

***Presentation to the 2019 Health and Human Services
Joint Appropriation Subcommittee***

**Developmental Services Division
Medicaid and Health Services Branch
Department of Public Health and Human Services**

The following topics are covered in this report:

- Overview
- Summary of Major Functions
- Highlights and Accomplishments during the 2019 Biennium
- Funding and FTE Information
- Change Packages

Overview

The Developmental Services Division (DSD) offers a wide range of services to fulfill its mission *of facilitating efficient delivery of effective services to adults and children with developmental disabilities and children with serious emotional disturbances*. DSD's work is guided by a goal of assisting Montanans with disabilities and children with serious emotional disturbances in living full lives within their communities.

DSD is comprised of:

- The Children's Mental Health Bureau (CMHB)
- The Developmental Disabilities Program (DDP)
- The Montana Developmental Center (MDC)
- The Intensive Behavior Center (IBC)

The Division's leadership team includes our new CMHB Chief, Meghan Peel, who comes to us from the Health Resources Division; the DDP Bureau Chief, Novelene Martin, who has worked for DPHHS for 30 years; Jill Buck, the Interim Superintendent at the MDC and IBC, who you may know from her work at the Montana State Hospital Galen Campus; and Jen Garber, the Division's new Fiscal Bureau Chief. Jen comes to us from the developmental disability provider world—DSD appreciates this community provider experience in staff because not only is it critical to have experience working with our target population but also to understand from a field perspective the challenges that providers of our services face.

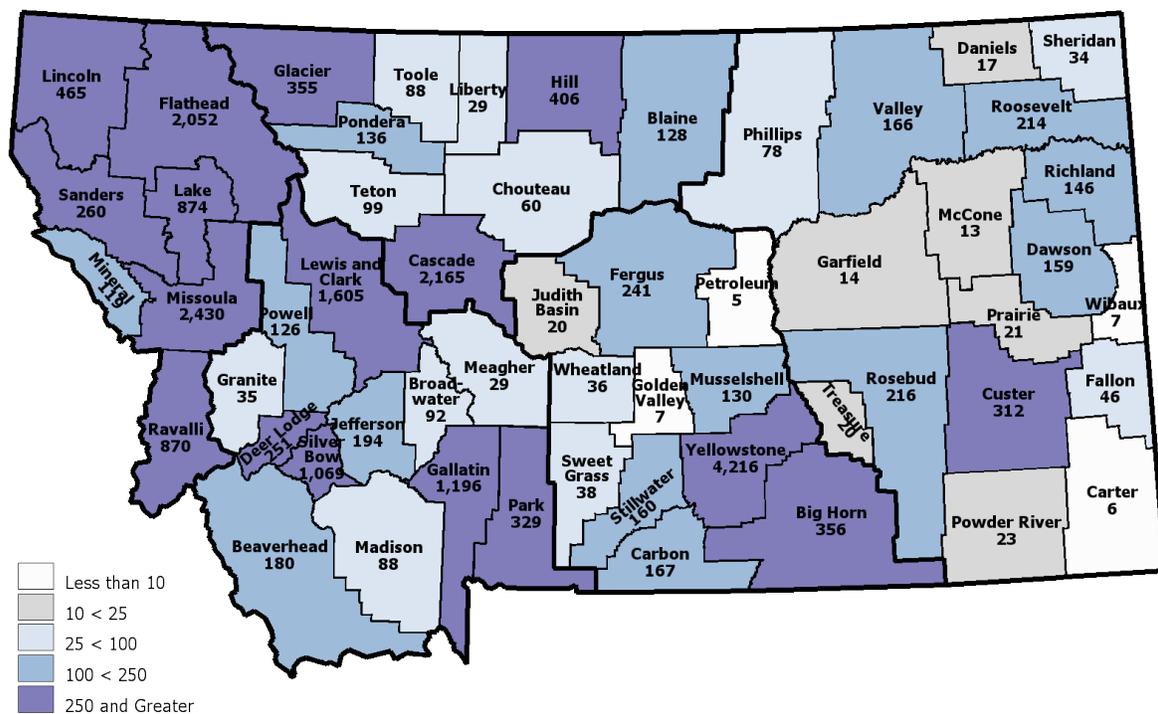
With a budget of nearly \$298 million, DSD provides services on an annual basis to an average of 27,100 Montanans. 92% of the annual DSD budget funds benefits and claims. DSD works with hundreds of large and small providers across the state to assist individuals with disabilities and children with serious emotional disturbances and provides services in every county in Montana. In order to serve individuals with disabilities and children with serious emotional disturbances at the appropriate level of care, DSD continually evaluates policy and processes through utilization review and quality improvement.

Summary of Major Functions

Children’s Mental Health Services

The Children's Mental Health Bureau (CMHB) supports and strengthens Montana youth and families through the provision of Medicaid mental health services. Services range from home and community-based services to facility-based services. CMHB managed and funded mental health services for over 21,000 youth enrolled in Montana Medicaid in FY 2018. Services were provided to children in every county of Montana, as reflected in the below map.

DPHHS Children's Mental Health Services
FY2018 Number of Youth Served



Community-Based Services

Many services are available to children within their homes, schools, and communities. Community-based services such as outpatient therapy, comprehensive school and community treatment, and home support services are supportive interventions added to a child's everyday life. These services focus on improving a youth’s functional level by facilitating the development of appropriate behavioral and life skills. Below are highlights of some of the services administered by the CMHB.

- **Outpatient Therapy:** Outpatient therapy is intended to address behavioral health needs of youth and families who need a lower level of care and can be provided by a variety of providers, such as Licensed Clinical Professional Counselors and Licensed Social

Workers, and in various outpatient settings such as Mental Health Centers. Outpatient psychotherapy can be provided to individuals or in group settings. Treatment, including goals, frequency, and duration, is individualized to address the needs of each patient.

- **Comprehensive School and Community Treatment (CSCT):** CSCT is a comprehensive planned course of community-based mental health outpatient treatment that includes therapeutic interventions and supportive services provided in a public school-based environment. Services are focused on improving the youth's functional level by facilitating the development of skills related to exhibiting appropriate behaviors in school and community settings. Targeted youth typically require support through cueing or modeling of appropriate behavioral and life skills to utilize and apply learned skills in normalized school and community settings. In FY 2018, over 5,000 children throughout Montana received CSCT services within their schools and communities.
- **Home Support Services and Therapeutic Foster Care:** Home support services are in-home therapeutic and family support services delivered by providers for youth living in biological, adoptive or kinship families who require more intensive therapeutic interventions than are available through other outpatient services. Services are focused on the reduction of symptoms and behaviors that interfere with the youth's ability to function in the family and facilitation of the development of skills needed by the youth and family to prevent or minimize the need for more restrictive levels of care. Therapeutic foster care services are in-home therapeutic and family support services for youth living in a therapeutic foster home environment, for youth unable to live with their biological or adoptive parents, in kinship care, or in regular foster care. Targeted youth require more intensive therapeutic interventions than are available through other outpatient services. Services focus on skill building and integration for adaptive functioning to minimize need for more restrictive levels of care and to support permanency or return to the legal guardian. In FY 2018, nearly 1,500 children received home support or therapeutic foster care services.
- **Therapeutic Group Homes (TGH):** TGH is a community-based treatment alternative provided in a structured group home environment. TGH is appropriate for youth requiring specific therapeutic treatment services and social supports which require higher levels of intensity than are available through traditional outpatient services. This level of therapeutic treatment intervention includes: consideration of the safety and security needs of the youth; degree of self-care skills demonstrated by the youth; and likelihood of the youth to benefit from a community integrated program. In FY 2018, over 650 children were served in a therapeutic group home environment. Montana has approximately 50 licensed therapeutic group homes with over 350 beds.

"Our family is grateful for the state's help in locating a quality, in-state, therapeutic group home for our adopted son. We were mentally, physically and emotionally bankrupt dealing with his disabilities that were beyond our ability. Without Medicaid and the state's assistance we would have been financially bankrupt, too. Now that our son is receiving wrap-around support, we are able to heal as a family."

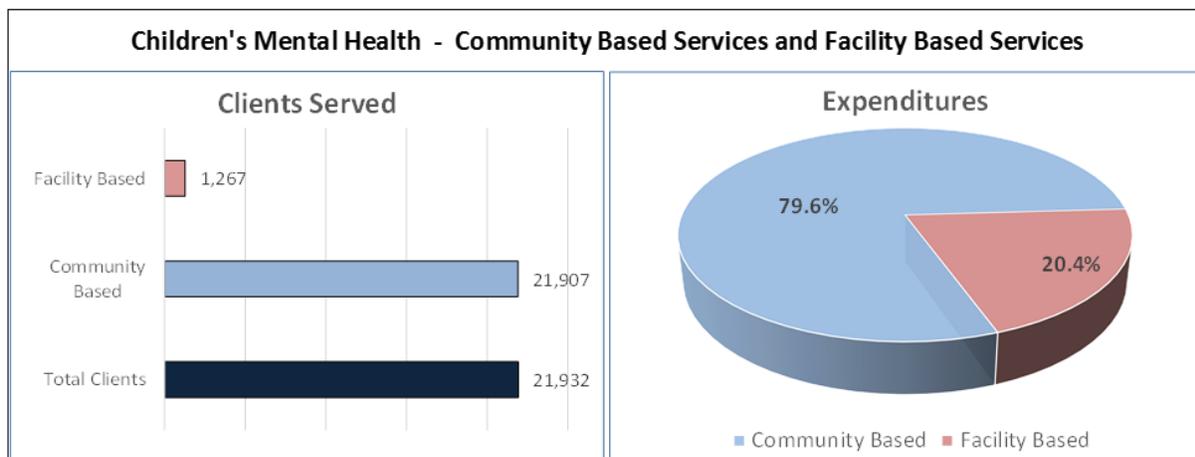
-Michelle & Major Robinson

Facility-Based Services

Sometimes, children have needs at a level of severity that they cannot be safely treated within their communities. Children receiving services within acute psychiatric inpatient hospital or psychiatric residential treatment facilities are generally at elevated risk and have needs that cannot be addressed within their communities. Facility services are designed to provide a structured, safe environment for children to receive needed medical supervision, assessment, and stabilization, with a goal to regain a level of functioning which is safe to transition back into their communities.

- **Acute Inpatient Hospitalization:** Acute inpatient hospitalization is the placement of youth in a hospital for observation, evaluation, and/or treatment. Services are medically-oriented and include 24-hour supervision; services may be used for short-term treatment and crisis stabilization. Generally, length of stay in an acute inpatient setting is three to ten days. 990 children received care in an acute inpatient setting in FY 2018.
- **Psychiatric Residential Treatment Facilities (PRTF):** Psychiatric residential treatment is active intervention in a 24-hour non-acute secure facility setting directed at addressing and reducing the specific impairments that led to the admission and at providing a degree of stabilization that permits safe return to the home environment and/or community-based services. A PRTF is a secure residential facility that typically serves 10 or more youth, provides 24-hour staff and psychiatrist supervision, and may include individual therapy, group therapy, family therapy, behavior modification, skills development, education, and recreational services. Lengths of stay tend to be longer in residential treatment centers than in hospitals. 636 children received services in a PRTF in FY 2018, with 85 days as the average length of stay.

Of the 21,932 children who received children’s mental health services in FY 2018, only 5.8% received a service in a facility setting (including Psychiatric Residential Treatment Facilities and inpatient hospital stays related to a mental health diagnosis), while 99.9% of total children served received a community-based service. This demonstrates not only DSD’s commitment to community-based services, but also that essentially all children who receive services in a facility also receive services within the community.



Innovation

In addition to traditional Medicaid services, CMHB encourages innovation through participation in various grants. In the last biennium, CMHB managed a SAMHSA (Substance Abuse and Mental Health Services Administration) Transitioning Youth at a Healthy Age grant to increase access to and quality of substance abuse and mental health services for adolescents and young adults aged 16 to 25 years of age. Additionally, through this grant, the CMHB established the Interagency Planning Council, bringing together leaders from various agencies and organizations to work together to link and coordinate between state systems serving transitional aged youth, in order to promote access to comprehensive, integrated services. More recently, CMHB collaborated with the Children's Special Health Services area of DPHHS' Public Health and Safety Division to secure grant funding to provide pediatric psychiatry consultation to pediatricians and primary care providers throughout the state through a new project—the Montana Access to Pediatric Psychiatry Network (MAPP-Net).

Bureau Staff

In addition to Central Office Bureau staff, Regional Resource Specialists are Bureau staff that assist both providers and families to locate and refer children to home and community services, facilitate difficult transitions, and connect families to other helpful community resources. Regional Resource Specialists also work collaboratively with our Utilization Review Contractor to provide aftercare follow up calls for youth discharged from out-of-state residential treatment facilities. Families are contacted at 7 and 30 days post-discharge and surveyed on utilization of community services. In FY 2018, 94% of discharged youth had been engaged in outpatient therapy and 69% had received medication management services at 30 days post-discharge. All staff promote youth and family stabilization and reunification efforts using family-driven and community-based values and practices.

Developmental Disabilities Program (DDP)

The mission of the DDP is to create a system that coordinates resources, supports, and services for individuals to have meaningful lives in their communities. As we all do, individuals with developmental disabilities desire to live and work within a community of their own choice. For some, the assistance and support of friends and families may be enough for independence, while others need their natural resources supplemented with services provided through the DDP. The DDP offers developmental disability services for individuals throughout their lifetime; our youngest service recipient is under 12 months while our oldest service recipient is 97.

Montana has played a **pioneering role in expanding the availability of community-based services through having one of the first waivers in the country**. In 1982, we were one of only six states with an approved Medicaid Home and Community Based Services (HCBS) waiver. By 2009, 48 states and the District of Columbia offered 125 different HCBS waivers for people with developmental disabilities. HCBS waivers are alternatives to long-term care in an institutional setting. These waivers allow a state to pay for an expanded array of medical care and support services that assist people to continue to live in their communities.

The **DDP's 0208 Comprehensive Waiver**, which offers persons with developmental disabilities 31 various services such as day supports, employment support, assisted living, and behavioral

support services throughout their lifespan, serves an average of almost 2,700 individuals annually. DDP serves the entire continuum of developmental disability needs from individuals who require minimal support to thrive in the community to individuals with very intensive needs who require 24-hour care.

Individual cost plans range from \$1,594 to \$434,687 per year. The average cost plan per participant is \$49,485 per year. An individual might need very limited supports such as supported living, companion, and homemaker services. Another individual might need supported living along with supported employment to maintain a job, as well as transportation supports to get to and from work or out into the community. Individuals with more intensive needs live in group homes and attend day or retirement services, generally sharing some of the staff with other individuals. As individuals needs increase, so do the amount of supports a person needs. Persons needing individualized support for nearly 24 hours per day often have cost plans exceeding \$175,000 per year.

Examples of cost plans and supports included:

\$7,485	\$27,939	\$50,048	\$88,146	\$254,546	\$434,687
Supported living	Supported living	Group home with transportation	Group home with Transportation	Group home	Supported living
Companion and homemaker services	Supported employment	Day supports	Day supports	Behavior support services	Behavior support services
	Transportation		Retirement services	Transportation	Transportation
			Supported living (non-Medicaid)		Nutritionist

Non-waiver services are also important in creating an effective life-long continuum of care for individuals with developmental disabilities. Montana Milestones and Family Education and Support (FES) provide early identification and intervention services to Montana children and families. Examples of early intervention services include assessment and evaluation, occupational and physical therapy, service coordination, and psychological services. Early intervention services served nearly 2,000 children in FY 2018.

Montana Milestone Early Intervention Services: Story of Impact

Ethan Martin was adopted into the Martin family on January 31, 2005. At 6 months of age, Ethan's mother, DDP Bureau Chief, Novelene Martin, noticed he was not reaching expected developmental milestones. "I was encouraged to just be patient, as he just might need a little extra time. When he was 10 months old, I was out of patience and we had more information on his genetics. I made my appointment with a Montana Milestones provider, Developmental Educational Assistance Program (DEAP) in Miles City," Novelene remembers.

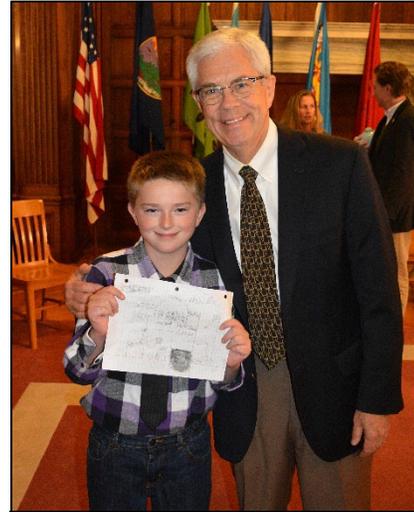
At the intake meeting, basic developmental assessments were completed, and it was identified that Ethan, at the age of 10 months old, had a gross motor skill of about two months old – which means that at 10 months old, he wasn't rolling over, sitting up, or trying to crawl. So began the Martin family's journey with DDP's early intervention non-waiver services.

"With the help of our Service Coordinator, we had evaluations completed by a physical therapist, occupational therapist, and speech therapists. These evaluations were used to develop our Individual Family Service Plan – which laid out the goals and outcomes we had as a family for Ethan," Novelene reflects. The Service Coordinator arranged for Ethan to begin physical therapy and occupational therapy, with speech therapy following later. The Service Coordinator also assisted in identifying payment sources for the therapies – including the family's private insurance and Ethan's adoption subsidy from Medicaid.

As we all know, a family's routine can quickly change, especially when a new member is brought into the family. With Ethan's developmental needs, the Martin Family recognized that they now had a new routine; a new normal. With each therapy appointment, they were taught what they could do between appointments to strengthen Ethan's development.

A year later, Ethan was re-assessed, and his gross motor development was between 20-24 months of age. The value of DDP's early intervention services of providing a Service Coordinator to help families focus on goals and outcomes and facilitate essential early intervention services that allow a child with developmental disabilities to grow and thrive was personified in Ethan's progress.

"While we knew he was likely to always have a developmental/intellectual disability, we knew that the impact of this was lessened by the early intervention services," Novelene states. "We were given the skills we needed to help Ethan accomplish his dreams. So now I have a young man who is a leader in his classroom, who participates in Special Olympics sports, enjoys a dance class and is planning for a future. He was a key speaker at the Montana ABLE press conference where he shared his plans for the future. A future that includes owning a home, having friends to live with him, having staff to help with his day-to-day needs, having a career doing something he loves like recycling, participating in his community, and being a strong self-advocate."

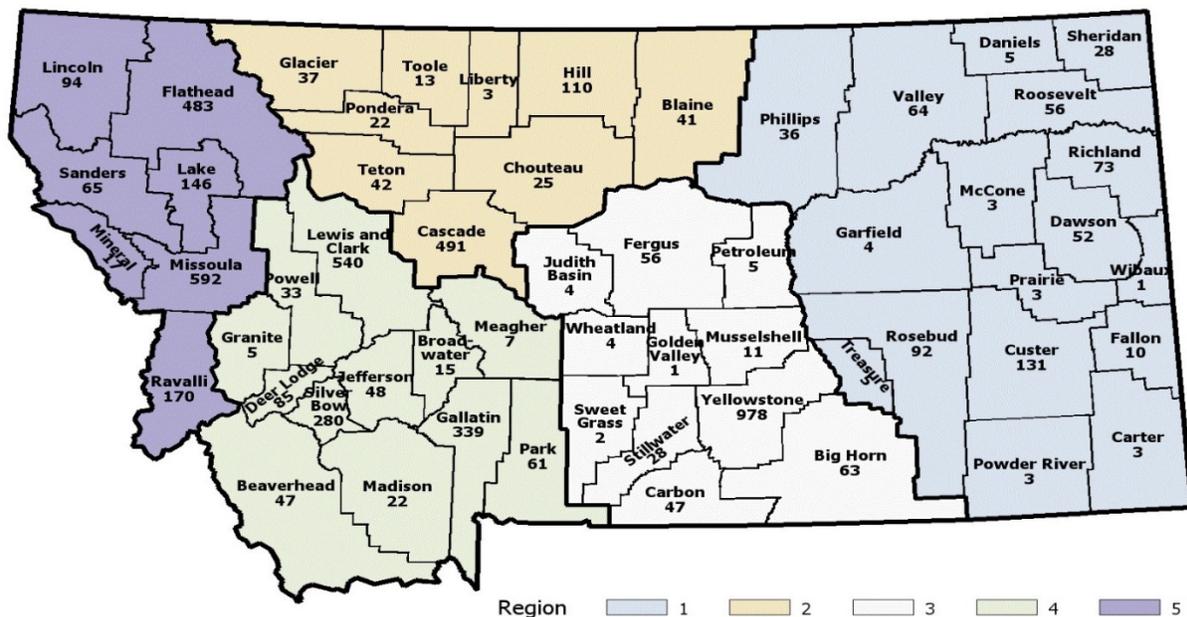


*Ethan Martin and Lt. Governor Mike Cooney at ABLE press event.
Photo by Jon Ebelt.*

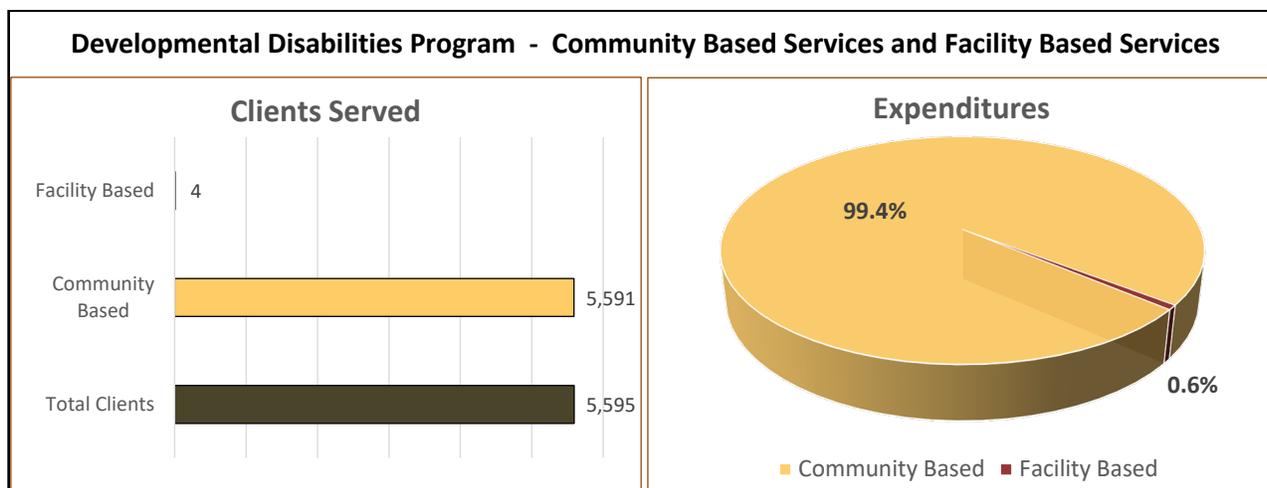
Additionally, **targeted case management** is available to individuals ages 16 and older with a developmental disability. Targeted case management services are comprehensive and include assessment of an eligible individual, development of a specific care plan, referral to services, and monitoring. These services are delivered across the state by either a DDP Case Manager or a Contracted Case Manager. Over 3,200 individuals are currently enrolled in targeted case management.

The DDP contracts with providers to deliver services to individuals with developmental disabilities. These service programs are located in communities throughout Montana and provide an array of residential, habilitative, and employment opportunities for adults, and children. DDP is currently serving individuals in every county in Montana as illustrated by the below map.

DPHHS Developmental Disabilities Program FY2018 Number of People Served



DDP managed and funded services for over 5,590 Montanans with developmental disabilities in FY 2018. Services are primarily delivered through Medicaid waivers and State Plan services. Of the 5,595 individuals served by DDP in FY 2018, only 0.6% received a service in a facility setting, while 99.4% of individuals served received a community-based service.



Bureau Staff

DDP’s central office provides similar administrative and support services to those provided by the Children’s Mental Health Bureau with a particular emphasis on waiver management. Five regions with offices located in Helena, Missoula, Great Falls, Billings, Glasgow, Miles City, Butte, and Kalispell provide critical boots on the ground support to service recipients and providers, and valuable feedback to the central office regarding gaps and trends at the regional level, a service essential in a state as large and regionally diverse as Montana.

Intensive Behavior Center/Montana Developmental Center (IBC/MDC)

Since 1893, the MDC existed to provide an environment for building healthy, effective, and fulfilling lives for people with serious developmental disabilities who had been determined by a court to meet commitment requirements. MDC’s programs prepared clients for discharge to appropriate community settings and played a valuable role in the continuum of care for persons with developmental disabilities.

During the 2015 legislative session, Senate Bill 411 was passed, mandating downsizing and eventual closure of MDC. The short timeframe to do so was two years with an implementation deadline of June 30, 2017 and prohibition of court commitments after December 31, 2016. At the time the bill was passed, there were 52 residents of MDC who required community placement within the next two years. To assist DPHHS in accomplishing this task, SB 411 established a multidisciplinary transition planning committee to make recommendations and advise DPHHS in planning for and accomplishing the closure of the MDC.

The committee had their first meeting in June 2015, and continued meeting regularly, ultimately providing a set of recommendations to Governor Bullock's office regarding closure of the facility. Successfully transitioning the remaining MDC clients to the community would require additional time.

House Bill 387, passed by the 65th legislature, extended the closure date for MDC by two years from June 30, 2017 to June 30, 2019. Additionally, it authorized the establishment of a 12-bed Intensive Behavior Center (IBC) for individuals with a developmental disability who are in need

of intensive treatment because of continuous or repeated behaviors that pose an imminent risk of serious harm to self or others. The IBC was authorized to operate in the former 12-bed, secure Assessment and Stabilization Unit of the MDC campus.

The MDC officially closed on November 1, 2018. The Intensive Behavior Center is currently operating.

Implementing HB 387

While HB 387 extended the MDC closure date to July 1, 2019, there was still much work to be done to successfully transition the remaining 23 MDC clients into community placements. Of these 23 clients, many were ready to be discharged to the community. Several had accepted community proposals and were waiting for the providers to be appropriately staffed to maintain client health and safety in the community. During this difficult period in which both clients and staff were in limbo, DPHHS continued to work with providers on successfully preparing to transition challenging clients into the community. In late October 2018, the last MDC client transferred out of MDC and the facility was officially closed. Staff attention now focuses exclusively on successfully implementing the Intensive Behavior Center.

Development and Implementation of the Intensive Behavior Center

Despite the closure of MDC, the DDP community recognized the need for intensive therapeutic placement for individuals with developmental disabilities. HB 387 addressed this need through the development of the Intensive Behavior Center (IBC); a 12-bed facility that would serve as an option for individuals who are not able to be safely served in the community. Since there would only be 12-beds available, DPHHS had to carefully consider the population that the IBC could serve.

Given the limited number of beds, the stay at IBC would ideally be short-term and the 12-bed facility would serve a targeted and fairly homogenous population. Based on data in 2016 gathered by the DDP Behavior Consultation Team (BCT), of the 58 referrals that the BCT received, 35 were for individuals with Autism Spectrum Disorder (ASD) or a similar condition. BCT is the entity that receives referrals from community providers when an individual in their care is displaying problem behaviors to such an extent as to be at-risk for loss of placement or harm to self or to others.

Based on this information and the professional recommendation from the MDC/IBC treating psychiatrist, it was decided that the IBC would focus on the population of adults with autism spectrum disorder. Individuals with ASD have deficits in social communication and social interaction as well as restricted and repetitive patterns of behavior or interests. They often struggle with change and transition and have sensory issues. They may have co-occurring medical and psychiatric conditions and can struggle to articulate discomfort, pain, and distress, instead presenting with challenging and problematic behavior that may place them and those around them at-risk of harm.

Development of the IBC is an ongoing process. In addition to maintaining the existing functions of MDC, staff made time to work on changes that would need to take place once the IBC was the

only secure treatment center available. This ongoing work has resulted in **significant accomplishments** including the following:

- Policy and procedure for the facility have been reviewed and are currently being revised by a group led by the DDP Medical Director.
- Functional Assessments have been completed on current clients, with the goal of generating current Behavioral Support Plans.
- A sensory room was constructed and successfully utilized for physical activation and sensory integration activities. Individuals regularly utilize it with positive results.
- Regular staff training (in person and recorded on video) has been re-implemented and will include topics related to the target population. Additionally, discipline staff have been offering time in a mentoring role for direct care staff.

Highlights and Accomplishments during the 2019 Biennium

In addition to maximizing existing resources and efficiencies during budget reductions, DSD implemented initiatives in the past biennium to drive innovation and improve health, with the central goal of assisting Montanans with disabilities and children with serious emotional disturbances in living full lives within their communities. We drove strategic innovation to improve health and address disparities by:

- Improving relationships and expanding collaboration with stakeholders across the state to improve outcomes, while facilitating DPHHS' ability to collect and analyze data;
- Improving the decision-making process of the Development Disabilities Program;
- Ensuring successful transitions back into the community; and
- Expanding much needed services for Medicaid recipients, specifically for the growing number of youth with Autism Spectrum Disorder (ASD).

Efforts to Reduce Native American Youth Suicide

In January 2017, DPHHS in partnership with a coalition of tribes and Urban Indian Health Organizations (UIHO) across the state, published the Montana Native Youth Suicide Reduction Strategic Plan to address the suicide rate among Native youth. Montana's Native youth suicide deaths for ages 11 to 24 occur at a rate that is five times greater, at nearly 43 per 100,000 deaths, than the statewide suicide death rate of the same age group. This plan targets suicide reduction through the adoption of Zero Suicide, a prevention model developed to address a systems approach to suicide care within health and behavioral health organizations.

During the 2019 Biennium, DPHHS and the newly established Montana Native Youth Suicide Reduction Advisory Coalition successfully completed priority action steps as identified in the inaugural version of its Strategic Plan, including:

- **The Advisory Coalition**, established in January 2017, met in April 2017 for an introduction to the Zero Suicide model and to set the pace for members to be community champions for

the initiative. The coalition actively recruited tribes, UIHOs and IHS health and behavioral health programs to ensure wide representation across the state.

- **The Zero Suicide Academy**, was held in October 2017 in Helena and was presented by the Suicide Prevention Resource Center (SPRC). The Academy hosted over 75 participants, including trainees from six tribes, four UIHOs, five IHS service units and the IHS Billings Area Office, and DPHHS. This historic event spearheaded the implementation of Zero Suicide across the state of Montana within tribal and urban Indian communities. From these efforts, each tribe and UIHO now has an established and trained group of individuals within their community health and behavioral health organizations to support and lead Zero Suicide implementation.



Coalition member, Erin Irvine, presenting ideas at a coalition meeting. Photo by Lesa Evers.



Gertie Heavy Runner speaks to coalition members at the Fall 2018 coalition meeting. Photo by Lesa Evers.

- **House Bill 118** was passed in the 2017 Legislature, and appropriated \$250,000 to DPHHS for assisting with state and tribal efforts to implement the action steps of the Montana Native Youth Suicide Reduction Plan and fuels implementation of best practices. Each participating tribe and UIHO received \$15,883 in the spring of 2018 to seek training for self-care best practices for frontline health and behavioral health staff and community members.

- In August 2018, Director Hogan expanded the coalition, at the recommendation of the coalition, to include youth representatives from each tribe and UIHO. The expanded coalition, consisting of 52 members, participate in monthly technical assistance calls, receive a bi-monthly newsletter including tools, resources, and local Zero Suicide success stories related to Zero Suicide. Additionally, the coalition will participate in two in-person meetings, the first of which was held on November 15, and included participation of 33 coalition members.

Monitoring Children’s Mental Health Outcomes

Passed in the 2017 Legislature, House Bill 589 requires DPHHS to monitor the status of youth receiving state funded Targeted Case Management (TCM) services for mental health reasons each fiscal year to determine whether, while receiving services, the children remain at home, in school, and out of trouble.

The Children’s Mental Health Bureau experienced positive collaboration with TCM providers to define a survey to match each requirement in HB 589 and collect data from targeted case managers, and we are thankful for their participation. All providers were committed to the process and submitted data during the expected timeframe and total youth reported by providers was 99% of claims paid.

In July 2018, the initial findings of HB 589 were presented by DPHHS to the Child, Family, Health, and Human Services Interim Committee (CFHHS). Given the point-in-time nature of the survey and absence of scientific method, conclusions should not be drawn from survey results, but high-level findings included:

- No youth completed suicide.
- 4% reported the youth had attempted suicide.
- 77% reported the youth did live in the home in the past 12 months.
- 17% reported the youth returned home from an out-of-home placement.
- 23% reported the youth went to an out-of-home placement while receiving case management.
- 4% reported the youth returned home from foster placement.
- 10% reported the youth went to a foster placement while receiving case management.
- 2% reported the youth was placed in a correctional setting.
- 1.6% reported the youth returned from correctional setting.
- 1.91% reported the youth dropped out and returned to school.
- 2.49% reported the youth dropped out of school.
- 3.7% reported the youth had substance abuse treatment.
- 6.7% reported, “Yes,” the youth had youth court involvement.

Following presentation to the CFHHS Interim Committee, CMHB prepared individual reports for each provider that participated in the TCM survey, which compared individual outcomes to the reported averages. These reports were shared with providers in October 2018 with an invitation to meet with CMHB to discuss the data as well as to solicit feedback from providers about the survey process. Meetings were conducted with the majority of TCM providers during the last week of October, and information gathered will guide the bureau as it continues to collect this data.

Provider/Stakeholder Collaboration

In an effort to meaningfully engage providers/stakeholders in the decision-making process of the Developmental Disabilities Program, DPHHS implemented a new collaboration strategy. Regular provider calls were increased from one monthly update call to weekly calls designed to prioritize and develop solutions to improve the system. This Friday morning large group held their first call in March 2018 and was soon supplemented with small in-person work groups targeted at solving distinct challenges that were prioritized by the larger stakeholder group. Volunteers were requested for small groups with participants selected based upon the need for broad representation of stakeholder groups.

There are currently two small workgroups focused on transportation and congregate living which have implemented a number of valuable changes to increase

“Our members are pleased with the hard work that is being put in by DDP staff to partner with us to resolve issues which challenge our system, such as invoicing. We are building mutual trust and MACDS is committed to continue working closely with DDP on behalf of people with disabilities.”

-Dave Eaton, President of Montana Association of Community Disability Services (MACDS)

efficiency and effectiveness. Each small group is chaired by a DDP representative who coordinates and provides administrative support for the meetings. The Congregate Invoicing workgroup has been meeting since April 3, 2018 for a total of nine meetings; all but one being a face-to-face meeting. The Transportation workgroup met from March 2018 to July 2018 over a series of 12 meetings.

Successful Transitions of MDC Clients to the Community

With the imminent closure of MDC, came concerns regarding how the clients would transition to community placements. The 2017 Legislature passed House Bill 458, requiring the DPHHS to monitor MDC Residents, including residents who have transitioned out of the facility as required under Senate Bill 411 of the 2015 Legislative Session. HB 458 states DPHHS is to monitor clients who have discharged from the MDC into a community home per Montana Code Annotated (MCA) 53-20-302.

Monitoring is being conducted quarterly as per House Bill 458. The first quarter of monitoring completed was the period of July 1, 2017 through September 3, 2017. Thus far, we are seeing that overall client transitions to the community have gone well. Providers who are serving these clients in the community are working diligently with the clients and the state to ensure that clients have the supports in place to establish and maintain successful lives. **Not a single client who has transitioned to a community-based setting from MDC has returned or been sent to an institutional placement.** This is a testament to the provider/state collaboration that has been critical in ensuring a successful transition. Quarterly monitoring will continue through the discharge of all clients from MDC and will monitor community placements for two years following community placement as required by HB 458.

Autism Service Expansion (ASD)

Services for individuals with Autism Spectrum Disorder (ASD) have been funded through the Montana Medicaid program beginning as early as 2003 when the diagnosis was first included in the medical necessity criteria for children's mental health Medicaid-funded services. When the most recent three years of complete claims data is pulled for the 5,929 of Medicaid members under age 21 with either an ASD diagnosis or indicator we find the following services were delivered:

- 19% or 965 received mental health case management or targeted case management.
- 32% or 1,901 received outpatient therapy provided by a licensed clinical social worker or licensed clinical professional counselor.
- 9% or 507 received a mental health center service such as day treatment or community based psychiatric and rehab services.
- 20% or 1,167 received mid-level services and 81% or 4,781 received physician services.
- 2% or 131 received personal care services.
- 12% or 719 received psychiatry services.
- 8% or 453 received psychologist services.
- 6% or 329 received home support services or therapeutic foster care.
- 2% or 107 received mental health therapeutic group home services.
- 18% or 1,053 received speech pathology services.
- 37% or 2,179 received school based mental health or psych aid services.

- 20% or 1,167 received optometric services.
- 16% or 950 received occupational therapy.
- 9% or 217 received audiology services.

Despite the provision of services, ASD continues to be one of the fastest growing developmental disabilities in the country and outcomes for those diagnosed with ASD include very low rates of independent living, community access, and employment rates. In an effort to improve outcomes, in 2009, the Developmental Disabilities Program implemented a Children's Autism Waiver (CAW) to provide a three-year behaviorally focused program for young children. The CAW expanded services available through a Medicaid waiver to include specialized services such as Program Design and Monitoring and Children's Autism Trainer. While this program was quite popular, it was also limited in two significant aspects. First the waiver was only available to children ages 15 months to 8 years of age; second, it was limited to serving only 55 youth.

Thanks to Governor Bullock's initiative and legislative approval during the 2015 Legislative session, the state was able to embark on an effort to expand Medicaid funded autism services, moving from the limited waiver package of services offered through the CAW to creating a comparable package of services available for youth up through age 20 through State Plan Medicaid services.

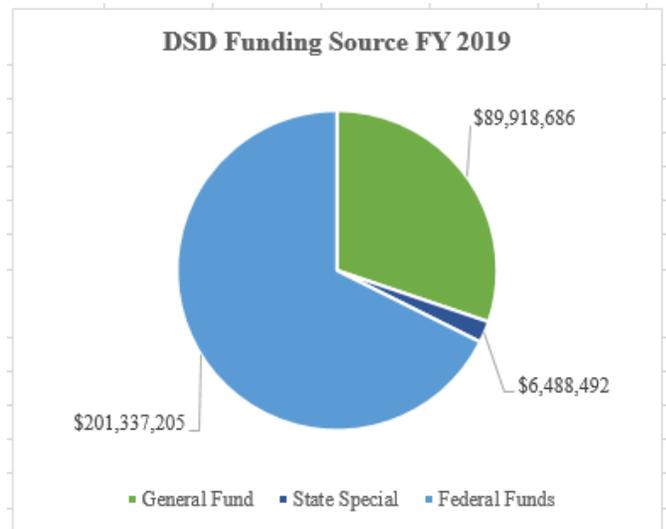
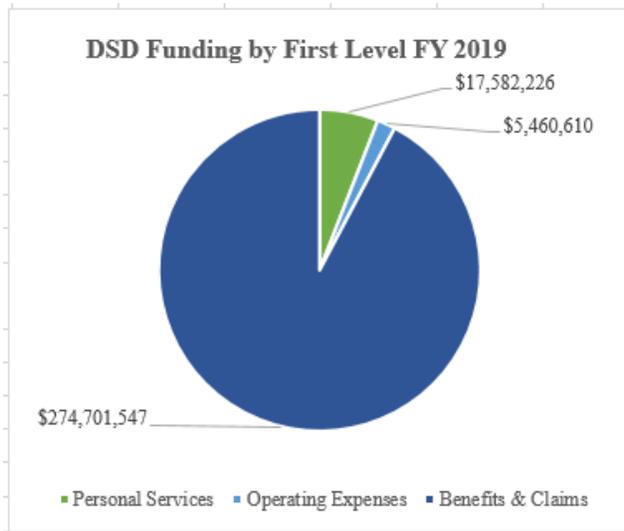
Moving from the provision of services through a waiver to a state plan is a challenging task. Montana developed an Autism Advisory Work Group in 2015 to solicit stakeholder input for the Autism State Plan Amendment (SPA) submitted to CMS in December 2015. The SPA was approved March 2017 with a retroactive effective date of January 1, 2017.

DDP continues to implement the Autism SPA. In designing the state plan services, the state prioritized the accurate diagnosis of an ASD. This gave rise to the inclusion of a multi-disciplinary evaluation and review team that the state has faced challenges implementing. The CMS approved state plan provides a comprehensive package of services comparable to the services available in the Children's Autism Waiver, but with varying levels of intensity. Implementation of such services requires a level of professional staff that is providing to be challenging for Montana. There are currently not enough eligible providers to meet the service demand; only 12 licensed BCBAs who are approved Medicaid providers currently exist statewide. DDP is evaluating our current SPA and accompanying rule set to determine the need for changes in order to facilitate the efficient delivery of services.

To ensure service delivery during this period, requests for Medicaid autism treatment services are being processed through the Early and Periodic Screening, Diagnosis, and Treatment program. In FY 2018, there were 47 applications received and processed for Medicaid/Healthy Montana Kids Autism Treatment services.

Funding & FTE Information

Disability Services Division	SFY 2019 Budget	SFY 2020 Request	SFY 2021 Request
FTE	206.91	188.91	188.91
Personal Services	\$ 17,582,226	\$ 12,416,190	\$ 12,416,305
Operating Expenses	\$ 5,460,610	\$ 5,382,405	\$ 5,371,858
Benefits & Claims	\$274,701,547	\$275,776,184	\$292,255,228
TOTAL COSTS	\$297,744,383	\$293,574,779	\$310,043,391
	SFY 2019 Budget	SFY 2020 Request	SFY 2021 Request
General Fund	\$ 89,918,686	\$ 88,164,099	\$ 92,070,208
State Special	\$ 6,488,492	\$ 6,496,482	\$ 6,502,012
Federal Funds	\$201,337,205	\$198,914,198	\$211,471,171
TOTAL FUNDS	\$297,744,383	\$293,574,779	\$310,043,391



Change Packages

Present Law Adjustments:

SWPL - 1 - Personal Services

The budget includes a reduction of \$3,972,989 in FY 2020 and \$3,971,130 in FY 2021 to annualize various personal services costs including FY 2019 statewide pay plan, benefit rate adjustments, longevity adjustments related to incumbents in each position at the time of the snapshot, and vacancy savings.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	(\$4,254,180)	\$2,529	\$278,662	(\$3,972,989)
FY 2021	(\$4,254,413)	\$2,499	\$280,784	(\$3,971,130)
Biennium Total	(\$8,508,593)	\$5,028	\$559,446	(\$7,944,119)

SWPL - 2 – Fixed Costs

The request includes a reduction of \$83,669 in FY 2020 and \$95,530 in FY 2021 to provide the funding required in the budget to pay fixed costs assessed by other agencies within state government for the services they provide. Examples of fixed costs include liability and property insurance, legislative audit, warrant writer, payroll processing, and others. The rates charged for these services are approved in a separate portion of the budget.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	(\$83,669)	\$0	\$0	(\$83,669)
FY 2021	(\$95,530)	\$0	\$0	(\$95,530)
Biennium Total	(\$179,199)	\$0	\$0	(\$179,199)

SWPL - 3 – Inflation Deflation

This change package includes an increase of \$5,464 in FY 2020 and \$6,778 in FY 2021 to reflect budgetary changes generated from the application of inflation to specific expenditure accounts. Affected accounts include those associated with the statewide Motor Pool operated by the Department of Transportation.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	\$2,408	\$0	\$3,056	\$5,464
FY 2021	\$2,986	\$0	\$3,792	\$6,778
Biennium Total	\$5,394	\$0	\$6,848	\$12,242

PL - 10001 – Medicaid Waiver FMAP – DSD

This present law adjustment is necessary to maintain existing services for the Medicaid programs in the DSD. The change package requests an increase in general fund of \$2,647,821 in FY 2020 and \$2,371,975 in FY 2021 with offsetting federal fund reductions for each year. The total cost for the program does not change.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	\$2,647,821	\$0	(\$2,647,821)	\$0
FY 2021	\$2,371,975	\$0	(\$2,371,975)	\$0
Biennium Total	\$5,019,796	\$0	(\$5,019,796)	\$0

PL - 10002 – Medicaid Core Services FMAP – DSD

This present law adjustment is necessary to maintain existing services for the Medicaid programs in the DSD. The change package requests an increase in general fund of \$577,979 in FY 2020 and \$425,305 in FY 2021 with offsetting federal fund adjustments for each year. The total cost for the program does not change.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	\$577,979	\$0	(\$577,979)	\$0
FY 2021	\$425,305	\$0	(\$425,305)	\$0
Biennium Total	\$1,003,284	\$0	(\$1,003,284)	\$0

PL - 10003 – Medicaid Waiver Caseload – DSD

This present law adjustment for Medicaid Waiver caseload growth in the DSD covers the increase in the number of eligible individuals, utilization, acuity levels, and cost-per-service for medical care. This change package requests \$24,228,559 in total funds. The biennial funding is \$8,475,025 in general fund, and \$15,753,534 in federal funds.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	\$4,233,838	\$0	\$7,828,379	\$12,062,217
FY 2021	\$4,241,187	\$0	\$7,925,155	\$12,166,342
Biennium Total	\$8,475,025	\$0	\$15,753,534	\$24,228,559

PL - 10004 – Medicaid Core Caseload – DSD

This present law adjustment for caseload growth in the DSD covers the increase in the number of eligible individuals, utilization, acuity levels, and cost-per-service for medical care. This change package requests a reduction of \$17,250,895 in total funds. This reduction in biennial funding includes \$6,036,503 in general fund and \$11,214,392 in federal funds.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	(\$4,420,240)	\$0	(\$8,198,202)	(\$12,618,442)
FY 2021	(\$1,616,263)	\$0	(\$3,016,190)	(\$4,632,453)
Biennium Total	(\$6,036,503)	\$0	(\$11,214,392)	(\$17,250,895)

PL - 10011 – Med Fed Caseload – DSD

This present law adjustment for Medicaid Federal caseload in the DSD - Children's Mental Health covers children receiving comprehensive school and community treatment services. This change package requests an increase in federal funds of \$1,573,422 over the biennium.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY2020	\$0	\$0	(\$818,373)	(\$818,373)
FY2021	\$0	\$0	\$2,391,795	\$2,391,795
Biennium Total	\$0	\$0	\$1,573,422	\$1,573,442

New Proposals:

NP - 10005 – PRI – Medicaid Core PRI – DSD

This new proposal requests a 0.91% provider rate increase in FY 2020 and a 1.83% increase in FY 2021 Medicaid Core programs in the DSD. This percentage increase in rates is the same percentage applied in the Executive Budget to K-12 Schools, Office of Public Defender providers, and Corrections services providers. This change package requests \$3,682,049 in total funds over the biennium and \$1,285,895 in general fund.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	\$307,406	\$0	\$570,145	\$877,551
FY 2021	\$978,489	\$0	\$1,826,009	\$2,804,498
Biennium Total	\$1,285,895	\$0	\$2,396,154	\$3,682,049

NP - 10006 – PRI – Medicaid Waiver – DSD

This new proposal requests a 0.91% provider rate increase in FY 2020 and a 1.83% increase in FY 2021 Medicaid Waiver programs in the DSD. This percentage increase in rates is the same percentage applied in the Executive Budget to K-12 Schools, Office of Public Defender providers, and Corrections services providers. This change package requests \$4,511,814 in total funds over the biennium and \$1,575,504 in general fund.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	\$392,867	\$0	\$726,414	\$1,119,281
FY 2021	\$1,182,637	\$0	\$2,209,896	\$3,392,533
Biennium Total	\$1,575,504	\$0	\$2,936,310	\$4,511,814

NP - 10007 – PRI – Non-Medicaid – DSD

This new proposal requests a 0.91% provider rate increase in FY 2020 and a 1.83% increase in FY 2021 Non-Medicaid program providers in the DSD. This percentage increase in rates is the same percentage applied in the Executive Budget to K-12 Schools, Office of Public Defender providers, and Corrections services providers. This change package requests \$389,187 in total funds over the biennium and \$144,170 in general fund.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	\$34,230	\$5,461	\$56,462	\$96,153
FY 2021	\$109,940	\$11,021	\$172,073	\$293,034
Biennium Total	\$144,170	\$16,482	\$228,535	\$389,187

NP - 10009 – PRI – Medicaid Federal – DSD

This new proposal requests a 0.91% provider rate increase in FY 2020 and a 1.83% increase in FY 2021 Medicaid Federal program providers in the DSD. This percentage increase in rates is the same percentage applied in the Executive Budget to K-12 Schools, Office of Public Defender providers, and Corrections services providers. This change package requests \$1,494,182 in federal funds over the biennium.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	\$0	\$0	\$356,250	\$356,250
FY 2021	\$0	\$0	\$1,137,932	\$1,137,932
Biennium Total	\$0	\$0	\$1,494,182	\$1,494,182

NP - 10012 – Transfer of Existing FTE – DSD

This new proposal requests transferring 18.00 FTE from the DSD to the Child and Family Services Division. HB 387, passed by the 2017 Legislature, directed DPHHS to close the Montana Developmental Center (MDC) in FY 2019. As a result, these FTE are not needed at MDC for the 2021 Biennium.

Fiscal Year	General Fund	State Special	Federal Funds	Total Request
FY 2020	(\$1,193,047)	\$0	\$0	(\$1,193,047)
FY 2021	(\$1,194,791)	\$0	\$0	(\$1,194,791)
Biennium Total	(\$2,387,838)	\$0	\$0	(\$2,387,838)