Behavioral Health System for Future Generations (BHSFG) Commission Report

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

June 2024

DRAFT

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 HB 872, the report comprises detailed recommendations on how to make historic investments in Montana's behavioral health and developmental disabilities 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 ten public meetings across Montana over the last 12 months, each with extensive testimony by community stakeholders and subject matter experts, 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 behavioral health service delivery systems, expanding the capacity of the developmental disabilities 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, and a full list is included 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. We look forward to discussing them with the Governor's Office and key legislative interim committees throughout 2024, and the Legislature during the 2025 regular session.

Sincerely,

Representative Bob Keenan, Chair

Director Charlie Brereton, Vice-Chair

Commission Background and Purpose

HB 872

The Behavioral Health System for Future Generations (BHSFG) Commission was established through passage of the HB 872 legislation. Along with a historic investment of $300M, the Commission was charged with providing recommendations to reform and improve Montana's behavioral health (BH) and developmental disabilities (DD) service systems. This legislation makes $225M available for recommendations made by the Commission, subject to legislative approval and 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 Department of Public Health and Human Services 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 and with a wide variety of medical and other needs. Included in this critical service system is the behavioral health and developmental disabilities programs. These two special populations have some of the most complex service needs and, together, comprise approximately 22% of the total annual $1.2B Medicaid spend for the program, equal to total hospital spend. The complexity of needs covered within these two populations, while often grouped together, are 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 behavioral health and developmental disabilities service systems. A central component of the Governor's Budget for Montana Families, the $300M investment was made to expand intensive and community-based behavioral health care and developmental disabilities services across Montana. Key to HB 872 was the establishment of the Behavioral Health System for Future Generations Commission to serve as a governing body and collect stakeholder input and feedback, evaluate system challenges, and formalize recommendations to be supported by the historic investment and other long-term funding sources.

The seven priorities established by the BHSFG commission serve as the cornerstone of the 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 DD service delivery system**
6. **Capacity of co-occurring populations service delivery system**
7. **Family and caretaker supports (BH & DD)**

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, behavioral health and developmental disability 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 behavioral health and developmental disability 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 behavioral health service delivery systems, expanding the capacity of the developmental disabilities 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): (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.[1]

5. The Commission then developed 21 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 Priorities.[2]

6. The Commission recommended **X**[3] Near-Term Initiatives (NTIs), supported by the Governor and launched by the Department, aimed at immediately addressing systemic issues raised through

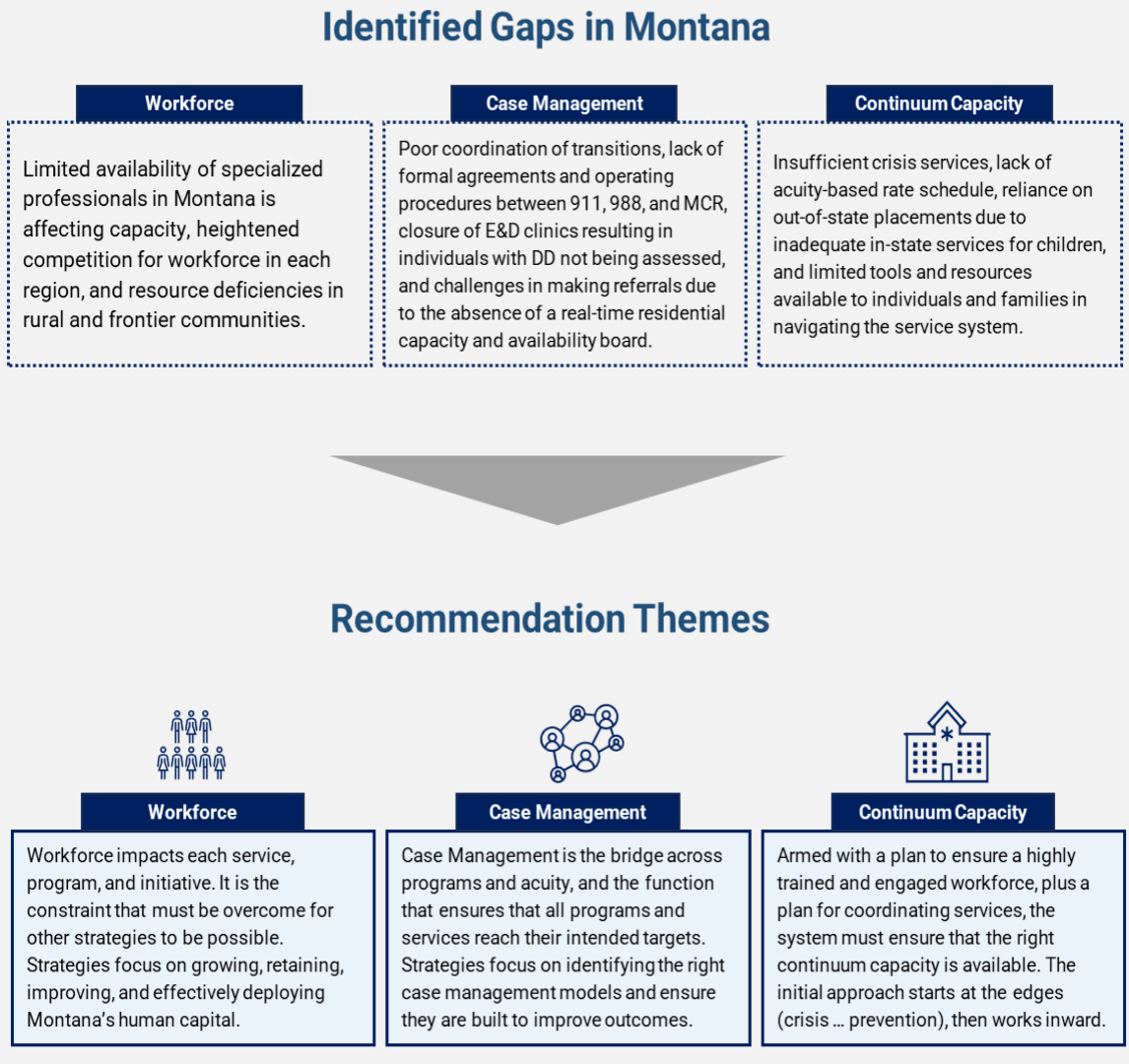
[1] On behalf of the Commission, the Department also engaged Alvarez and Marsal (A&M) to support its HB 872 workstreams by providing project management and health and human services policy and operational expertise.
[2] See Overview of Commission Process.
[3] The number of NTIs is not yet final and subject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

the Commission process. To date, the Department has initiated **X** initiatives with up to **$44M** in funding available to implement them.

7. The Commission has estimated a funding level of **$87M**[4] 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 immediately implement all its recommendations.

Themes

Figure 1 | Themes



[4] See the Budget Summary portion of the Recommendations section for detail. Cost estimates contained in this draft report are subject to change.

Summary of Recommendations and Near-Term Initiatives

This report includes **21 recommendations and X NTIs** that aim to improve Montana's behavioral health and developmental disabilities 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 behavioral health and developmental disabilities systems.

Figure 2 | Summary of Recommendations and NTIs

Recommendations: *aim to improve Montana's behavioral health and developmental disabilities systems over the long term. These recommendations span the entire continua 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 Waiver Services Rates
2. Expand Access to Waiver Services Through a Supports Waiver
3. Expand Service Options for People with Dual Diagnosis
4. Redefine and Reopen Evaluation and Diagnostic Clinics
5. Identify Improvements to the 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. Enhance Information Technology
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
17. Redesign Rates to Improve In-State Youth Residential Services
18. Invest in School-Based Behavioral Health Initiatives
19. Incentivize Providers to Join the Behavioral Health Workforce
20. Expand Training Content Available to Behavioral Health Workers
21. Enhance Behavioral Health Integration Efforts

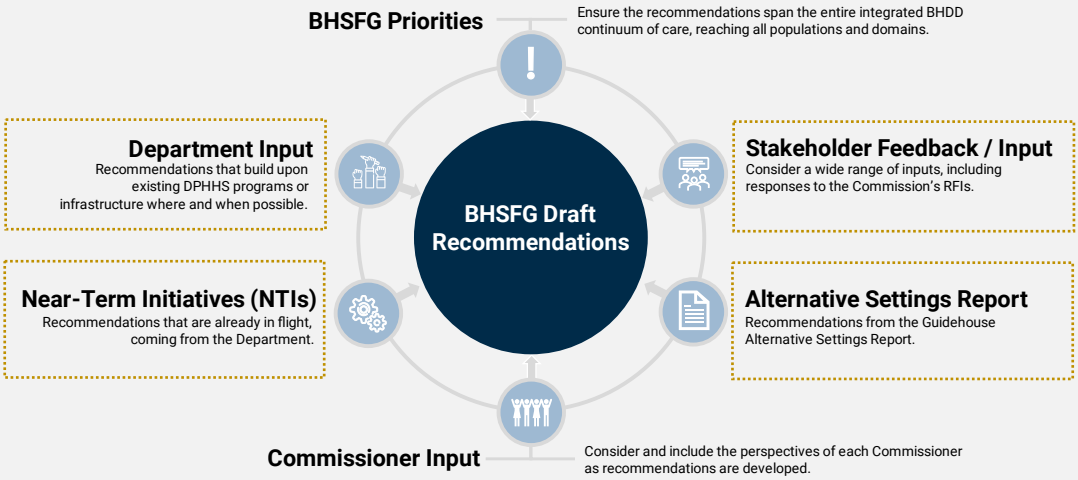
Near-Term Initiatives: *initiatives the Commission recommended, and the Governor passed, throughout the Commission's tenure. NTIs reflect common sense, actionable ideas to address known and worsening gaps in Montana's BH and DD systems. NTIs were specifically designed to address problems that could be 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. Healthcare and I/DD Workforce Training and Certification
6. Family Peer Supports

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 BHSFG Commission as they collaboratively developed NTIs and recommendations. Stakeholders shared insights by completing online forms, e-mailing the department directly, and 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 behavioral health needs. In addition to the initial behavioral health study, subsequent sub-studies were also conducted on workforce issues, developmental disabilities service system needs, and housing. Guidehouse submitted and presented final reports to the Commission in April 2024.

- **Department Input:** DPHHS and the Commission reviewed a plethora of past data points 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 Departmental data sources and sets to conduct relevant analysis 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 issuance of the final recommendations.

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 or addictions to drugs or alcohol. Public mental health and substance use disorder 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.[5]

The 2024-2025 Montana DPHHS biennial budget proposed $970M for behavioral health (mental health and substance use) and developmental disability services.[6] This investment provided access to screening, services, and treatment for Montana children, adolescents, and adults. The public behavioral health system includes services paid for by Medicaid, 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 behavioral health 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 SDMI and youth with 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 severe and disabling mental illness (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.[7] In 2021, the State provided rehabilitative mental health services to over 50,000 adults and 21,000 youth enrolled in Medicaid.[8] 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.[9]

[5] Montana 2022 Biennial Report. Available at: BHDD - Presentation to the 2023 HHS Joint Appropriation Subcommittee (mt.gov).
[6] Department Of Public Health & 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.
[7] Medicaid Expansion in Montana & Nationwide Financial Modernization & Risk Analysis (MARA) Study Committee 2025 Biennium January 9, 2024 Available at: PowerPoint Presentation (mt.gov).
[8] Montana Healthcare Foundation 2022 Annual Report. Available at: Medicaid-in-MT-2022_4.12.22-FINAL.pdf (mthcf.org).
[9] Ibid.

Access to behavioral health 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.[10] Behavioral health needs are particularly acute among Medicaid enrollees. In 2021, nearly one-third of Medicaid expansion enrollees (36,949) had one or more behavioral health diagnoses recorded on a Medicaid claim.[11]

Despite these challenges, BHDD, providers, community partners, and advocates have continuously worked to enhance the state's behavioral health system, through initiatives that strengthen prevention, treatment, and recovery services. This includes investing in each component of Montana's behavioral health 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. In 2024, the state 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 behavioral health crisis.

The Department has taken several additional steps to transform the behavioral health system. This includes collaboration with providers, stakeholders, advocates, tribal partners, and policy makers to identify recommendations aimed at enhancing the system. In 2023, the Montana Legislature passed a $339M provider rate increase package over SFYs 2024 and 2025 aimed at stabilizing Medicaid providers and increasing access to appropriate services for Medicaid beneficiaries. The state furthered its support for individuals with substance use disorders by amending its existing 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.

Developmental Disabilities

The Developmental Disabilities Program manages an active service array to meet the support needs of individuals with developmental disabilities, from birth to death (*see Appendix B – Developmental Disabilities Continuum of Care*). Developmental disabilities[12] 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

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

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 developmental disabilities 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 $55,000 per person per year. The waiver includes a schedule of reimbursement rates to obtain services from a network of roughly 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 July 1, 2023. In addition to waiver services, DPHHS also manages a series of state plan services for individuals with developmental disabilities, including Targeted Case Management and Applied Behavior Analysis, and a 12-bed residential facility for individuals with complex needs, which is the Intensive Behavior Center (IBC) in Boulder.

While the current services provide an array of options, DDP manages a waitlist of roughly 2,100 individuals waiting for waiver services. People waiting for services enroll in the waiver through either (1) chronological selection when waiver slots open; or (2) reserved capacity for individuals who enter a defined crisis; and/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 delay in ensuring those waiting receive the services they need due to provider capacity issues.

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

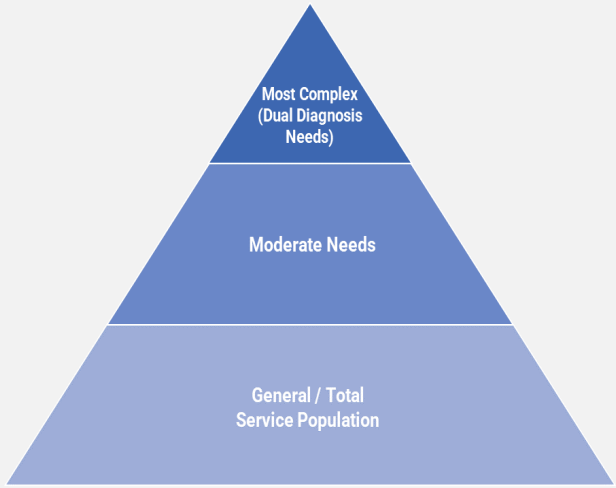
Recommendations

How the Recommendations Address Montana's BH and DD Systems

This report includes sixteen recommendations focused on improving Montana's behavioral health system and five recommendations focused on improving Montana's developmental disability system. These recommendations touch every aspect of the behavioral health and developmental disabilities 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 developmental disabilities 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. 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), to 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 developmental disabilities 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 developmental disabilities.

In parallel, the behavioral health 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, 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 **behavioral health workforce**, ensuring greater stability and higher quality of services.

Recommendations Budget Summary

Based on this approach, DPHHS and the Commission have developed One-Time Only (OTO) cost estimates totaling **$47M,** and an additional **$40M** 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 to the state budget, for each recommendation.

The Commission has already unlocked 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) sustainably fund the recommendation into the future as part of the state's "base budget" (Recurring Operational).

Critically, as recommendations are implemented, and prior to their inclusion in the state budget as recurring line items, the Commission's funding also 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 Fund		Long Term Sustainability
One-Time Only	**Operational**	**Recurring Operational**
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.***	Cost to fund the recommendation annually through a combination of Medicaid reimbursement, Federal grant programs, the General Fund, or other sources. ***The impact to the state budget going forward and the strategy to execute it.***

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 and appropriation by the Governor's Office and Legislature.

Figure 5 | Cost Estimates Build Up Summary

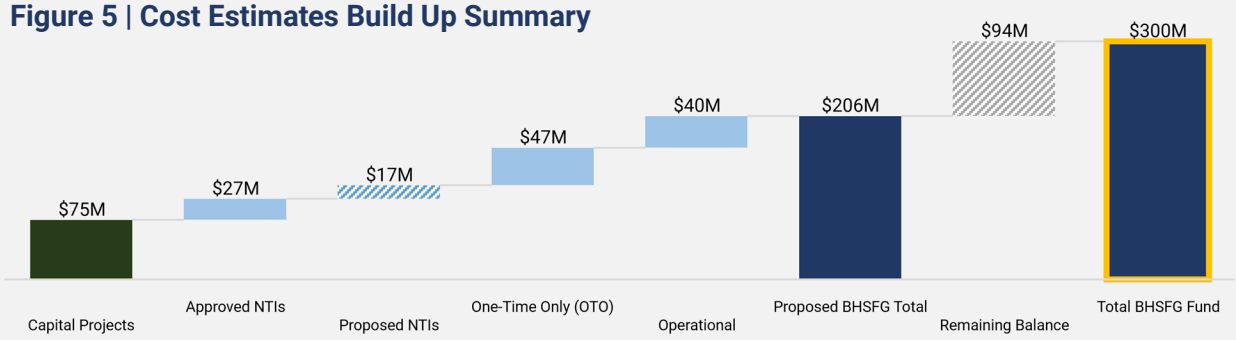


Figure 6 | Breakdown of Cost Estimates by Recommendation

BHSFG Funding Amount

Recommendation	Domain	OTO	Operational
1. Refine and Reconfigure Waiver Services Rates	DD	$1.7M	$300K
2. Expand Access to Waiver Services Through a Supports Waiver	DD	$500K	$66K
3. Expand Service Options for Individuals with Complex Needs	DD	$1.9M	$17.6M
4. Redefine and Reopen Evaluation and Diagnostic Clinics	DD	$50K	$2M
5. Identify Improvements to the Waitlist Management Process	DD	$750K	$100K
6. Enhance the Targeted Case Management Program	BH	$710K	$2.2M
7. Develop a Targeted Case Management Training Program	BH	$1M	$10K
8. Implement a Care Transitions Program	BH	$250K	$2M
9. Enhance Information Technology	BH	$4.1M	$7.3M
10. Expand Mobile Crisis Response to Additional Regions	BH	$2.6M	$4M
11. Introduce New Crisis Stabilization and Receiving Center Services	BH	$14M	$1.3M
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	$1.5M
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	BH	$500K	-
17. Redesign Rates to Improve In-State Youth Residential Services	BH	$150K	-
18. Invest in School-Based Behavioral Health Initiatives	BH	$2.6M	-
19. Incentivize Providers to Join the Behavioral Health Workforce	BH	$7.1M	-
20. Expand Training Content Available to Behavioral Health Workers	BH	$2M	-
21. Enhance Behavioral Health Integration	BH	$3.9M	-
	Total:	**$47M**	**$40M**

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 level of acuity and support needs.

Background

Current practices in DDP 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 have 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 system 6. Capacity of co-occurring populations
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings – Panels and Public Comment

Intended Outputs

- More expansive rate methodology providing tiered rates set by level of acuity across service domains.
- DDP providers begin 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 to their unique needs.

Key Performance Indicators

- ED and/or out-of-state placements are reduced.
- Greater detail is available through MMIS to support state budgeting and waitlist management.
- Provider capacity is stabilized and/or expanded.
- Reliance on state-operated facilities is reduced.

Proposed Funding

BHSFG Funding		Long Term Funding
One-Time Only (OTO)	**Operational**	**Recurring Operational**
$1.7M	**$300K**	**$7.6M**

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 who are on the current waitlist for services are only able to access State Plan service options. State Plan services are limited in type, scope and duration, focused primarily on Targeted Case Management and therapy-based services. Outside of State Plan services, individuals and families lack a more robust service array. This places greater unfunded demand on families, which may increase crisis situations. Through this option, DDP would be able 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 system 6. Capacity of co-occurring populations 7. Family and caretaker supports
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

- Individuals and families receive more timely access to a limited-service array, reducing crisis points.
- Individuals have more service options to choose from, better aligning to their unique needs.
- Early access to services that reduce reliance on more costly options if access is delayed.

Key Performance Indicators

- Reduced ED and/or out-of-state placements.
- Reduced number of people on the waiting list.
- Reduced length of time waiting for services.
- Reduced reliance on state-operated facilities.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$500K	**$66K**	**$21M**

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 level of support. While this approach is appropriate for the general population of people using 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 people continuing to be served at the Intensive Behavior Center, other state-run facilities and/or in 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 in the system and consider changes in scope or location, in alignment with the Alternative Settings recommendations.

Summary

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

Intended Outputs

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

Intended Outcomes

- People with complex support needs can stay in their local communities, leverage natural supports, and receive adequate services and resources to meet their needs.

Key Performance Indicators

- Reduced out-of-state placements.
- Reliance on state-operated facilities is reduced.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$1.9M	**$17.6M**	**$8.3M**

Recommendation #4: Redefine and Reopen Evaluation and Diagnostic (E&D) Clinics to Support Families More Effectively

- Engage with stakeholders (families, medical professionals, and service providers) to redefine the intent and scope of 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. Closure of these clinics has caused a significant bottleneck for families seeking evaluation services to most efficiently gain access to DDP services. The loss of these services has created an extended waitlist for families to receive screening, further extending the time families spend waiting for services. Conversely, nationally, DD programs 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 scenarios wherein people otherwise unknown to the service system are coming 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 help reduce or delay the needs of 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 system 7. Family and caretaker supports
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

- Individuals and families will have greater access to screening services, reducing wait times and increasing the effectiveness of identifying appropriate/eligible services.

Key Performance Indicators

- Reduced wait times for screening.
- More accurate and up-to-date data on service eligibility and demand.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$50K	**$2M**	**$1M**

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 roughly 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 reduces the state's ability to proactively forecast service demand, provider capacity need, and legislative appropriations to 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 system 7. Family and caretaker supports
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings – Public Comment

Intended Outputs

- Increase ability to project current and future service needs to better support capacity development and budget planning.

Intended Outcomes

- More refined structures may help reduce waiting times for families and improve equitable access to services.

Key Performance Indicators

- DDP can make more targeted, data informed budget requests to inform program access and growth.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$750K	**$100K**	**$100K**

Recommendation #6: Enhance the Targeted Case Management (TCM) Program to Improve Health Outcomes for Eligible Individuals

- Re-evaluate the current TCM reimbursement model (e.g., by population, quality, intensity, or outcomes) for all TCM services.
- Expand the TCM program, service availability, and current met and unmet service need.
- 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 FY23 TCM was delivered to approximately 8,000 Medicaid members, accounting for 2% of the Medicaid population. the Targeted Case Management model for individuals with severe disabling mental illness and/or substance use disorder and children with serious emotional disturbance (SED) and developmental disabilities would be updated.

Summary

Theme:	Case Management
Population Impacted:	All
Place in Continuum of Care:	All
BHSFG Priority # (1-7):	3. Capacity of adult BH service delivery 4. Capacity of children's BH service delivery 5. Capacity of DD service delivery system 6. Capacity of co-occurring populations delivery system 7. Family and Caregiver Supports
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

- Decrease avoidable, high-cost service utilization (e.g., inpatient psychiatric) for people receiving TCM.
- Increase utilization of preventive care for people receiving TCM.

Key Performance Indicators

- Reduction in Emergency Department visits.
- Increase in primary care visits for people receiving TCM.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$700K	**$2.2M**	**$2.8M**

Recommendation #7: Develop a Training Program for Targeted Case Managers

- 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.
- Integrate staff training that accounts for the cultural and linguistic diversity that is reflective of Montana's unique populations (i.e., American Indian / tribal population).

Background

A new TCM curriculum will ensure (1) program compliance, (2) employment of effective case management practices, (3) capacity to effectively deliver a new tiered TCM model (recommended in this report), and (4) fidelity to the model. There are several states (e.g., AL, KY, MN, M) that offer TCM training programs as well as existing national trainings 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 4. Capacity of children's BH service delivery 5. Capacity of DD service delivery system 6. Capacity of co-occurring populations delivery system
Stakeholder Input:	BHSFG Commission Meetings

Intended Outputs

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

Intended Outcomes

- Increase targeted case manager skill, as measured through competency-based surveys (e.g., pre-post tests).
- Increase the speed and efficacy of targeted case management services, as measured by post-event (ED, MCR) tracking.

Key Performance Indicators

- Increased quality of the workforce.
- Improved compliance with staffing requirements.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$1M	**$10K**	**$5K**

Recommendation #8: Implement a Care Transitions Program

- Design and implement a care transitions service, for individuals discharged from institutions, which facilitates reintegration back into their communities.
- Provide culturally and linguistically responsive discharge planning that reflects the diversity of unique populations across Montana (i.e., American Indian / tribal population).
- 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, correctional settings). This recommendation aims to enhance the existing TCM program and initiate a new case management program 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
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

- Reduce readmissions for people discharged from inpatient psychiatric care.
- For people who are readmitted to a hospital, reduce their length of stay.

Key Performance Indicators

- Increase in number of individuals re-integrated into the community following discharge.
- Decrease in readmissions to psychiatric settings.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$250K	**$2M**	**$900K**

Recommendation #9: Enhance Information Technology

- 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 MCR services are not locally available.
- Support virtual technology solutions for first responders and mobile crisis teams.
- Support a web-based system that monitors real-time BH bed availability and maintains an updated inventory of state-wide and community-specific resources is essential to comprehensive care management.

Background

The Department has identified a need to make further investments in information technology for its behavioral health system of care. This includes providing additional funding to enhance the 988 call center IT systems virtual technology for mobile crisis, first responders and to develop an electronic bed registry. Other rural states have invested in innovative virtual technology solutions to connect first responders to BH professionals when people are experiencing a crisis. Montana, like many other states, seeks to improve its coordination of behavioral health services by making a web-based bed registry accessible to front line crisis counselors in local behavioral health agencies, mobile crisis teams, crisis call centers, and hospital emergency departments.

Summary

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

Intended Outputs

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

Intended Outcomes

- Decrease the number of calls that require Emergency Department (ED) or higher level of intervention.
- Decrease the number of people with BH crisis who are arrested. Decrease the number of individuals with 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.

Key Performance Indicators

- Agreements between 988 and local 911 are formalized.
- Decrease in readmissions to psychiatric settings.
- Agreements between bed registry vendor and providers are formalized.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$4M	**$7M**	**$4M**

Recommendation #10: Expand Mobile Crisis Response (MCR) to Additional Regions in Montana

- Offer grant funding to providers, for 1) start-up and 2) non-billable service costs, to expand access to Medicaid-covered 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., BH, CMHCs) to virtually support local MCR teams, first responders and/or available providers to rapidly respond 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, and none 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" — peers, CHWs, EMT, MCRs – 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 crisis system 3. Capacity of adult BH service delivery
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings

Intended Outputs

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

Intended Outcomes

- Reduce the number of behavioral health emergencies resulting in jail or emergency department interaction.
- Increase MCR team response within one hour of dispatch in urban (two hours for rural communities; three hours for remote communities).
- Increase the number of people receiving MCR support.

Key Performance Indicators

- Grant funding that prioritizes underserved regions, released in a timely manner.
- Adherence to the Crisis Now model guidelines for "someone to respond" in urban areas.
- Innovative model options for rural areas are identified.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$2.6M	**$4M**	**$1.4M**

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, extreme 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 service and rates for crisis stabilization service models for children and adolescents.

Background

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

The Commission heard from stakeholders who shared support in providing crisis supports for 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; keeping them out of emergency departments and other facilities to ensure referrals and access to specialized mental health treatment for stabilization support and recovery services. This recommendation proposes to fund construction and startup costs for between 4-8 crisis stabilization and receiving centers or BH urgent care throughout the state based on need and demand. This recommendation proposes to fund construction and start-up costs for between 4-8 crisis stabilization and receiving centers or BH urgent care throughout the state based on need and demand.

Summary

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

Intended Outputs

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

Intended Outcomes

- Decrease use of emergency departments for BH crises.
- Decrease number of clients who need psychiatric hospitalization.

Key Performance Indicators

- Establish new regulations, Medicaid policies and rates for child and adolescent services.
- Decrease in youth psych ED boarding.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$14M	**$1.3M**	**$1.3M**

Recommendation #12: Expand the Scope of the Certified Adult Peer Support Program by Widening Eligibility and Increasing Applicable Settings

- Amend the certified peer support Medicaid benefit to include (1) non-Severe Disabling Mental Illness (SDMI, or individuals with moderate behavioral health conditions), and (2) settings designated as "licensed agency" 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 are shown to 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 (SUD) 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
Stakeholder Input:	Alt. Settings Report, RFI

Intended Outputs

- Offer peer support services to people with moderate mental health diagnoses.
- Increase the number of people reached by peer support specialists by adding eligible settings.

Intended Outcomes

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

Key Performance Indicators

- Inclusion of Medicaid benefit amendment in State Plan.
- Increase in the number of certified peer support specialists.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$300K	**-**	**$1.3M**

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 and are experiencing or 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 and prevent homelessness barrier resolution and 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
Stakeholder Input:	BHSFG Commission Meetings – CMH, MT Coalition to Solve Homelessness

Intended Outputs

- Expand coverage of tenancy support services.

Intended Outcomes

- Increase the number of people with SMI/SUD experiencing homelessness who receive BH services.
- Reduce ED utilization for people with SMI/SUD experiencing homelessness.

Key Performance Indicators

- Increased funding allocation for tenancy support specialists.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$1.1M	**$1.5M**	**-**

Recommendation #14: Launch a Campaign to 1) Inform Montanans of New Behavioral Health Services, and 2) Raise Awareness and Reduce Stigma Around Behavioral Health

- Communicate consistent messaging to all communities about ways to connect and access BH supports and services.
- Offer clear "How do I engage with DPHHS providers?" guidance to anyone in need of behavioral health care.
- Campaign materials, messaging and delivery integrates cultural and linguistic diversity across Montana that is reflective of its unique populations (i.e., American Indian / tribal population).

Background

Montana's frontier nature can be challenging, and 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 build off their state's identity. Montana can borrow applicable ideas from other state campaigns. The BHSFG Commission is expanding services and improving access. The proposed campaign would highlight existing and new opportunities for people to access help, especially 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

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

Intended Outcomes

- Increase in mental health and SUD services delivered to people in need.
- Decrease in mental health and SUD services provided by emergency departments and law enforcement (when avoidable).

Key Performance Indicators

- Increase in community engagement with campaign materials and platform.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$1M	**-**	**-**

Recommendation #15: Reduce barriers to care for non-emergency medical transportation (NEMT)

- 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, 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 a NEMT broker through an RFI, with no responses. States use NEMT broker-led models to improve access, efficiency, and client experience. Currently, the Senior and Long-Term Care division uses a pre-pay program referred to as GoGo.

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 4. Capacity of children's BH service delivery
Stakeholder Input:	RFI

Intended Outputs

- Increase access to safe, reliable transportation.

Intended Outcomes

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

Key Performance Indicators

- Increase in average time from dispatch to pick up.
- Increase in the average driver turnaround.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
-	**$1.7M**	**$1.7M**

Recommendation #16: Expand the Family Peer Support (FPS) Program for Parents and Caregivers of Children with Behavioral Health Issues and/or Developmental Disabilities

- 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 is minimally offered in Montana and is not yet certified. It is therefore not yet Medicaid billable. In SFY 2023, 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, shown to break down stigma and deliver 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 4. Capacity of children's BH service delivery 5. Capacity of DD service system 7. Family and caretaker supports
Stakeholder Input:	BHSFG Commission Meetings – CMH, MT's Peer Network

Intended Outputs

- Increase the number of family peer support workers in Montana.
- Formalize a path to certification for family peer support workers.

Intended Outcomes

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

Key Performance Indicators

- Growth in the number of employed individuals within the family peer support network.
- Formalization of family peer support inclusion in the Medicaid State Plan.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$500K	**-**	**$1.7M**

Recommendation #17: Redesign Rate Structure 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 the 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. 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 BH service delivery
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings - CMH

Intended Outputs

- Design a tiered rate methodology, matching level of acuity to level of service.
- Secure provider and other stakeholder buy-in to adjusted rate design.

Intended Outcomes

- Reduce out-of-state residential placements.
- Unique needs of each individual are better addressed through improved service alignment.

Key Performance Indicators

- Lower out-of-state placement costs.
- Improved patient outcomes (e.g., no re-entry to residential care in 180 days, readmissions).

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$150K	**-**	**$6.6M**

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 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 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 BH service delivery
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings - CMH, RFI

Intended Outputs

- Advance the implementation of MTSS through comprehensive school-based mental health services for Montana youth.
- Increase 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.

Key Performance Indicators

- Funds released in a timely manner.
- Increase number of school personnel receiving youth BH training and professional consultation.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$2.6M	**-**	**$7.3M**

Recommendation #19: Incentivize Providers to Join the Behavioral Health Workforce via Tuition Reimbursement

- Develop a tuition reimbursement program that encourages behavioral health workers to practice in Montana. This program targets workers that are (1) essential to BHSFG initiatives, and (2) underrepresented in currently available tuition reimbursement programs.

Background

Montana is grappling with workforce shortages statewide, mirroring a prevalent issue across the nation. Particularly in Montana, this has significantly impacted the behavioral health system, impacting the delivery of services without the appropriate staff. Throughout the commission meetings, a recurring theme has been the urgent need to tackle Montana's workforce shortage, particularly the importance of investments in programs like this to bolster the behavioral health workforce. This is one of the three key workforce recommendations aimed at addressing this issue. Individuals working in the developmental disability system are included in this recommendation.

While there are existing tuition reimbursement programs for various healthcare professions, this initiative specifically targets providing tuition reimbursement opportunities for the behavioral health workforce, particularly less credentialed members of the behavioral workforce, such as case management staff and direct care workers.

1. Lack of staffing has a ripple effect throughout the entire behavioral health system.
2. Economic factors, including the cost of tuition for various members of the BH workforce, make recruitment difficult.
3. Without appropriate staff, sites are not able to deliver the services they otherwise could.

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

- Increase the number and geographic coverage of behavioral health workers.
- Increase the number of workers in targeted program types and regions, with enhanced payments to cover high need areas and/or populations.

Intended Outcomes

- Increase access for people seeking services impacted by workforce shortages.
- Improve participant satisfaction with access to services.

Key Performance Indicators

- Decrease in the shortage of behavioral health workers in selected provider types across Montana.
- Reduced waitlists for appointments in clinics.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$7M	**-**	**-**

Recommendation #20: Expand Training Content Available to Behavioral Health Workers

- Partner with a university to develop a learning platform that hosts and tracks training programs for behavioral health workers.
- 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 that is reflective of unique needs of Montanans (i.e., American Indian / tribal population).

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 has a substantial impact on employee wellbeing.

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

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

Intended Outcomes

- Decrease workforce turnover (e.g., help providers retain staff).
- Increase workforce self-reported satisfaction scores (measured by survey).

Key Performance Indicators

- Launch of the learning platform developed in partnership with a university.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$2M	-	-

Recommendation #21: Enhance Behavioral Health Integration Efforts

- Support efforts to 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 reporting, services, insurance type), and (3) assess outcomes (e.g., 7 and 30 day follow up, emergency department 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), health prevention, promotion and literacy.
- 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 to 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 (Kaiser, 2023). CHWs in Montana are a growing workforce with the training and community connections needed to impact behavioral and overall health outcomes. The most appropriate scope of practice for CHWs in Montana may be focused on health promotion and literacy (i.e., preventive measures), which complements high-intensity services such as targeted case management.

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 4. Capacity of children's BH service delivery
Stakeholder Input:	Alt. Settings Report, BHSFG Commission Meetings – AMH, RFI, Primary Care Association

Intended Outputs

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

Intended Outcomes

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

Key Performance Indicators

- Increase in primary care visits for the assigned population.
- Decrease in ED events for the assigned population.

Proposed Funding

BHSFG Funding		Long Term Funding
OTO	**Operational**	**Recurring Operational**
$3.9M	**-**	**$1.8M**

Near-Term Initiatives

Summary

NTIs recommended by the Commission and approved by the Governor 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[1]	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	$10M	HB 872 funds are awarded to residential setting providers to increase capacity.	Received 136 applications requesting a total of nearly $30M in proposals. Reviewed applications based on Departmental priorities.
3	Support Mobile Crisis Response and Crisis Receiving & Stabilization Services	5/31/24	$7.5M	HB 872 funds are awarded to existing mobile crisis providers to enhance financial stability & crisis receiving and stabilization providers to expand capacity.	Shared contracts with mobile crisis providers. Released RFP to provide resources to crisis receiving & stabilization providers.
4	Development and Deployment of a Comprehensive Crisis Worker Curriculum and Certification Course	TBD	$500K	HB 872 funds are awarded to a university partner to develop (with DPHHS) and host a crisis curriculum for all crisis workers.	Met with University of Montana to discuss course timeline, scope of work, budget, and sustainability plans.
5	Healthcare and DD Workforce Training and Certification	4/19/24	$600K	HB 872 funds are awarded to providers to train their workforce in supporting individuals with DD and to providers to help DSPs obtain certification in providing services to individuals with DD.	Successfully launched DD Workforce training on 4/19/24 and Healthcare Workforce training on 5/10/24.
6	Family Peer Supports	TBD	TBD	HB 872 funds are awarded to organizations with a proven track record of providing family peer support services in Montana.	Passed BHSFG commission meeting on 3/29/24 and awaiting Governor's review.

Initiative #1: Incentivize Community-Based Court Ordered Evaluations

Purpose: There are very few options to perform court-ordered forensic fitness evaluations (COEs) in the State of 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 Highlights

DPHHS successfully launched this NTI on 3/8/24 and has completed and paid for multiple COEs in community settings. This has started to reduce the waitlist at Galen.

Implementation Progress to Date

Date Approved by Commission:	10/13/22
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 necessary residential bed capacity to meet the state's needs. To address this, this NTI will provide $10M 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 Highlights

DPHHS launched a grant program and received 136 applications requesting a total of nearly $30M in proposals. The Department reviewed applications and is in the process of selecting awardees based on Departmental priorities outlined in the application.

Implementation Progress to Date

Date Approved by Commission:	10/13/22
Date Approved by Governor:	12/19/23
Funding Level:	$10M
Place in Continuum:	Treatment, Recovery
Population Served:	BH – Adult, DD – Adult
Next Steps:	Select final awardees and distribute award letters

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 Mobile Crisis Response (MCR) and new Crisis Receiving and Stabilization providers to stabilize MCR programs and increase Crisis Receiving and Stabilization service capacity across Montana.

Implementation Highlights

DPHHS shared contracts with existing MCR providers to begin the process of distributing additional funds to them. DPHHS finalized and is preparing to launch an RFP to provide one-time grants to crisis receiving and stabilization providers.

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 – Adult
Next Steps:	MCR contracts signed, crisis receiving, and stabilization applications reviewed, and awardees selected

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 vendor experienced in curriculum development, that will be available to providers delivering crises services.

Implementation Highlights

DPHHS conducted initial meetings with the University of Montana to discuss course timeline, scope of work, budget, and sustainability plans.

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 - Adult
Next Steps:	Draft contract with University of Montana to create and administer course

Initiative #5: Healthcare and DD Workforce Training and Certification

Purpose: The Developmental disabilities workforce faces significant constraints that limit the ability to provide people with needed services. To help offset that, this initiative will provide up to $350,000 to pilot a direct support professionals (DSP) credentialing structure to help stabilize the DSP workforce and will provide up to $250,000 to enhance training opportunities for healthcare professionals to better support individuals with DD.

Implementation Highlights

DPHHS launched the DSP credentialing initiative via an RFP on 4/19/24 and is currently accepting applications. The healthcare workforce training initiative launched on 5/10/24.

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:	Select awardees for DSP credentialing and healthcare workforce training initiatives

Initiative #6: Family Peer Supports

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 wellbeing 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 Highlights

The Commission passed this NTI on 3/29/24. It is now awaiting approval from the Governor.

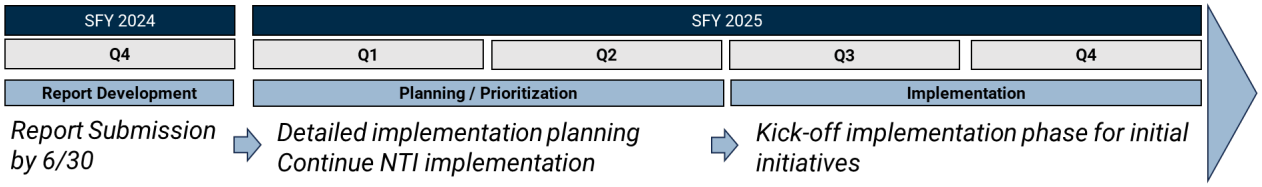
Implementation Progress to Date

Date Approved by Commission:	3/29/24
Date Approved by Governor:	TBD
Funding Level:	TBD
Place in Continuum:	Prevention, Recovery
Population Served:	BH - Children
Next Steps:	TBD

Implementation Planning

Following the submission of this report, focus will transition to the pivotal phase of implementation planning. The planning period between report submission and approval is critical, as it enables the Department and Commission 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.[13]

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, manuals to ensure compliance and identifying any legal or regulatory issues that may require 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.

[13] Note that 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. The complexity tier also reflects the 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[14]	
Complexity Tier	**Description**
High *# of Recs = 9 (43%)*	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 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, Addressing the Wait List, Care Transitions, and Access to Stabilization Services (1, 2, 3, 6, 8, 11, 16, 17, 18). ***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 (24%)*	Require fewer steps to implement than the higher-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 updating the DD waitlist management system/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 (33%)*	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**: Enhancing Information Technology, 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 higher and medium-tiered categories.***

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.

[14] 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.

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 to best support individuals with developmental disabilities that have complex, dual diagnosis needs. The START Program is foundational to this recommendation and is a critical step in building needed capacity to serve individuals with complex needs. This helps establish a stronger continuum of care. This program will serve as a critical stop gap 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 • Request for Proposal for Qualified Service Provider(s) • Identify pilot location • Identify pilot scope – Clinical Team vs Clinical Team Plus model • MMIS service codes / modifiers • Revisions to Personal Support Planning Process
Legislative / Regulatory:	• Review and updates to ARMs • Newly established and updated 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. However, if funding is not available, 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 require extended travel to receive services.

Recommendation #6: Enhance the Targeted Case Management Program	
Overview: Under this recommendation, Montana would update the Targeted Case Management model for individuals with SDMI and/or SUD, children with SED, and individuals with developmental disabilities. 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 need (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 • Update contracts with existing TCM providers to include VBP 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. • Difficulty in 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 Transition 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, state institutions). This recommendation would initiate and fund startup 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 school-based Multi-Tiered System of Support (MTSS). MTSS investments encompass universal screening, referrals, and evidence-based interventions aimed at enhancing youth wellbeing. 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 the Office of Public Instruction (OPI) and identifying funding sources to ensure sustainability, such as Medicaid due to 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 key performance indicators, reporting, quality metrics. • Identify contracting mechanism for PROJECT ECHO or interprofessional training of school staff • Support of 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:	• Parental consent to provide BH services delivered in schools may be difficult to obtain. • Evidence-based programs implemented to fidelity. • SPA development, submission, and approval may be subject to change and elongated timelines. • Funding source(s) for interprofessional training of school staff may be difficult to secure. • Successful partnership with OPI is critical to avoiding delays in project implementation.

Recommendation #19: Incentivize Providers to Join the Behavioral Health Workforce	
Overview: Under this recommendation, Montana would offer additional tuition reimbursement for less credentialed members of the behavioral health workforce, including case management staff and direct care workers. This recommendation proposes to incentivize providers to join the behavioral health 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 that are (1) essential to BHSFG initiatives and (2) underrepresented in currently available tuition reimbursement programs.	
Implementation Requirements	
Staffing:	• 1 FTE Program Coordinator
System / Infrastructure:	• Identify the eligible behavioral health providers for tuition reimbursement • Crosswalk to existing tuition reimbursement programs. • Establish program standards
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 behavioral health providers to discuss program and receive their input on applicant eligibility requirements, 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
Risks:	• Lack of interest from behavioral health workers. • Lack of buy-in from behavioral health providers. • Limited ability to receive long-term funding.

Conclusion

In the months ahead, the BHSFG Commission will continue its diligent work to transform Montana's behavioral health and developmental disabilities systems to meet needs of all Montanans. As part of this effort, the Commission will continue to implement NTIs, meet as needed, and will submit this report to various legislative interim committees and the Governor in advance of the 2025 legislative session.

Critically, the Commission will prioritize planning for implementation of the recommendations contained in this report while remaining cognizant of the various dependencies, such as a requirement for long-term budget authority, associated with the implementation of certain recommendations. Specifically, the Commission will ensure implementation plans and timelines align with both BHSFG budget constraints and the budgeting process for the 2025 legislative session. Implementation plans will emphasize the work required to launch recommendations with HB 872 funds, while also incorporating a long-term sustainability strategy for those that necessitate recurring state and/or federal funding.

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 decisionmakers, both current and future, continue making necessary and prudent investments to ensure long-lasting reform.

Stakeholders in Montana have invested heavily in the Commission process with their time, energy, and expertise. The Commission is deeply grateful for their participation; 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 catalogued and will continue to be evaluated as the Commission works through implementation of these recommendations and builds a foundation for the future.

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

Acknowledgements

This report presents an overview of findings and recommendations collaboratively compiled by the Department and the Commission. We extend our 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. Your input has been instrumental in shaping our recommendations. Thank you for your collaboration and dedication to our shared goal of improving Montana's behavioral health and developmental disabilities service systems.

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Project Manager

Governor's Office

Rachel Green
Policy Director

Mark Blasdel
Director of Economic Development

Legislative Fiscal Division

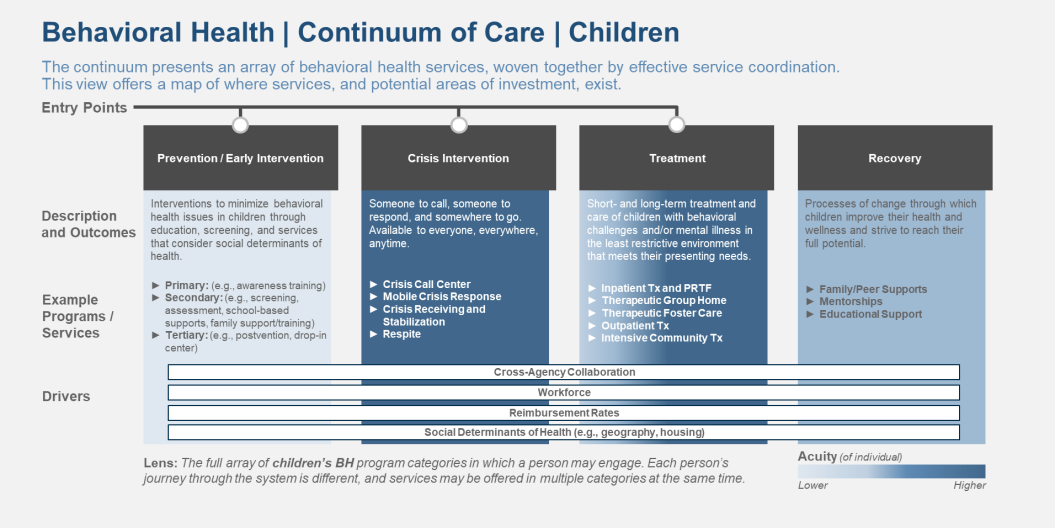
Julia Hamilton
Fiscal Analyst I

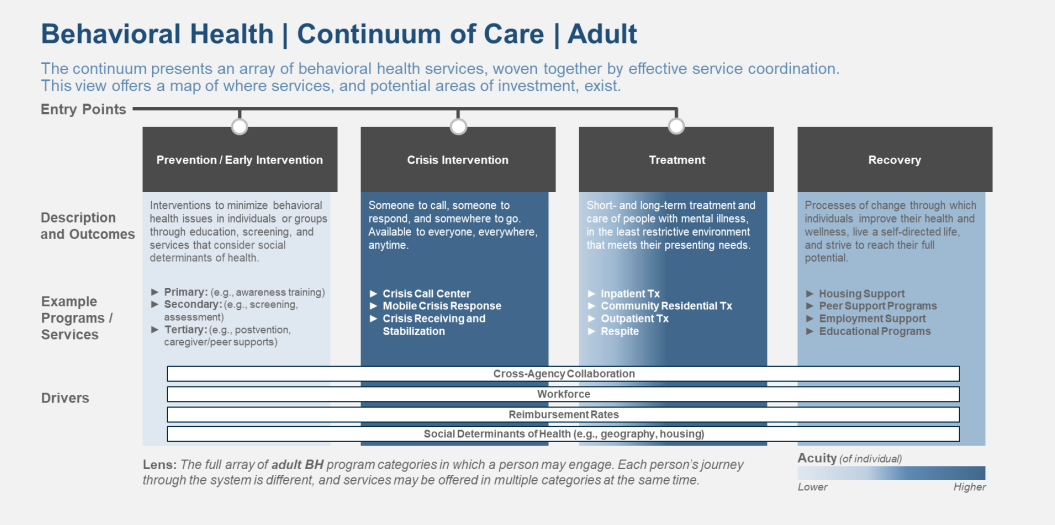
Appendix

Appendix A: BHSFG Commission Meetings

- **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 Recommendations
- **May 20, 2024:** BHSFG Meeting #9
- **June 27, 2024:** BHSFG Meeting #10

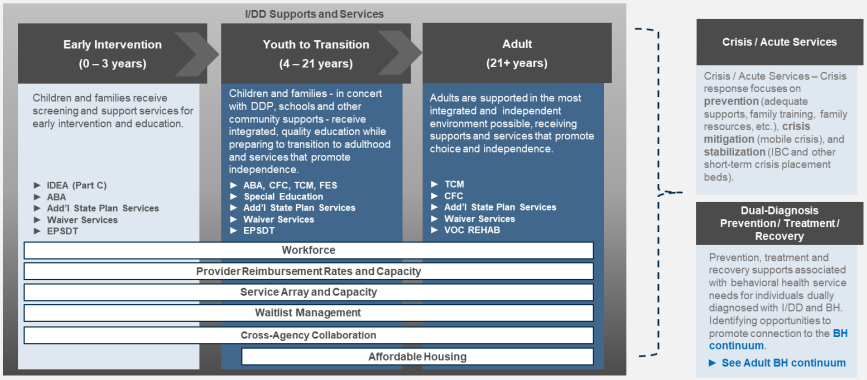
Appendix B: Behavioral Health and Developmental Disabilities Continuum of Care





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.*