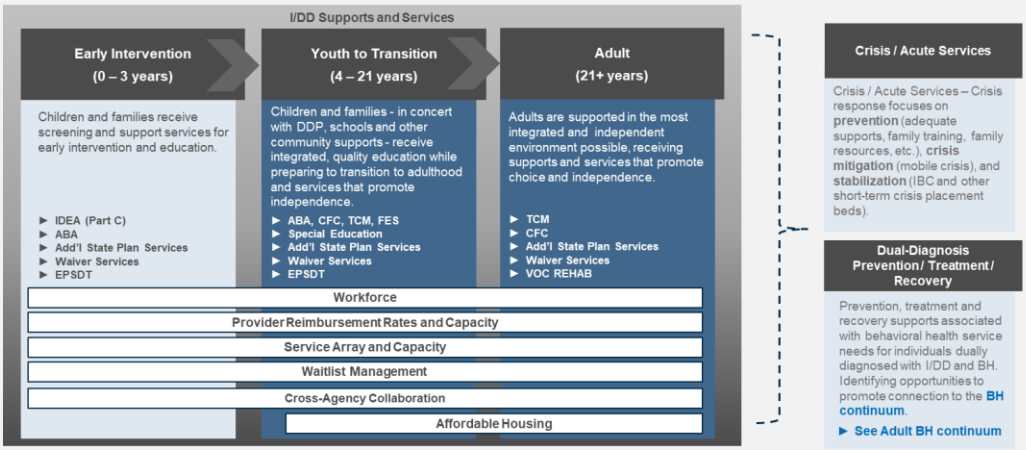
Commission Meetings Across Montana



Appendix B: Behavioral Health and Developmental Disabilities Continuum of Care

Developmental Disabilities | Continuum of Care

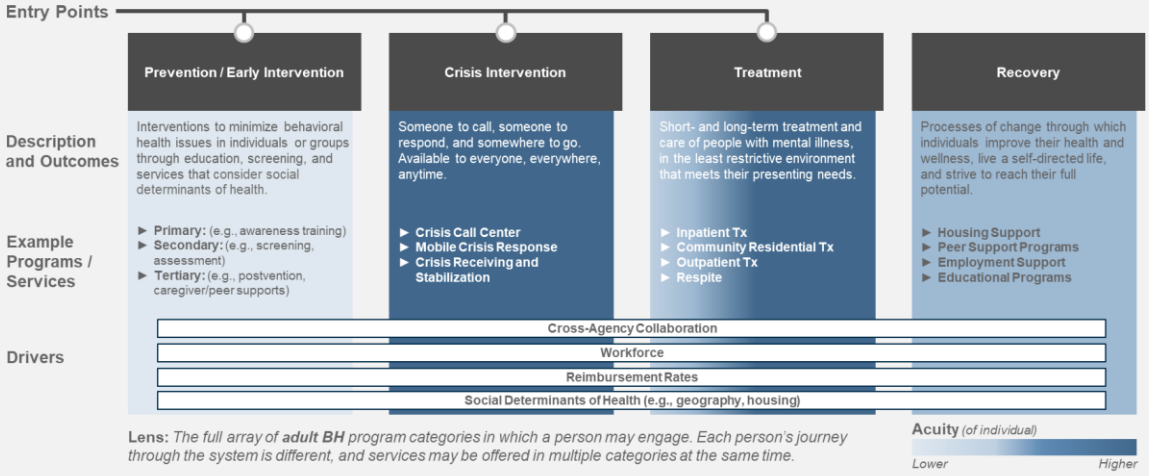
The continuum presents the array of services, woven together through service coordination.
This view offers a map of where services, and potential areas of investment, exist.



Lens: *The full array of program categories in which a person may engage. Each person's journey through the system may differ, including point of entry and scope of support needs.*

Behavioral Health | Continuum of Care | Adult

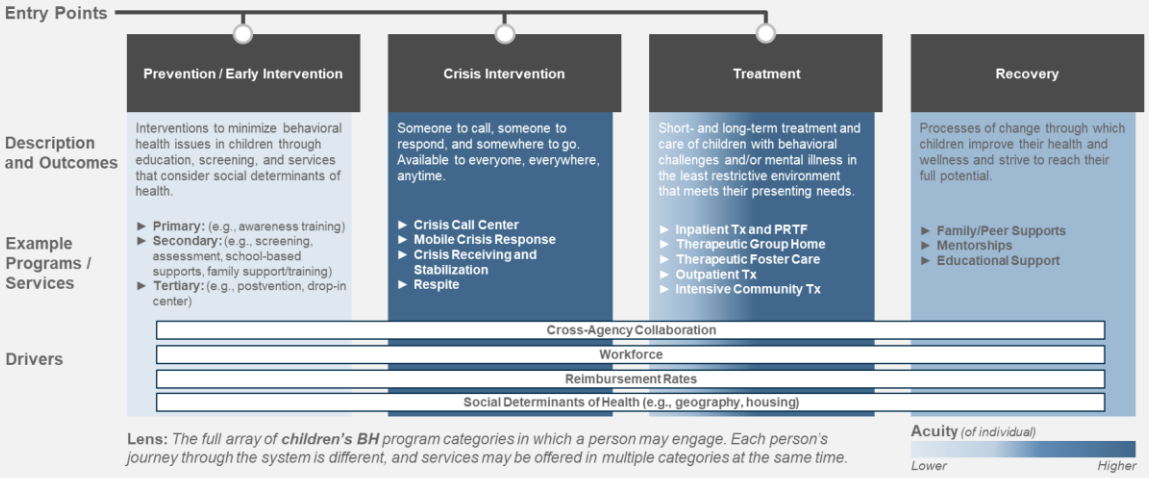
The continuum presents an array of behavioral health services, woven together by effective service coordination. This view offers a map of where services, and potential areas of investment, exist.



Lens: *The full array of **adult BH** program categories in which a person may engage. Each person's journey through the system is different, and services may be offered in multiple categories at the same time.*

Behavioral Health | Continuum of Care | Children

The continuum presents an array of behavioral health services, woven together by effective service coordination. This view offers a map of where services, and potential areas of investment, exist.



Lens: *The full array of **children's BH** program categories in which a person may engage. Each person's journey through the system is different, and services may be offered in multiple categories at the same time.*

Appendix C: Performance Measures

HB 872 requires the Behavioral Health System for Future Generations Commission to include outputs, outcomes, and performance measures for recommendations included in its final report. The Commission has used the definitions outlined in HB 190 to guide its development of these key indicators[18]. Specifically, the Commission has identified a set of performance measures (below) that are thematically applicable to the various recommendations included in the report. In some instances, recommendations will be associated with several performance measures given their complexity and projected impact.

Additionally, the Commission has identified initial baseline data points associated with these performance measures for collection and reporting upon implementation of the recommendations. The baseline data points provided below require refinement as part of implementation planning and execution. Timelines for finalizing the baseline data reflect the Commission's and Department's current best estimates and may be modified as part of implementation planning efforts[19].

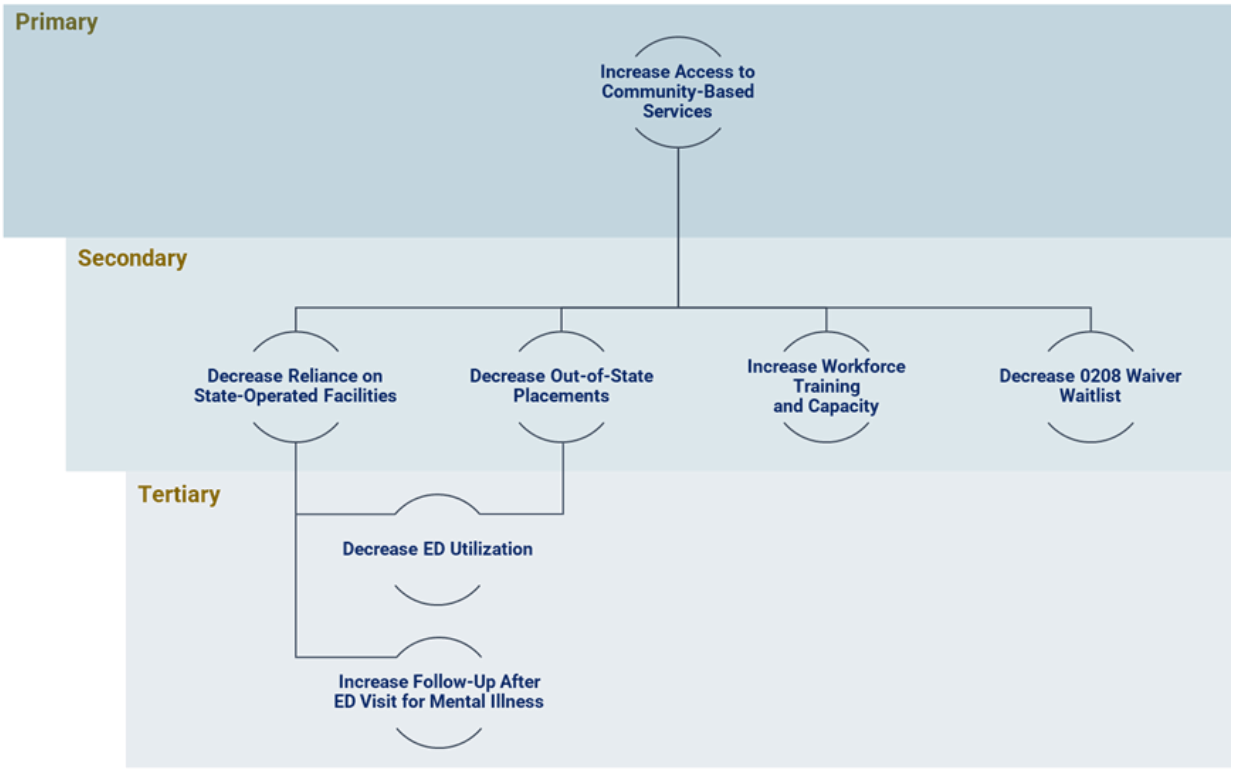
Performance Measures	Definition	Recs	Baseline Data Examples	Data Source Examples	Timeline to Baseline Availability
Decrease ED Utilization	Reducing inappropriate ED visits by individuals through improved access to alternative care options, improved preventative care, and better management of chronic conditions.	1, 2, 6, 11, 12, 16, 21, 22	❖ Annual number of ED visits for Montana Medicaid beneficiaries avoidable with BH and/or DD diagnosis receiving defined services to be determined by DPHHS	❖ Claims Data ❖ EHR Data ❖ Cost Reports ❖ Administrative Data	12+m
Increase Access to Community-Based Services	Increasing the utilization of specific, key available services to ensure beneficiaries receive appropriate community-based and comprehensive care tailored to their individual needs and levels of care instead of more costly, restrictive care options.	1, 4, 5, 6, 10, 11, 13, 14, 15, 18	❖ Annual number of Montana Medicaid beneficiaries receiving community-based services; examples include residential habilitation, day habilitation, personal support services, TCM services, or tenancy support services ❖ Percentage of individuals with documented discharge plans in place prior to release	❖ Claims Data ❖ Administrative Data	12+m

[18] As defined by HB 190:
"Outcomes" means a quantification of the public benefit for Montanans derived from actions by
"Outputs" means a quantification of the number of services that a department produces for
"Performance measure" means a metric or measurement that is designed to help guide government by assessing what a department aspires to achieve pursuant to its annual plan with respect to the outcomes and outputs of its programs.
[19] The Commission will coordinate with the Office of Research and Performance Analysis (ORPA) and Office of Strategy and Transformation (OST) within DPHHS to support data collection activities.

Performance Measures	Definition	Recs	Baseline Data Examples	Data Source Examples	Timeline to Baseline Availability
Decrease Out-of-State Placements	Decreasing the number of individuals receiving out-of-state residential level of care (i.e., PRTF) due to the complexity of support they need.	1, 2, 3,11, 17	❖ Annual number of Montana Medicaid beneficiaries receiving out-of-state residential services	❖ Claims Data ❖ Program Reports	0-6m
Decrease 0208 Waiver Waitlist	Improving the data management of current waitlist management systems and/or reducing the number of people on waitlists through increased service access.	1, 2, 4, 5	❖ Avg. length of wait time prior to 0208 Waiver access ❖ Annual number of individuals on the 0208 Waiver waitlist	❖ Waitlist Reports ❖ Claims Data	6-12m
Increase Workforce Training and Capacity	Expanding and improving the educational and professional development opportunities for staff to recruit new and enhance the skills and effectiveness of direct support workers.	7, 12, 16, 18, 19, 20, 22	❖ Tenure of direct care staff ❖ Burnout rate of direct support workers ❖ Annual unduplicated number of people enrolled in a DPHHS-approved education or training program that offers a credential recognized by an industry or occupational organization	❖ Program Reports ❖ Survey	12+m
Decrease Reliance on State-Operated Facilities	Reducing the likelihood of individuals being readmitted to state-operated facilities and decreasing their dependence on such facilities by expanding the use of alternative service providers and models.	1, 2, 3, 8, 9, 17	❖ Number of patients readmitted to MSH and IBC within specified periods (e.g., 30, 60, 90, or 180 days) after initial discharge ❖ Annual number of involuntary commitments	❖ Administrative Data ❖ Program Reports ❖ EHR Data	12+m
Increase Follow-Up After ED Visit for Mental Illness	Increasing the percentage of follow-up visits for a principal mental illness diagnosis within 30 days of an ED visit for a mental health-related event.	8, 10, 21, 22	❖ Annual number of Montana Medicaid beneficiaries who received a follow-up BH or PCP visit within 30 days post-ED visit	❖ EHR Data ❖ Claims Data	0-6m

Appendix D: Relationships of Performance Measures

In the development of Performance Measures for the BHSFG report, the Commission considered how measures may have relationships among one another. In doing so, the Commission identified increasing access to community-based services as the overall intended outcome of the recommendations. Secondary and tertiary measures are used to both verify and support increased access to community-based services.



Appendix E: Recommendation Sequencing Overview

The Commission used a structured process to refine and advance a selection of recommendations for initial implementation and funding under HB 872. This process, designed to build incrementally upon each step, allows for core recommendations to be prioritized for implementation and serves as a strategic foundation for sequencing remaining initiatives.

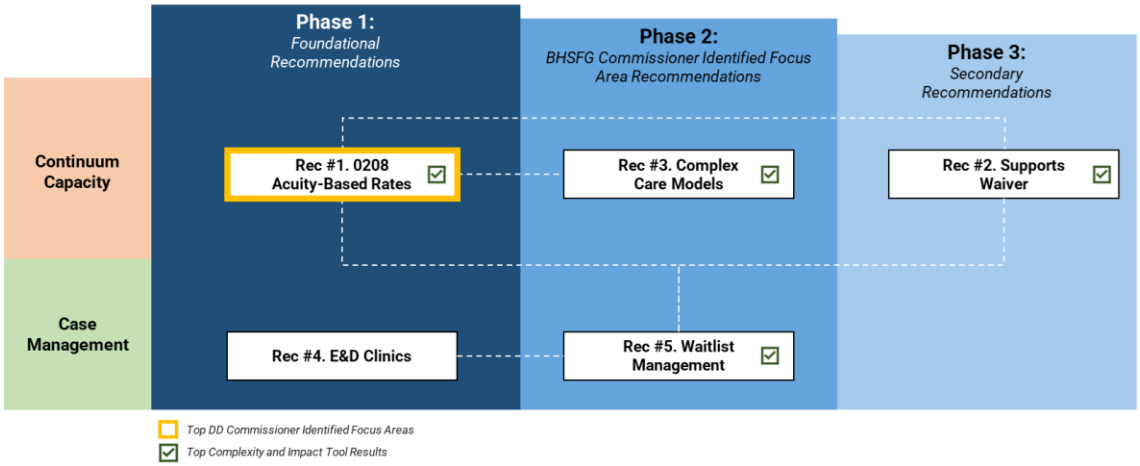
Recommendations were organized using a complexity and impact tool that categorized them by complexity, resource requirements, and anticipated benefits; Commissioners then identified their top BH and DD recommendations. The sequencing process incorporates these inputs while considering the interrelationships between several recommendations to establish a structure to support more focused project planning and the anticipated implementation of recommendations over time.

The recommendations have been organized into three phases, with careful consideration of their interrelationships to guide the sequencing of implementation activities. These phases are structured to reflect the stepwise progression necessary to effectively advance each recommendation and prevent waste of resources.

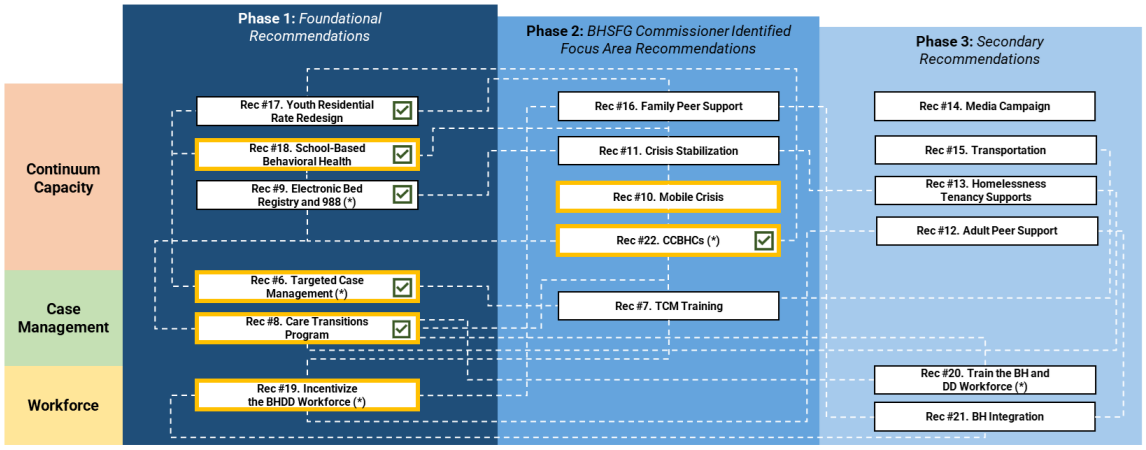
Phase	Recommendation Type	Definition
Phase 1	**Foundational Recommendations**	• A **Foundational Recommendation** builds the needed infrastructure for subsequent recommendations to succeed **AND/OR** is critical to strengthening and sustaining system operations.
Phase 2	**BHSFG Commissioner Identified Focus Area Recommendations**	• A **BHSFG Commissioner Identified Focus Area Recommendation** is one in which the Commission identified, through polling, as a leading focus area that may be impacted by the completion of a foundational recommendation and/or is not foundational in nature.
Phase 3	**Secondary Recommendations**	• A **Secondary Recommendation** is an area identified by the Commission as a value-add to the service delivery system in the future but has less immediate impact on service access, capacity, or quality.

*Below are graphics that demonstrate the shared relationships among the recommendations and their impact. This is **not** meant to serve as an implementation plan. Rather, it is intended to inform future program planning and execution.*

DD Recommendation Sequencing by Phases *(Top DD Commissioner Identified Focus Areas and Complexity / Impact Tool Results)*



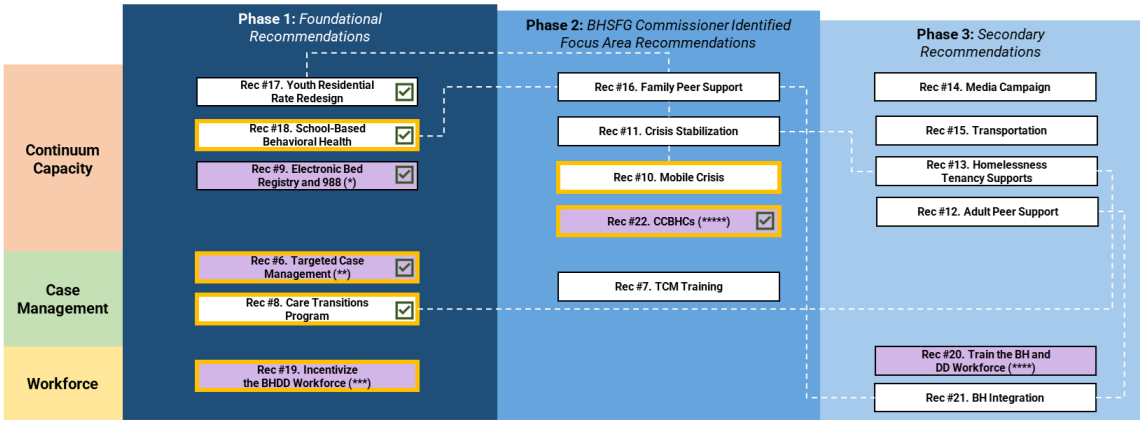
BH Recommendation Sequencing by Phases *(Comprehensive View of Relationships: Top BH Commissioner Identified Focus Areas and Complexity / Impact Tool Results)*



***Notes**: (*) Recommendations that are critical, impacting four or more other recommendations across the continuum of care.*

Top BH Commissioner Identified Focus Areas *Top Complexity and Impact Tool Results*

BH Recommendation Sequencing by Phases *(Simplified View of Relationships: Top BH Commissioner Identified Focus Areas and Complexity / Impact Tool Results)*



The recommendations below are critical, impacting four or more other recommendations across the continuum of care.

***Electronic Bed Registry (*):** Impacted recommendations include #8, 11, 17, 18, and 22.*
***Targeted Case Management (**):** All EXCEPT recommendations #14 and 20.*
***Incentivize the BHDD Workforce (***):** Impacted recommendations include #6, 8, 10, 11, 13, 17, 18, and 22.*

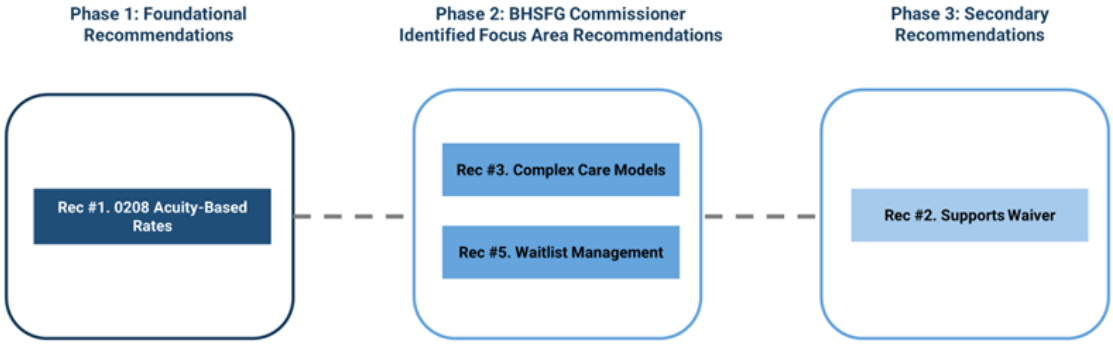
***Train the BH and DD Workforce (****):** Impacted recommendations include #8, 10, 11, 12, 13, and 17.*
***CCBHCs (*****):** Impacted recommendations include #6, 8, 9, 15, 16, 17, 18, 20 and 21.*

Top BH Commissioner Identified Focus Areas
Top Complexity and Impact Tool Results

Below are the foundational recommendations of Phase 1 and their relationships with other recommendations in subsequent phases.

Foundational Recommendation | Rec #1. 0208 Acuity-Based Rates

Refining the 0208 Waiver for developmental disabilities services is a key step towards aligning an individual's needs (acuity level) with what an individual receives (service rate).

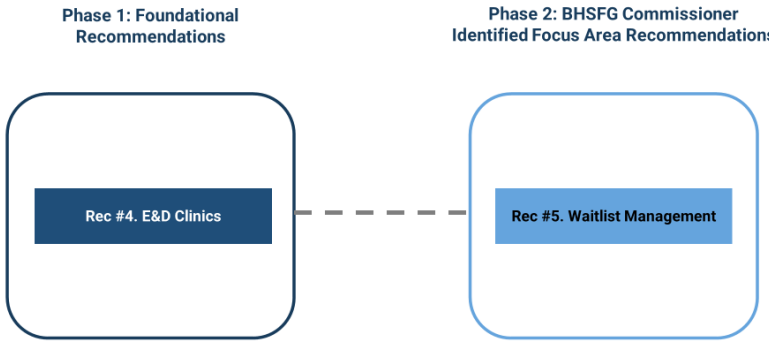


Relationship Summary

- By better aligning service reimbursement rates with the discrete needs of the individuals supported, service providers will be better able to (a) ensure they are supporting the person at the most appropriate level without under or over-serving them, and (b) consider future capacity development with more accuracy.
- Once a more refined rate model is available using a standardized assessment, the system will be more able to support the day-to-day needs of individuals with complex behavioral or medical support needs. This helps ensure that the development of future complex care models is focused on supporting those with the most complex needs in the system.
- Introduction of a standardized acuity assessment tool will also help promote person-centered planning and aide case managers and families in making better informed decisions between the 0208 Comprehensive Waiver and a future-state Supports Waiver through revised waitlist management processes.

Foundational Recommendation | Rec #4. E&D Clinics

Prior to their closure following budget reductions in 2017, Evaluation and Diagnostic (E&D) clinics played a key role in facilitating access to the developmental disabilities system for families. Serving as a "front door" to entry, they provide families with critical services as they seek access to the 0208 Waiver.



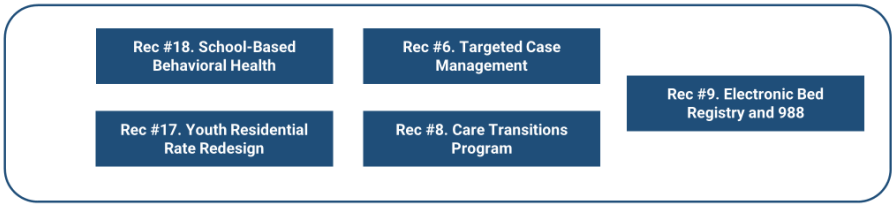
Relationship Summary

- E&D clinics are well-positioned to serve as the front door to the developmental disabilities program. By working with stakeholders to better understand the current needs of families and redefining the roles and responsibilities of E&D clinics, DPHHS can be assured that these services best align with the needs of families not yet receiving services but planning to receive services in the future.
- E&D clinics serve as the entry point to the system, but, due to resource and capacity limitations that may exist, DDP manages a waitlist for 0208 waiver slots. In developing a more robust E&D clinic model, DDP will also be better positioned to evaluate how the clinics can help support data gathering for waitlist management and ensure data collected and managed for the waitlist is current, accurate, and appropriate.

BH Foundational Recommendations | Overview

Phase 1 recommendations collectively strengthen and sustain the behavioral health continuum by building a comprehensive, integrated system of care. Serving as the core infrastructure of the BH system, these recommendations ensure individuals receive high quality assessments, access to person-centered services, when they need them, and linkages to the appropriate level of care.

Phase 1: Foundational Recommendations

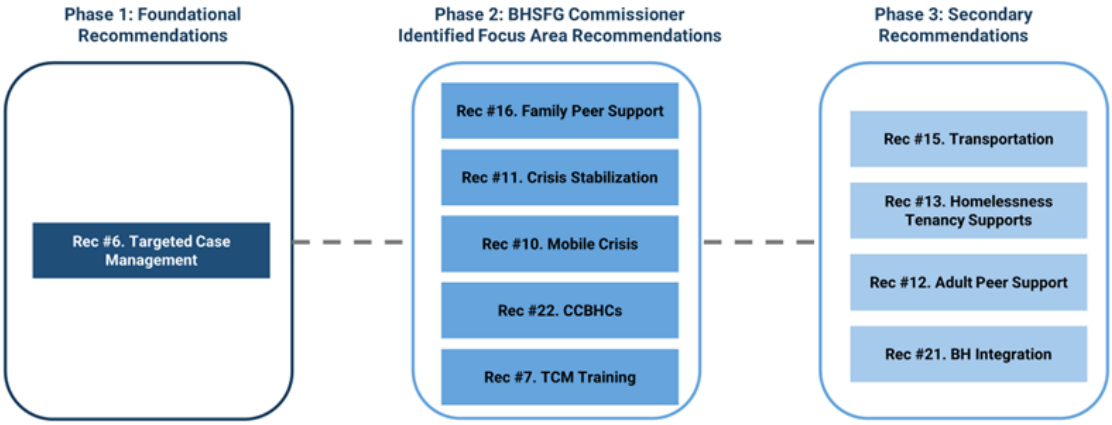


Relationship Summary

- Youth residential rate design ensures that resources and reimbursement are properly aligned with the clinical needs and services required, thereby strengthening the overall system and improving outcomes for youth.
- The Electronic Bed Registry and 988 Enhancement facilitates planning, responding and tracking of behavioral health services such as Youth Residential Services, Care Transitions Program Services and other supports across the system.
- Through enhanced Targeted Case Management, adults and youth with BH and/or IDD will receive individual assessments, care coordination and referrals to high levels of care such as Youth Residential Services.
- School-Based Behavioral Health Services strengthens the system by ensuring youth and families receive crucial screenings, connections, and referrals, preventing unnecessary hospitalizations and the trajectory of more costly higher levels of care.
- Through the Care Transitions Program, individuals receive flexible, intensive support while transitioning from higher levels of care back into the community, which reduces reliance on state hospitals, prevents readmissions, and strengthens the overall system.

Foundational Recommendation | Rec #6. Targeted Case Management

Targeted Case Management impacts nearly every Phase 2 and Phase 3 recommendation as it impacts the full continuum of assessment, planning, linkage, and support to ensure people receive the appropriate level of care and access to resources.

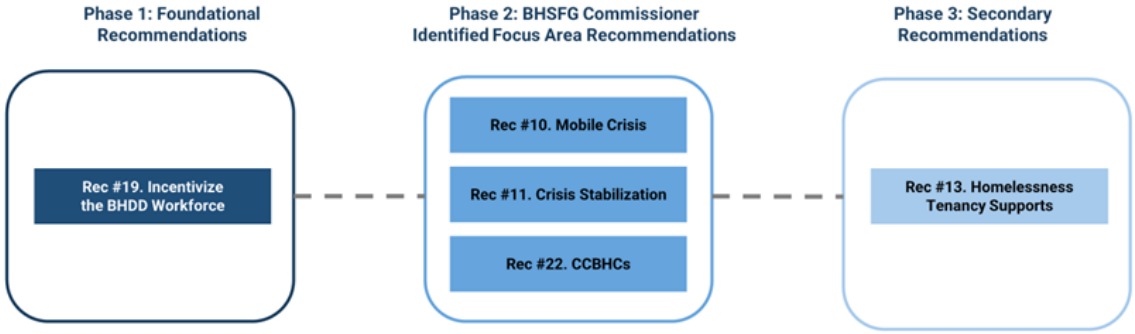


Relationship Summary

- Targeted Case Management impacts nearly every BH recommendation as it assesses acuity and aligns individual person-centered needs to comprehensive services and supports across the behavioral health and developmental disabilities system.
- Through the TCM assessment tool, people with BH and/or IDD needs will be identified and referred to the necessary services and supports—including those offered from the Family Peer Support, Crisis Stabilization, Mobile Crisis, and CCBHC services.
- By providing standardized TCM training, there will be consistency in the quality, services and resources provided by care managers that is aligned with an individual's needs.
- Through the standardized assessment, it will ensure that individuals are connected to services that support individuals' daily needs in the community such as Non-Emergency Medical Transportation, Homelessness Tenancy Supports, Adult Peer Support, and BH Integration Services.

Foundational Recommendation | Rec #19. Incentivize the BHDD Workforce

Incentivizing the BHDD Workforce is a key step to increase the supply of behavioral health and disabilities workers necessary to support the delivery of core services across the system.

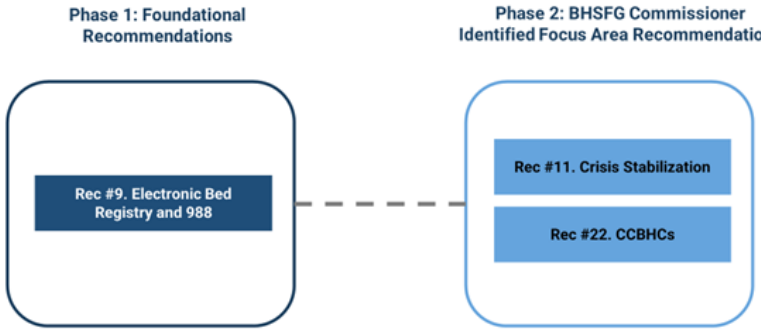


Relationship Summary

- Incentivizing the BHDD Workforce is a foundational recommendation because it can help address workforce shortages that providers across the BH and DD landscapes currently face.
- By recruiting and retaining workers to address workforce shortages, this recommendation can increase the supply of workers across Mobile Crisis, Crisis Stabilization, CCBHCs, and Homelessness Tenancy Supports.

Foundational Recommendation | Rec #9. Electronic Bed Registry and 988

Adopting an Electronic Bed Registry and 988 enhancements will facilitate more effective health system and provider communication, care coordination, and access to necessary treatment and support services for people with behavioral health needs.

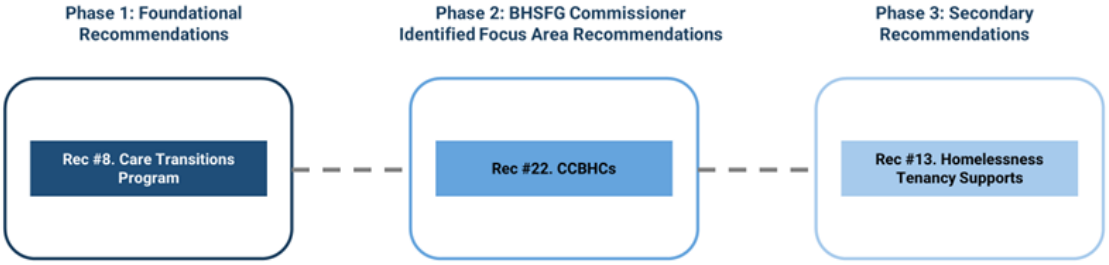


Relationship Summary

- The Electronic Bed Registry and 988 Recommendation is the entry point of the behavioral health system to:
  a) increase access to crisis stabilization services and available community-based services; and
  b) reduce unnecessary ED utilization and inpatient stays.
- The Electronic Bed Registry will support the implementation of Montana's CCBHCs by ensuring that providers:
  a) have the most up-to-date information about bed availability; and
  b) can seamlessly track and make referrals across the behavioral health system to improve efficiency, accuracy and timeliness of care.

Foundational Recommendation | Rec #8. Care Transitions Program

Care Transitions Program is a key recommendation because it targets people who present with complex needs who are at high risk of readmitting and can reduce readmissions and length of stay. Serving as a critical bridge, Care Transitions Programs offer intensive, flexible support of people transitioning from higher levels of care back to community to reduce reliance on state hospitals and prevent readmissions.

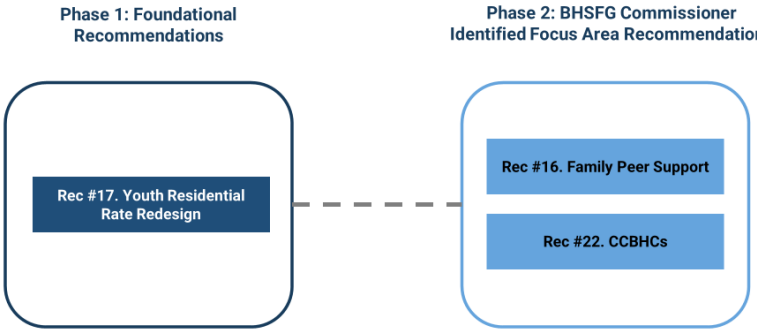


Relationship Summary

- Care Transitions Program is foundational as it improves and facilitates transitions of care to community based mental health services and housing supports, that include nine of the core CCBHC services.
- By providing timely, individual assessments during care transitions, individuals' needs will be more proactively identified, and they will receive immediate connections to necessary resources such as homelessness tenancy support specialists.

Foundational Recommendation | Rec #17. Youth Residential Rate Redesign

Refining the Youth Residential Rate Redesign is a key step to ensuring resources and reimbursement are sufficiently aligned with clinical needs (acuity) and the necessary services that youth receive.

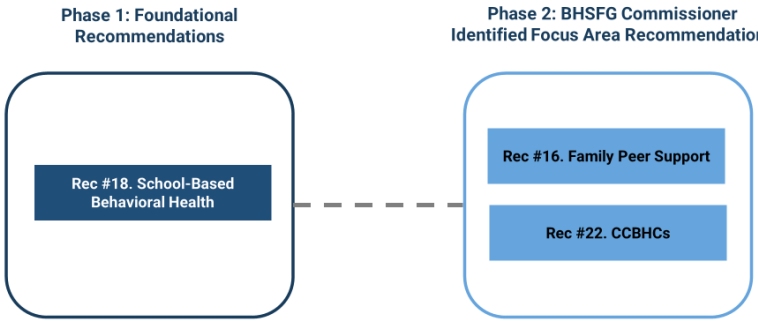


Relationship Summary

- Youth Residential Group homes provide high-quality treatment using evidence-supported behavioral health services, life-skill coaching, crisis management, and 24/7 monitoring to children who have been unable to succeed in their home and community. By more appropriately aligning acuity to the level of service, it will ensure the system is providing the right level of care and staffing to support the daily needs of youth with complex behavioral health needs.
- By developing an enhanced reimbursement model, with a standardized assessment tool, youth will be connected to appropriate resources and services at discharge planning such as Family Peer Support to facilitate transitions of care for youth returning to home and community settings.
- Through discharge planning in Youth Residential Group homes, youth will be referred to comprehensive community-based care.

Foundational Recommendation | Rec #18. School-Based Behavioral Health

Enhancing School Based Behavioral Health Services is key step to ensure youth, and their families receive the necessary preventative screening, connections, and referrals to community-based resources to avoid unnecessary hospitalizations and involvement with higher levels of care.



Relationship Summary

- School personnel are often the first individuals to identify youth and families struggling with behavioral health needs.
- By working in partnership with families, schools can connect families to peer support specialists who can best support their individual needs at home and community settings.
- CCBHCs provide comprehensive care, and school-based personnel frequently refer to CCBHCs for more extensive support.

Appendix F: Population Impacted

Below are the projected estimates of population impact for each recommendation, based on relevant population considerations. Please note that these figures are approximations and subject to change as underlying assumptions are refined.

Recommendation	Projected # of People Impacted (*approx.*)
1. Refine and Reconfigure the Current 0208 Comprehensive Waiver Services Rates	2,500
2. Expand Access to Waiver Services Through a §1915(c) Supports Waiver	1,000
3. Expand the Service Delivery System to Support Individuals with Complex Needs	1,900
4. Redefine and Reopen E&D Clinics to Support Families More Effectively	600
5. Conduct an In-Depth Study of the Current DDP Waitlist Management Process	2,100
6. Enhance the Targeted Case Management Program	10,000
7. Develop a Targeted Case Management Training Program	8,000
8. Implement a Care Transitions Program	120*
9. Adopt Electronic Bed Registry and Enhance 988	10,500
10. Expand Mobile Crisis Response to Additional Regions	1,800
11. Introduce New Crisis Stabilization and Receiving Center Services	700*
12. Expand Scope of the Certified Adult Peer Support Program	500*
13. Increase Support for Individuals with SMI and/or SUD Experiencing Homelessness	200*
14. Launch a Media Campaign to Raise Awareness and Reduce Stigma	20,000
15. Reduce Transportation-Related Barriers to Care	11,000
16. Expand the Family Peer Support Program for Parents and Caregivers	375
17. Redesign Rates to Improve In-State Youth Residential Services	2,600
18. Invest in School-Based Behavioral Health Initiatives	40,000
19. Incentivize Providers to Join the BH and DD Workforce	10,000
20. Expand Training Content Available to BH and DD Workforce	10,000
21. Enhance Behavioral Health Integration Efforts	4,000
22. Expand and Sustain Certified Community Behavioral Health Clinics	10,000

(*) = identify recommendations that have pilot initiatives.

Appendix G: Glossary of Abbreviations and Acronyms

Acronym	Term
AMH	Adult Mental Health
ARM	Administrative Rules of Montana
BH	Behavioral Health
BHDD	Behavioral Health and Developmental Disabilities Division
BHSFG	Behavioral Health System for Future Generations
B	Billion
CAH	Critical Access Hospital
CCBHC	Certified Community Behavioral Health Clinics
CDC	Centers for Disease Control
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CMH	Children's Mental Health
CMHB	Children's Mental Health Bureau
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COE	Court Ordered Evaluation
CSCT	Comprehensive School and Community Treatment
CTI	Critical Time Intervention
DD	Developmental Disabilities
DDP	Developmental Disabilities Program
DPHHS	Department of Public Health and Human Services
DSP	Direct Support Professional
E&D	Evaluation and Diagnostic
ED	Emergency Department
FMHF	Forensic Mental Health Facility
FMR	Fair Market Rent
FPS	Family Peer Support
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
HCBS	Home and Community-Based Services
HEART	Healing and Ending Addiction Through Recovery and Treatment
HB	House Bill

Acronym	Term
IBC	Intensive Behavior Center
IMD	Institutions for Mental Diseases
IT	Information Technology
K	Thousand
M	Million
MCR	Mobile Crisis Response
MHSP	Mental Health Services Program
MOU	Memorandum of Understanding
MTSS	Multi-Tiered System of Support
NCSS	National Center for Start Services
NEMT	Non-Emergency Medical Transportation
NTI	Near-Term Initiative
OCHE	Office of the Commissioner of Higher Education
OPI	Office of Public Instruction
OT	Occupational Therapy
OTO	One-Time-Only
PA	Physician Assistant
PRTF	Psychiatric Residential Treatment Facility
PSAP	Public Safety Answering Point
RFI	Request for Information
RFP	Request for Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SDMI	Severe and Disabling Mental Illness
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SLRP	State Loan Repayment Program
SMI	Serious Mental Illness
SPA	State Plan Amendment
START	Systemic, Therapeutic, Assessment, Resources, and Treatment
SUD	Substance Use Disorder
TBD	To Be Determined
TCM	Targeted Case Management
TGH	Therapeutic Group Home
VBP	Value-Based Payment

Appendix H: Response to Comments from the Joint Meeting of the Legislative Finance Committee, Interim Budget Committee Section B, and Children, Families, Health, and Human Services Interim Committee

GREG GIANFORTE
GOVERNOR

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

CHARLIE BRERETON
DIRECTOR

August 26, 2024

Amy Carlson
Legislative Fiscal Division
State Capitol
PO Box 201711
Helena, MT 59620-1711

Re: Response to Comments from the Joint Meeting of the Legislative Finance Committee, Section B Interim Budget Committee, and Children, Families, Health, and Human Services Interim Committee

Dear Ms. Carlson,

On behalf of the Behavioral Health System for Future Generations (BHSFG) Commission, Director Brereton and I would like to thank you for the opportunity to present the Draft BHSFG Commission Report to various legislative committees on July 23, 2024, and for the thoughtful comments subsequently provided on August 13 by your staff on behalf of legislators. The Commission recognizes that feedback from legislators is key to advancing the recommendations included in the report and ultimately improving Montana's behavioral health and developmental disabilities systems. The draft report now reflects some of this valuable feedback.

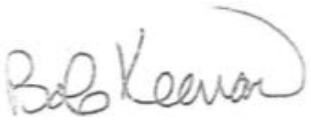
The most significant set of revisions to the draft report in response to the feedback related to Key Performance Indicators (KPIs). The draft report now includes a streamlined list of Performance Measures that more clearly delineate outcomes from process measures and more directly align with the requirements and definitions set forth in both HB 872 and HB 190. These revisions are captured for each recommendation in the body of the draft report. There is also a new section of the report appendix that further clarifies and summarizes the Commission's approach. We acknowledge the importance of measuring the success of all implemented recommendations and will coordinate with the Office of Research and Performance Analysis (ORPA) and the Office of Strategy and Transformation (OST) within DPHHS to establish required baseline data points once certain recommendations are authorized and funded for full implementation.

In further response to legislator feedback, we have also added a new section of the draft report appendix that demonstrates the relationships and linkage among various recommendations, as well as visualizes implementation sequence. Looking ahead, we acknowledge the benefit in identifying an initial set of "foundational recommendations"

that require long-term funding and, upon implementation, would establish the foundation for this important and potentially decades-long work. It is important to note that from the Commission's perspective, every recommendation included in this report is a priority despite our attempt to clarify which recommendations should be implemented first due to limited personnel and financial resources.

Otherwise, the Commission believes that the recommendations set forth in the draft report address much of the remaining feedback from legislators.

Respectfully,



Representative Bob Keenan, Chair

Director Charlie Brereton, Vice Chair

Comment Summaries and Commission Responses

Comments from LFD Memo	Response
1) Key Performance Indicators The most frequently mentioned topic was the key performance indicators (KPIs). Comments on this subject emphasized that clarity on processes, along with solid, measurable and impact-based KPIs are crucial for the Commission's success. To achieve this clarity in the eyes of legislators and stakeholders, legislators stressed that a plan for baseline measurements is essential. Some comments specifically urged the commission to ensure that KPIs measured impact rather than process and suggested the inclusion of additional KPIs.	*See response above; it is our hope that the revisions to and additional material contained in the report better address the topic of Key Performance Indicators.*
2) Content Refinement and Resource Suggestions Refinements: highlight which programs are proposed as pilot programs and would therefore need future consideration to be included in the base; outline which recs are linked and the dependencies they have, in order of implementation; clarify and narrow the intent of the report as a whole. Supplemental Resources: add an acronym guide to the end of the report for ease of reading; include a list of proposed recommendations that did not make it into the final analysis and the report draft; include a list of possible programs (e.g., on a state or local level) that may implement recommendations if the Commission's recommendations are not adopted.	*See response above; it is our hope that the addition of recommendation sequencing in the report provides further clarity.* *An acronym guide has been added to the appendix of the report; the Commission will discuss the request for providing a list of recommendations not included in the report, which would also include possible programs that could be implemented in lieu of the Commission's recommendations.*
3) Points of Further Clarification Funding: Questions arose regarding the sufficiency of funding in Recommendation 4 to fully replace the closed E & D clinics, as well as the adequacy of the amount proposed in	*The Commission worked with DPHHS program staff and community partners to review available, historic data to guide budget projections by recommendation. DPHHS will closely monitor and keep the Commission*

Comments from LFD Memo	Response
Recommendation 10 to bring and manage services statewide in a timely manner.	*updated on budget versus actuals for approved recommendations to identify any areas where revisions may be needed.*
Implementation: The timeline of a CCBHC demonstration waiver is of interest. Regarding Recommendation 14, concern was expressed about potential messaging and whether guardrails would be put in place to ensure that any media campaign does not undermine the key principle that illegal drug use is inherently harmful. Further detail about the tuition reimbursement program in Recommendation 19 was also requested.	*An effort will be made to assure that the media campaign spreads an appropriate message for Montana. Related to the request for more information regarding Recommendation #19, it is anticipated that tuition reimbursement will be managed in a similar process to the current Montana State Loan Repayment Program (SLRP).*
Learning from Previous Examples: There is a concern that HB 660 from 2019, which provided a similar opportunity to Recommendation 10, did not attract applications from rural communities. Regarding Recommendation 1, a question was brought forward about whether other states successfully reconfigured similar Medicaid waivers and if so, what lessons can be implemented in Montana given its unique geographical challenges.	*Project planning for approved recommendations will seek to mitigate identified past issues associated with similar initiatives. Regarding Recommendation #1 and more broadly, examples from other states were reviewed and considered during development of the report.*
Scope and Duplicity Issues: Questions arose about Recommendation 18 and whether further investment in school-based behavioral health initiatives is necessary, given the wide reach of the CSCT program. Concerns were also raised regarding Near-Term Initiative 10 and whether this initiative is assuming a responsibility that should be addressed by the federal government.	*Special consideration will be given to ensure efforts are not duplicative with the existing CSCT program. Additional concerns were raised regarding NTI #10, which is directed at one-time only funding to local colleges and universities to stand up programs in Montana but does not offer continuous funding for program operations.*

Comments from LFD Memo	Response
4) Additional Recommendations • Expand training opportunities into continuing education opportunities • Support workforce housing, particularly in rural areas	*The Commission believes that current recommendations regarding the health care workforce are comprehensive and will take this feedback under advisement as it finalizes the report for submission to the Governor.*
5) Comments in Support • One legislator emphasized their support for what NAMI dubbed, "the consistent six," or recommendations that were both identified by the Commission and the Montana Legislature separately • Another legislator wrote in support of Recommendation 18 as an augmentation of the current CSCT program	*The Commission appreciates all comments in support of the recommendations provided in the draft report, including those summarized in the August 13 memo from LFD.*