Mississippi Children's Behavioral Health Needs Assessment

Findings and Recommendations

The Institute for Innovation & Implementation at
the University of Maryland School of Social Work

and the Technical Assistance Collaborative

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ACKNOWLEDGMENTS

This report was a significant undertaking, particularly for the Department of Mental Health and the Division of Medicaid, who worked within a very short timeframe to identify and assemble documents, and to provide data for the analysis. We want to recognize their cooperation, responsiveness and assistance throughout the process.

We appreciate the candidness of providers and stakeholders who spoke with us; and the flexibility provided us in meeting during our site-visits. The range of issues queried, system challenges discussed, and opportunities identified were possible because of the time offered by providers and stakeholders.

We are indebted to the families and youth who shared very difficult, personal information in an effort to improve the behavioral health system for others. While all who contributed to the report have a valid and valuable perspective, it is the feedback from persons who utilize the system that must guide priorities and actions.

Reports of this nature are difficult, particularly as the purpose is to identify challenges that need to be addressed. Challenges identified in this report should not diminish the work of the dedicated state staff, stakeholders and providers we encountered. Rather, we hope it will provide purpose and direction to the many dedicated people we encountered to cooperatively address those challenges.

EXECUTIVE SUMMARY

INTRODUCTION

In 2011 the U.S. Department of Justice (DOJ) launched an investigation of the State of Mississippi's system for delivering services and supports to individuals with mental illness and/or developmental disabilities. As it relates to children, DOJ found that Mississippi fails to provide medically necessary services to children with disabilities in violation of the Social Security Act's Early Periodic Screening Diagnosis and Treatment (EPSDT) mandate. As a result, many Medicaid-eligible children do not have access to home and community-based mental health and substance use disorder services and enter psychiatric facilities when they could be served in the community if such services were available. In addition to non-compliance with EPSDT, DOJ found that the state's failure to serve youth in the most integrated settings appropriate to their needs violates Title II of the Americans with Disabilities Act (ADA).

In an August 29, 2014, letter of agreement, Mississippi and DOJ agreed to engage in intensive negotiations for the purpose of reaching a comprehensive settlement agreement to resolve DOJ's claims relating to services for children with mental health conditions. As part of these negotiations, the state agreed to contract with consultants from the Technical Assistance Collaborative (TAC)/The Institute for Innovation & Implementation housed at the University of Maryland (The Institute) to conduct an assessment of Mississippi's children's behavioral health system and identify recommendations for system improvements.

METHODOLOGY

The assessment was conducted over an eight-week period from October 2014 to December 2014. TAC/The Institute's approach to information gathering for this assessment was twofold: 1) A quantitative analysis of Mississippi Medicaid and DMH participant characteristics, claims, and encounters; and 2) An in-depth qualitative analysis of all relevant documents, selected records of youth's care and interviews with stakeholders, youth and adult consumers, family members, associations, advocacy groups, and state personnel. Specific methods included:

- Analysis of populations served, service utilization, Medicaid claims and expenditures, quality data, and other system indicators from DOM and DMH.
- Review of one hundred two (102) state documents.
- Review of eighteen (18) client records.
- Discussions with two hundred eighteen (218) key informants.

LIMITATIONS/CONSTRAINTS

This assessment faced several limitations and constraints. First, the agreement between MS and DOJ required a very rapid timeline for this project. The assessment began in late September 2014, with a first draft of the report due in January 2015, and a final report due in February 2015. While DMH and DOM worked rapidly to provide the range of documents and data requested, the condensed timeframe limited the scope to DMH and DOM expenditures and activities. As a result, a broader cross-system review of other important behavioral health expenditures and activities conducted by the state, in child welfare, juvenile justice, education and public health, could not be included.

Additionally, data related to the uninsured or those privately insured, to physical health and primary care clinician behavioral health screenings, or pharmacy data were also not part of this review. Finally, Medicaid claims data were presented by the Mississippi Division of Medicaid in aggregate form only and were not broken out by demographic variables (e.g., race, ethnicity, gender, age, etc.). Consequently, data pertaining to behavioral health disparities among underserved and minority populations were not analyzed.

MAJOR FINDINGS

CHAPTER 1: MEDICAID DATA

TAC/The Institute conducted an analysis of five years of Medicaid fee for service claims data (2010-2014) and two years of managed care data (2013-2014, coinciding with the implementation of managed care for behavioral health services in Mississippi).

Results of this analysis indicated that, while only a minority of claims is for institutional placements, these claims represent a disproportionately large share of expenditures. It is concerning that spending and utilization of institutional care have increased over the past few years.

Mississippi has the opportunity to serve many more youth in less restrictive and more integrated settings by promoting greater use of services, such as mobile crisis intervention, crisis stabilization, intensive outpatient program (both MYPAC and as a step-down from MYPAC), and peer support. More effective use of these services could help divert youth from placement in costly institutional settings. While utilization and expenditure trends for HCBS services are largely in the right direction, continued work is needed to promote greater uptake of these services in Mississippi.

OVERVIEW OF MEDICAID DATA

- In FY 2014, Mississippi Medicaid spent a total of $184,485,255 on children's and youth's behavioral health services, or $1,183 per child receiving behavioral health care. Nationally, mean expenditure for children in Medicaid using behavioral health services was $4,400 in 2008 (the most recent year for which comparable national data are available).[1]
- Overall spending has decreased over the last four years by about 13% since FY 2010.

INSTITUTIONAL CARE UTILIZATION AND EXPENDITURES

- Forty-nine percent (49%) of Medicaid child behavioral health dollars in FY 14 were spent on services provided in institutional settings. Nationally, in 2008, 28.3% of child behavioral health dollars spent by Medicaid were spent on inpatient or psychiatric residential services.
- Spending for psychiatric residential treatment facilities and inpatient psychiatric hospitals increased by 11% and 6%, respectively, from FY 2010 to FY 2014.
- Among the institutional services, inpatient psychiatric hospitals experienced the greatest increases in the number of unduplicated utilizers. There was an increase of approximately 22% in the number of youth who utilized inpatient psychiatric hospitals from FY 10 to FY 14.
- In FY 10, there was a 10% increase in the number of youth who utilized psychiatric residential treatment facilities. Utilization remained steady from FY 11 to FY 14.

HOME- AND COMMUNITY-BASED UTILIZATION AND EXPENDITURES

- Among the home- and community-based service expenditures, significant amounts (over $1 million in a given year) are spent on assessment, community support, day treatment, individual therapy, intensive home-based treatment (MYPAC), and targeted case management; while relatively small amounts (under $1 million in a given year) is spent on services such as mobile crisis, crisis residential, peer support, and intensive outpatient.
- Despite declines in day treatment utilization, nearly a quarter of HCBS dollars continues to be spent on day treatment.
- There was a 64% increase in spending on MYPAC intensive home-based treatment from FY 10 to FY 14, with declines from FY 13 to FY 14, despite increases in claims and utilizers.
- In FY 14, there were almost $1 million in claims for crisis services, compared to approximately one-quarter of a million dollars in FY 12. This is a positive trend; however, in FY 14, only a small fraction of

[11]1 S. Pires, K. Grimes, T. Gilmer, K. Allen, and R. Mahadevan. "Examining Children's Behavioral Health Service Utilization and Expenditures." *Center for Health Care Strategies*. December 2013. Available at: **www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3/**

Medicaid beneficiaries' utilized crisis residential or mobile crisis services, suggesting a need to promote availability of these services among potential referral sources, including youth and families.

- An analysis of place of service data for community-based services revealed that in FY 2013, spending on services delivered in the home surpassed spending on services that occurred within the CMHC's offices, increasing by 21% from FY 10 to FY 14. This is an important finding, given the state's goal to increase service provision in homes and other community settings, rather than offices.

CHAPTER 2: EXPANDING THE HOME- AND COMMUNITY-BASED SERVICE ARRAY

Chapter 2 offers an analysis of Mississippi's current HCBS benefit array, including design, operational policies and procedures, and utilization. It goes on to describe services that should be available in robust benefit design for youth, and offers recommendations to improve Mississippi's benefit design and operations. TAC/The Institute's review of Mississippi's HCBS service array found the following:

- While some providers are utilizing functional assessment tools, there is no common system-wide assessment being used to identify the service and support needs of youth or to measure system performance across providers and levels of care.
- A range of services, including some evidence-based practices and best practice approaches, are covered in Mississippi for those that are Medicaid enrolled or receiving DMH funded services. These services include crisis, wraparound, certain outpatient EBPs, respite, and flexible funding from DMH sources through the Making A Plan (MAP) team process. These services need to be grown and expanded further, and their outcomes monitored, so that rapid system and program adjustments can be made to achieve the intended benefit.
- Given how intensive care coordination and intensive family-based therapy are currently defined, it is not clear the extent to which these services are available.
- Services that are not currently covered are therapeutic mentoring, a substance use service continuum for youth, and supported education, vocational, and housing supports for transition-age youth. The availability of these services will help Mississippi achieve its goal to successfully address the behavioral health needs of youth. The benefit array is geared towards mental health treatment, with a limited array of substance use treatment services available.
- Additional infrastructure within the DMH and the DOM, as well as in providers, are necessary to support effective service delivery. These include additional training investment in family-centered EBPs and additional system infrastructure for quality monitoring and data collection and analysis to inform policy decisions.
- Mississippi has worked to meet the needs of special populations, such as transition-age youth and youth experiencing traumatic stress. These efforts are important and the state needs additional resources to expand such efforts to other populations that drive costs in the system, such as the foster care population; and to monitor and address any health disparities based on race, ethnicity, gender, and age.
- The components of the intensive care coordination using wraparound are optional; and the IOP service definition does not fully align with an intensive in-home family-based therapy definition. It is not clear what has been defined to bundle together to make a MYPAC level of care and an IOP level of care. Both MYPAC and IOP use the same state plan definition, yet each service is intended to be a different program, meeting different needs of different populations. Technical assistance and guidance offered to providers to date has not helped them to understand the state's expectations regarding the use of the new rehabilitation services, how to become a provider of these services, and how to bill for these services.
- Referrals to IOP have been slower than estimates of need would indicate. Reasons cited for this include: lack of awareness about the availability of this service among potential referral sources; some referral sources found wait times upon making a referral, thus some sources believed that making further referrals was futile; current level of care criteria and admission processes (specifically the psychiatric evaluation and IQ test requirements) critically delay access to this service; the bundled payment methodology has also created certain disincentives that limit interest of CMHCs and families in participating in IOP.

- The addition of mobile crisis to the service array is a positive development in Mississippi's system; its potential as an intervention to divert youth from more restrictive settings is not yet realized, and additional investments are needed in this critical service area.
- Mississippi's CSU operates similarly to an acute inpatient unit with reported lengths of stay of approximately 14 days, as opposed to a crisis stabilization unit, which would suggest a 2-3 day intervention intended to quickly stabilize the crisis and return the youth to their home and local schools.
- Respite is a service desired by many families, but access and availability of this service is limited. Currently, the Making A Plan (MAP) team process has access to limited funds from the DMH to purchase respite impacting the extent of its use in Mississippi.
- The capacity of institutions to use family-centered practices that ensure connection to family and community varied across the state.
- While providers report great success with peer support in substance use residential programs, crisis stabilization, and mobile crisis services, its use in providing support, systems navigation, and enhancing engagement among caregivers and young adults' remains relatively limited.

CHAPTER 3: PROVIDER CAPACITY

Chapter 3 highlights critical provider capacity issues facing Mississippi, details provider and workforce capacity information and trends, and discusses results of the various key informant interviews. The assessment of provider capacity included an evaluation of the available behavioral health workforce and its ability to competently deliver services and supports to youth with behavioral health challenges in home and community-based settings.

- The workforce shortage issues facing Mississippi have limited the capacity of community providers to serve youth and families. Child psychiatrists and mental health professionals with child-specific training and expertise were cited as factors contributing to access to care issues for youth and families in community settings. This is further hampered by the rural nature of the state, making it difficult to provide care and reach certain geographic locations.
- While wait time information is an important indicator of provider capacity, the state does not systematically gather information to monitor this issue reported by its stakeholders.
- Telehealth in Mississippi has grown with respect to its use in primary care and other medical specialties, yet was used by few behavioral health providers. There was a lack of information and awareness about available opportunities to expand tele-psychiatry among the CMHCs and IOP providers.
- Physicians are prohibited from entering into a collaborative agreement with an advance practice registered nurse (APRN) whose practice location is greater than 40 miles from the physician's practice site, and physicians may not enter into collaborative agreements with more than four APRNs at any one time. Given the rural nature of Mississippi, these requirements may limit the potential of APRNs to provide psychopharmacology to youth who may require it.
- DOM and DMH recently partnered to develop a training center for Wraparound Facilitation Training and Coaching. This is a critically important initiative and one that the state should be commended for undertaking. Stakeholders reported positive experiences with the training provided but expressed that greater family involvement in the design, development, and delivery of these trainings was needed.

- DMH's peer support specialist certification program is another positive area of workforce development. While the certification process established by DMH and the inclusion of peer support in the state's rehabilitation option is extremely positive, efforts need to address caregivers of youth with behavioral health challenges or young adults.

- While there are a total of nine certified providers of Wraparound and eight certified IOP providers, three providers delivered almost 97% of Wraparound facilitation services as of the end of FY 2013. CMHC providers offered that the low reimbursement rates for Wraparound facilitation and IOP have limited their interest in delivering these services.

- Uncompensated care is another issue constraining provider capacity in Mississippi. While the state's network of CMHCs are required by DMH to deliver a number of "core" services, providers report that the funding contributed by the state and the counties do not adequately cover the costs of delivering these services. DOM and DMH have offered to conduct a rate study on services this offer was reportedly declined by the Mississippi Association of Community Mental Health Centers.

- There appears to be great inconsistency and variation across the state with respect to the understanding of the different Medicaid service requirements, how to bill, and what is and is not allowable.

CHAPTER 4: QUALITY

Guided by standards published by the Institute of Medicine, in Chapter 4, TAC/The Institute evaluated Mississippi's approach to ensuring that care delivered to youth is of high quality. Major findings included:

- Mississippi's current approach to quality has largely focused on monitoring provider adherence to regulations established by DMH and DOM. The exception to this is the On-Site Compliance Review (OSCR) process established to monitor provider compliance and quality of care in the MYPAC and PRTF programs. DOM plans to implement an OSCR process across all mental health programs.

- With the exception of MYPAC and PRTF, Mississippi has not yet deployed a systemwide quality improvement process that uses both qualitative and quantitative data to drive changes to the care delivery process. This type of approach requires data infrastructure and staff resources that DOM and DMH do not have at this time. Without this infrastructure, DMH and DOM will be hampered to fully implement needed changes in their system.

- Our review found there is no systematic review of data across child systems to inform statewide planning or to identify quality of care issues requiring attention. There is an obvious need for investments in establishing data collection and reporting mechanisms, identifying key quality indicators and metrics that can be used to evaluate performance, and connecting results to performance improvement activities and initiatives.

- In sum, Mississippi's performance against many of those key indicators of quality described by the IOM, such as timeliness, effectiveness, efficiency, and family-centeredness, suggests the need for improvements in multiple areas in order to improve outcomes and care for the youth and families served by its public mental health system.

CHAPTER 5: INTERAGENCY COLLABORATION

Interagency collaboration and governance is a prerequisite for building an effective system of care and ensuring that children and youth have the services and supports necessary for remaining at home and in their communities. In Chapter 5, TAC/The Institute reviewed: the extent to which Mississippi's existing policies, structures, and procedures support interagency collaboration and coordination; limitations or barriers to

effective interagency collaboration; and the connection between agency-level policy priorities and client-level barriers and needs identified at a local level. Results of this analysis were:

- Mississippi's System of Care legislation enacted in 2010 provides a clear and impressive framework for establishing a three-tiered interagency governance structure. However, it has not been implemented with the desired intent at the state level.

- DOM is not able to manage a significant cost driver in its program, institutional care. This creates significant challenges for an agency that needs to control the Medicaid budget; and impacts the ability of DMH and DOM to redirect institutional placements with appropriate home- and community-based options. Instead, they manage lower cost services, in which only nominal savings can be achieved.

- There is disparate administration and financing of major components of the system across child welfare, juvenile justice, education, and public health. This has exacerbated the inherent differences between the roles of state agencies, has diffused accountability for the overall performance of the children's behavioral health system, and has perhaps created unintended incentives for cost- or care-shifting between systems and providers.

- The ICCCY, established to align child-specific issues, has not been implemented per the legislation, and the group has not convened since 2012. In addition, the ICCCY does not have authority to impact policy and funding decisions across all public service sectors.

CHAPTER 6: REDIRECTING INSTITUTIONAL CARE

Both institutional settings and home and community-based settings serve important functions in every behavioral health system. Chapter 6 evaluates: the balance of services, access, and utilization across community-based and 24-hour services, what system structures, policies, and procedures are in place to monitor appropriate use of restrictive settings, and whether any cross-system issues impact the use of restrictive settings over community-based options. Major findings included:

- Currently, the behavioral health system in Mississippi is weighted towards institutional settings. The majority of DMH dollars and DMH staffing, along with Medicaid and child welfare expenditures, are locked into maintaining institutions.

- Mississippi spends a greater proportion on institutions compared to national Medicaid expenditure data. In State Fiscal Year 2014, expenditures for psychiatric residential treatment facilities accounted for 26 percent of total Medicaid mental health spending, 7 percentage points higher than the national average.

- The average cost per user of residential was $49,000 in SFY 2014, more than double the national average. Spending on inpatient psychiatric services (including inpatient medical surgical) was greater than the national average, accounting for 24 percent of total mental health Medicaid expenditures in SFY 2014 (compared to 5 percent nationally).

- DMH spent $28.6 million on state mental health hospitals for children and youth, compared to a national average of $11 million. Per capita spending for state hospitals was the second highest in the country. In contrast, only $69 million was spent on community-based programs, compared to a national average of $179 million.

- The average length of stay for children receiving treatment at Oak Circle was 47.2 days in FY 2014, while the average stay for youth receiving psychiatric and substance abuse treatment at the Bradley Sanders Complex in FY 2013 was 125 and 87 days respectively. This level of service utilization exceeds the targeted length of state hospital service in most states.

- Mississippi is the only state in the country where inpatient care is left out of Medicaid managed care when managed care is utilized. This substantially limits the capacity for CCOs to prevent unnecessary hospitalizations, coordinate discharges, and arrange warm hand-offs.

- As previously stated, there is limited community-based alcohol and drug residential treatment beds accessible for publicly funded youth in Mississippi.

- Mobile crisis response was recently expanded, and its potential to divert children from institutional placements has not yet been realized. Additional investments in marketing the service, and supporting provider practice and system infrastructure, are needed.

- The role of courts as an opportunity to engage youth in appropriate treatment was repeatedly mentioned by those interviewed. For families and youth that had such experiences, they frequently indicated that they needed help but were not sure how to get the right help.

RECOMMENDATIONS

TAC/The Institute used the information learned during the environmental scan, empirical knowledge of best practices, systems expertise, and data analysis to develop a list of actionable short- and long-term recommendations for Mississippi to implement. These recommendations include:

EXPAND THE HOME- AND COMMUNITY-BASED SERVICE ARRAY

Recommendations in this chapter focus on implementing an effective benefit array across Medicaid and DMH. Streamlining and enhancing key components of Mississippi's HCBS benefit, including MYPAC/IOP, mobile crisis response and stabilization services, and other HCBS services based on national models, is necessary to support greater opportunities for youth to thrive in integrated community settings.

1. Review screening policies and data.
2. Implement a standardized assessment tool, and incorporate it into level of care determinations.
3. Further invest and develop a cohesive approach to mobile crisis response and stabilization, including issues related to call center capacity, availability, community education, training in best practices, stabilization capacity, warm-line capacity, allowable providers and other infrastructure.
4. More clearly define intensive care coordination, differentiate services that are bundled together, address MYPAC-specific requirements that impact access, address rate issues and allow reimbursement for coordination, and expand training efforts.
5. More clearly define in-home family-based therapy, differentiate services that are bundled together, address access, address rate issues and allow reimbursement for coordination, and implement an evidence-based training effort specific to in-home family-based models (e.g., multisystemic therapy, or MST).
6. Explore opportunities to expand respite and goods and services (flexible) funding.
7. Establish policies that support family-centered practice and effective transitions from institutional settings, and training for institutional staff in wraparound.
8. Expand SUD services for youth.
9. Further develop caregivers as peer workforce, and implement a caregiver support certification process.
10. Further support efforts for outpatient programs in EBP training and fidelity monitoring.
11. Continue to promote trauma-informed practices across the system.
12. Identify sustainable funding for transition-age youth services.
13. Implement a strategy to ensure access to HCBS for children that are not eligible for Medicaid.

ENHANCE AND EXPAND PROVIDER CAPACITY

1. Develop a provider network management strategy.
2. Review rates to ensure adequate coverage of transportation costs in service rates.
3. Improve access to child psychiatry services in the community.

4. Align staff credentials to their position responsibilities.
5. Review APRN Collaborative Agreement Requirements.

IMPROVE AND MONITOR QUALITY

1. Create a children's behavioral health quality dashboard.
2. Obtain regular feedback from youth and families about system performance.
3. Establish systems to help identify youth in need of services and make families aware of available behavioral health services.
4. Require the UM/QIO and MCOs to engage in at least one children's behavioral health performance improvement project annually.
5. Establish an on-site quality and compliance review process for state hospital facilities.
6. Establish strategies for rapid notification of CCOs and providers about admissions and discharges at 24-hour levels of care.
7. Publish an annual statewide report of findings from MAP teams.

PROMOTE INTERAGENCY COLLABORATION

1. Establish a Children's Cabinet.
2. Facilitate interagency collaboration.
3. Further empower MAP teams.

REDIRECT INSTITUTIONAL CARE

1. Redirect care towards increased use of HCBS and decreased use of institutions.
2. Include the institutional benefit into Medicaid managed care strategies.
3. Conduct an immediate review of all institutionalized youth.
4. Conduct ongoing reviews of youth at risk for institutional placement.
5. Redirect expertise of institutional staff towards needed community-based care.
6. Promote mental health collaboration in youth and chancery courts.
7. Revisit Inclusion of Treatment Foster Care as a Medicaid Benefit

INTRODUCTION

DOJ INVESTIGATION AND FINDINGS

In 2011 the U.S. Department of Justice (DOJ) launched an investigation of the State of Mississippi's system for delivering services and supports to individuals with mental illness and/or developmental disabilities. Their review found that the State of Mississippi failed to meet its obligations under Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § § 12131-12134, and its implementing regulations, 28 C. F. R. pt. 35, by unnecessarily institutionalizing individuals with mental illness or developmental disabilities in public and private facilities, and failed to ensure that they are offered a meaningful opportunity to live in integrated settings consistent with their needs. Specifically, DOJ found the state in violation of Olmstead v. L.C., 527 U.S. 581 (1999), which requires that individuals with mental illness and developmental disabilities receive services and supports in the most integrated setting appropriate to their needs.

As it relates to children, DOJ found that Mississippi fails to provide medically necessary services to child with disabilities in violation of the Social Security Act's Early Periodic Screening Diagnosis and Treatment (EPSDT) mandate. As a result many Medicaid-eligible children do not have access to home- and community-based mental health and substance use disorder services and enter psychiatric facilities when they could be served in the community if such services were available. In addition to non-compliance with EPSDT, DOJ found that the state's failure to serve youth in the most integrated settings appropriate to their needs violates Title II of the Americans with Disabilities Act (ADA).

In an August 29, 2014, letter of agreement[2], Mississippi and DOJ agreed to engage in intensive negotiations for the purpose of reaching a comprehensive settlement agreement to resolve DOJ's claims relating to services for children with mental health conditions. These negotiations include counsel for the Troupe plaintiffs[3] and an attempt to resolve the Troupe claims within the agreement. The State also agreed to contract with consultants from the Technical Assistance Collaborative (TAC)/The Institute for Innovation & Implementation housed at the University of Maryland (The Institute) with system expertise in successfully serving children with significant behavioral health needs in community settings. TAC is a national nonprofit organization that provides policy leadership, technical assistance and consultation for many federal, state and local government agencies on such topics as mental health, substance use, developmental disabilities, child welfare, juvenile justice, homelessness, and affordable housing systems. The Institute is a national technical assistance center addressing policy, systems design, financing, training, technical assistance, and evaluation. The Institute works with federal agencies, states and localities, foundations and private organizations to design, implement, and evaluate effective systems and practices to best meet the needs of children and youth with complex behavioral needs and their families.

The primary role of TAC/The Institute identified in the August 29, 2014, letter was to assist the State and DOJ during settlement discussions by assessing the State's current service array, quality, and availability, and make recommendations for necessary improvements. Per the agreement between the State and DOJ, any final settlement would contain provisions that address, at a minimum, the following issues:

- Wraparound facilitation, implemented in fidelity to the national model;
- Flexible, intensive home- and community-based services per national models;

[2] Letter of Agreement between Mississippi Attorney General and the U.S. Department of Justice, August 29, 2014.

[3] In 2010, a lawsuit was filed in the United States District Court for the Southern District of Mississippi on behalf of the class of Mississippi Medicaid-eligible children with behavioral health disorders. The lawsuit, Troupe v. Barbour, alleged that Mississippi systematically failed to meet the needs of children and unlawfully placed them in institutional settings that did not provide adequate services. It also claimed that Mississippi failed to make available federally mandated and medically necessary home- and community-based behavioral health services and violated the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act.

- Mobile crisis intervention and stabilization for all children who are at serious risk of institutionalization, including those who are receiving intensive home- and community-based services;
- A process through which the State will identify all children who are institutionalized or at serious risk of institutionalization and ensure the availability of these services for the children who need them; and
- Provisions to expand and improve provider capacity.

METHODOLOGY

TAC/The Institute were engaged by Mississippi Leadership to conduct an assessment of Mississippi's children's behavioral health system and identify recommendations for system improvements. This Needs Assessment was conducted over an eight-week period from October 2014 to December 2014. TAC/The Institute's approach to information gathering for this assessment was twofold: 1) A quantitative analysis of Mississippi Medicaid and DMH participant characteristics, claims, and encounters; and 2) An in-depth qualitative analysis of all relevant documents, selected records of youth's care, and interviews with stakeholders, youth and adult consumers, family members, associations, advocacy groups, and state personnel.

TAC/The Institute applied a multifaceted approach to gathering information, including conducting a literature review, synthesizing quantitative and qualitative data, interviewing stakeholders and key informants, and applying TAC/The Institute's extensive expertise analyzing similar data in other states. Specifically, methods included:

- Analysis of populations served, service utilization, Medicaid claims and expenditures, quality data, and other system indicators from DOM and DMH.
- Review of one hundred two (102) state documents.
- Review of eighteen (18) client records.
- Discussions with two hundred eighteen (218) key informants.

The state provided quantitative data from DMH and DOM. Data from DMH included Substance Abuse and Mental Health Services Administration (SAMHSA)-mandated State Mental Health Authority Uniform Reporting System (URS) tables, as well as enrollment and utilization of state psychiatric hospitals, therapeutic group homes and therapeutic foster care, and crisis intervention services.

DOM provided five years of Medicaid fee for service claims data (2010-2014) and two years of managed care data (2013-2014, which coincided with implementation of managed care in MS). These data included Medicaid enrollment, utilization, place of service and expenditures for behavioral health services. A listing of claim/encounter fields received can be found in the Attachments.

TAC/The Institute reviewed documents and literature from a variety of sources, including DMH, DOM, Department of Human Services (DHS), Department of Health, and the Department of Education. The State identified and provided numerous legislative and other reports, policy, quality, and procedural documents for review. In total, one hundred two (102) documents were provided from DMH and DOM. These documents offered details on system indicators and issues being tracked by the programs, and policy and quality issues identified and monitored by leaders in various state agencies. A listing of documents provided can be found in the Appendix.

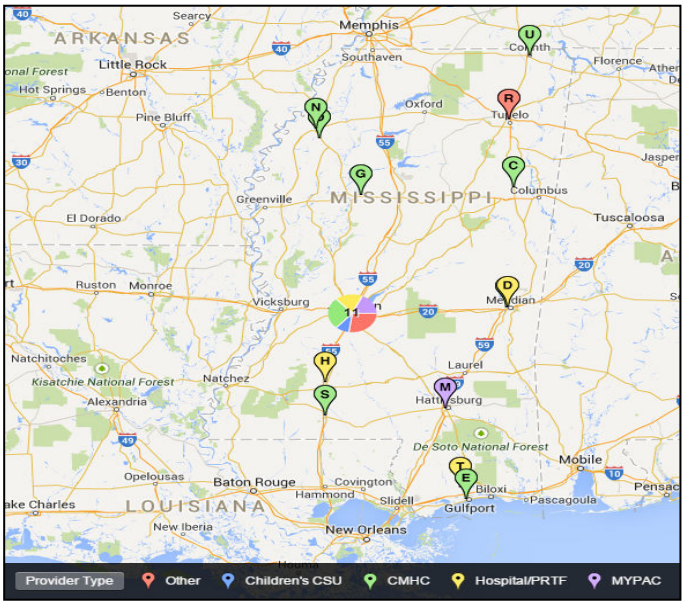
A review of approximately eighteen (18) clinical records of youth served in the behavioral health system was also conducted to evaluate the appropriateness of services utilized by youth, admissions and discharges from services, and coordination across services and child-serving systems. Records selected included samples from children presented to the statewide Making A Plan (MAP) team, children served by each of the three Mississippi Youth Program Around the Clock (MYPAC) providers post the 2012 migration of that service from the Medicaid waiver to coverage under the state plan, and records of children that had at least two

institutional placements and were not enrolled in MYPAC. Records reflected regional variation across the state, and included information from across the provider system for those youth. The sample of records is too small to generalize in an empirical way to the broader system; however, the review did provide a snapshot of system interface, provider response, and planning of care that cannot be gleaned from claims analysis.

A significant part of the qualitative analysis involved engaging and interviewing an exhaustive list of stakeholders. TAC/The Institute conducted interviews with two hundred eighteen (218) people individually or in small focus groups. These individuals included youth, adult consumers and families, providers, state personnel, Medicaid's MississippiCAN vendors called Coordinated Care Organizations (CCOs), and its Medicaid fee for service utilization management and quality vendor (UM/QIO), advocates, and associations. Key informants were identified using a "snowball" identification process, where State officials and DOJ identified an initial group of key informants for each of the identified topic areas, and this initial group of informants identified additional subject matter experts, and so on. Interviews were confidential and were not conducted in the presence of DMH or DOM staff, with the exception of a state hospital site-visit and the CCO interviews. A complete listing of key informants can be found in the Appendix. Please note that names of current consumers and some family members are not included in order to maintain their confidentiality as service recipients; however, they are included in aggregate numbers. Note that during the course of interviews with recipients of care, TAC/Institute did not collect specific information from individuals interviewed, including specific services that were received and the time frame (dates) in which those services were received.

Interviews with key informants took place telephonically and via two site-visits. The first site-visit occurred from October 21 to October 23 and included meetings with state leadership from DMH, DOM, and DHS, MYPAC providers, mobile crisis and stabilization providers, focus group at MS Families as Allies, and Community Mental Health Center (CMHC) leadership. The second site-visit took place from November 1 to November 11 and consisted of visits to a statewide sample of behavioral health service providers, including state psychiatric hospitals, psychiatric residential treatment facilities (PRTFs), MYPAC providers, CMHCs, crisis stabilization units (CSUs), therapeutic group home and foster care providers, and the Mississippi Adolescent Center, a facility that primarily serves children and youth with intellectual and developmental disabilities. In all, TAC/The Institute visited 22 total providers and 25 provider sites located throughout the state. The map below indicates the location of providers visited; and a complete listing of the providers visited can be found in the Appendix. Specifically, providers visited included all three (3) MYPAC providers, 79 percent of CMHCs, both state psychiatric hospitals serving children and youth, the one CSU provider for children, and 25 percent of in-state PRTFs. The themes that emerged from these meetings, interviews, and reviews of written materials are included throughout this report.

Provider Site-Visit Locations



TAC/The Institute used the information learned during the environmental scan, empirical knowledge of best practices, systems expertise, and analysis of MS data to develop a list of actionable short- and long-term recommendations for Mississippi to implement. These recommendations include:

1. *Expanding the Home- and Community-Based Service Array.* Recommendations in this chapter focus on implementing an effective benefit array across Medicaid and DMH. This chapter identifies methods to streamline and enhance key components of Mississippi's HCBS benefit, including IOP, mobile crisis response and stabilization services, and other HCBS services based on national models.
2. *Expanding Provider Capacity.* This chapter also addresses Mississippi's workforce shortages and explores provisions to expand and improve provider capacity, including psychiatry, licensed staff, credentialed staff, and use of peers.
3. *Improving and Monitoring Quality.* This chapter identifies quality priorities, and necessary processes and measures to promote quality across the children's behavioral health system.
4. *Promoting Interagency Collaboration*. This chapter addresses governance structures, interagency priorities and processes to build an effective system that promotes behavioral health for all Mississippi youth.
5. *Redirecting Institutional Care*. This chapter includes recommendations that primarily address DOJ's concern of ensuring a process through which the State identifies all children who are institutionalized or at serious risk of institutionalization, including front door, tracking, and policies with other systems.

LIMITATIONS/CONSTRAINTS

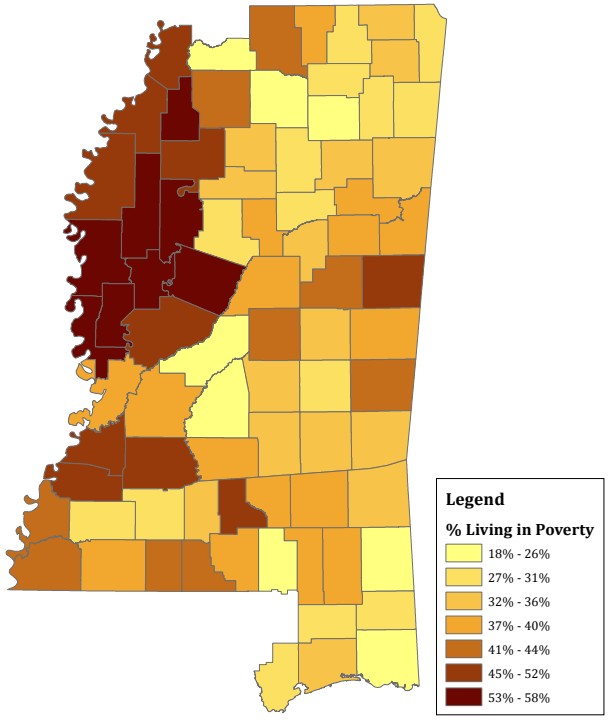
This assessment faced several limitations and constraints. First, the agreement between MS and DOJ required a very rapid timeline for this project. The assessment began in late September 2014, with a first draft of the report due in January 2015, and a final report due in February 2015. While DMH and DOM worked rapidly to

provide the range of documents and data requested, the condensed timeframe limited the scope to DMH and DOM expenditures and activities. As a result, a broader cross-system review of other important behavioral health expenditures and activities conducted by the state, in child welfare, juvenile justice, education, and public health, could not be included. Additionally, data related to the uninsured or those privately insured, to physical health and primary care clinician behavioral health screenings, or pharmacy data were also not part of this review. Finally, Medicaid claims data were presented by the Mississippi Division of Medicaid in aggregate form only and were not broken out by demographic variables (e.g., race, ethnicity, gender, age, etc.). Consequently, data pertaining to behavioral health disparities among underserved and minority populations were not analyzed.

STATE CONTEXT

There are 909,608 children and youth ages 0 to 21 residing in Mississippi. An estimated 51 percent of children are male and 49 percent are female. About 49 percent of the childhood population is Caucasian, 43 percent African American, and 4 percent Hispanic or Latino[4]. The unemployment rate among adults is about 9 percent, the third highest in the country[5], and 32 percent of high school students do not graduate on time, the second highest rate in the country[6]. An estimated 44.8 percent of children live in single-parent households. In addition, approximately 34 percent of Mississippi's childhood population lives in poverty, the highest rate in the country, with about 17 percent of children living in extreme poverty (50 percent below the Federal Poverty Line). An estimated 28 percent of children live in areas of concentrated poverty (the highest in the country by 6 percentage points). Minority groups are disproportionately represented in these areas, with 47 percent of African American and 23 percent of Hispanic or Latino children living in high poverty areas, compared to 28 percent of Caucasian children.[7]

Percent of Mississippi Children Living in Poverty, By County



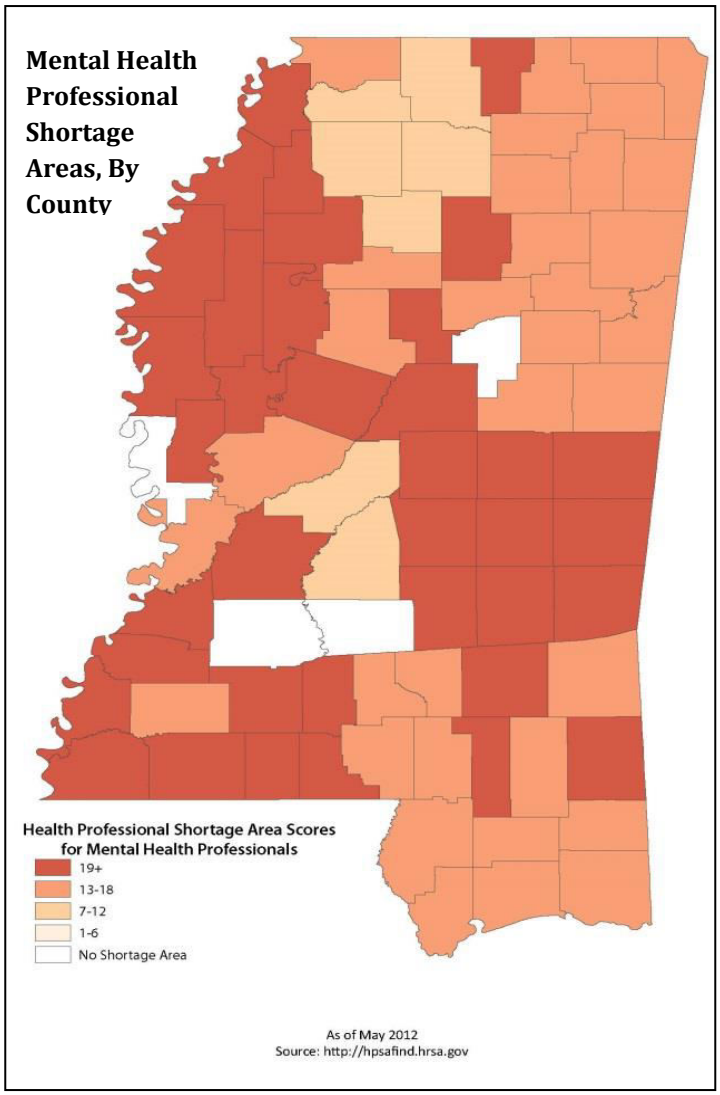
[4]U.S. Census Bureau, [2009-2013] American Community Survey

[5]U.S. Department of Labor, Bureau of Labor Statistics (BLS). Local Area Unemployment Statistics, Annual Average, "Unemployment rates for states" [2013]

[6]Population Reference Bureau, analysis of data from the U.S. Department of Education.
U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), State Dropout and Completion Data, accessible online at http://nces.ed.gov/ccd/drpcompstatelvl.asp.

[7]U.S. Census Bureau, [2009-2013] American Community Survey

To calculate prevalence rates of serious emotional disturbance (SED) among children and youth in Mississippi, we apply methodology issued by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services[8], which uses poverty as a proxy to provide a range of estimates of the prevalence of SED among youth ages 9 to 17. In 2013, there were approximately 369,698 youth between the ages of 9 and 17 living in Mississippi.[9] At this time, the poverty rate among youth ages 5 to 17 was 29.1 percent, the second highest in the United States (note: poverty rates specific to the 9 to 17 age group were not available).[10] This relatively high poverty rate places Mississippi in a group of states with the highest prevalence of SED in the country. It is estimated that 11 to 13 percent of the population ages 9 to 17, or 40,667 to 48,061 youth, have an SED. The estimated prevalence of the more severely impaired group of children and youth is seven to nine percent of the population ages 9 to 17, ranging from 25,879 to 33,273 youth. The prevalence rate of SED among transition-age youth ages 18 to 21, is calculated at 9.2 percent, accounting for a total of 15,840 youth. Please note that prevalence data of SED among youth younger than 9 years old were not available for this assessment.



According to the U.S. Department of Health and Human Services, National Survey of Children's Health, 20 percent of parents of children ages 2 to 17 report that a doctor told them their child has autism, developmental delays, depression or anxiety, ADD/ADHD, or behavioral/conduct problems.[11] Further, about 6 percent of Mississippi's youth ages 12 to 14 reported dependence on or abuse of illicit drugs or alcohol in the past year.[12]

[8]FEDERAL REGISTER, Volume 63, Number 137, July 17, 1998.

[9]U.S. Census Bureau. [2014]. Annual Estimates of the Civilian Population by Single Year of Age and Sex for the United States and States: April 1, 2010 to July 1, 2013.

[10]U.S. Census Bureau. [2014]. 2014 Annual Social and Economic Supplement.

[11]U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. [2011-2012] National Survey of Children's Health.

[12]Substance Abuse and Mental Health Services Administration. [2011-2012]. State Estimates of Substance Use from the 2011-2012 National Surveys on Drug Use and Health Report, Appendix B.

With about 51 percent of its population living in a rural area (compared to 19 percent nationally), Mississippi is the fourth most rural state in the country.[13] According to information from Northeast Mississippi Area Health Education Center at Mississippi State University, as of April 2012, approximately 2.1 million Mississippi residents reside in a mental health professional shortage area, with an estimated 1.1 million of those residents considered "underserved."[14] It is estimated that about 279,400 children reside in an undeserved area, accounting for approximately 38 percent of the total childhood population. In addition, Mississippi has only 4.3 child and adolescent psychiatrists per 100,000 youth, the lowest rate in the country.[15]

Mississippi's public community mental health system served 36,990 children and adolescents (0 through 21) with serious emotional disturbance in FY 2012. Of this total number of people, about 96 percent met the federal criteria for an SED. Children and youth served by the public behavioral health system were 36 percent more likely to be African American/Black and male. [16]

In 2012, Mississippi's mental health authority, the Department of Mental Health (DMH), spent about $98 million on mental health services for children ages 0 to 18, compared to a national average of $190 million.[17] Of that total, $69 million was spent on community-based programs, with a per capita spending of $93. Nationally, total spending on community-based programs for youth averaged $179 million, with an average per capita spending of $124.[18] DMH's expenditures for state mental health hospitals among youth totaled $28 million, the fourth highest in the country (the national average was $11 million). Per capita spending in this category was $38, the second highest in the country (compared to a national average of $8).[19] Table 1 on the next page displays total expenditures and per capita spending by state mental health authorities in the Southeast region of the United States.

[13]U.S. Census Bureau. [2010]. Urban, Urbanized Area, Urban Cluster, and Rural Population, 2010: United States.

[14]Northeast Mississippi Area Health Education Center at Mississippi State University. (n.d.) Healthcare Infrastructure Shortage Areas. Retrieved on November 17, 2014 from: http://nemsahec.msstate.edu/?page_id=437

[15]Substance Abuse and Mental Health Services Administration. [2012]. Behavioral Health, United States, 2012.

[16]Mississippi Department of Mental Health. [2012]. 2012 URS File.

[17]Substance Abuse and Mental Health Services Administration. [2012]. Table 13: SMHA-Controlled Mental Health Expenditures by Age Group and State: FY 2012. Retrieved from http://www.nri-incdata.org/ Data includes Medicaid match unless otherwise indicated.

[18]Substance Abuse and Mental Health Services Administration. [2012]. Table 15: SMHA-Controlled Mental Health Expenditures at Community-Based Programs, by Age Group and State: FY 2012. Retrieved from http://www.nri-incdata.org/ Data includes Medicaid match unless otherwise indicated.

[19]Substance Abuse and Mental Health Services Administration. [2012]. Table 14: SMHA-Controlled Mental Health Expenditures at State Mental Hospitals, by Age Group and State: FY 2012. Retrieved from http://www.nri-incdata.org/ Data includes Medicaid match unless otherwise indicated.

Table 1: State Mental Health Authority- Controlled Mental Health Expenditures at State Psychiatric Hospitals and Community-Based Programs for Children and Adolescents (Southeast US)

	State Psychiatric Hospitals		Community-Based Programs	
	Total (in millions)	Per Capita	Total (in millions)	Per Capita
Alabama	$0.00	$0.00	$32.55	$28.95
Arkansas	$7.31	$10.28	$4.35	$6.12
Florida	$0.00	$0.00	$88.56	$22.13
Georgia	$0.00	$0.00	$105.27	$42.28
Louisiana	$14.22	$12.73	$26.64	$23.84
Mississippi	$28.62	$38.39	$69.82	$93.68
North Carolina	$24.72	$10.81	$631.59	$276.22
South Carolina	$15.50	$14.35	$51.30	$47.51
Tennessee	$0.00	$0.00	$180.50	$120.82
Virginia	$9.60	$5.17	$113.70	$61.24

In addition to the aforementioned data from DMH, data was also provided by the Division of Medicaid. According to Mississippi Medicaid claims data for children and youth ages 0 to 21, in 2014 institutional placements accounted for nearly half (49 percent; $91.2 million) of total behavioral health spending, compared to 51 percent ($93.3 million) for home- and community-based services. The largest total amount of spending for any one service in 2014 was for Psychiatric Residential Treatment Facilities (26 percent of total spending). Other inpatient services, including psychiatric hospitalization, outpatient hospitalization, and medical surgical hospitalization, accounted for an additional 24 percent of total spending.

Mississippi served 456 youth (0.6 per 1,000 youth) ages 0 to 17 and 219 (1.6 per 1,000 youth) young adults ages 18 to 21 in state psychiatric hospitals in 2012. Nationally, these rates were 0.2 per 1,000 youth and 0.5 per 1,000 youth, respectively. In addition, the proportion of children and youth served in state hospitals compared to other age groups is higher than the national average, with about 11.8 percent of those served being youth ages 0 to 17, compared to 7.0 percent nationally.

KEY STATE AGENCIES

This next section summarizes the principal agencies (namely the Division of Medicaid and Department of Mental Health) and programs that comprise Mississippi's behavioral health system for children and youth. While it is understood that other child-serving agencies are important elements in every system of care, they will only be described insofar as they interact with the behavioral health system to keep within the scope of this needs assessment. Behavioral health treatment services purchased by agencies other than DMH and DOM were not examined.

DEPARTMENT OF MENTAL HEALTH

Mississippi's public behavioral health system is administered by the Department of Mental Health (DMH). DMH is organized into three components: The Board of Mental Health, the DMH Central Office, and DMH-operated Programs and Community Services Programs. The Board of Mental Health is responsible for governing DMH and includes a physician, a psychiatrist, a clinical psychologist, a social worker with relevant experience, and citizen representatives. The Central Office oversees administrative functions of DMH and implements policies set forth by the State Board of Mental Health. The DMH Central Office is divided into six bureaus, including the Bureau of Administration, the Bureau of Mental Health, the Bureau of Community

Mental Health Services, the Bureau of Alcohol and Drug Services, the Bureau of Intellectual and Developmental Disabilities, and the Bureau of Quality Management.

Established within the Bureau of Community Services, DMH's Division of Children and Youth Services is responsible for determining the behavioral health needs of children and youth in the state and for planning and developing programs to meet those needs. They also allocate budgetary resources and coordinate the establishment of programs. Some federal and state funds for direct community mental health services for youth are provided by grants between the DMH and the regional CMHCs and/or other public or private non-profit mental health service providers.

The components of the behavioral health delivery system include: DMH-operated programs, regional community mental health centers (CMHCs), and other nonprofit/profit service agencies/organizations that provide community services and/or institutional services.

State-operated programs. DMH-operated hospitals and facilities that serve children include:

1. Oak Circle Center at the Mississippi State Hospital, a 60-bed facility that provides acute, short-term inpatient psychiatric treatment for children and adolescents, ages 4 to 17;
2. Bradley A. Sanders Adolescent Complex at East Mississippi State Hospital, a 50-bed short-term (up to 90 days) unit that provides psychiatric and substance abuse treatment to adolescent males.
3. Mississippi Adolescent Center, a 32 -bed facility for youth with intellectual or developmental disabilities that has recently expanded to include youth with behavioral health needs; and
4. The Specialized Treatment Facility, a 48-bed PRTF for youth who have come before Youth Court and have been diagnosed with a mental disorder.

Community Mental Health Centers. The Regional Commission Act provides the structure for Mississippi's mental health service system and program development by authorizing the 82 counties to form multi-county regional commissions on mental health. Regional commissions are authorized to plan and implement mental health and intellectual or developmental disability programs in their respective areas, delivered through community mental health centers (CMHCs). There are currently 14 CMHCs operating in the State, funded by a combination of local, state, and federal dollars, forming the backbone of Mississippi's public, community behavioral health service delivery system. DMH certifies the centers to provide services and monitors state and federal dollars allocated to them via DMH. The primary goals of the CMHCs are to:

- Provide accessible services to all citizens with mental illness, and emotional and substance use disorders
- Reduce the number of initial admissions to the state hospitals
- Prevent readmissions through supportive aftercare services

CMHCs operating under the authority of regional commissions must provide the following core services for children and youth in each county in the CMHC's entire catchment area:

- Day Treatment Services
- Outpatient Therapy
- Community Support Services
- Psychiatric/Physician Services
- Emergency/Crisis Services, including mobile crisis for youth
- Pre-Evaluation Screening for Civil Commitment (for youth age 14 and over)
- Making a Plan (MAP) Teams
- Targeted Case Management Services
- Peer Support Services for adults
- Support for Recovery/Resiliency Oriented Services

Other nonprofit/profit service agencies/organizations. These programs are certified by and may receive funding from DMH, as well as other sources, to provide additional community-based or institutional services. In addition to the fourteen (14) Community Mental Health Centers, DMH certifies fifteen (15) nonprofit agencies that provide community services to children with mental health needs, and an array of providers

offering community-based substance abuse services and community services for persons with intellectual/developmental disabilities. In addition to DMH operated programs, there are eleven (11) organizations providing acute inpatient and PRTF services. It is important to note that many of these institutional providers are based on a certificate of need that is determined by the health department and approved by the state legislature.

DIVISION OF MEDICAID

The "Mississippi Administrative Reorganization Act of 1984" established the powers and responsibilities of the Division of Medicaid in the Office of the Governor. The Division of Medicaid is the single state agency designed to administer the Medicaid Program. The duties of the Division of Medicaid Agency are set out by State and Federal legislation and the approved Mississippi State Plan and include setting regulations and standards for the administration of the Medicaid programs, with approval from the Governor, and in accordance with the Administrative Procedures Law.

DOM's Office of Mental Health oversees mental health programs and it is comprised of two divisions, including Mental Health Services Division, which is responsible for:

- Acute freestanding psychiatric facilities,
- Community/private mental health centers,
- Therapeutic and evaluative mental health services for children,
- Outpatient mental health hospital services,
- Pre-admission screening and resident review,
- Psychiatric residential treatment facilities, and
- Psychiatric units at general hospitals.

The other division is the Special Mental Health Initiatives Division, which administers:

- Autism pilot program,
- Federally qualified health centers and rural health clinics,
- In-patient detox for chemical dependency,
- Intellectual disabilities/developmental disabilities,
- Mississippi Youth Programs Around the Clock (MYPAC), and
- Psychiatric services by physician or nurse practitioner.

In 2011, Mississippi implemented a coordinated care program for Mississippi Medicaid beneficiaries called the Mississippi Coordinated Access Network (MississippiCAN) under a 1932(a) State Plan Authority. Managed by the DOM Bureau of Coordinated Care, MississippiCAN employs two coordinated care organizations (CCOs), Magnolia Health Plan and United Healthcare that offer the full range of Medicaid benefits to enrollees. In 2012, mental health benefits, previously offered fee for service, were included. Coverage is available fee for services, outside of this managed care arrangement, for inpatient hospital services, Waiver services, and transportation services. MississippiCAN is available in all 82 counties, and covers 45 percent of Medicaid beneficiaries. This enrollment number is mostly adults with increased enrollment of children in CCOs planned in 2015.

Services that are left out of MississippiCAN (inpatient hospital services, Waiver services, and transportation services) are provided through Mississippi Medicaid's traditional fee-for-service system. Both non-managed care enrolled Medicaid beneficiaries and fee-for-service benefits are managed by eQHealth Solutions (eQHealth), which serves as the state's Utilization Management and Quality Improvement Organization

(UM/QIO). The eQHealth conducts prior authorizations and quality of care reviews for beneficiaries enrolled and services covered in the fee-for-service system.

In State Fiscal Year (SFY) 2014, there were 539,261 children ages 0 to 21 enrolled in Mississippi Medicaid. Of this total, 91,966 (17%) were enrolled in the state's managed care program and 447,295 (83%) were enrolled in the traditional fee-for-service program. Of those enrolled in Medicaid, 156,524 used some type of behavioral health service in SFY 2014. This number is a combined number across both managed care and fee for service, thereby duplicating the count of total utilizers[20].

There are eight hospital-based facilities (six private/nonprofit and two DMH operated) providing acute psychiatric inpatient services for children and adolescents in Mississippi. The Mississippi state legislature has placed a moratorium on the approval of new Medicaid-certified child and adolescent beds within the state. There are also a total of seven psychiatric residential treatment facilities (PRTFs) in the state (six private and one DMH-operated facility.)

Mississippi's preeminent institutional diversion program for children and youth is Mississippi Youth Programs Around the Clock (MYPAC), administered by DOM's Special Mental Health Initiatives Division. MYPAC (begun in 2007) was formerly a 1915(c) Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program and in 2014 was integrated into Mississippi's State Rehab Option as intensive outpatient psychiatric (IOP) services. Its benefit array includes a bundle of services, most notably wraparound facilitation based on a national model.

As noted earlier, along with the state's behavioral health authority, DMH, Medicaid has a significant role in providing behavioral health benefits to children. A critical component to Medicaid for youth is Early Periodic Screening Diagnosis and Treatment (EPSDT), which is designed to ensure the availability and accessibility of health care services and to assist eligible individuals and their families in effectively using their health care resources. The EPSDT program is intended to ensure that health problems, including mental health and substance use issues, are diagnosed and treated early before they become more complex and their treatment more costly.[21] DOM is currently updating its guidance and requirements for the behavioral health screening component of EPSDT.

Beyond Medicaid enrollees, there are a host of children that are either uninsured or privately insured that do not have access to the same benefits as Medicaid enrollees. For these children, the availability of home- and community-based services through other funding is important. Additionally, there are behavioral health services not allowable under Medicaid that have evidence to their effectiveness. It is for these reasons that opportunities to identify all potential funding streams are identified in this report in order for the state to provide a full continuum of behavioral health care for all Mississippi children and families.

OTHER CHILD-SERVING AGENCIES

Mississippi Department of Education. This agency oversees the State's local education authorities (LEAs) and designates policies to address behavioral health needs in school. Youth presenting with behavioral health or emotional needs are referred to Teacher Support Teams (TSTs), problem-solving units responsible for developing intensive interventions specifically designed to meet students' individual needs. TSTs are comprised of teachers, counselors, and/or school psychologists and engage in a four-step management plan to address behavioral health needs. The steps include functional behavioral assessment and identification, planning, intervention, and referral. TSTs frequently refer youth and families to CMHCs when their needs cannot be met with school supports alone. In addition, CMHCs routinely collaborate with LEAs to provide day treatment and other therapeutic services in the schools.

[20] Please see Chapter 1 *Medicaid Data Analysis* for further discussion of this issue.

[21] http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf

Mississippi Department of Human Services. This agency is responsible for Mississippi's child welfare and juvenile justice programs. DHS requires that all youth involved in the child welfare system receive an initial mental health assessment within 30 days of the opening of their case. To facilitate this requirement, some CMHCs designate a specific day of the week to assess DHS-involved youth. Standards specify that CMHCs must offer services to DHS-involved youth with behavioral health needs (this process is in place to address the Olivia Y. Lawsuit).

The Division of Youth Services (DYS) within DHS administers the community services and institutional programs for juveniles who have been adjudicated delinquent in Mississippi Youth Courts or who are at risk of becoming delinquent. In addition, DYS operates the Adolescent Opportunity Program in partnership with DMH, which serves as a mechanism to coordinate services, share resources, and reduce the number of young offenders placed in state custody. DHS operates one state juvenile facility, called the Oakley Youth Development Center.

Mississippi Department of Health. The Mississippi Department of Health (DOH), Office of Health Facilities Licensure and Certification is the Mississippi regulatory agency responsible for licensing hospitals and psychiatric residential treatment facilities. The office establishes and monitors minimum standards of operation for PRTFs and is authorized to deny, suspend, or revoke a license for failure to comply with requirements established under the law and regulations. The DOH reviews applications for a Certificate of Need (CON) for the establishing, offering, or expansion of acute psychiatric, chemical dependency beds for children and adults, and psychiatric residential treatment beds and services. In its 2014 State Plan, DOH indicated that there were 250 child and adolescent psychiatric beds operating in Mississippi in 2014, and projected a statewide child and adolescent psychiatric bed need of 251 beds (0.55 per 1,000 population aged 7 to 17) in 2015. In addition, DOH projected that Mississippi would need 283 PRTF beds in 2015, 15 fewer than the number of licensed beds in 2014. The Mississippi State Legislature has placed a moratorium on the approval of new Medicaid-certified child and adolescent beds.[22]

Youth and Chancery Courts. Youth Courts are offered in 21 counties that have a County Court and manage issues involving abuse and neglect of children and youth under the age of 18, in addition to offenses committed by juveniles. In the remaining counties that do not have a County Court, a Chancery Judge may hear Youth Court matters, or may appoint a lawyer to act in a judicial capacity as a Youth Court Referee. Once a child is ordered into custody, the Youth Court or Chancery Court has authority to commit the child to DMH or order DHS or any other public agency to provide for the custody, care, and maintenance of the child. As of 2013, there were 83 Youth Courts (82 counties and one municipality), 16 county detention facilities (entirely funded at the local level), 21 County Court judges, 49 chancellors, 62 referees, and one municipal court judge.

[22] MS Department of Health. (2014). Mississippi State Health Plan. Retrieved from http://www.babc.com/files/Publication/102e84c1-78cc-4720-92f3-426c77506093/Presentation/PublicationAttachment/4a031e53-adb6-495a-9a45-e3903ba1669b/2014%20State%20Health%20Plan.pdf

CHAPTER 1: MEDICAID DATA ANALYSIS

INTRODUCTION

The following chapter summarizes an analysis of five years of Medicaid fee for service claims data (2010-2014) and two years of managed care data (2013-2014, coinciding with the implementation of managed care for behavioral health services in Mississippi). These data included Medicaid enrollment, utilization, place of service, and expenditures for all behavioral health services provided to children and youth ages 0-21, including inpatient care and home- and community-based services (HCBS). Lengths of stay data for acute inpatient facilities and the state-run psychiatric residential treatment facility (PRTF) are also provided.

The following categorization of services was used:

- The institutional placement category included psychiatric residential treatment, inpatient psychiatric hospitalization, outpatient hospitalization, and inpatient medical surgical hospitalization.
- All other services comprised the home- and community-based category, including, but not limited to, day treatment, crisis residential, MYPAC services, intensive outpatient psychiatric (IOP), community support services, targeted case management, and partial hospitalization.

When reviewing the data, please note that some services can be provided concurrently and that none of the services are exclusive.

The Medicaid claims data analysis was limited by the condensed timeframe for this report which only allowed for review of Medicaid data in aggregate form. Data were not broken out by demographic variables (e.g., race, ethnicity, gender, age, etc.) and as a result, data relating to behavioral health disparities among underserved and minority populations were not analyzed. In addition, validity of place of service data may be limited due to provider coding and data entry errors. DOM recognizes that increased training is needed in this area.

The chapter is organized into six sections:

- Overview of Medicaid fee for service and managed care spending and utilization for behavioral health services in Mississippi, including lengths of stay data for selected inpatient providers;
- Medicaid expenditure data for each behavioral health service category (institutional and home and community-based);
- Total claims and unduplicated counts of utilizers for each service;
- Analyses on specific home- and community-based services, including day treatment, crisis services and intensive home-based treatment (MYPAC) services;
- Average length of stay data for psychiatric acute inpatient facilities for children and youth under 21 and DMH-operated psychiatric facilities;
- Analyses of place of service codes.

All charts and tables that correspond with this summary can be found in the Data Appendix.

MEDICAID BEHAVIORAL HEALTH EXPENDITURES AND MEDICAID ENROLLMENT

In State Fiscal Year (FY) 2014, Mississippi Medicaid spent **a total of $184,485,255 on children and youth's behavioral health services, or $1,183 per child receiving behavioral health care.** Nationally, mean expenditures for children in Medicaid using behavioral health services was $4,400 in 2008 (the most recent year for which comparable national data are available).[23] Overall spending has decreased by about 13% since FY 2010, from a high of $210 million in FY 2010 to approximately $185 million in FY2014.

[23] S. Pires, K. Grimes, T. Gilmer, K. Allen, and R. Mahadevan. "Examining Children's Behavioral Health Service Utilization and Expenditures." *Center for Health Care Strategies*. December 2013. Available at: **www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3/**

This reduction in expenditures is striking given the increase in youth Medicaid covered lives during this same timeframe. Medicaid enrollment went from 455,064 covered youth in FY 2010 to 539,261 covered youth in FY2014.

During this timeframe, the Medicaid penetration rate by children ages 0-21, or the rate of utilization of behavioral health services, decreased from 36% in FY 2010 (164,103 utilizers) to 29% in FY 2014 (156,524 utilizers). **It is important to note that the number of utilizers reported is a duplicated count and overinflates the penetration rate.**

An analysis of expenditure data by service type (institutional or home and community) indicates **an overall decrease in all behavioral health spending during this time period.** From FY2010 to FY2014, spending for community-based services declined from approximately $109 million to $93 million, an approximate 15% decrease. During this time period, spending for institutional services decreased by 11% (from $103 million in FY2010 to $91 million in FY2014).

In terms of the distribution of dollars across institutional settings and home and community based care**:**

- 49% of Mississippi Medicaid child behavioral health dollars in FY 14 were spent on institutional services.[24] Nationally, in 2005, 24.9% of child behavioral health dollars spent by Medicaid were spent on inpatient or psychiatric residential. [25]

- 51% of Mississippi Medicaid child behavioral health dollars in FY 14 were spent on home-and community-based services (HCBS)26 (98.6% of all claims ; compared to 75.1% of all spending nationally in 2005.[27])

These data reflect that, while only a small number of claims are for institutional placements, these claims represent a disproportionately large share of expenditures. This result mirrors other analyses of Medicaid spending on community-based care.

Specific to certain institutional settings, **spending for residential psychiatric treatment facilities and inpatient psychiatric hospitals increased by 11% and 6%, respectively, from FY2010 to FY2014.** The decrease in overall spending for this category is attributed to inpatient medical surgical hospitals, which saw a 50% decrease in spending. This shift in use of medical-surgical hospital inpatient units was the result of policy decisions to prioritize other provider types, coupled with utilization management to reduce overall institutional utilization. The use of outpatient hospitals for behavioral health care has remained low, representing 1-2% of all spending on institutional placements across years.

Among the home and community based service expenditures, **significant amounts are spent on assessment, community support, day treatment, individual therapy, intensive home based treatment (MYPAC), and targeted case management**. Most of these services, with the exception of day treatment, have capacity to be individualized to meet the different clinical and functional needs of children. Meanwhile,

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[24] Institutional placements include Residential Psychiatric Treatment Facility, Inpatient Psychiatric Hospital, Outpatient Hospital, and Inpatient Medical Surgical Hospital placements.

[25] S. Pires, K. Grimes, T. Gilmer, K. Allen, and R. Mahadevan. "Examining Children's Behavioral Health Service Utilization and Expenditures." *Center for Health Care Strategies*. December 2013. Available at: **www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3/**

[26]HCBS include an array of services, including Wraparound facilitation, IOP, crisis stabilization, outpatient psychotherapy, medication management, assessments, peer support, and day treatment. Throughout the document, all services other than the 4 listed as institutional are included in the category of HCBS.

[27] S. Pires, K. Grimes, T. Gilmer, K. Allen, and R. Mahadevan. "Examining Children's Behavioral Health Service Utilization and Expenditures." *Center for Health Care Strategies*. December 2013. Available at: **www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3/**

relatively small amounts (under $1 million in a given year) are spent on services such as mobile crisis, crisis residential, peer support, and intensive outpatient.

BEHAVIORAL HEALTH SERVICES CLAIMS AND UTILIZATION

There was a decrease in utilization across both the institutional and home and community based service categories[28].

- There were 248 fewer claims for institutional services in FY14 than in FY10, representing a decrease of 2%.
- There were 3,349 fewer claims for HCBS in FY2014 than in FY2010, representing a 17% decrease.

Certain Medicaid-funded behavioral health services are utilized more frequently than others. However, no service was accessed by more than 7% of all Medicaid enrollees. Claims for some services, like day treatment, were much higher than others**. The volume of claims and total expenditures are not consistent with the percent of beneficiaries accessing the services. This indicates that a smaller population of Medicaid beneficiaries are driving service utilization and claims through longer lengths of stay and/or utilization of more expensive services.**

Although expenditures for institutional settings are greater than any one home- and community-based service, **the percent of beneficiaries utilizing institutional settings is less than 1% of all beneficiaries in each of the five years of data reviewed.** The degree of overlap between the youth receiving institutional services and the youth receiving HCBS is unknown given the aggregate data provided.

The number of unduplicated youth that accessed different categories of services.

- The greatest increase in utilization of institutional services was in inpatient psychiatric hospitals. **The number of youth who utilized inpatient psychiatric hospitals increased by 22% from FY10 to FY14.**

- There was a smaller fluctuation in the number of youth who utilized inpatient medical surgical hospitals and/or residential psychiatric treatment facilities compared to inpatient psychiatric hospitals.

- The utilization rate for residential psychiatric treatment facilities has remained steady, in contrast to the increase in the number of claims and the total spending on this service during this time period. **Since FY10, there has been a 10% increase in the number of youth who utilized residential psychiatric treatment facilities. This increase occurred from FY10 to FY11 and utilization remained steady from FY11 to FY14.**

- Most of the HCBS that were available in FY10 experienced a decrease in the number of unduplicated youth who utilized them.

- Injectable medication was removed as a pharmacy service due to safety concerns of beneficiaries and became a new medical service available in 2012. Consequently, medication management and pharmacotherapy experienced a large increase of 451% during this time period.

- There was a sharp decline in the number of youth who utilized skill building services (including day support and psychosocial rehabilitation (PSR available to 18-21 year olds)) during this time period.

- There was a large increase in the use of partial hospitalization from FY10 to FY11, with a high of 60 utilizers in FY12, which has since dropped off to almost no utilizers in FY14 (n=5).

[28] DOM is aware of this decrease in HCBS claims resulting from UM/QIO contractor prior authorization procedures to reduce improper billing and service delivery.

- MYPAC respite-Waiver also had a large increase in the number of youth utilizing the service from FY2010 to FY2011 and FY202, which has since decreased to fewer youth in FY2014 than in FY10. This decrease occurred because MYPAC respite was only available to youth enrolled in the CA-PRTF Demonstration Waiver as of September 30, 2012.

- More youth utilized peer support, which was added on 1/1/12, in FY2014 than in FY2013.

- Service planning, which includes treatment plan development, MYPAC plan of care development (a required service component of the National CA-PRTF Demonstration Waiver), and community-based wraparound services, has been declining since its peak in FY11.

- In FY2011, school-based services were utilized by more than 8,000 youth, but the service ended on 6/30/12. Utilization of intensive home-based treatment, which includes Wraparound-MYPAC-State Plan, Wraparound-MYPAC-Waiver, and MYPAC-Waiver services, has been increasing since FY2010; over 1,000 youth utilized the service in FY2014.

ANALYSIS OF SPECIFIC HOME- AND COMMUNITY-BASED SERVICES

A closer review was conducted on certain home and community based services. These are: day treatment, mobile crisis and MYPAC. Day treatment was examined as it is a service that both DOM and DMH had concerns with regard to utilization and quality; and intended that the uptake in the new rehab option services would decrease the utilization of this service over time. Crisis services and MYPAC were selected in order to understand the uptake of these new services.

DAY TREATMENT

Medicaid spending on day treatment has declined by 42% since FY10, and there were 48% fewer claims in FY14 than in FY10 for the service. There was a 27% decrease in the total number of unduplicated utilizers of the service from FY10 to FY14. However, **nearly a quarter of HCBS dollars continues to be spent on day treatment.**

The number of youth utilizing day treatment has been declining and, in FY14, represented 0.7% of all Medicaid enrollees in both fee for service and managed care. In FY10, 1.1% of all Medicaid enrollees utilized day treatment. DOM is aware of this decrease resulting from UM/QIO contractor prior authorization procedures to better educate providers about this service, and to reduce any improper billing and service delivery.

CRISIS SERVICES

Mobile crisis and crisis residential services became available through Medicaid during FY2012. Claims for both services have increased sharply since FY12; there were 2,960 claims for crisis services in FY14, an increase of 626% from FY12.

Consistent with the increase in claims, the total spending on crisis services increased from FY12 to FY14, although total spending on crisis services is only about 1% of all HCBS expenses**. In FY14, there were almost $1 million in claims for crisis services, compared to approximately $250 million dollars in FY12**. This is a positive trend, as utilization of crisis services typically suggests lower use of emergency department and inpatient care. However, in FY14, only a small fraction of Medicaid beneficiaries' utilized crisis residential or mobile crisis services, suggesting a need to promote availability of these services among potential referral sources including youth and families. Many more youth utilized one or both crisis services in FY14 than in FY12. However, in FY14, only 0.02% of Medicaid beneficiaries' utilized crisis residential through the fee-for service system and only 0.04% of Managed Care enrollees utilized crisis residential

services. In FY14, 0.21% of Medicaid beneficiaries utilized mobile crisis through the fee for service system and 0.1% of managed care enrollees utilized mobile crisis services.

MYPAC

The MYPAC services migrated from 1915 (c) waiver services to new rehab option services called IOP in FY 2012.

MYPAC included Plan of Care Development (part of Service Planning), MYPAC Intensive Home-Based Treatment, and Respite (MYPAC).

- Plan of Care development was a required component of the National CA-PRTF Demonstration Waiver. Utilization of this service went down to zero in FY14.
- The number of youth receiving Respite (MYPAC) decreased to 24 in FY14, with spending declining by 47%. Children previously enrolled in the Waiver prior to 9/30/12 continued to receive respite services under the Rehab Option service until they were no longer enrolled in the Waiver.
- Intensive home-based treatment includes three types of subservices: 1) MYPAC-Waiver, 2) Wraparound-MYPAC-Waiver, and 3) MYPAC-State Plan Service.
    - A relatively equal number of youth accessed MYPAC-Waiver and Wraparound-MYPAC-Waiver each year. Billing for MYPAC-State Plan Services began in FY13 corresponding with the conclusion of the Waiver demonstration.
    - There was an increase in the number of youth who received MYPAC intensive home-based treatment from FY10-FY14 (either through MYPAC-Waiver, Wraparound-MYPAC-Waiver or Wraparound-MYPAC-State Plan Service).
    - There also was an increase in the number of claims for this service from FY10-FY14 (+128%).
    - The increase in spending was less substantial, only 64% higher in FY14 than in FY10 despite increases in claims and utilizers, reflecting a decline that occurred from FY13 to FY14.

LENGTHS OF STAY

Length of stay information was not available for all Medicaid purchased services, as data were collected and analyzed in aggregate form. However, DMH collects and analyzes lengths of stay data for its state-operated psychiatric hospitals and PRTF and psychiatric acute inpatient facilities. In addition, information was provided by DOM from claims data for the average lengths of stay for youth served in psychiatric acute inpatient facilities. From FY 2010 to FY 2014:

- The average length of stay for Oak Circle Center at Mississippi State Hospital (a state psychiatric hospital serving children and youth[29]) increased by about 4%.
- The average length of stay at the state-run PRTF, Specialized Treatment Facility, increased by 23% during that time.[30]
- The average length of stay for youth served in psychiatric acute inpatient facilities for children and youth under 21 increased in 3 out of the 6 facilities[31] for which data were available for this time frame.[32]

LOCATION OF COMMUNITY-BASED SERVICES

[29] FY14 data were not available for the Bradley A. Sanders Adolescent Complex at East Mississippi State Hospital, and therefore not included. Please refer to the Data Appendix for FY10-FY13 data for this facility

[30] Source: Mississippi DMH State Hospital Admission and Discharge Data

[31] ALOS data were provided for 7 inpatient facilities, however FY14 data were not available for Crossroads Regional Hospital and therefore 6 facilities are referenced above. Please refer to the Data Appendix for FY10-FY13 data for this facility.

[32] Source: Division of Medicaid Acute Inpatient Facilities Data.

Providers bill for a range of services that include information about the location that services occurred. These "Place of service" codes were analyzed as part of the Medicaid data analysis. Place of service codes are not required for claims to be submitted so the data may be unreliable. Given the state's goal to increase service provision in the community versus within offices, it is important to analyze these data to understand where providers are delivering care.

From FY2010 to FY2012, services within the CMHC offices accounted for the greatest percentage of fee-for-service spending. In FY2013, spending on services in the home surpassed spending on services that occurred within the CMHCs offices, increasing by 21% from FY2010 to FY2014. Meanwhile, **as a location of service, spending in CMHC offices fell by 46% from FY2010 to FY2014.** This is an important finding given the state's goal to increase service provision in homes and other community settings rather than offices.

In 2013 and in 2014, approximately one-third of Medicaid fee for service spending was for services received in the home. About 50% of Medicaid fee for service spending was for services received in community mental health centers (25% and 26%) and in schools (21% and 24%). **However, services provided through managed care were more commonly provided in community mental health centers (54% and 49%).** The second most common location for managed care services to be provided was in schools (24% and 26%) followed by in the home (13% both years).

CONCLUSION

Mississippi has the opportunity to serve many more youth in less restrictive and more integrated settings by promoting greater use of services such as mobile crisis intervention, crisis stabilization, intensive outpatient program (both MYPAC and as a step-down from MYPAC), and peer support. More effective use of these services could help divert youth from placement in costly institutional settings. While utilization and expenditure trends for HCBS services are in the right direction, continued work is needed to promote greater uptake of these services in Mississippi.

CHAPTER 2: EXPANDING THE HOME- AND COMMUNITY-BASED SERVICE ARRAY

INTRODUCTION

Developing a clear definition of the service being purchased is an important first step when implementing a new service. This helps purchasers, service providers, family members, and other system partners, understand what the service is supposed to look like "on the ground." It provides clarity about what activities are and are not expected as part of the service

This chapter offers an analysis of Mississippi's current HCBS benefit array, including design, operational policies and procedures, and utilization. It goes on to describe services that should be available in robust benefit design for youth and offers recommendations to improve Mississippi's benefit design and operations.

A critical component to ensuring that youth in Mississippi with serious behavioral health challenges can remain in their homes and local communities and avoid overutilization of restrictive settings such as state hospitals and PRTFs is ensuring that a continuum of treatment options in the community exists. For this assessment, we examined the availability of a broad array of *effective* services and supports (i.e. evidence-based and promising practices) that occur in the home or a community setting.

This chapter is comprised of three sections:

- Evidence-Based Benefit Design defines fifteen (15) service elements informed by scientific knowledge and state experience that successfully address the behavioral health needs of children;
- Mississippi's Benefit Array includes an analysis of current benefits and operational policies, and recommendations for improvements organized by certain evidence-based benefits design elements discussed in section one;
- Financing Beyond Medicaid briefly speaks to the need for home and community based benefits to be available to children that are not eligible for Medicaid.

Several questions drove the quantitative and qualitative aspects of this benefit design analysis. These questions included:

1. What are the array of services available in Mississippi; and how do those service align with evidence on what is effective?

2. How are the services being implemented? To whom are those services available; i.e., Medicaid enrollees, any child in Mississippi regardless of insurance status? How are decisions made about the types of services that children receive?

3. Are there operational or other policy barriers that impact the service design and availability of services?

The next chapter, Chapter 2, considers provider capacity, the availability of a behavioral health workforce[33], and its ability to competently deliver services and supports to youth with behavioral health challenges in home and community-based settings. While a robust home and community based service array is closely connected to provider capacity, we have presented that information in a separate chapter in order to better address specific issues and recommendations.

[33] Throughout this report, when discussing the available "workforce" or "practitioners" we are referring to the individuals who deliver mental health and substance use services. Some of these individuals are employed by community mental health centers or other agencies while others (e.g. licensed psychologists or psychiatrists) may operate as a solo practitioner or as part of a small group practice. When using the term "provider" we are referring to agencies.

EVIDENCE-BASED BENEFIT DESIGN

The goal of a behavioral health system benefit design is to provide high quality services to meet the range of clinical, family, age, gender, and cultural needs of the youth. The services that are available in a system should reflect the scientific knowledge that is available. Additionally, services should align with the important role that families, schools and communities have in supporting children's behavioral health.

A number of services and supports have been found effective to support children with behavioral health conditions. As described in the Centers for Medicare and Medicaid May 2013 Informational Bulletin regarding Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions[34] , the implementation of home and community-based services for this population has made significant improvement in the quality of life for these children, youth, and families. Findings include:

1. Reduced costs of care – The PRTF Waiver Demonstration evaluation showed that state Medicaid agencies reduced the overall cost of care. For example, home and community-based services provided to children and youth in the PRTF demonstration cost 25 percent of what it would have cost to serve the children and youth in a PRTF, an average savings of$40,000 per year per child. State Medicaid agencies' annual costs per child were reduced significantly within the first 6 months of the program.

2. Improved school attendance and performance - After 12 months of service, 44percent of children and youth improved their school attendance and 41 percent improved their grades as compared to their attendance and grades prior to participating in the program.

3. Increase in behavioral and emotional strengths - 33 percent of youth significantly improved their behavioral strengths after 12 months of service and 40 percent after 24months compared to their strengths as measured prior to participating in the program. Behavioral and emotional strengths include the ability to form interpersonal relationships, positive connection with family members, positive functioning at school, ability to demonstrate self-confidence.

4. Improved clinical and functional outcomes - According to caregiver reports, 40 percent of children served in SAMHSA's Children's Mental Health Initiative (CMHI) showed a decrease in clinical symptoms from when they entered the program.

5. More stable living situations - The percentage of children and youth in CMHI who remained in a single living situation rather than multiple living situations during the previous 6 months increased from 70 percent at intake to 81 percent at 24 months.

6. Improved attendance at work for Caregivers - Caregivers who were employed at intake reported missing an average of 6.2 days of work in the 6 months prior to participation in the program due to their child's behavioral or emotional problems. This decreased to 4.0days at 12 months of program participation, and to 2.8 days at 24 months of program participation.

7. Reduced suicide attempts - Within 6 months of service in CMHI, the number of youth reporting thoughts of suicide decreased from intake into the program by 51 percent and the number of youth reporting a suicide attempt decreased by 64 percent.

8. Decreased contacts with law enforcement - For youth involved in the juvenile justice system, arrests decreased by nearly arrests decreased by nearly 50 percent from intake into the program after 12months of service in CMHI.

[34] http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html

States that have achieved such robust outcomes have common benefit design elements. We highlight and define the following fifteen components:

Figure 34: Benefit Design Elements

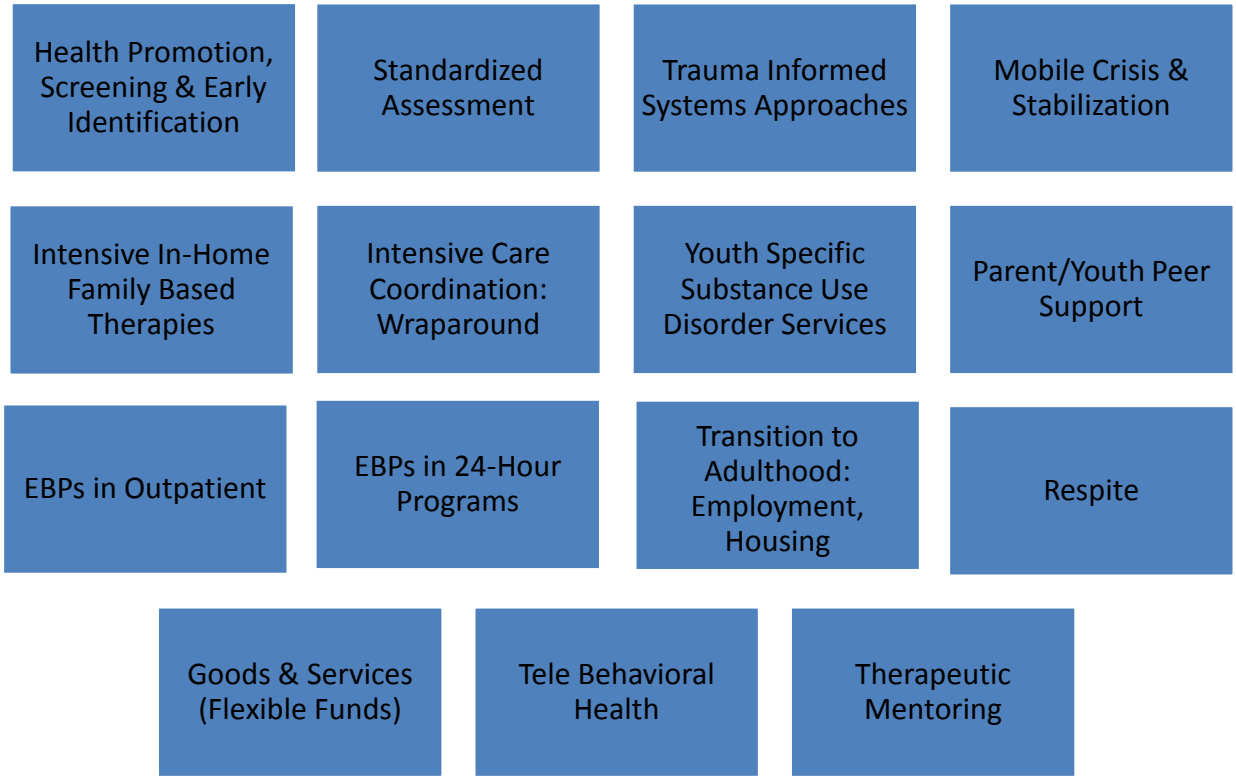

Table 19: Benefit Design Elements

HEALTH PROMOTION, PREVENTION, SCREENING & EARLY IDENTIFICATION
Health promotion, prevention, screening, and early identification are necessary components of a "good and modern" addictions and mental health service system.[35] Health promotion -Health promotion is a significant component of a comprehensive prevention and wellness plan, and plays a key role in efforts to prevent substance abuse and mental illness. Since health promotion efforts have been traditionally community-and school-based in the public sector, there is an opportunity to engage the private sector (particularly employers and insurers) in health promotion initiatives. Prevention- The field of prevention science, well known for advancing the health of people at risk for illnesses such as cancer, diabetes, and heart disease, has also produced effective strategies for the mental health and substance abuse fields. The system must have three levels of prevention practice: Universal, which addresses populations at large; selective, which targets groups or individuals who are at higher risk of developing a substance abuse problem or mental illness; and indicated, which addresses individuals with early symptoms or behaviors that are precursors for disorder but are not yet diagnosable. Prevention efforts can support safer schools and communities, better health outcomes, and increased productivity. Prevention science tells us that a comprehensive approach to a particular problem or behavior is an effective way to achieve the desired permanent behavioral or normative change. Health reform recognizes that prevention is a critical element in bending the cost curve and in improving the overall health of all Americans. All health-related prevention efforts

[35] https://www.idph.state.ia.us/bh/common/pdf/substance_abuse/good_and_modern.pdf

should recognize and address the interrelated impact of mental health and substance use on overall well-being.

Screening and early identification- Services should include mental and substance use screens available through Early and Periodic Screening Diagnosis and Treatment (EPSDT). The Bright Futures toolkit developed by the American Academy of Pediatrics is one resource used by some states and localities to support primary care practitioners. The United States Preventative Services Task Force has also developed recommendations regarding screening for various behavioral health conditions among people age 12 years and older. Screening may also be used to identify warning signs for suicide to enable early intervention and suicide prevention. Standardized screening tools are available to support screening for behavioral health conditions in children and youth.

STANDARDIZED ASSESSMENT

Standardized assessment tools gather clinical, functional and environmental information to support clinical decision-making. These standardized tools support the clinical interview process and biopsychosocial assessment documentation. These tools ensure that children receive the appropriate type and amount of service, promote consistency and equity in service provision, and provide objective rationales for service authorization decisions. In addition to informing client specific clinical decision-making, these tools support the monitoring of behavioral health system performance, and inform decisions for improving the quality of care. Examples include Child and Adolescent Functional Assessment Scale (CAFAS), Child and Adolescent Service Intensity Instrument (CASII), Child Behavior Checklist (CBCL) and Youth Self Report (YSR), and Child and Adolescent Needs and Strengths (CANS).

TRAUMA INFORMED SYSTEM

Across the country, behavioral health systems are increasingly aware of the impact of trauma. Children and youth with the most challenging mental health needs often have experienced significant trauma in their lives. The Adverse Childhood Experiences (ACE) study[36] has reported short and long-term outcomes of childhood exposure to certain adverse experiences that include a multitude of mental health, health and social problems. Examples include Cognitive Behavioral Interventions for Trauma in Schools (CBITS)[37], Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Parent-Child Interaction Therapy (PCIT). [38]

MOBILE RESPONSE AND STABILIZATION

Mobile Crisis Response & Stabilization (MCRS) services includes immediate 24/7 response to urgent mental health needs by a licensed mental health professional or a team approach, as well as access to short-term, individualized services that assist in stabilizing the youth in the home and community. Mobile crisis response and stabilization services are instrumental in defusing and de-escalating difficult mental health situations and preventing unnecessary out-of-home placements, particularly hospitalizations. Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call and available to respond. The team may be comprised of professionals and paraprofessionals (including peer support providers), who are trained in crisis intervention skills and in serving as the first responders to children and families needing help to resolve the crisis, the team works with them to identify potential triggers of future crises and learn strategies for effectively dealing with potential future crises that may arise. In newer and more effective models of mobile response, one-to-one crisis stabilizers may work

[36] http://www.cdc.gov/ace/findings.htm

[37] https://cbitsprogram.org/

[38] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

with a child and family over a 30 day or longer period. Crisis stabilization provides intensive short term, out of home resources for the child and family, helping to avert the need for psychiatric inpatient treatment. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time with ongoing services. During the time that the child is receiving residential crisis stabilization, there is regular contact between the team and the family to prepare for the child's return to the family.

INTENSIVE CARE COORDINATION: WRAPAROUND PRACTICE MODEL

The wraparound approach is a form of intensive care coordination for children with significant mental health conditions. It is a team-based, collaborative process for developing and implementing individualized care plans for children and youth with complex needs and their families. This approach focuses on all life domains and includes clinical interventions and formal and informal supports. The wraparound "facilitator" is the intensive care coordinator who organizes, convenes, and coordinates this process and provides intensive care coordination at low ratios (1:8 or 1:10). Within the wraparound approach, a child and family team is individualized for each youth that includes the child, family members, involved providers, and key members of the child's formal and informal support network, including members from the child serving agencies. The child and family team develops, ensures implementation of, and monitors the service plan. This service is different from intensive in-home family therapy approaches as it is not therapy but a definable approach to care management. It is used in conjunction with therapeutic approaches to address the behavioral health needs of youth.

INTENSIVE IN HOME FAMILY BASED THERAPIES

Intensive in-home services (IIHS) are therapeutic interventions delivered to children and families in their homes and other community settings to improve youth and family functioning and prevent out-of-home placements in inpatient or other settings. The services are typically developed by a team that can offer a combination of therapy from a licensed clinician and skills training and support from a paraprofessional. The components of intensive in-home services include individual and family therapy, skills training and behavioral interventions. Typically, staff providing intensive in-home services have small caseloads to allow them to work with the child and family intensively, gradually transitioning them to other formal and informal services and supports, as indicated. Specific examples include, but are not limited to, Flexible Family Therapy, Multi-Systemic Therapy and Brief Strategic Family Therapy. IIHS are designed to be maximally flexible, delivered at times and locations selected by the youth and family. By conducting the assessment, treatment planning, and interventions in the youth and family's home, school, and/or community it allows for customization of services to the youth and their unique familial and environmental contexts. Unlike typical outpatient individual or family therapy that occurs in an office, IIHS services offers the opportunity for trained staff to help youth and families practice skills in "real world" settings, increasing the likelihood that they will be able to apply these skills to a range of "everyday" situations.

RESPITE

Respite services are intended to assist children to live in their homes in the community by temporarily relieving the primary caregivers from the stress of caregiving. Respite services provide short-term safe and supportive environments on a short-term basis for on a planned or unplanned basis. Caring for a child with a behavioral health challenge places unique demands and stresses upon caregivers they must attend frequent meetings with doctors, teachers, therapists, and other helping professionals; and they must engage in highly specialized parenting approaches to support their child's treatment plan, coordinate numerous meetings, work with doctors to monitor side-effects of psychotropic medications, and respond to crises or other critical issues that emerge for their child as he/she grows. Much like parents of children with physical disabilities, parents of a child

with a behavioral health challenge often cannot make use of typical child care arrangements because caregivers need special training or skills to manage the child's emotional and behavioral issues.[39]. The sustained effort it takes to parent a child with behavioral health challenges can be emotionally, financially, and physically taxing, placing the child at increased risk of an out-of-home placement.

FAMILY CENTERED PRACTICES IN INPATIENT/INSTITUTIONAL PROGRAMS

In addition to a range of evidence-based practices to address the clinical treatment needs of youth such as trauma informed CBT, inpatient and other 24 hour programs must also use family-centered practices that ensure connection to family and community, particularly for those programs that have longer lengths of stay. These family-centered approaches are an emerging best practice and include the following elements: [40]

1. Maximizing regular contact between the child and family such as through home visits, telephone calls and electronic communication;
2. Engaging youth and families in all aspects of service planning, including active sharing of information; and treating parents as experts and with respect;
3. Working with youth and families on transitions; and using treatment strategies that families can use in their homes; including culturally appropriate services;
4. Providing ongoing support and aftercare for the child and family, including use of approaches that serve the whole family during and after care.

YOUTH SPECIFIC SUBSTANCE USE DISORDER SERVICES

Given the specific developmental needs of youth, SUD services for youth must be able to address identification, treatment and recovery needs of youth that are developmentally appropriate and incorporate the family. [41] Examples include Screening, Brief Intervention, Referral to Treatment (SBIRT), developmentally appropriate and familial engaging adaptations to family therapy approaches such as Brief Strategic Family Therapy, Adolescent Community Reinforcement Approach, and Medication Assisted Treatments.

PARENT/YOUTH PEER SUPPORT

Providers of peer support services are family members or youth with "lived experience" who have personally faced the challenges of coping with serious mental health conditions, either as a consumer or a caregiver. These peers provide support, education, skills training, and advocacy in ways that are both accessible and acceptable to families and youth.

EBP'S IN OUTPATIENT

Psychiatric issues commonly observed in outpatient behavioral health settings for youth such as anxiety, depression, trauma, or conduct problems should be addressed using practices with evidence of their effectiveness. Evidence-based interventions include practices such as Parent Child Interaction Therapy (PCIT), Trauma-Focused Cognitive Behavioral Therapy, Functional Family Therapy (FFT), Brief Strategic Family Therapy

[39]Parent/Professional Advocacy League & Massachusetts Department of Mental Health (2013). Respite care: What families say. Boston, MA: Author.

[40]http://www.buildingbridges4youth.org/sites/default/files/BB-Joint-Resolution.pdf

[41]Substance Abuse and Mental Health Services Administration. (2013). *What does the research tell us about good and modern treatment and recovery services for youth with substance use disorders?* Report of the SAMHSA Technical Expert Panel. Rockville, MD: Center for Substance Abuse.

(BSFT), Strengthening Families, and Triple P – Positive Parenting Program.

HOUSING & EMPLOYMENT –SUPPORTING SUCCESSFUL TRANSITION TO ADULTHOOD

Transition aged youth with serious behavioral health challenges are in need of services specifically geared to support their unique developmental needs as they enter adulthood. Transition services should include a focus on supported education, vocational/employment, and housing support. The Achieve My Plan (AMP) model [42] and the Transition to Independence Process (TIP) model[43]are examples of an evidence-based approaches to supporting youth as they transition to adulthood.

THERAPEUTIC MENTORING

Therapeutic Mentoring offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs. Therapeutic Mentoring services include supporting, coaching, and training the youth in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution, and relating appropriately to other children and adolescents, as well as adults, in recreational and social activities as part of an individualized plan of care. These services help to ensure the youth's success in navigating various social contexts, learning new skills and making functional progress, while the Therapeutic Mentor offers supervision of these interactions and engages the youth in discussions about strategies for effective handling of peer interactions.

TELE-BEHAVIORAL HEALTH

Tele-behavioral health is the use of telecommunications technology to provide behavioral health services. Tele-behavioral strategies have been used across a range of services including individual therapy, family therapy, medication assessment and management appointments, care plan team meetings and consultations, and primary care appointments and consultations.

GOODS & SERVICES (FLEXIBLE FUNDS)

Customized Goods & Services are flexible funds that can be used to creatively support the strengths and needs of the youth and family and are directly reflected in the goals and strategies of the individualized care plan. Typically, these resources are available to children receiving intensive care coordination as a means to support individualized care planning, engagement with natural supports and to further enable community vs. institutional placement. These funds are used for certain non-recurring expenses such as onetime expenses for a bed for a child returning home, clothing, or memberships to local girls or boys clubs, etc
.

MISSISSIPPI'S BENEFIT ARRAY AND RECOMMENDATIONS

The following section provides a descriptive overview of Mississippi's current benefit array across the Department of Mental Health and the Division of Medicaid, analysis of Mississippi's current benefits, including a review of policies and procedures, and qualitative information related to stakeholder experiences; and recommendations for improvements organized by certain evidence-based design elements discussed in section one of this chapter.

[42] http://www.pathwaysrtc.pdx.edu/proj-3-amp

[43] http://www.tipstars.org/

OVERVIEW OF CURRENT BENEFITS

As Table 20 indicates below, Mississippi has a wide array of behavioral health services for youth across Medicaid and DMH funding.

Table 20: Medicaid and DMH funded behavioral health services for youth

Service	DMH	DOM
Inpatient hospital	X	X
Partial		X
Community Support Services*		X
Crisis response	X	X
Crisis stabilization (crisis residential)	X	X
Day treatment*		X
Emergency/crisis services*	X	X
Family education	X	
Individual, family & group psychotherapy*		X
Wraparound facilitation	X	X
IOP (MYPAC)		X
Other IOP		X
Making a Plan (MAP) team*	X	
Peer support*		X
Psychological evaluation	X	X
Psychosocial assessment	X	X
Treatment plan development & review	X	X
Pre-evaluation screening for civil commitment (ages 14 and up)*	X	
Psychiatric Residential Treatment Facilities (PRTF)	X	X
Psychiatry*, including medication management	X	X
Psychosocial rehabilitation (ages 18 and up only)		X
Residential Treatment for Substance-Abusing Adolescents	X	
Support for recovery/resilience-oriented services*	X	
Therapeutic foster care	X	
Therapeutic group home	X	+

**Indicates DMH core service. +For therapeutic group home, DOM covers the therapeutic services that are delivered within the therapeutic group home. Note: Physical health services, including primary care screenings and nursing assessments, are not listed.*

A review of benefits listed in the Medicaid state plan, and available through DMH funding, indicate a range of services, including some evidence-based practices and approaches, are covered in Mississippi for those that are Medicaid enrolled or receiving DMH funded services. These services include crisis, wraparound, and outpatient EBPs investments, and respite and flexible funding from DMH sources through the Making A Plan (MAP) team process. Some of these services and investments, such as mobile crisis, are newer, and their effect and outcomes have not yet been experienced by the system. These services need to be grown and expanded further, and their outcomes monitored so that rapid system and program adjustments can be made to achieve the intended benefit. Some services may not be new to the system but have not been taken up fully across the system for various reasons. These services, such as MYPAC and telehealth, are needed across the system more broadly. These services need to be reviewed to see why they are not being taken up, and to identify what barriers may exist to their full implementation. Services that are not currently covered are therapeutic mentoring, training investment in institutional family centered EBPs, a substance use service continuum for youth, and supported education, vocational and housing supports for transition age youth. The availability of these services will help Mississippi achieve its goal to successfully address the behavioral health needs of youth. Finally, as will be discussed, it is not clear to what degree intensive in home family based therapies, separate from intensive care coordination, is occurring.

The efforts to make available a range of home and community based services has been an important step. In addition to the presence or absence of certain services in the system, we also examined the implementation and execution of the services. It is in this area that we see significant opportunity for Mississippi to align its goals to achieve the outcomes it seeks. Our review indicates that there are several implementation decisions that should be modified or augmented that will better support the state's goals of improved service access, utilization, quality and outcome. We see these issues as easily rectifiable.

HEALTH PROMOTION, SCREENING, AND EARLY IDENTIFICATION

Mississippi EPSDT requirements include screening for developmentally appropriate social and behavioral issues. While the scope of our assessment did not include an analysis of this physical health data regarding screening for behavioral health conditions, we raise here the importance of a review of the policies and utilization of this vital service. Given the states goal to ensure that children get access to needed behavioral health care, understanding positive screens for behavioral health need, and working with primary care to understand where to refer for services, is vital. Given the estimated prevalence of behavioral health conditions among Mississippi's youth, we anticipate that there is additional need for behavioral services than current service utilization indicates. Establishing early identification as a policy priority can support children in getting services earlier, leading to the use of less costly services.

Notwithstanding the requirements under EPSDT, numerous groups endorse the use of screening of behavioral health for children during well-child visits including the US Preventive Services Task Force, and the American Academy of Pediatrics' (AAP) Bright Futures. Other states including North Carolina, Colorado, South Carolina, and Massachusetts have worked to improve their behavioral health screening efforts. North Carolina's Assuring Better Child Health and Development (ABCD) program has greatly increased the number of behavioral health screenings occurring in primary care offices. By working closely with local community care networks and pediatricians the state improved communication about the need for screening, identified standardized screening tools and trained doctors on how to use them during the course of a pediatric visit. The Massachusetts Medicaid program, MassHealth, has required primary care clinicians seeing youth under 21 to use one of several approved screening tools during well-child visits. The state updated its regulations, published guidance on how to obtain reimbursement for conducting a screening, and convened trainings on how to use the various screening tools. More information including additional state examples is located in the March 2013 guidance on prevention and early identification of mental health and substance use conditions published by the Centers for Medicare and Medicaid Services.[44]

[44] Centers for Medicare and Medicaid Services, (March, 2013). Prevention and early identification of mental health and substance use conditions. Retrieved on March 1, 2015 from: http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf

RECOMMENDATION

1. REVIEW SCREENING POLICIES AND UTILIZATION DATA

Data regarding the screening of children's behavioral health by primary care providers should be reviewed to assess the need for any additional communication, education and/or training for providers. Consider any additional need for notification and information to enrollees regarding screening for behavioral health needs as a Medicaid benefit Once this review is complete, the state should consider how the Center for Advancement of Youth (CAY) and/or the Children's Collaborative group could be used to provide training and support to pediatricians, nurse practitioners, and family practice physicians on behavioral health screening in primary care settings.

STANDARDIZED ASSESSMENTS

An underpinning to all behavioral health services is the need for a consistent standardized assessment tool across all services. DMH requires that certified providers conduct functional assessments; and has invested in training and data efforts to support providers to adopt this practice. Over two years ago, DMH began training and implementation of a specific standardized assessment tool- the Child and Adolescent Functional Assessment Scale (CAFAS).

Certain programs, such as MYPAC, use functional tools as part of the practice. Some providers are using tools more broadly to help inform individual decisions about a youth's care or evaluating the performance of their own program (i.e. CAFAS, CANS). The DMH Operational Standards require children/youth mental health providers to conduct a functional assessment within 30 days of admission and six months thereafter to measure client's progress. In FY 2013, DMH introduced a web-based version of the Child and Adolescent Functional Assessment Scale (CAFAS) to serve as the required assessment.

Many state examples exist on the use of standardized assessment tools to support screening, level of care decisions, care planning and outcomes. The state of Washington has adopted the CANS instrument to screen for the need for services within 10 days of receiving a referral, as well as to support care planning decisions. This data is also used to monitor how the system is performing.[45] Massachusetts also uses the CANS instrument for screening, care planning and system and child level outcomes. [46]

DMH intends for full statewide implementation of the CAFAS by 2016. We fully support DMHs decision to move towards statewide adoption of a standardized tool across providers. Data from standardized tools will make it possible for DMH and DOM to be able to monitor how well the current system of services and supports is meeting the needs of Mississippi's youth.

RECOMMENDATION

1. IMPLEMENT A STANDARDIZED ASSESSMENT TOOL ACROSS ALL PROVIDERS

This will allow for a broader use of data across all providers (institutional and community-based) including eligibility, clinical decision making, care planning and service provision and intensity; client outcomes, provider quality and system outcomes. A common system-wide assessment instrument is needed to identify the service and support needs of a youth and measure system performance across providers and levels of care (e.g. outpatient, inpatient, day treatment, MYPAC, etc.). Without this, DMH, DOM and other system partners have limited ability to use data to help service providers; and to design, augment and adjust their system to meet emerging needs, and to inform other policy makers, such as the legislature on agency needs.

[45] http://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISe%20manual%20v%201.3%20FINAL.pdf

[46] http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/child-and-adolescent-needs-and-strengths-cans/

The implementation of a common instrument across the system will also help DMH and DOM address provider variability in service delivery. While a standardized tool does not replace clinical judgment it can help create a common language among providers, payers, families/youth and lead to a more uniform process for making placement and treatment decisions. The current variability with respect to the information collected about the needs of youth makes it difficult to draw an accurate picture of who is being served by the system and how the system is performing.

2. INCORPORATE THE STANDARDIZED TOOL IN LEVEL OF CARE DETERMINATIONS

It is recommended that Mississippi build on this existing infrastructure and expand the use of the CAFAS as a standardized assessment throughout the behavioral health delivery system as children seek services, for service planning, for level of care determinations, for ongoing assessment, and to support outcomes tracking.

Mississippi's current level of care criteria would benefit from the inclusion of a standardized assessment tool. Standardized assessment tools should be utilized to support recommendations regarding the level of intensity of the services needed by particular youth at specific points in time. Assessment tools can be used at various points of time, including with those youth who have been given a diagnosis based on a psychiatric evaluation or comprehensive psychosocial assessment or who have been referred to an out-of-home or restrictive level of service provision, such as MYPAC or IOP. A tool will support clear service eligibility guidelines, and ensure that youth who are most in need of services can access care. Providers must then seek authorization from the youth's managed care entity which is ultimately responsible for determining eligibility for services. We recommend that standardized tools be used more frequently than every six months.

Some states, including Georgia and Michigan, use the CAFAS to screen for eligibility for their intensive care coordination programs. In Georgia, the CAFAS is used for eligibility screening for their Community Based Alternatives for Youth Program, Alternatives to Psychiatric Residential Treatment demonstration waiver, Money Follows the Person, ad 1915(c) waiver. They use a tiered approach, where youth who score 140 or above on the CAFAS are eligible for the aforementioned programs, while youth who score 110 or above are eligible for the state's non-waiver CME program. In Michigan, the CAFAS is used to determine the level of functional impairment and to assist with eligibility determination for SED criteria. Further, given its utility for effectively assessing level of care, it is recommended that the CAFAS be employed to determine eligibility for MYPAC and IOP, as well as to inform acute inpatient hospitalizations and PRTF placements.

An additional benefit of DMHs decision to expand the use of the CAFAS throughout the behavioral health system is that it can serve as a foundation for a coordinated statewide evaluation system. The CAFAS should be utilized for intake, periodic review, and at discharge for all children receiving publically funded behavioral health services, with providers being required to input CAFAS scores into the web-based system currently operated by DMH. Wholesale use of the CAFAS as an eligibility determination and outcomes monitoring tool will help promote accountability in the public behavioral health system and ensure that children and youth are receiving the appropriate services and supports.

MOBILE CRISIS & STABILIZATION

Mobile crisis response and stabilization is an effective mechanism for preventing unnecessary placement in institutions and increasing access to HCBS. Mobile crisis and stabilization is a DOM rehabilitation option service that CMHCs are required to provide. DMH has invested in developing the mobile crisis infrastructure through grants to the CMHCs.

DMH began plans for mobile crisis capacity several years ago and conducted a tour of the State of Georgia's system and met with Behavioral Health Link, a private company that specializes in providing crisis call center and crisis intervention services. DMH decided to have its initial grant investment focus on building provider's capacity to offer mobile crisis; with future investments planned for crisis infrastructure such as centralized triage or crisis number capacity.

The addition of mobile crisis to the service array is a new and positive development in Mississippi's system, so it's potential as an intervention to divert youth from more restrictive settings has not yet been realized and needs further development. Providers are in the process of ramping up access, and deploying and training staff. Expectations for mobile crisis are new and providers have not yet fully transitioned from historical uses of phone triage to a "in-vivo crisis intervention approach." A specific model is needed to guide the clinical intervention that occurs as variation was evident from interviews in how providers are responding to crisis calls. Some are providing phone triage and follow-up the next day at the child's school; while others were going out to homes and other community-settings. There was also variation in the CMHCs approach used to staff crisis response. Some providers did deploy child trained clinicians while many used generalist teams serving both adults and youth. DMH recognizes the need for training support for mobile crisis providers and plans to require that providers ensure that staff are trained in best practices for responding to youth and their families in crisis.

Although mobile is offered in the state, it is an underutilized service that needs to be better marketed to youth and families, system partners, and the general community. As interviews indicated, it appears to be mostly communicated at this point to existing CMHC clients. Numerous family stakeholders, advocates, and non-CMHC behavioral health providers that we interviewed stated that they were not aware of the mobile crisis service and its availability for children.

We also found that locating the mobile crisis number was not always easy, with some mobile crisis numbers not readily found on the CMHC website. Some CMHCs had different mobile crisis numbers for each county that they covered, meaning one CMHC could be operating several different numbers. For families experiencing a crisis, ready access to a number to call is critical to avoiding use of emergency departments and 911 systems.

Promoting the availability of crisis response to the community-at-large would assist to divert children and families from seeking help in emergency departments or police departments; and would potentially lead to decreases in admission rates to 24 hour programs. Many CMHCs noted that many crisis calls (for youth) they received were for existing clients. This indicates the need for enhanced clinical planning for clients already engaged in services, and a review of the marketing and clinical orientation of the crisis response service. In other words, there is a need to more clearly define requirements for an urgent response/triage system for existing CMHC clients, versus a crisis response system for those youth experiencing a behavioral health crisis that has the potential to lead to an out-of-home placement.

To assist the state in considering ways to promote clearer delivery of mobile crisis, two states definitions are provided below.

Arizona defines it service as meeting the following requirements[47]:

> *Crisis Services stabilize individuals as quickly as possible and assist them in returning to their baseline of functioning; assess the individual's needs, identify the supports and services that are necessary to meet those needs, and connect the individual to appropriate services; provide solution-focused and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, or placement in a more segregated setting; utilize the engagement of peer and family support services in providing crisis services; coordinate with all clinics and case management agencies to resolve crisis situations for assigned members;*
>
> *Crisis Services-Mobile Crisis Teams maintain the following capabilities: Ability to travel to the place where the individual is experiencing the crisis; ability to assess and provide immediate crisis intervention; have the capacity to serve specialty needs of population served including youth and children, hospital rapid response, and developmentally disabled; stabilize acute psychiatric or*

[47] http://www.azdhs.gov/bhs/policy/documents/policies/bhs-policy-111.pdf

behavioral symptoms, evaluate treatment needs, and develop plans to meet the individual's needs; respond on site within the average of ninety (90) minutes of receipt of the crisis call.

Massachusetts defines Mobile Crisis as[48]:

Mobile Crisis Intervention is the youth-serving component of an Emergency Services Program (ESP) provider. MCI teams provide a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, 7 days a week, and 365 days a year. Between the hours of 10pm and 7am, Mobile Crisis Intervention staff may be on-call and dispatched by pager. Each encounter, including ongoing coordination following the crisis assessment and stabilization intervention, may last up to 7 days, based on the individual needs of the youth served.

The service includes a crisis assessment; engagement in a crisis planning process, which may result in the development/update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family, up to 7 days of crisis intervention and stabilization services including on-site, face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology Intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff coordinates with the youth's ICC care coordinator throughout the delivery of the service. With consent, Mobile Crisis Intervention also coordinates with the youth's parent(s)/caregiver(s), primary care clinician, any care management program provider, other behavioral health providers, and/or any state agencies that are providing services to the youth throughout the delivery of the service.

Mobile crisis intervention services are designed to optimize clinical interventions by meeting clients in home or school settings where they are more comfortable, where strengths and cultural differences are more apparent, and where caregivers are more available. Community-based crisis interventions provide a highly effective alternative for de-escalation and resolution of a crisis event, allowing many youth and families to bypass the stigma of hospital settings, as well as the trauma and disruption of an emergency out-of-home placement. This is accomplished by safety planning in an actual site where long-term safety will most matter, and with the people who are crucial to the plan. MCI services optimally produce more holistic evaluations, solutions and referrals. They are also intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments (EDs) and ESP offices, to reduce the likelihood of psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intrusive manner. The nature and anticipated benefits of a community-based crisis intervention should be discussed with the youth and parent at the earliest stages of the MCI encounter, in order to ease anxiety or safety concerns, support informed consent and decision-making by the youth/caretaker, and clarify the intended purpose of the service.

DMH recognizes this need for marketing of this new service more broadly. DMH plans to work with mobile crisis providers to market the service to local school districts, colleges/universities, social services, and other community organizations to ensure that more children and families, providers and stakeholders are informed about this important service.

[48] http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/home-and-community-based-behavioral-health-srvcs.html https://www.masspartnership.com/provider/CBHIPerformanceSpecs.aspx?id=1

Crisis stabilization units are another essential component of a crisis response system and are critical to reducing 24 hour placement. They are designed to actively engage in crisis intervention work with families to stabilize the crisis and ameliorate the situation that led to the crisis. These services are significantly lower in cost, can be developed across the state to address current access issues resulting from the constellation of providers in two areas in the state, and allow for closer interaction between CSU team and the IOP service.

As an example, Arizona defines its Crisis Stabilization Services as[49]:

> *Crisis Stabilization Settings offer twenty-four (24) hour substance use disorder/psychiatric crisis stabilization services including twenty-three (23) hour crisis stabilization/observation capacity; short-term crisis stabilization services (up to seventy-two (72) hours) in an effort to successfully resolve the crisis and returning the individual to the community instead of transitioning to a higher level of care.*

Currently there is only one crisis stabilization unit for adolescents in the state. This CSU provides a range of services including mobile crisis and in home therapy. These are very important elements for crisis stabilization units. We observed that the CSU operates similarly to an acute inpatient unit with reported lengths of stay of approximately 14 days, as opposed to a crisis stabilization unit which would suggest a 2-3 day intervention intended to quickly stabilize the crisis and return the youth to their home and local schools. Given there is only one child CSU, it's model is to operate mobile and in-home capacity independent of the providers that the system has invested in operating those same services. These structures makes it difficult to expand CSU capacity. CSU capacity could be more easily expanded, and offered consistent with a 2-3 day stabilization approach if certain service elements, such as mobile crisis and intensive in-home therapy, were not duplicated by every CSU provider but rather provided by a designated mobile crisis team or a designated in-home therapy team for that child's home area in the state. Billing restrictions that do not allow for reimbursement of the CSU and any ongoing treatment providers should be lifted to allow for active treatment planning. A CSU will be able to provide rapid stabilization of 2-3 days when the CSU and ongoing service providers work "hand and glove" to identify and develop an effective plan; and support the family to ensure that the child can safely return home. Without the availability of an integrative approach across services, the current CSU will continue to operate by default as an acute inpatient service.

RECOMMENDATIONS:

1. FURTHER INVEST AND DEVELOP A COHESIVE APPROACH TO MOBILE CRISIS RESPONSE AND STABILIZATION

The development of mobile crisis response and stabilization, while underutilized by youth, is a positive step in enhancing Mississippi's service system. Additional investment in and policy priority of mobile crisis and stabilization is needed to improve access to this service, expand knowledge of its availability, implement best practices approaches, and monitor for quality. Mississippi should consider newer generation approaches to mobile crisis that allow for one-to one crisis stabilizers to work with youth and families over an extended period (e.g., 30 days). Outcomes associated with these approaches include not only reduced use of institutional placements but also reduced placement disruptions in child welfare. Given its rural nature, Mississippi also should consider use of tele-behavioral health to augment its mobile crisis response. While telehealth is currently allowed as a billable service, the state would benefit from actively encouraging its use to address needed crisis capacity in hard to reach areas of the state.

2. CONSOLIDATE 24/7 CRISIS CALL CAPACITY

We recommend that Mississippi consolidate 24/7 crisis call capacity to one centralized function. Currently, crisis call capacity is spread across 14 CMHCs. Centralized capacity would allow the state to better ensure triage, tracking and access to mobile crisis. Following triage, if a mobile intervention as needed, this one statewide crisis triage function would then mobilize the local CMHC teams as needed to conduct the crisis

[49] http://www.azdhs.gov/bhs/policy/documents/policies/bhs-policy-111.pdf

intervention in the community. Consolidation of this function would allow CMHCs to focus on crisis intervention, support consistency in response across the state, and provide oversight of this important function. Additionally, one call center could be more easily tied to warm-line/support capacity with peers/family partners. This could be a provider contracted capacity or potentially a role for a CCO or UM/QIO vendor, particularly since those vendors have some type of 24/7 call capacity currently. If capacity does not allow a statewide centralized function, consider reducing the number of call lines that CMHCs advertise and use to assist community stakeholders, who also serve people across different counties, in knowing how to access the service.

3. EFFECTIVELY COMMUNICATE THE AVAILABILITY OF CRISIS SERVICES FOR CHILDREN AND FAMILIES

We support DMHs plan to further communicate the availability of mobile crisis response as a Medicaid-billable service for children and families. In addition to DMHs plans to work with community providers, the state could also consider EPSDT notification and information materials for Medicaid enrollees and other Medicaid providers.

4. REQUIRE AN UPDATED COMMUNITY EDUCATION PLAN FOR CRISIS SERVICES

Provide additional guidance and oversight to CMHCs regarding a community education plan of crisis service availability, including mobile crisis services, to schools, pediatricians, church groups, hospitals, police and other community organizations. Teams are currently developing specific education and outreach plans to local school districts. This provides an opportunity for the state to ensure consistency in approach across providers, and to model best practice outreach and education efforts that can be used with other important referral sources.

5. IMPLEMENT A BEST-PRACTICE MODEL FOR CRISIS RESPONSE

Design and execute a statewide, child and family focused crisis response training and coaching model that is focused on crisis resolution and trauma informed competencies. Drawing upon the state's investments made in trauma informed approaches and wraparound, address clinical practice issues impacting mobile crisis service delivery. Require that providers use standardized triage methods that allow for the accurate determinations of intensity of services. Drawing from the IOP/MYPAC quality approach, develop and implement a quality and network management strategy for this important service. Use peer specialists in training to reduce stigma, increase insight into lived experience, what helps/harms in a crisis, and the limitations to services like hospitalization. Examine the data regarding place of service for mobile crisis interventions to inform any practice, policy and training supports for providers.

6. EXPAND CSU CAPACITY

Expand CSU capacity, restructuring approach to a shorter term model connected to IOP and/or in-home therapy options for rapid intervention in the home. Address barriers to billing for CSU services when concurrent with MYPAC/IOP or other intensive community-based treatment services. Although the addition of CSU capacity is important, priority should be given to expansion of effective mobile response teams and their infrastructure and training first. We suggest that the need for CSU capacity be considered after additional investment in crisis response infrastructure in the state.

7. ADD A STATEWIDE "WARM LINE"

Add a statewide "warm line" capacity that would be staffed by parents/caregivers and attached to the crisis service capacity, with the necessary funding to support the infrastructure and staffing for this type of position. Warm lines reduce calls to crisis centers, can reduce visits to emergency departments for behavioral reasons and serve as a source for community resources. By employing parents/caregivers in this professional capacity, MS will direct the limited licensed staff time to crisis intervention services, expand its commitment to family and recovery directed approaches, enhance its support to families, and engage persons with lived experience as an important workforce solution. Typically warm lines are covered through state-only funds (i.e., general state revenue funds). We suggest that the need for warm line be considered after additional investment in crisis response infrastructure in the state.

8. CONSIDER EXPANDING ALLOWABLE PROVIDERS BEYOND CMHCs

Selection of providers for mobile crisis is best made on their capacity to deliver this type of services. Many states contract with child welfare and juvenile justice providers who are not historically part of Medicaid networks but who have the experience and skills to provide rapid intervention in homes and communities. In terms of rural models, one state manages mobile crisis by contracting for single crisis teams (meaning single clinician or clinician/peer specialist team available around the clock--sometimes on-call rather than "on the clock") within a number of treatment agencies rather than one agency with a team that is based in a big population center and traveling out to smaller places (with smaller places getting slower response time and less local relationship development). This capacity is tied to a centralized 24/7 crisis line that triages requests, dispatches teams, supports resource linkage and follow-up. This model means that teams serve areas in which they live, are familiar and have relationships. It means the little population centers get as much attention as the big population centers. Additionally, consider the use of a 2 person teams to encourage home and community based interventions, particularly at nighttime. If using 2-person response, pair clinician and peer specialist so that there is diversified response. To some degree, some CMHCs are using this approach by the nature of the counties they serve; but combined with the potential to add providers other than CMHCs in the pool, more in-reach to rural communities could be achieved.

9. CRISIS SYSTEM INFRASTRUCTURE RESOURCES

DMH grant funds are able to be used for important aspects of mobile crisis response infrastructure such as community marketing and education about the service, cell phones, laptops and tracking tools. It is important to ensure that these initial investments meet the needs; and can be augmented as this new service grows in its capacity.

INTENSIVE CARE COORDINATION

It is difficult to analyze Mississippi's benefits for intensive care coordination and intensive in-home family based therapies separately as both services are linked in Mississippi's current benefit array. The Mississippi service known as Intensive Outpatient Program (IOP) contains elements of both the intensive care coordination and the intensive in-home family based therapy best practice design elements discussed in section one of this chapter. The section below will discuss IOP as it relates to the best practice benefit element of Intensive Care Coordination; and the next section will discuss IOP related to the best practice design element of intensive in-home family based therapy approaches.

Mississippi has experience providing intensive care coordination through wraparound as one of nine states to participate in the 1915(c) Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program, a 5-year demonstration waiver in effect from 2007 to 2012 that enabled states to provide home and community-based services to children as alternatives to PRTFs. In Mississippi, this program was referred to as Mississippi Youth Programs Around the Clock (MYPAC). The special services offered by MYPAC through the Demonstration waiver included intensive case management, wraparound facilitation based on a national model, and respite care. These services were provided by three organizations, including Mississippi Children's Home Services, Youth Villages, and Pine Belt Mental Healthcare. Enrollment in the waiver ended September 30, 2012. A total of 1,484 youth enrolled in the waiver, accounting for the second highest total among participating states, or about 28 percent of the total national 1915(c) waiver population.

When the state migrated the MYPAC service from the waiver to the rehab option, some of the MYPAC components were written into the rehab option under Intensive Outpatient Program (IOP) and wraparound facilitation, and under another service called Community Support Services (CSS). IOP and CSS already existed as services but were used for a different population and with different requirements. These historical uses for these defined services continue and also now include this new use for these defined services.

In terms of intensive care coordination using a wraparound approach, both the Intensive Outpatient Program (IOP) and Wraparound Facilitation are defined in the rehabilitation option to serve these functions.

The IOP rehabilitation option definition states:

a. treatment provided in the home or community to individuals up to the age of twenty-one with serious mental illness for family stabilization to empower the individual to achieve the highest level of functioning. Based on a wraparound model, this service is a time-limited intensive family intervention to diffuse current crisis, evaluation its cause, and intervene to reduce the likelihood of a recurrence. "

b. the clinical purpose is to is to stabilize the living arrangement, promote reunification and prevent the utilization of out-of-home therapeutic resources to allow the individual to remain at home and in the community.

c. The components are based on an all-inclusive model that covers all mental health services the individual may need, [and] may include:

1. Treatment plan development and review
2. Medication management
3. Intensive individual and family therapy provided in the home
4. Group therapy
5. Day treatment
6. Peer support services
7. Skill building groups
8. Wraparound facilitation

The Wraparound Facilitation definition states:

a. the development and implementation of a treatment plan which addresses the prioritized needs of an individual up to the age of twenty-one (21). The treatment plan empowers the individual to achieve the highest level of functioning through the involvement of family, natural and community supports.

b. the clinical purpose of wraparound facilitation is to assist an individual to function at the highest level at home, school and the community through the intensive individualized treatment plan.

c. The service components may include:

1. Treatment plan development and review
2. Identifying providers of services and other community resources to meet [the] family and the individuals needs
3. Making necessary referrals for the individual

In terms of how services are defined, the definitions in the state plan amendment for wraparound facilitation and IOP are clear but the expectations for how each is used in the system, and how each is paired together with other services to support an evidence-based practice approach to intensive care coordination is confusing.

The IOP service is intended to fulfill three service system needs:

1. Intensive care coordination for children that meet PRTF level of care-this is what is referred to as the MYPAC program;
2. A step-down intensive care coordination program for children that need intensive care coordination but are not PRTF level of care-this is called IOP;
3. No matter if the service is MYPAC or IOP, the service is supposed to provide the element of intensive in-home family based therapy.

To differentiate IOP in the claims data for when it is used for children that are PRTF level of care (called MYPAC) and when used for children as a step-down (just referred to as IOP), a modifier is used to indicate MYPAC. This is added by DOM when a child has been determined eligible for that service through a MYPAC specific assessment process.

The IOP service is billed as an all-inclusive service using one procedure code. The all-inclusive package of services defined are supposed to meet the needs of enrolled children. Separate behavioral health services cannot be billed when a child is designated with the MYPAC modifier. However, when a child is not designated with the MYPAC modifier, the provider may bill other service codes on days that the provider does not bill the IOP code, such as individual or family therapy. Providing intensive care coordination using wraparound is an optional component of IOP and not a requirement. Providers of IOP are required to use appropriate evidence-based practices to address the intensive in home family therapy needs of youth.

For some functions, the state has maintained the prior waiver processes for MYPAC, including program requirements, assessment processes and provider certification requirements. Some of these processes do not apply to IOP for non PRTF level of care children. For example, children enrolled in IOP with the MYPAC claim modifier are required to use wraparound but when IOP is not designated for use with PRTF level of care children, wraparound is optional. As another example, providers assessing a child for the MYPAC designation are required to follow assessment processes that include collection of reports from past and current providers, other agencies and the child's school.

Analysis of the data as discussed in Chapter One of this report indicates that the majority of IOP claims include the modifier, and therefore are used as part of the MYPAC program. Only a small amount of utilization exists without the modifier, indicating little usage of IOP for children that do not meet PRTF level of care. Given that IOP can be used as a step-down service, as well as for its historical uses such as outpatient therapy for mental health or substance use needs, understanding the purpose of those IOP services cannot be understood through a claims analysis. Review of records and interviews would be needed. Additionally, as indicated in chapter one, analysis of data indicated service codes for "service planning" but it is unclear of that utilization what may be specific to the wraparound facilitation rehabilitation option service.

Referrals to IOP have been slower than estimates of need would indicate. Several reasons for this issue were noted. As of this writing, the two Demonstration Waiver providers and one CMHC offer this service. DOM has sought to expand this service to other providers; however, the state has received limited interest by providers. Second, providers report that the IOP rate is insufficient to cover the required elements, and that they are confused about the required service elements, and have been slow to offer that service. The IOP rate offered to new providers is significantly less than the MYPAC rate that continues to be paid to the original MYPAC providers. A rate differential between MYPAC and IOP is appropriate if the services are really differentiating intensity of population. Given the low utilization of IOP, it is not clear what populations are being served in the programs. DOM and DMH offered to conduct a rate study but that offer was declined by the Mississippi Association of Community Mental Health Centers. DOM is meeting with providers to address these issues. Additionally, some CMHCs reported no interest in providing this type of service no matter the rate established.

Third, families and other child serving system staff interviewed reported no or little knowledge of IOP. Stakeholders and providers had inconsistent knowledge of and understanding of the service or a misconception that it was a "waiver" service and not available to any Medicaid child. The state has made efforts to provide written information and to train other agencies. Given this reported lack of knowledge and misinformation, a review of the training approach is recommended to identify ways to augment and promote greater knowledge of this important service.

Fourth, with a limited pool of providers, capacity was limited and referral sources found wait times, thus some referral sources believed that making further referrals was futile. As previously mentioned, DOM would like to see more providers offer this service.

Fifth, eligibility criteria and processes impact rapid access to this service. Children must meet the following criteria to be determined eligible:

1. The youth must have been diagnosed by a psychiatrist or licensed psychologist in the past 60 days with a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria for SED specified with the DSM on Axis I;

2. The youth has a full scale IQ of 60 or above, or, if IQ score is lower than 60, there is substantial evidence that the IQ scores is suppressed due to psychiatric illness; and

3. The evaluating psychiatrist or licensed psychologist advises that the youth meets criteria for PRTF level of care. The youth meets the same LOC for admission to a PRTF, but can be diverted to MYPAC as an alternative to residential treatment; or the youth is currently a resident of a PRTF or acute care facility, who continues to meet the LOC for residential treatment, but who can be transitioned back to the community with MYPAC services.

4. The youth needs specialized services and supports from multiple agencies including community support services or targeted case management, and an array of clinical interventions and family supports.

Current level of care criteria and admission processes for MYPAC and IOP (specifically the psychiatric evaluation and IQ test requirements) critically delay access to this service with stakeholder reports ranging from 2-6 months for enrollment. The majority of states in the country do not limit the capacity to diagnose behavioral health conditions to only psychiatrists or psychologists. Mississippi does not restrict this practice within their licensing requirements of other "practitioners of the healing arts" such as independently licensed social workers. The scope of independently licensed practitioners such as social workers includes the ability to diagnose behavioral health conditions. By limiting the pool of practitioners, particularly to the severely limited number of psychiatrists and psychologists available, impacts access to this service. The requirement for IQ testing on all children referred was migrated from the CMS waiver requirements but is not necessary for rehab option services. This holdover procedure results in unnecessary delays to care, unnecessary expenditures, and discourages families from pursuing this service. Operating within the scope of their license, independently practitioners are able to ascertain whether an intellectual disability may be present that could impact the ability of a youth to benefit from this service. In those instances when an intellectual disability may be present, IQ testing would be warranted; however, to carry out IQ testing when youth and family interviews, school information and other and historical information can corroborate the absence of an intellectual disability is unnecessary. Rapid assessment and admission is key to maintaining a child in the home and community. Delays from referral to enrollment can be costly for both families and the state, resulting in disengagement from care and/or decompensation in functioning.

The current service definition for IOP also bundles most mental health services together. The package includes medication management, day treatment, skills groups, and individual, group and family therapy, peer support, and wraparound. In states that use bundling approaches of such a range of different behavioral health services, it is used in conjunction with population based enrollment and capitated risk (or similar) arrangements. An example would be paying a health plan for a population of children (e.g., SED population) a monthly per member per month to provide a range of services that children may need. In this instance, Mississippi is not asking providers to manage a population of children with different needs. It is asking providers to provide intensive in-home family therapy, and optional intensive care coordination using wraparound. One of the reasons for this bundling approach by DOM was out of concern regarding the amount and quality of day treatment services children were receiving. While the state worked diligently to find a solution to address day treatment quality concerns, they may have inadvertently created a lack of clarity that could lead to other quality and provider issues.

The inclusion of all of the other mental health benefits under this description does not support individualized approaches to care; not does it provide clarity on what the state wants to purchase from providers. A bundling approach for effective intensive care coordination should involve what it takes for providers to

deliver this service effectively. This would include components like travel time, telephone consultation, care plan teams development, care plan team convening, care planning, assessment of needs and strengths, and resource linkage and referral.

As an example, below is Montana's 1915(i) definition for Intensive Care Coordination. Please note we abbreviated the description table for space[50].

> *High Fidelity Wraparound Facilitation Wraparound Facilitation services are comprehensive services comprised of a variety of specific tasks and activities designed to support the family and youth in identifying, prioritizing, and achieving their goals using the wraparound process within a team of the family's choosing. Wraparound facilitators work under the supervision of a licensed mental health professional.*
>
> *The following table provides a breakdown of billable/non-billable activities. Wraparound Facilitator duties include:*

FACE-TO-FACE (billable per 15 minute code)	***COORDINATION (billable per 15 minute code with modifier)***	***PAPERWORK (not billable; activities are included in the rate)***
Engaging the family	*Engaging the family*	
Completing the Strengths, Needs and Cultural Discovery with the family Review completed SNCD with family for editing	*Completing the Strengths, Needs and Cultural Discovery with the family (can possibly occur multiple times as family dynamics/circumstances change)*	*Completing the Strengths, Needs and Cultural Discovery with the family; Edits to the SNCD; typing and updating*
	Assembling the wraparound team (mostly coordination; some face-to-face)	*Agenda for meeting and progress notes (meeting overview minutes)*
Facilitating family team meetings and developing a crisis plan (mostly, some coordination)	*Updating/coordinating w/ team members not present at the meeting; Gathers information from team members who will not be at the meeting/reminder calls of meeting time and date.*	*Typing/writing the meeting overview*
Convening regular meeting with family and team to review accomplishments and progress towards goals and to make adjustments	*Convening regular meeting with family and team to review accomplishments and progress towards goals and to make adjustments*	*Preparing agenda for meeting, updating ground rules, etc*
	Calls to team members to elicit information/updates if member will not be in attendance and ensuring follow through of role on team responsibilities	*Documenting and maintaining all information regarding the, approved service plan including revisions approved by the regional manager*
	Presenting the team's suggested service plan changes to the regional manager for approval	
Providing copies of the current approved service plan to the youth and family/ legal representative and to professional and agency team members	*Providing copies of the current approved service plan to the youth and family/guardian and to professional and agency team members*	*Making copies of current approved service plan and mailing out copies to those not present and/or after revisions have been made and approved by the regional manager*

[50] https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/providermanuals/1915%28i%29HomeandCommunityBasedServicesProviderPolicyManual.pdf

	Monitoring the service plan to ensure services are provided as planned; ongoing with Regional Manager	
	Consulting with family to ensure services received continue to meet identified needs	
	Maintaining communication between all wraparound team members	
	Preparing family for transition out of formal wraparound 1915(i) HCBS State Plan	*Documenting proposed team revisions to service plan to support transition and providing this to the regional manager for approval and revision of the service plan*
Complete MT CANS (to occur at admission, every 3 months, and at discharge)	*Complete MT CANS (to occur at admission, every 3 months, and at discharge)*	*Complete MT CANS (data entry; report activities)*

This definition provides one example that clearly defines intensive care coordination, and the service components required to effectively deliver care consistent with evidence-based practices for care coordination. This example was also selected because it is from a state that has a separate definition for intensive in home family therapy; clearly differentiating the intent and purpose of both of these different services in their systems.

In addition to the issues discussed above with the current bundling approach, some services such as individual therapy, family therapy and day treatment can no longer be provided by the existing providers or in the case of children with the MYPAC designation, must be purchased by the MYPAC provider directly. During interviews, both the MYPAC providers and the CMHCs indicated little purchasing by the MYPAC providers of these bundled services since the migration of this service to a rehab option benefit from the waiver. This results in youth being discharged from the care of any existing providers and creates disincentives for existing providers to refer. While CMHCs do make referrals to IOP, many voiced preference to not refer because they thought their quality of care was better, or out of concern in disrupting relationships. This is further complicated by the fact that the state allows these other billing codes to be used for IOP enrolled children that do not have the MYPAC designation.

While the IOP definition shares components of a best practice definition for intensive in home therapy and intensive care coordination, the definitions do not fully align with practices that are specific to each. Additionally, allowing providers to bill other "like" services on days that IOP is not billed does not support evidence-based approaches for intensive care coordination or intensive in home family therapy. A service definition should support an evidence-based approach, and allowing for other individual or family therapy to be provided outside of the IOP services that by its definition is supposed to provide those very services undermines effective service delivery.

For providers, this leads to confusion on what model and approach they are using when; and when they can use a certain service alone and when it can only be used in conjunction with two other services (CSS and wraparound facilitation). This also creates challenges for DMH and DOM to monitor provider performance. Given the concerns that DOM and DMH have about provider performance, the use of definitions that are not differentiated and have optional components vs required components makes oversight of service delivery difficult. Clearer definitions that explicitly state what is expected to be delivered, when and how, will aid the state in ensuring quality of care, will decrease the likelihood of services being used inappropriately and will increase the likelihood that providers will perform to expectations. Clearer service definitions also need to align with staffing requirements. Wraparound facilitators are responsible for facilitation of the planning process and should coordinate an array of services and supports. They are not required to have a master's degree in a mental health field; therefore, wraparound facilitators should not and cannot deliver individual or family therapy. The facilitator role and the clinician role should be separate and distinct.

Based on discussions with providers, it appears that technical assistance and guidance offered to providers to date has not helped them to understand the state's expectations regarding the use of the new rehabilitation services, how to become a provider of these services, and how to bill for these services. For example, some providers thought of IOP as only a substance use treatment service. Others described IOP as "MYPAC light" to be used for children who do not need MYPAC. Others report they use wraparound facilitation in lieu of targeted case management for children that do not need the intensity of MYPAC but need some type of coordination. The fact that the state continues to offer a per diem rate to the two providers who delivered MYPAC under the waiver, while suggesting that other providers would need to bill a combination of Wraparound facilitation, IOP, or CSS does in order to achieve the same level of intensity as MYPAC further contributes to a lack of clarity and potential interest by the CMHC providers in delivering IOP.

We applaud DOM for their effort to invest in IOP and increase use of an evidence-based practice in their system; particularly to encourage a system to move from a traditional use of day treatment to a more evidence-based group therapy approach. We further support MS efforts to use innovative financing approaches such as bundling to incent the use of certain services in their system. We do see, however, unintended consequences from the implementation of these efforts that are impacting access to care.

RECOMMENDATIONS:

1. CLEARLY DEFINE SERVICES TO ENSURE THE PROVISION OF INTENSIVE CARE COORDINATION USING WRAPAROUND

Revise service definitions to more clearly differentiate services that are intended to do different things for different populations, and to include required instead of optional elements. Consider separate rehabilitation option definitions for the intensive care coordination function and the intensive in-home family therapy function. Given that it is not clear from claims data when a code indicates intensive care coordination using wraparound, intensive family therapy or both services, separate service definitions would ensure the delivery of effective services and that a review of data would indicate services provided. If the state does not want to consider separately defined benefits for intensive care coordination and intensive in-home family therapy, then the service definition should be revised to indicate that both are required (vs allowing intensive care coordination using wraparound to be optional.) Both services need to be available in a system; and as discussed in the next section on intensive in-home family therapy, not all children will require both services at the same time-that is why many states define them as separate benefits and why we are recommending separate benefit definitions.

Within the effort to more clearly define services, reconsider the use of two levels of IOP- one for PRTF level of care and one as a step-down from PRTF level of care. The differentiation of PRTF level of care is no longer needed now that the service is approved under the rehabilitation option. The state's efforts to ensure that IOP is available as a step-down are laudable. IOP is an essential service for children with serious mental health needs whether or not they are at a PRTF level of care. Because IOP services are expected to be individualized to the unique needs of a child, training staff in the evidence-based practice, and authorization and quality oversight can ensure that the appropriate amount of care is delivered to meet the individualized needs of each child.

As service definitions are fine-tuned, it will be important to ensure that participation in care planning team meetings for non-IOP Medicaid providers that are part of a child's treatment plan are reimbursable. This will necessitate a review of other rehabilitation option service descriptions to ensure that those services allow for clinicians to participate in the care plan teams. Having IOP be the point of coordination in the system even when a child is admitted to a 24 hour service will further align policy with best practice. Currently, when a child is admitted to a 24 hour service, the child must be discharged from IOP and later reenrolled following that hospitalization. This leads to wait times for the child to resume IOP when re-referred but also prohibits IOP from continuing to coordinate care. In other states where the intensive care coordination provider

continues to be involved when a child is hospitalized, systems see shorter lengths of stay by having this service continue to coordinate care.
Further, re-examine the purpose for a service called wraparound facilitation separate from a newly defined intensive care coordination service definition.

2. REVIEW THE BUNDLED APPROACH TO SERVICE DEFINITION

Aside from the issue of IOP defined to meet both intensive in home family therapy and intensive care coordination, the current IOP definition includes services such as day treatment, medication management, individual, family and group therapy, peer support, wraparound facilitation and skill building groups. This constitutes most of the behavioral health benefits under one service definition.

Wraparound provides a unique opportunity to manage care by identifying strategies that align with a family/child's strengths and needs. The state should consider eliminating the current bundling of disparate services and consider a limited bundled approach that supports individualized approaches to care and evidence based practices. Specifically, combining day treatment, skills groups, medication management and other components previously discussed in the bundle do not align with the clinical purpose of intensive care coordination.

Rather than bundling services of concern (e.g., day treatment), use other utilization and quality approaches to address quality issues. Additionally, consider a single plan of care approach for children enrolled in an intensive care coordination approach through which other behavioral health services are approved. This ensures that all services are coordinated, that the range of services children need concurrently make sense and are not duplicative. This could be tied to the authorization processes of Medicaid vendors such as the CCOs and UM/QIO. This approach poses an additional opportunity for MYPAC to be the point of coordination in the system even when a child is admitted to a 24 hour service.

3. EXPAND ACCESS TO AND PROVISION OF IOP SERVICES

The state needs to continue its efforts to expand the number of providers that deliver IOP services. The state currently has limited capacity with three providers. Given the state's intent that IOP provide care to children that are "a step-down" from PRTF level of care, additional capacity is needed to ensure that this service is more widely available to more children.
Clearer communication, in writing, to providers and referral services is needed about the population for referral to IOP. Many providers and stakeholders do not understand the range of children's issues that could be referred to this service.

4. ENSURE RAPID ACCESS TO MYPAC

The process for referral, document collection and approval to MYPAC is very labor intensive and time consuming. The state has maintained processes used under its waiver program which are not needed under the rehabilitation option. Families often seek such services in times of heightened need and it is critical that they access services quickly, otherwise they may become discouraged or frustrated and rely on more traditional types of care. Intake staff are typically the family's initial contact with the program and as a result, quality consumer service is essential. A positive first experience can promote engagement with and attrition to the program and enhance the program's image in the community. The use of standardized assessment tools discussed previously and the reduction or elimination of these historical requirements can ensure that this service is rapidly available to families.

Mississippi could consider use of data from their CCOs or UM/QIO to streamline and ensure appropriate admissions to intensive home- and community-based services. MCOs have capacity, expertise, and leverage with providers to facilitate rapid enrollment in intensive home- and community-based services. By reviewing data, children that may benefit from this service could be triaged quickly. Additionally, Louisiana's eligibility determination process for their Coordinated System of Care included presumptive eligibility and may be beneficial to Mississippi to consider.

5. ELIMINATE THE REQUIREMENT FOR IQ SCORE FOR MYPAC ENROLLMENT

Among states implementing intensive care coordination programs, Mississippi is the only state to require IQ testing in its eligibility criteria. It is recommended that the requirement for IQ score be eliminated and replaced with clinical judgment of absence of an IQ issue with testing required for uncertain clinical scenarios, as other states have done. This will reduce unnecessary testing, wait times and unnecessary costs in the system.

6. RE-EVALUATE REQUIREMENT FOR PSYCHIATRIC DIAGNOSIS BY A PSYCHIATRIST OR PSYCHOLOGIST

Re-evaluate requirement for psychiatric diagnosis by a psychiatrist or a psychologist given the lengthy wait times reported for appointments with these two disciplines; and allow independently licensed staff of other discipline to perform this function as allowed within the scope of their license. We understand that this is currently under review.

7. USE COORDINATION SERVICES AND BILLING CODES THAT ALLOW FOR IOP AND INSTITUTIONAL PROVIDERS TO COORDINATE CARE

To facilitate treatment and transitions, establish service definitions and billable codes, policies and practices that emphasize warm "hand-offs", joint care planning and the active exchange of information. Children would benefit from system incentives that encouraged institutional providers and community providers to more rapidly exchange information, and engage in informed care planning. For example, many Medicaid programs reimburse for one warm "hand-off" (face to face meeting) that includes the community provider, institutional provider, youth and family in order to support successful transitions. Another successful strategy is the reimbursement for telehealth, allowing for a "virtual" transition meeting. Additionally, other states allow for reimbursement to participate on the child and family teams.

8. ADDRESS RATE ISSUES AND PROVIDER CONFUSION

Medicaid is currently meeting with providers to address concerns about the IOP rate. As stated previously, DOM and DMH have also offered to conduct rate studies on services. In other chapter, we discuss and recommend that a range of provider communication approaches be used to facilitate policy issues including regular meetings specific to children's behavioral health policy issues, active dialogue with providers, written communication to all providers of behavioral health services, and an increased focus in translating individual provider questions into more frequent policy communications to all behavioral health providers.

9. TRAINING AND INFORMATION

Mississippi has made an introduction to wraparound training available to behavioral health service providers (in addition to providers delivering MYPAC), and to system partners such as child welfare staff. Given that wraparound engages all involved systems in the plan of care, we recommend that a system-wide coordinated training plan be developed to address ongoing training needs across all child serving systems and other behavioral health service providers. Information and training on wraparound and their role in the wraparound process is vital to successful outcomes for this evidence-based practice. In addition to a coordinated interagency effort on joint training, written materials geared towards schools, child welfare and juvenile justice would be beneficial as part of that ongoing effort. The state has partnered with the University of Southern Mississippi to provide training infrastructure for wraparound across the state. USM could provide this additional planning and training support.

INTENSIVE IN-HOME FAMILY BASED THERAPIES

DOM has indicated that IOP is intended to be the intensive in-home family therapy model in Mississippi. As mentioned in the previous section, it is difficult to analyze Mississippi's benefits for intensive care coordination and intensive in-home family based therapies separately as both services are linked in

Mississippi's current benefit array. Given how it is defined, and that the same definition is used to also address intensive care coordination, it is not clear if a separate service called intensive in-home family therapy is available for children in Mississippi (and likewise if a separate service called intensive care coordination is available.)

As part of the 2012 Medicaid rehabilitation option revisions, DOM submitted an intensive in home family therapy definition for approval by CMS but it was denied by CMS due to a perceived duplication to IOP. In response, DOM added clarification to the IOP service description including family therapy as part of that service. We commend DOM for recognizing the importance of intensive in home family therapy approaches, and attempting to resolve this Medicaid benefit issue by including family therapy as part of IOP.

Combining two separate services into one service has created system challenges. First, providing wraparound is an optional component of IOP and not a requirement. While the IOP definition shares many components of a best practice definition for intensive in home therapy and intensive care coordination, allowing one service definition to be used interchangeably-either for intensive in home or intensive care coordination, is confusing. It creates challenges for DMH and DOM to monitor provider performance and to clearly understand the services that are being provided when data is reviewed. Given the concerns that DOM and DMH have about provider performance, clearer definitions that explicitly state what is bought, when and how, will aid the state in ensuring quality of care and decrease the likelihood of services being used inappropriately.

The components of intensive in-home family based services include individual and family therapy, skills training, and behavioral interventions."[51] This array of interventions is meant to be used flexibly and delivered where the youth and family choose. One substantial benefit of this benefit is that trained staff can help youth and families practice skills in "real world" settings, which increases the likelihood that they will be able to apply these skills in a variety of situations they face every day. As stated in the discussion about care coordination, the current definition does not clearly align with delivery of in home family based therapy; and bundles an array of mental health benefits together that are not consist with family based therapy models. Given that many in home family based therapies such as Multi-Systemic Therapy (MST) involve team approaches, further clarification of expectations to provide a therapeutic mentoring like components would also help differentiate the type of clinical intervention being provided in IOP. Components of therapeutic mentoring exist in several rehabilitation option definitions including IOP, Community Support Service (CSS), and Peer Support.

As an example, Massachusetts defines In-Home Family Therapy[52] as:

> *In-Home Therapy Services: This service is delivered by one or more members of a team consisting of professional and paraprofessional staff, offering a combination of medically necessary In-Home Therapy and Therapeutic Training and Support. The main focus of In-Home Therapy Services is to ameliorate the youth's mental health issues and strengthen the family structures and supports. In-Home Therapy Services are distinguished from traditional therapy in that services are delivered in the home and community; services include 24/7 urgent response capability on the part of the provider; the frequency and duration of a given session matches need and is not time limited; scheduling is flexible; services are expected to include the identification of natural supports and include coordination of care. In-Home Therapy is situational, working with the youth and family in their home environment, fostering understanding of the family dynamics and teaching strategies to address stressors as they arise. In-Home Therapy fosters a structured, consistent, strength-based therapeutic relationship between a licensed clinician and the youth and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family. Interventions are designed to enhance and improve the*

[51] United States Department of Health and Human Services, Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration. (2013). *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*. Retrieved on June 20, 2014 from: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

[52] http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/home-and-community-based-behavioral-health-srvcs.html

family's capacity to improve the youth's functioning in the home and community and may prevent the need for the youth's admission to an inpatient hospital, psychiatric residential treatment facility or other treatment setting. The In-Home Therapy team (comprised of the qualified practitioner(s), family, and youth), develops a treatment plan and, using established psychotherapeutic techniques and intensive family therapy, works with the entire family, or a subset of the family, to implement focused structural or strategic interventions and behavioral techniques to: enhance problem-solving, limit-setting, risk management/safety planning, communication, build skills to strengthen the family, advance therapeutic goals, or improve ineffective patterns of interaction; identify and utilize community resources; develop and maintain natural supports for the youth and parent/caregiver(s) in order to promote sustainability of treatment gains. Phone contact and consultation are provided as part of the intervention.

Montana defines In-Home Family Therapy as[53]:

In-Home Therapy In-home therapists provide face-to-face, individual, and family therapy for youth and parent(s)/legal representatives in the residence of the youth at times convenient for the youth and family. As part of the provision of the therapy and for the purposes of the service plan, the in-home therapist must: (a) communicate with the department regarding the status of the youth and their treatment; (b) develop and write an individual treatment plan with the youth and parent(s)/legal representative specific to mental health therapy; (c) provide crisis response during and after working hours; (d) assist the youth with transition planning; and (e) attend family and team meetings and other activities pertinent to support success in the community. The in-home therapist and high fidelity wraparound facilitator cannot be employed by the same agency when serving on the treatment team and providing services to a specific youth enrolled in the 1915(i) HCBS State Plan program.

Both of these examples are important for two reasons. While these state plan definitions are different in scope, both clearly define intensive in home family therapy, provide a definition that is consistent with evidence-based practices, and state how providers are expected to perform/deliver care. These examples were also selected because they are two of many states that also have separate definitions for intensive care coordination; clearly differentiating the intent and purpose of both of these different services in their systems.

Not all children need both intensive care coordination and intensive in home family therapy at the same time. By bundling the two together, the state may not be fully realizing effective quality and efficient financing that could be realized if these services were defined separately.

Families and providers highlighted the need for an intensive in-home therapy model. Providers reported that engaging families in treatment could be "difficult" and that, "there is no way to deal with problems in the home." Clinicians reported little time and ability to provide the type of family therapy they knew was needed to help a child; from the lack of reimbursement for travel time to safety concerns about being in a family's home, clinicians and managers reported frustration with not being able to meet the needs of families.

Time did not allow our review of the intensive in-home family therapy service descriptions submitted to CMS; therefore, we cannot speak to any apparent duplication between those proposed services. However, other states have received CMS approval of both intensive care coordination and intensive-in home therapy including Georgia, Massachusetts, and Montana. Additionally, the joint informational bulletin released in May 2013 by the Centers for Medicaid and CHIP Services (CMCS) and the Substance Abuse and Mental Health Services Administration (SAMHSA), which provided guidance to states on establishing benefit designs

[53] https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/providermanuals/1915%28i%29HomeandCommunityBasedServicesProviderPolicyManual.pdf

intended to help youth with behavioral health challenges remain in their homes and local communities, clearly defined Wraparound facilitation and intensive-in home therapy as distinct services[54].

RECOMMENDATIONS:

The recommendations made in the previous section on intensive care coordination are also applicable to intensive in home family based therapy. There is a need to more clearly define in-home family based therapy consistent with evidence-based practices and addressing bundling of other services with a family based definition; address expanded access to the service, coordination with other services, and rate and provider issues. In addition, we also recommend:

IMPLMENTATION OF EVIDENCE-BASED PRACTICE SPECIFIC TO INTENSIVE IN HOME FAMILY BASED THERAPY

We recommend that a system-wide coordinated training and fidelity effort be developed specific to at least one evidence- based in-home family based therapy model. While providers are required to use EBPS, it is not clear what specific models are being consistently used. If the state invested in at least one model, the state would be better able to realize its system goals for this service. As an example, the state could select Multi-Systemic Therapy (MST) that was previously introduced to providers in Mississippi.

RESPITE

Respite services are intended to assist children to live in their homes in the community by temporarily relieving the primary caregivers. Respite services provide safe and supportive environments on a planned or unplanned short-term basis for children with mental health conditions when their families need relief. Respite services are provided either in the home or in approved out-of-home settings. Currently, the Making A Plan (MAP) team process has access to limited funds from the Department of Mental Health to purchase respite. While a review of MAP Team processes and expenditures was beyond the scope of our work; DMH reports that a small amount of dollars, approximately $ 722,696 is able to be allocated to MAP teams; thereby impacting the extent of its use in Mississippi. Additionally, DOM supported the purchase of respite services through the waiver that covered MYPAC services.

In April 2013 DMH and the Strategic Planning and Best Practices Committee established as part of the Rose Isabel Williams Mental Health Reform Act, conducted a survey of external stakeholders to identify needed or desired revisions to the core services that CMHCs and other DMH approved and certified mental health service providers offer. Recommendations from this survey for additional core services for youth included: respite care, family support, and supportive housing options for young adults, prevention services, and creative therapies such as art or music.[55] Additionally, interviews conducted with stakeholders for this assessment identified the need for similar additions to the service array for youth. Respite care, (not just crisis or overnight respite but respite care a family could access even for a few hours in the afternoon or evening) was mentioned repeatedly by families as a service that could help them to maintain their child at home and avoid placement in PRTF and/or hospitals.

States are using a variety of funding streams for this service, often blending general revenue and certain federal dollars from other child-serving agencies such as child welfare and juvenile justice. In addition, some states are using Medicaid as a sustainable funding source for respite care, employing a variety of different Medicaid authorities. Indiana which had a 1915(c) Community Alternatives PRTF Demonstration Grant, leveraged the Money Follows the Person (MFP) Rebalancing Demonstration Grant, which helps states rebalance their Medicaid long-term care systems, to support youth transitioning from PRTF settings into the

[54]United States Department of Health and Human Services, Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration. (2013). *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*. Retrieved on June 20, 2014 from: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

[55] Rose Isabel Williams Mental Health Reform Act of 2011 Strategic Planning and Best Practices Committee. Report to the Legislature. (June, 2013). Retrieved on November 17, 2014 from: http://www.dmh.ms.gov/wp-content/uploads/2012/08/SPBP-Final-Report_Scanned-Version.pdf

community. Montana used the 1915(i) HCBS State Plan authority to include respite along with several other services in its state Medicaid plan. Through its Coordinated System of Care (CSoC) effort, Louisiana uses the 1915(b)(1) mandatory managed care enrollment combined with a 1915(c) HCBS waiver to cover short-term respite care for youth with serious behavioral health challenges. Louisiana also uses managed care savings under the Medicaid 1915(b)(3) authority to pay for respite services for youth who meet eligibility criteria for enrollment in the CSoC but who do not meet the institutional level of care criteria under its 1915(c) waiver.

While CMS does not allow coverage of respite through a Rehabilitation Option, there are other viable options that Mississippi is encouraged to explore to fund this service. As an example, Indiana, also a former 1915(c) Community Alternatives PRTF Demonstration Grant state, leveraged the Money Follows the Person (MFP) Rebalancing Demonstration Grant, a program that helps states rebalance their Medicaid long-term care systems to support youth transitioning from PRTF settings into the community. Respite providers in Indiana bill in 15 minute increments when respite is provided for less than seven hours in any one day; or at a daily rate when respite is provided from seven to 24 hours. Indiana also allows crisis respite care to be provided for a minimum of eight to 24 hours billable at a daily rate.

Montana used the 1915(i) HCBS State Plan authority to include respite along with several other services in its state Medicaid plan. Montana respite providers who deliver care for less than 24 hours bill in 15 minute units, also using the Healthcare Common Procedure Coding System (HCPCS) code S5150, while those providing overnight respite bill a daily rate using code S5151. In addition, through its Coordinated System of Care (CSoC) effort, Louisiana uses the 1915(b)(1) mandatory managed care enrollment combined with a 1915(c) HCBS waiver to cover short-term respite care for youth with serious behavioral health challenges. Louisiana also uses managed care savings under the Medicaid 1915(b)(3) authority to pay for respite services for youth who meet eligibility criteria for enrollment in the CSoC but who do not meet the institutional level of care criteria under its 1915(c) waiver. Like Montana, providers in Louisiana bill for respite services in 15 minute increments using HCPCS code S5150.

Montana defines respite as[56]:

> *Respite Care is the provision of supportive care to the youth when the unpaid persons normally providing day to day care for the youth will not be available to provide care. Respite care services may be provided only on a short term basis, such as part of a day, weekends, or vacation periods. Respite Care services may be provided in the place of residence of the youth, another private residence or other community setting, excluding psychiatric residential treatment facilities. The provider of respite care must ensure that its employees providing respite care* services are: (a) physically and mentally qualified *to provide this service to the youth; (b) aware of emergency assistance systems and crisis plans; (c) knowledgeable about the physical and mental conditions of the youth; (d) knowledgeable about common medications and related conditions of the youth; and (e) capable to administer basic first aid. Respite care cannot be billed at the same time as Crisis Intervention Service. Per federal regulation, the cost for room and board furnished in a residential setting is excluded.*

Louisiana defines respite as:[57]

> "Short term respite care provides temporary direct care and supervision for the child/youth in the child's home or a community setting that is not facility-based (e.g., not provided overnight in a provider-based facility). The primary purpose is relief to families/caregivers of a child with a SED or relief of the child. Respite services help to de-escalate stressful situations and provide a therapeutic outlet for the child. Respite may either be planned or provided on an emergency basis. Normal activities of daily living are considered to be included in the content of the service when providing respite care and cannot be billed separately. These include support in the home, after school or at

[56]https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/providermanuals/1915%28i%29HomeandCommunityBasedServicesProviderPolicyManual.pdf

[57] http://new.dhh.louisiana.gov/assets/docs/BehavioralHealth/LBHP/LBHPSvcsManv4b.pdf

night, transportation to and from school/medical appointments or other community-based activities and/or any combination of the above. The cost of transportation is also included in the rate paid to providers of this service. Short term respite care can be provided in an individual's home or place of residence or provided in other community settings, such as at a relative's home or in a short visit to a community park or recreation center. Respite services provided by or in an Institution of Mental Disease (IMD) are not covered. The child must be present when providing short-term respite care. Short term respite care may not be provided simultaneously with crisis stabilization services and does not duplicate any other Medicaid State Plan service or service otherwise available to recipient at no cost.

It is important to note that room and board costs cannot be included in the rate for Medicaid funded respite services. To account for this, Louisiana leverages funding from other agencies that from the Louisiana Behavioral Health Partnership, such as the Office of Juvenile Justice and the Department of Children and Family Services, to cover the costs of room and board for overnight respite care.

RECOMMENDATION: EXPAND RESPITE SERVICES

TAC/The Institute recommends that DOM and DMH continue to explore various avenues to expand funding for respite care, including how Medicaid could be utilized in order to draw down additional federal dollars. In addition to expansion of funding, a certain portion of MAP team funds could be designated to specifically support youth and families who need respite. Depending on related efforts to reduce institutional care, some capacity may be able to be repurposed for respite care. This would require training and other policy changes to ensure that any repurposed capacity met its new goals.

GOODS & SERVICES

As mentioned in the aforementioned respite section, DMH is able to allocate limited dollars to the MAP teams for use in purchasing goods and services. As with respite care, states have several options to make this service available. Most states blend dollars across child-serving agencies to make flexible funding available for high need children receiving intensive care coordination. Chapter 4 in this report on Interagency Collaboration discusses opportunities for Mississippi's child serving agencies to better meet the behavioral health needs of children, including blending or braiding of funding to collectively pool dollars together, compensating for certain funding rules/restrictions. As with respite care, states have several options to make flexible funding available to families. Maryland is implementing use of customized good and services as part of its 1915(i) Medicaid state plan amendment. Other jurisdictions including Milwaukee County, Wisconsin, Cuyahoga County, Ohio and New Jersey have leveraged state dollars for flexible funding.

Wraparound Milwaukee defines its flexible funds as:[58]

> *Funds intended for the purchase of a service or commodity that is needed to meet a specific client mental health need. The disbursement of those funds by a Care Coordinator must be directly related to achieving a specific need in the Plan of Care for the child or family enrolled in Wraparound Milwaukee. The following categories should be used to identify specifically what the discretionary request is for. Incentive Money, Rent, Security Deposit, Utilities, Phone, Household Supplies, Groceries, Clothes, Shoes, Classes, Books, Workshops, Miscellaneous Memberships (i.e., YMCA), Recreation.*

The Maryland definition is[59]:

[58] http://wraparoundmke.com/wp-content/uploads/2013/07/015-Discretionary-Funds.pdf

Customized Goods and Services are those used in support of the child and family's POC for a participant receiving care coordination from a CCO. All customized goods and services expenditures must be used to support the individualized POC for the child and family and are to be used for reasonable and necessary costs. A reasonable cost is one that, in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. Necessary costs have been generally determined to be those that are likely to improve outcomes or remediate a particular and specific need identified in the POC. This item or service must aim to decrease the need for other Medicaid services, promote inclusion in the community, or increase the participant's safety in the home environment. A participant may access the service only if the individual does not have the funds to purchase the item or service, or the item or service is not available through another source. Experimental or prohibited treatments are excluded.

RECOMMENDATION: EXPAND FUNDING FOR GOODS AND SERVICES (FLEXIBLE FUNDING)

DMH has made efforts to ensure that flexible funding is available to the MAP teams. Additional funding is needed to expand flexible funding availability. The state should explore how other resources from DOM, child welfare, or juvenile justice, can be used to increase access to flexible good and services. Chapter 4 of this report on Interagency Collaboration discusses opportunities for Mississippi's child serving agencies to better meet the behavioral health needs of children, including blending or braiding of funding to collectively pool dollars together, compensating for certain funding rules/restrictions.

FAMILY-CENTERED PRACTICE IN INSTITUTIONAL PROGRAMS

The focus on our analysis in this section was the capacity of institutions to use family-centered practices that ensure connection to family and community. These include maximizing regular contact between the child and family such as through home visits, telephone calls and electronic communication; engaging youth and families in all aspects of service planning, identifying and building on the families' strengths; assisting families with transportation to visit their children at the hospital if the family has no options; educating families about their child's illness and any medications if prescribed/revised from the time of admission; working with youth and families on transitions; and using treatment strategies that families can use in their homes, including culturally appropriate strategies. Institutions varied in their capacity to support connection to families and communities through these various means.

Geographic distance hampers the ability of institutions to engage some families; particularly given the rural nature of Mississippi and that many of the institutions are located centrally in the state. Many programs had established requirements for monthly or bi-monthly family meetings; several used day and overnight passes home as part of transitioning. Many states have found the use of family or youth (young adult) peers as a key way to engage families, and support a successful transition. All providers would benefit from additional support to engage families and support transitions.

RECOMMENDATIONS

1. ESTABLISH POLICIES AND PRACTICES THAT SUPPORT TRANSITION FROM INSTITUTIONAL SETTINGS

Successful transition from institutional settings requires policies and practices that can divert re-entry, and support engage with needed services. Strategies discussed throughout this report, including increased use of telehealth approaches, allowing the concurrent billing of Medicaid between institutional and community providers to support warm 'hand-offs" and successful transitions, the hiring of persons with lived experience as part of institutional teams, and transportation reimbursement so families can participate in family meetings, are best practice approaches. We discuss other institutional setting issues in greater deal in Chapter 5 of this report.

[59] http://dhmh.maryland.gov/bhd/SitePages/1915%28i%29%20Intensive%20Behavioral%20Health%20Services%20for%20Children,%20Youth%20and%20Families.aspx

2. TRAIN INSTITUTIONAL STAFF IN WRAPAROUND

TAC/The Institute recommends that all institutional settings participate in wraparound training. This will further support involvement of institutional staff on care planning teams, and institutional staff focus on community integration. Much like the effort to engage CMHCs in the importance of family driven care, methods to engage families in their youths care, institutional settings should also be expected to identify needs, develop individualized plans of care, and engage families to those same standards. Given that many of these children are involved with the child welfare system, successful transitions requires alignment with child welfare policies and procedures, and coordination across agency staff and providers.

YOUTH SPECIFIC SUD SERVICES

The benefit array is geared towards mental health treatment, with limited substance use treatment services available. Certain services are funded by Medicaid and DMH including IOP and residential services. A January 2015 CMS Informational Bulletin regarding *Coverage of Behavioral Health Services for Youth with Substance Use Disorders* [60] cites the need for a comprehensive benefit design covering vital evidence-based treatment and best practices to identify and treat SUD in the youth and adolescent population. Most states have expanded their SUD benefit array for youth as required under EPSDT provisions.

As an example, the state of Louisiana[61] defines a full continuum of services specific to substance use treatment for youth according to the criteria established by the American Society of Addiction Medicine (ASAM). The state follows the ASAM criteria that includes an array of individual-centered outpatient, intensive outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors. Services for adolescents must be separate from adult services, be developmentally appropriate, involve the family or caregiver and coordinate with other systems (such as child welfare, juvenile justice and the schools). These services are designed to help youth achieve changes in their substance abuse behaviors.

RECOMMENDATION

EXPAND AVAILABLE SUD SERVICES

Mississippi should expand the availability of SUD services for youth and build the capacity of providers to deliver this service. This includes screening, brief intervention and referral to treatment opportunities, greater use of outpatient, community-based, residential settings, and Medication Assisted Therapies specific to the developmental needs of this population.[43] [62]

PARENT AND YOUTH PEER SUPPORT

Between July 2013 and June 2014, approximately 178 individuals received Medicaid funded peer support services.[63] While providers report great success with peer support in substance use residential programs, crisis stabilization, and mobile crisis services, its use in providing support, systems navigation, and enhancing

[60] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-26-2015.pdf

[61] http://new.dhh.louisiana.gov/assets/docs/BehavioralHealth/LBHP/LBHPSvcsManv4b.pdf

[62] Substance Abuse and Mental Health Services Administration. (2013). *What does the research tell us about good and modern treatment and recovery services for youth with substance use disorders?* Report of the SAMHSA Technical Expert Panel. Rockville, MD: Center for Substance Abuse.

[63] Only represents claims for peer support on behalf of Medicaid beneficiaries under 21.

engagement among caregivers and young adults' remains relatively limited. Despite the enthusiasm for peer support expressed by providers, they cited the low reimbursement rate for this service as a barrier to developing greater capacity and utilization, particularly for providers serving more rural areas. DOM and DMH offered to conduct a rate study; the Mississippi Association of Community Mental Health Centers declined such a study. The use of peer support for caregivers and young adults has largely been in the SAMHSA funded MTOP program. Given severe workforce shortages, expansion to appropriately credentialed persons with lived experience would allow for effective access to care and redirection of licensed workforce towards functions that only licensed persons can provide. Additionally, persons with lived experience are an invaluable resource to engaging youth and families in treatment; and supporting successful transitions from treatment.

States have used different approaches to define this service though all share the common element of hiring persons with lived experience as a primary caregiver of a child with a behavioral health need. For example, Massachusetts defines this as a separate free-standing service that is to be incorporated across all levels of care.

> *Family Support and Training is s service provided to the parent/caregiver of a youth (under the age of 21), in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and other community settings. FS&T is a service that provides a structured, one-to-one, strengths-based relationship between a Family Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent/caregiver to parent the youth so as to improve the youth's functioning as identified in the outpatient or in-home therapy treatment plan or individual care plan and to support the youth in the community or to assist the youth in returning to the community. Services may include education, assistance in navigating the child serving systems (child welfare, education, mental health, juvenile justice, etc.), fostering empowerment, including linkages to parent/peer support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.) support, coaching and training for the parent/caregiver.*

Arizona defines the service as:[64]

> *Home care training family services (family support) involve face-to-face interaction with family member(s) directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the person in the home and community. May involve support activities such as assisting the family to adjust to the person's disability, developing skills to effectively interact and/or guide the person, understanding the causes and treatment of behavioral health issues, understanding and effectively utilizing the system, or planning long term care for the person and the family. Parent staff who provide this service also utilize a wide array of other billing codes i.e. case management, peer support, behavioral health prevention and promotion, transportation, translation.*

Many states are pursuing opportunities to expand this important role. Maryland is working to integrate peer support services for caregivers of children with complex behavioral health needs with other State-sponsored services and to increase Medicaid reimbursement. Georgia is both developing a peer support training curriculum and certification process for caregivers of children with complex behavioral health needs and identifying ways to increase Medicaid reimbursement. Utah and Idaho are engaging "parent partners" to provide peer support and advice on quality improvement activities in pediatric practices participating in the CHIPRA quality demonstration medical home efforts. [65]

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[64] http://www.azdhs.gov/bhs/documents/covserv/covered-bhs-guide.pdf

[65] Agency for Health Care Research and Quality. (2014). *The National Evaluation of the CHIPRA Quality Demonstration Grant Program.* http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/highlight07.pdf

RECOMMENDATION

DEVELOP THE PEER WORKFORCE AND IMPLEMENT A CAREGIVER SUPPORT CERTIFICATION PROCESS

We recommend that DMH expand its efforts to certify peers and implement caregiver/peer support certification process. We would recommend some adaptations of a caregiver certificate process from the current peer certificate process as the current peer application packet is very labor intensive which could serve to discourage potential applicants.

EVIDENCE-BASED PRACTICES IN OUTPATIENT SETTINGS

As indicated in chapter one, claims analysis indicates that individual therapy is among the top services utilized based on percent of Medicaid enrollees receiving services. As such, it is a critical opportunity to ensure that these children receive evidence-based practices that support successful outcomes. All providers reported use of EBPs in outpatient settings. Providers of outpatient services are working to incorporate EBPs into practice but the infrastructure and fidelity monitoring that reinforces consistent use of EBPs needs to be addressed. Opportunities include selection of a couple of additional system wide EBPs that address clinical needs, in addition to the investment already made in trauma and wraparound. Given that a majority of children receiving care are using outpatient, efforts made by the state to ensure the quality of care in IOP should be extended to other outpatient services as well. Further, gathering of fidelity data on the use of EBPs in outpatient is recommended to provide invaluable information on both the individual and system level related to improved outcomes.

RECOMMENDATION

CONTINUE TO SUPPORT INVESTMENTS IN EBP TRAINING AND FIDELITY MONITORING

DMH has made investments in Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARC), and Wraparound Facilitation. Each of these requires three intensive learning sessions, bi-monthly technical assistance calls, and implementation of fidelity measures, all of which is provided at minimal cost to providers. We recommend that DMH continue to provide this infrastructure for evidence-based practices in both outpatient and institutional settings. Providers of outpatient services, in particular, are working to incorporate EBPs into practice but the infrastructure and fidelity monitoring that reinforces consistent use of EBPs needs to be addressed. Opportunities include selection of a couple of additional system wide EBPs that address clinical needs other than trauma and wraparound, for further focus and statewide infrastructure support.

TRAUMA-INFORMED SYSTEMS APPROACHES

Across the country, behavioral health systems are increasingly aware of the impact of trauma. Children and youth with the most challenging mental health needs often have experienced significant trauma in their lives. The Adverse Childhood Experiences (ACE) study[66] has reported short and long-term outcomes of childhood exposure to certain adverse experiences that include a multitude of mental health, health and social problems. Mississippi has been investing in trauma informed practices since 2007. Mississippi has been recognized by the National Child Traumatic Stress Network for its learning collaborative approach for Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Mississippi implemented a learning collaborative approach in several of its institutions; and has conducted three out of state trainings and numerous in state trainings that have included parents and youth. The state was selected to participate in a web based video tool available through Georgetown University's Center for Child and Human Development. The state also participated in a national learning collaborative hosted by the National Council. Recently, the MTOP grant

[66] http://www.cdc.gov/ace/findings.htm

evaluation produced a report on the outcomes from the trauma informed trainings, conferences and workshops which will guide future planning efforts.

RECOMMENDATION

PROMOTE USE OF TRAUMA INFORMED CARE PRACTICES

Mississippi can build on its successful efforts and expand its trauma informed care practices across all institutional care providers. Training staff in these settings on how to adapt their environments and work with youth with trauma histories could reduce restraint and seclusion practices and reduce length of stay in these environments. To deepen its efforts among community-based providers, the state will also need additional resources to support the broader use of TF-CBT among outpatient practitioners.

TRANSITION TO ADULTHOOD

Transition aged youth with serious behavioral health challenges need services specifically geared to support their unique developmental needs as they enter adulthood. Transition services should include a focus on supported education, vocational/employment, and housing support. The Achieve My Plan (AMP) model [67] and the Transition to Independence Process (TIP) model[68]are examples of evidence-based approaches to supporting youth as they transition to adulthood. The Mississippi Transition Age Youth (MTOP) program, funded through a grant from SAMHSA, was highlighted as a well-regarded program that has helped support young adults with serious behavioral health challenges in areas such as employment, housing, and recovery.

RECOMMENDATION

IDENTIFY SUSTAINABLE FUNDING SOURCES FOR TRANSITION AGE YOUTH SERVICES

Currently, there is limited access for transition-aged youth to support employment or housing opportunities, outside of the SAMHSA grant funding. DMH and DOM should work collaboratively to ensure there is a sustainable source of funding for supported employment, education, and housing for the young adult population once the SAMHSA funding ends.

FINANCING BEYOND MEDICAID

Throughout this assessment process we also heard from numerous advocates, providers, and family stakeholders that community-based services for those youth who were either uninsured or underinsured (e.g. typically those with commercial insurance) were extremely limited or non-existent. This dearth of community-based service options for youth lacking Medicaid was cited by stakeholders and family members as one of the factors contributing to the out-of-home placement of their child. Supporting access to a continuum of community-based services for youth with serious behavioral health challenges regardless of payer is integral to stemming the tide of youth entering state hospital and PRTF facilities. The state has invested in growing its Medicaid behavioral health benefits to meet the needs of Medicaid eligible children. It is equally important to meet the behavioral health needs of children that are not covered by Medicaid. Mississippi could achieve this through a coordinated purchasing plan across the various funders of behavioral health including child welfare, juvenile justice, public health and education.

[67] http://www.pathwaysrtc.pdx.edu/proj-3-amp

[68] http://www.tipstars.org/

RECOMMENDATION

IMPLEMENT A STRATEGY TO ENSURE ACCESS TO SERVICES REGARDLESS OF CHILD'S INSURANCE.

Other states and localities have created financial arrangements that combine funding streams in order to accomplish this objective of serving children who are not Medicaid-eligible. For example, in New Jersey providers of care management and mobile crisis can make Medicaid presumptive eligibility determinations. This means that if a youth is in need of mobile crisis services and is not a current Medicaid beneficiary, the provider can make that youth eligible for Medicaid on a short-term basis (30 days or until a formal Medicaid eligibility determination can be made) so providers can bill and service delivery is not delayed. For youth who are not found to be eligible for Medicaid, the youth is issued a "look-alike" number. This allows service providers to submit claims to the state's Medicaid fiscal agent who pays the claim(s)(for services provided to non-Medicaid eligible youth) with state only dollars. This reduces administrative burden on providers by having claims submission and payment for both Medicaid beneficiaries and non-Medicaid beneficiaries be a single entity. It also ensures access to the range of home and community-based services available under the state's Children's System of Care for youth who are not Medicaid eligible. In developing this arrangement, New Jersey has successfully created a system that is easy for both families and providers to navigate; and has allowed for greater access to a range of services to help youth in need of behavioral health treatment. The New Jersey system was financed with a combination of Medicaid, block grant, and state general revenue from the behavioral health and child welfare systems. Mississippi has recently implemented presumptive eligibility with hospitals; this effort could serve as a foundation for other providers to also provide that function.

Louisiana's Behavioral Health Partnership (LBHP) offers another example of a funding approach designed to support access to a continuum of behavioral health services. Medicaid and non-Medicaid adults and children who require specialized behavioral health services, including those children who are at risk for out of home placement under the state's Coordinated System of Care (CSoC) initiative can accessed services through the LBHP. Several state agencies comprised the LBHP including the Office of Behavioral Health, Medicaid, the Office of Juvenile Justice, the Department of Children and Families, and the Department of Education. A Statewide Management Organization had responsibility for coordinating care, provider contracting, and claims processing. With funds contributed by the different partners, the LBHP allowed youth who are found eligible for services available as part of the CSoC: wraparound facilitation, parent support and training, youth support and training, short-term respite care, and crisis stabilization access to these services regardless of their eligibility for the Medicaid program. It also helps to pay for aspects of services that cannot be paid for with Medicaid funds such as room and board costs for respite care. While Louisiana has recently decided to shift from this approach, other localities are considering such approaches based on the Louisiana design.

Finally, as Mississippi explores opportunities that redirection of institutional dollars provides, discussed in detail in a later chapter, this would further allow DMH appropriations to be used to address the community behavioral health needs of children that are not enrolled in Medicaid.

CHAPTER 3: PROVIDER CAPACITY

INTRODUCTION

This chapter highlights critical provider capacity issues facing Mississippi, details provider and workforce capacity information and trends, and discusses results of the various key informant interviews. The assessment of provider capacity included an evaluation of the available behavioral health workforce[69] and its ability to competently deliver services and supports to youth with behavioral health challenges in home and community-based settings.

In addition to the services that are available in a system, another critical component to ensuring that youth in Mississippi with serious behavioral health challenges can remain in their homes and local communities requires sufficient community-based provider capacity to deliver those services. An assessment of provider capacity included an evaluation of the available behavioral health workforce[70] and its ability to competently deliver services and supports to youth with behavioral health challenges in home and community-based settings.

PROVIDER LANDSCAPE

This section highlights critical provider capacity issues facing Mississippi, details provider and workforce capacity information and trends, and discusses results of the various key informant interviews. Several questions drove both the quantitative and qualitative aspects of this provider capacity and workforce analysis. These questions included:

1. To what extent are providers delivering services able to meet the community support needs of youth and their families?
2. Are there limitations or barriers to expanding community-based provider capacity?
3. To what extent are caregivers of youth with behavioral health challenges being utilized in the provision of mental health and substance use services?
4. What structures exist to support workforce development and provider capacity building?

It should also be noted that determining providing capacity is incredibly challenging. Much of the data that is available to assess capacity are proxy measures such as numbers of certified providers licensed/certified practitioners, or beds that do not reveal much about the true capacity of the system to serve youth and families. For example, budgets often limit the number of people who can be hired to perform the work. Data from licensing or certification boards are limited in that the numbers only reflect the total number of licensed/credentialed staff and not those who are specifically trained or interested in working with youth and families. These staff too may be working in other settings such as child welfare or juvenile justice. These numbers therefore overinflate the actual number of practitioners available to serve youth and families. These limitations must be taken into consideration when reviewing these data.

[69] Throughout this chapter, when discussing the available "workforce" or "practitioners" we are referring to the individuals who deliver mental health and substance use services. Some of these individuals are employed by community mental health centers or other agencies while others (e.g. licensed psychologists or psychiatrists) may operate as a solo practitioner or as part of a small group practice. When using the term "provider" we are referring to agencies.

[70] Throughout this chapter, when discussing the available "workforce" or "practitioners" we are referring to the individuals who deliver mental health and substance use services. Some of these individuals are employed by community mental health centers or other agencies while others (e.g. licensed psychologists or psychiatrists) may operate as a solo practitioner or as part of a small group practice. When using the term "provider" we are referring to agencies.

Mississippi's behavioral health service provider system consists of three major components: 1) state-operated facilities, 2) regional community mental health centers, and 3) private behavioral health providers. It should be mentioned here that the discussion below largely focuses on the capacity of those providers who offer services in home and community-based settings rather than those offering acute inpatient or PRTF services. Information specific to the use of institutional settings will be discussed in chapter 5.

STATE-OPERATED FACILITIES

There are four facilities operated by DMH that provide inpatient treatment for youth with serious emotional disturbance and/or intellectual disabilities:

- **East Mississippi State Hospital in Meridian** has a 50-bed unit that serves adolescent males between the ages of 12-17 for "short-term" treatment (up to 90 days). The unit also has capacity to provide alcohol and drug treatment for youth with substance use disorders.
- **Mississippi State Hospital in Whitfield** (Oak Circle Center) has capacity to serve youth between the ages of 4-17 in its 60-bed facility.
- **Mississippi Adolescent Center in Brookhaven** serves adolescents with intellectual or developmental disabilities in its 32 bed facility.
- **Specialized Treatment Facility in Gulfport** has capacity to serve up to 48 adolescents between 13 and 18, and gives priority to those that have some involvement with the judicial system and are diagnosed with a psychiatric disorder.

COMMUNITY MENTAL HEALTH CENTERS

The Regional Commission Act provides the structure for Mississippi's mental health service system and program development by authorizing the 82 counties to form multi-county regional commissions on mental health. Regional commissions are authorized to plan and implement mental health and intellectual or developmental disability programs in their respective areas, delivered through community mental health centers (CMHCs). There are currently 14 CMHCs operating in the State, funded by a combination of local, state, and federal dollars forming the backbone of Mississippi's public behavioral health service delivery system. DMH certifies the centers to provide services and monitors state and federal dollars allocated to them via DMH. The primary goals of the CMHCs are to:

- Provide accessible services to all citizens with mental and emotional problems
- Reduce the number of initial admissions to the state hospitals
- Prevent re-admissions through supportive aftercare services

The CMHCs provide a range of services and supports for youth. All CMHCs are required by DMH to offer certain core services (see Chapter 1 for specific services) for youth. Some offer additional services and supports beyond the core services typically as part of special grant funded initiatives such as Mississippi Transitional Outreach Project (MTOP) or the Adolescent Opportunity Program (AOP). A CMHC provider (Region 1) operates the one adolescent residential substance use program in the state.

PRIVATE BEHAVIORAL HEALTH PROVIDERS AND CENTERS

There are a number of private mental health providers throughout the state who offer certain specialized treatment services such as acute inpatient care, therapeutic group home, therapeutic foster care, PRTF, crisis stabilization, and IOP (MYPAC). These programs are certified by and may receive funding from DMH, in addition to other sources, to provide community-based services such as community-based substance abuse services, community services for persons with intellectual/developmental disabilities, and community

services for children with behavioral health needs. DOM added these providers to the Medicaid network of providers to address access issues and increase service capacity across the state.

WORKFORCE CHALLENGES

It has been widely recognized that that there are serious challenges facing mental health and substance use systems, both nationally and in Mississippi, with regard to the available workforce.7[71] Behavioral health systems all over the country are lamenting the lack of qualified and trained practitioners not only for today, but also for the future.79F[72]The health care workforce treating mental and/or substance-use (M/SU) conditions is not equipped uniformly and sufficiently in terms of knowledge and skills, cultural diversity and understanding, geographic distribution, and numbers to provide the access to and quality of M/SU services needed by consumers. This has long been the case and has been persistently resistant to change despite recurring acknowledgments for major improvements to address them (p. 286).

Behavioral health, as all human services, is a human resource dependent industry. Human resource costs often represent 80 percent or more of a behavioral health provider's or program's budget. The ability to recruit and retain adequate staff numbers of the right kind of professionals and the ability to assure those staff not only have but are able to continue learning the necessary information and skills to provide high quality care, is core to the success of the behavioral healthcare field and to the individuals and families it serves. Much is known about the difficulties facing the public behavioral health workforce, including: low salaries, poor working conditions, the aging workforce, high caseloads, lack of adequate training and graduate preparation programs, limited opportunities for advancement, lack of ethnic and linguistic diversity, and regulatory and scope of practice issues that limit who can provide reimbursable services. However, making headway resolving these issues has been slow in Mississippi and nationally.

Certainly the rural nature of the state impacts the ability of providers to meet demand. Indeed, Mississippi has the 4th largest rural population in the nation which presents the state with many challenges in terms of its workforce and provider capacity. Rural areas are particularly hard hit by shortages of mental health professionals. Rural areas experience unique challenges in the recruitment and retention of qualified mental health and substance use practitioners such as having a small pool of available workers, limited local educational opportunities, and geographic barriers such as transportation.

The workforce shortage issues facing Mississippi have limited the capacity of community providers to serve youth and families. While wait time information is an important indicator of provider capacity the state does not systematically gather information to monitor this issue reported by its stakeholders. However, most stakeholders lamented the lack of board-certified child psychiatrists in particular citing long appointment wait times. This shortage of child psychiatrists impacts both institutional and community based providers but is particularly felt in rural areas of the state as the majority of psychiatric capacity is centrally located in the larger communities. Mississippi needs to adopt policy priorities that support the recruitment and retention of psychiatrists in Mississippi. For example, psychiatry is not included as one of the medical specialties eligible for the Mississippi Rural Physician Scholarship program.

While telehealth in Mississippi has grown with respect to its use in primary care and other medical specialties, its reach is limited for the vast majority of youth in need of community psychiatric care. At the time of this writing, only a couple of providers are actively utilizing tele-psychiatry for youth. While there is reportedly grant funding available for the purchase of telehealth hardware and mechanisms for billing the Medicaid program for tele-psychiatry services, there was a lack of information and awareness about these opportunities among the CMHCs. DOM is looking at ways to expand telehealth capacity, including developing a revised state plan amendment to address this service.

[71]The Annapolis Coalition on the Behavioral Health Workforce (2007). An action plan for behavioral health workforce development: A framework for discussion. Cincinnati, OH: Author.

[72] National Council of Community Behavioral Healthcare Annual Survey, 2001: National Association of State Mental Health Program Directors as reported in Mental Health Weekly, 12(15), 1,4, and 6.

In addition to the lack of child psychiatrists, many stakeholders noted a shortage of mental health professionals with child-specific training and expertise in working with youth with serious behavioral health challenges. Licensed mental health professionals in particular were described as very difficult to recruit and retain in community mental health settings. Again, long wait times for services including IOP were reported by families and other stakeholders but statewide data on wait times were not available.

Providers also noted that the few licensed staff members they do have are not well utilized given that an increasing amount of their time is spent certifying treatment plans and obtaining treatment authorization from the CCOs. DMH responded to this shortage by creating a certification process for non-licensed individuals working within the "state mental health system." The DMH Professional Licensure and Certification (PLACE) program was a creative attempt to appropriately respond to the shortage of licensed mental health clinicians. It allows individuals without specific training in a behavioral health field to work in the public mental health system in Mississippi. In order to receive certification, individuals must participate in a core training program developed by DMH and pass a written exam. The table below shows the number of individuals holding a DMH professional credential as of October 2014. These numbers represent all individuals, not just those providing services to children. The numbers below are in addition to individuals with other credentials such as licensed social workers or counselors. Numbers of licensed staff were not available at the time of this report, though even if available, it would not likely reveal much about the capacity of the system to serve youth with behavioral health challenges.

Table 21: Number of individuals holding a DMH professional credential

Credential	Number as of 10/14/14
Mental health therapist	1,276
Community support specialist	964
IDD therapist	231
Licensed DMH administrator	79
Addictions therapist	111
TOTAL	**2,661**

Finally, in Mississippi it is required that Advance Practice Registered Nurses (APRNs) practice according to conditions specified in a Mississippi Board of Nursing-approved agreement, indicating that the collaborating physician's practice is compatible with the APRN's practice. Collaborative agreements also define the scope of practice, including mutually agreed upon guidelines for the health care provided and designate the agreed upon medication formulary to be used by the APRN and physician in practice. Physicians are prohibited from entering into a collaborative agreement with an APRN whose practice location is greater than 40 miles from the physician's practice site and physicians may not enter into collaborative agreements with more than four APRNs at any one time.

WORKFORCE DEVELOPMENT ACTIVITIES

It is well known across the behavioral health arena that few people come to their jobs adequately prepared to do the work with youth and families. Development of state structures to support training and provider capacity building are a critical component to ensuring the workforce has the necessary skills and competencies to deliver high quality care.

Numerous stakeholders mentioned the need for improved capacity and training in functional assessment, diagnostic capability, treatment/care planning, best practice and evidence-based approaches to working with

youth and their families. This further points to the need for a strong workforce development infrastructure that can support providers in training and coaching staff to deliver best practice services to youth and families.

Over the past few years, the University of Maryland's Institute for Innovation & Implementation has provided training and coaching in Wraparound facilitation. DOM and DMH recently partnered to develop the in-state capacity to do this work by jointly funding the University of Southern Mississippi, School of Social Work to develop a training center for Wraparound Facilitation Training and Coaching. This is a critically important initiative and one that the state should be commended for undertaking. Stakeholders reported positive experiences with the training provided but expressed that greater family involvement in the design, development, and delivery of these trainings was needed.

DMH's peer support specialist certification program is another positive area of workforce development. Use of persons with lived experience in the provision of services is a strategy more states are using to augment traditional mental health services and support better engagement in treatment. Growing this underutilized workforce is a key to developing greater capacity to serve adults and families with behavioral health challenges. While the certification process established by DMH and the inclusion of peer support in the state's rehabilitation option is extremely positive, efforts have focused primarily on adults with lived experience as opposed to caregivers of youth with behavioral health challenges or young adults. In FY 2014, Medicaid data suggest low utilization of peer support for youth under 21 in both managed care (50 utilizers) and the fee-for-service system (128 utilizers).

REIMBURSEMENT AND BILLING CONSTRAINTS FOR COMMUNITY-BASED SERVICES

Notwithstanding the real workforce challenges facing Mississippi that require creative solutions, it must be stated that if providers have the right incentives and enough youth needing and wanting services, they can typically grow to meet demand. We found disincentives limiting the growth of community-based interventions for children. CMHC providers offered that the low reimbursement rates for Wraparound facilitation and IOP have limited their interest in delivering these services. As of September 2014, there were nine providers certified by DMH to provide Wraparound facilitation and eight certified to deliver IOP. It should be noted here that simply because a provider is certified to deliver a service does not necessarily mean that they are. As the table below reflects, three providers delivered almost 97% of Wraparound facilitation services as of the end of FY 2013.

Table 22: DMH-Certified Wraparound facilitation providers

Service provider	# of trained staff as of 7/2014	# of youth served between 7/1/12 & 6/30/13
Region 2/Communicare	2	0
Region 14/Singing River	2	9
Region 6/Life Help	5	0
Region 4/Timber Hills	10	17
Region 7/Community Counseling	11	9
Region 10/Weems	31	6
Region 12/Pine Belt	42	267
Youth Villages	98	476
Mississippi Children's Homes Services	114	443
Total	**318**	**1,227**

While the state has made investments in developing Wraparound training and coaching capacity, some providers have been reluctant to dedicate staff to participate in these trainings. Almost 80% of the trained staff in the state represent three providers. Several CMHC providers endorsed their support for the Wraparound model, however, they stated they simply cannot provide the service due to the low reimbursement rate combined with the intensive service requirements. They cite the requirement that Wraparound involves meeting with families in their homes and other community-based locations yet the rate does not adequately account for travel time or mileage costs. As noted earlier, the rural nature of most of Mississippi means that time spent in transit is considerable. The failure of the rates to accurately account for the time lost delivering face to face activities due to time spent traveling to home and community-based settings is a significant barrier to increasing the capacity of providers to serve youth and families in their homes.

Providers are reportedly finding it difficult to become an IOP provider because the pathway to certification is providing Wraparound facilitation. However providers report that the rate for Wraparound facilitation is too low and with the caseload capped at 10 and no ability to bill for time spent in training, doing paperwork or for travel, CMHC providers cannot "make the numbers work." The existing IOP/MYPAC providers began delivering services as part of the state's 1915(c) PRTF demonstration waiver and were paid (and continue to be paid a per diem for each enrolled youth). This funding arrangement offered them greater flexibility with respect to travel, training, and paperwork time. Without support to cover these types of costs, the capacity to deliver these services to a greater number of youth will remain limited.

Uncompensated care is another issue constraining provider capacity in Mississippi. While the state's network of CMHCs are required by DMH to deliver a number of "core" services, providers report that the funding contributed by the state and the counties do not adequately cover the costs of delivering these services. DMH grants and county contributions only account for a very small overall percentage of any CMHCs overall budget. The Medicaid program is the single largest payer for care delivered by the CMHCs. A combination of Medicaid managed care cost containment priorities and decreases in available federal block grant dollars has further limited the ability of CMHCs to serve youth and their family members with behavioral health challenges. CMHCs report they have had to lay-off staff due to budgetary constraints and one CMHC had to close its doors. At the same time providers have reported that the number of referrals has increased, resulting in large caseloads for staff. With Medicaid billing comprising the majority of CMHCs budgets, they are particularly vulnerable to cost containment efforts such as service authorization denials and rate reductions. Furthermore, absent adequate sources of funding to pay for "core services", and care for people without health insurance, the ability of CMHCs to continue to provide access to community-based care will diminish.

Medicaid billing limitations which constrain efficient community-based service delivery efforts were also noted by providers. For example, providers cannot bill for a psychiatric visit and an individual therapy visit on the same day. This places an unnecessary burden on families who may have to travel long distances to come to the clinic, requiring them to expend extra time and money on transportation. Providers, who appropriately respond to a request for an urgent outpatient and psychiatric appointment on the same day in an attempt to stabilize a crisis, are in fact penalized for providing this type of care.

DOM and DMH have offered to conduct a rate study on services; this offer was declined by the Mississippi Association of Community Mental Health Centers. We recommend that rate studies occur. We understand that there are concerns that rate studies open up discussions about both rate increases and decreases. We recommend that rate analyses occur from a systems level perspective on how services fit together to achieve client and system level outcomes, including how to incent the use of more effective services, decrease the use of less effective services, and promote greater coordination. While rate analysis occurs service by service, final rate determinations need to include a systems level perspective on what is being incented, how services fit together to achieve the best health outcomes, what services need to be grown, and the cost of providing care.

PROVIDER NETWORK MANAGEMENT ISSUES

Throughout our meetings with providers we observed great inconsistency and variation across the state with respect to the understanding of the different Medicaid service requirements, how to bill, and what is and is not allowable. For example as described above, while some providers were offering telehealth, others did not appear to know that this option was available to them. Another example of this confusion or misinformation was with respect to IOP. While IOP is in the state plan under the rehabilitation option many of the CMHC providers stated they understood IOP as only MYPAC or as a substance use treatment service. Providers report that communication with the CCOs and UM/QIO are infrequent and not always clear in terms of medical necessity, service requirements and allowable billable activities. In general, our meetings with stakeholders revealed there is a marked distrust between DMH, DOM (including the CCOs and UM/QIO) and the behavioral health provider community in the state. Most providers described the primary role of DOM and its vendors as cost containment rather than promoting access to care or quality of care. DOM and DMH leadership have voiced concerns about some provider's ability to deliver quality services. This has furthered DMH and DOM's interest in including more private behavioral health providers in the network; and to deploy the CCOs and UM/QIO to implement various management strategies in an effort to ensure quality care. DOM and DMH report regular meetings with providers in the state, including webinars, face to face meetings and conference calls. Regular communication to Medicaid providers is conveyed through Medicaid Provider Bulletins and a daily document titled Late Breaking News. Providers reported periodic "all Medicaid provider meetings" but noted little behavioral health specific communication outside of compliance reviews. This difference in perspective provides an opportunity to review the communication approach and methods with behavioral health providers.

RECOMMENDATIONS

A necessary component of ensuring that youth with behavioral health challenges can access care in home and community-based settings is improving the capacity of the provider network to serve youth and their families. Below are several recommendations intended to support the development of greater provider capacity.

1. DEVELOP A PROVIDER NETWORK MANAGEMENT STRATEGY

DOM, its vendors and DMH should develop a joint behavioral health network management plan to include a particular focus on child behavioral health. This is beyond simply holding a meeting or conducting compliance reviews or recovery audits, but a strategy for how they will actively engage and communicate with providers regarding policy decisions, offer technical assistance, and support more effective and judicious use of Medicaid and DMH resources. This will require additional resources for DMH and DOM to implement. It is a necessary step to support communication of purchaser expectations for provider performance , to support monitoring of provider performance and to achieve outcomes(see Quality Management chapter for more information about possible performance and outcome metrics) A component of this network management strategy could include individual meetings with providers to review certain metrics such as access to care or follow-up after hospitalization and help policy makers better understand what barriers might exist. This could open up more opportunities for dialogue between policy makers and the provider community and promote a better working relationship. Good network management is transparent, and gives the provider community confidence that the state is a partner in ensuring that high quality care is delivered to the youth and families of Mississippi.

2. REVIEW RATES TO ENSURE ADEQUATE COVERAGE OF TRANSPORTATION COSTS IN SERVICE RATES

Given the rural nature of the state and the states goal to increase home and community based care, it will be important to review rates for services to ensure that time spent in transit and mileage costs are accounted for. Without adequate reimbursement for transportation time and mileage costs, the workforce will not be available to provide home and community-based interventions and uptake by providers of interventions such as IOP will remain limited. While travel time is not currently a billable activity under current CMS regulations, CMS does not preclude states from developing rates that incorporate time spent in transit. DOM and DMH have offered to conduct a rate study of services.

3. IMPROVE ACCESS TO CHILD PSYCHIATRY SERVICES IN THE COMMUNITY

DOM should continue its efforts to expand access to telehealth and continue its work to revise the state plan to support better use of this approach. Medicaid, DMH, and UMMC Center for telehealth should host a joint meeting with CMHC providers to discuss opportunities for the expansion of telemedicine and to clarify any issues related to billing and equipment use. Medicaid and DMH should set a joint goal of expanding use of telemedicine across all 14 CMHCs by the end of 2015.

To improve access to psychiatry in the community, Mississippi should consider a community psychiatry residency rotation where psychiatric residents from institutional settings are rotated through the CMHCs. As the state moves forward with reducing use of institutional settings for children, the capacity to deploy child psychiatry in this way will increase.

Mississippi should also consider developing a Child Psychiatry Access Program which uses child psychiatrists who can consult to pediatricians and family physicians so that they can serve as the lead prescribers for youth with less complex medication needs. Consultation models where psychiatrists consult to physicians and nurse practitioners about use of psychiatric medications for "routine" cases so as to free up psychiatrists for patients who require more complex medication regimes have been used successfully in states across the country. The state may wish to explore how the Center for the Advancement of Youth at UMMC could be used to support this type of consultation model. 3. Support workforce development and training activities

As described above, DOM and DMH have partnered to support the University of Southern Mississippi, School of Social Work to develop a training center and certification process for Wraparound Facilitation Training and Coaching. Increased financial support to expand the training center is key to ensuring providers have the capacity to deliver high-quality Wraparound. It will also be critically important for USM, DOM, and DMH to consider how to further include family members and youth in the design, development, and delivery of training activities. It would be very beneficial to include family's experiences in booster trainings and/or small presentations.

Further expansion of the activities of this center to support other workforce training initiatives could help address some of the concerns we heard with respect to the skills and competencies of the available workforce. For example, DMH could contract with USM to strengthen the current PLACE certification and/or develop a certification specifically for those interested in working with youth and families. Furthermore, if the state identifies some EBPs they would like to promote in outpatient settings, USM could become an intermediary purveyor of these EBPs similar to what they have done with Wraparound as a way to ensure sustainability of these practices in the state.

Partnering with local colleges and universities to create a pipeline of licensed staff is another strategy that could help address some of the workforce challenges the state is experiencing. Delta State University's Division of Counselor Education and Psychology was recently awarded a Behavioral Health Workforce Education and Training for Professionals and Paraprofessionals grant from the federal Health Resources and Services Administration for $1,125,278 over the next three years. This funding will provide internship stipends for 83 master's level counseling students who, following their training, will focus on youth at risk for developing, or who have developed, a behavioral health disorder. Grant funds will also provide support for University staff to conduct recruiting activities over the three-year project period. The USM School of Social Work has included Wraparound into their curriculum; and the university is looking to add this to the curricula of other behavioral health disciplines. This is a much needed infusion of support to increase the number of licensed clinicians available to work with youth with serious behavioral health challenges in Mississippi. DMH could offer this type of support for internships at a more modest scale as a way to increase the number of individuals who commit to working in the public mental health system after graduation.

With respect to child psychiatry, we understand that there was a loan forgiveness program approved by the legislature that was not funded. Developing and funding this type of program could help stimulate the pipeline of child psychiatrists. Including psychiatry as one of the medical specialties eligible for the Mississippi Rural Physician Scholarship program is also a potential option.

Another key workforce development activity for consideration is to adapt or building upon the existing peer support certification program to promote greater use of parents of youth with behavioral health challenges in the delivery of Medicaid reimbursable peer support services. Continuing partnerships with a family organization to assist in the development of a family peer support certification process would help bring legitimacy to the process and foster collaboration. . We note that the current peer support specialist application is complex and the associated fees and training costs were reportedly a burden for some. This is an area DMH should review so as to ensure these issues do not hinder expanded capacity of this service.

Finally, the state should consider how to utilize the Center for Advancement of Youth (CAY) and the Children's Collaborative group to provide training and support to pediatricians, nurse practitioners, and family practice physicians on behavioral health screening.

4. ALIGN STAFF CREDENTIALS TO THEIR POSITION RESPONSIBILITIES

Current DMH regulations require only a GED or high school equivalent for staff hired as Wraparound facilitators. We understand that DMH is in the process of raising this requirement to a bachelor's degree as part of its development of a certification process. . We fully support this effort to raise this requirement. Additionally, experience with youth with SED should be added as a preferred qualification. This would help bring Mississippi more in line with the credentials for this service nationally. Louisiana for example requires its Wraparound facilitators to have a bachelor's degree in a human services field or a BA in any field with a minimum of 2 years of full-time experience working in a relevant family, children/youth or community service capacity. Relevant alternative experience may substitute for the BA on a case by case basis. Georgia, Nebraska, and Oklahoma also require its Wraparound facilitators to have a minimum of a BA.

5. REVIEW APRN COLLABORATIVE AGREEMENT REQUIREMENTS

Many states are easing their scope of practice restrictions for advanced practice registered nurses (APRNs) as a way to increase access to primary care. It is well documented that APRNs perform a subset of primary care services at a level comparable to physicians and have the potential to offset critical physician shortages, especially in historically underserved areas. State laws and regulations governing APRN practice fall into three categories:

- **Full Practice**: State practice and licensure law provides for APRNs to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.
- **Reduced Practice**: State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of APRN practice. State requires a regulated collaborative agreement with an outside health discipline in order for the APRN to provide patient care.
- **Restricted Practice**: State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of APRN practice. State requires supervision, delegation, or team-management by an outside health discipline in order for the APRN to provide patient care.

Mississippi is characterized as a reduced practice state due to the requirement that APRNs must establish individualized collaborative agreements with physicians. Current trends indicate that more states are removing such requirements and becoming full practice states. There are 19 full practice states and the District of Columbia[73], many of which include such rural and frontier states such as Alaska, Arizona, Iowa, Montana, Nevada, New Mexico, North Dakota, and Wyoming. Full practice states find that the removal of formal collaborative agreements grants APRNs greater flexibility and improves access to care. In a rural state with few physicians such as Mississippi, collaborative agreements, especially those with proximity requirements, can significantly impede APRNs' ability to provide care. APRNs cite difficulty finding collaborating physicians that the Board of Medical Licensure would approve and that are located within a 40-

[73] Full practice states include AK, AZ, CO, CT, HI, ID, IA, ME, MN, MO, NV, NH, NM, ND, OR, RI, VT, WA, and WY.

mile catchment area of their practice. While Mississippi has made strides to ease these requirements in recent years, including an amendment to authorize a 90-day grace period for APRNs who cannot secure a collaborative physician, the geographic component of collaborative agreements is a major barrier that limits access to care. It is recommended that this requirement be removed to grant greater flexibility for Mississippi's 2,718 APRNs.

Mississippi is one of the few states that still place geographic limitations on its collaborative agreements, whereas other reduced and restricted practice states are increasingly eliminating such requirements. For example, Georgia allows APRNs to establish collaborative agreements with physicians whose practices are either located within the state or outside the state but within 50 miles of the APRN. In 2013 Texas, a restricted practice state with otherwise very austere APRN requirements, removed its proximity requirements and permitted APRNs to be supervised by a physician located anywhere in the state. Previously the supervising physician had to be located within 75 miles of the APRN's practice. Missouri's collaborative agreement regulations allow APRNs to provide services outside the geographic proximity requirements if the collaborating physician and advanced practice registered nurse use telehealth in the care of the patient and if the services are provided in a rural area of need. We understand that legislation has been introduced related to these requirements.

CHAPTER 4: QUALITY

INTRODUCTION

Guided by standards published by the Institute of Medicine, in this chapter, TAC/The Institute evaluated Mississippi's approach to ensuring that care delivered to youth is of high quality.

In its seminal document on improving quality in health care settings titled, *Crossing the Quality Chasm,*[74] the Institute of Medicine (IOM) identified six areas that should define how health care services are delivered. Health care should be:

- **Safe** - injuries and harm to those accessing health care services must be avoided.
- **Effective** –services with evidence of their effectiveness should be provided to those who need them and avoid offering services to those who are not likely to benefit (avoiding both over and under utilization of care).
- **Patient/family-centered** – care should be respectful, inclusive, and responsive to the preferences, needs, values, and beliefs of the individual/family receiving care.
- **Timely**- delays and long wait times to receive needed services must be avoided.
- **Efficient** – resources (both human and financial) should not be wasted.
- **Equitable**–quality of care should not vary due to factors such as gender, race/ethnicity, geography, or socioeconomic status.

TAC/The Institute used the framework to guide our assessment of Mississippi's children's behavioral health system as well as to inform our recommendations for potential improvements. In addition to the IOM quality areas, TAC/The Institute also considered the following:

- Both process and outcome measures should be developed to measure/monitor the behavioral health system and the quality of care provided.
- There should be a mix of indicators that address quality of care issues for service recipients, at the provider/service level, and at the larger system level.
- Feedback from multiple informants with different perspectives on the system including caregivers and youth, providers, and other system partners should be solicited.
- A mix of qualitative and quantitative information about system performance must be collected.
- Families should be included in the design and development of quality activities.
- Data should not sit on a shelf. Information should be made public and should be connected to quality improvement strategies and initiatives.

CURRENT CONTEXT

Mississippi's current approach to quality has largely focused on monitoring provider adherence to regulations established by DMH and DOM. The exception to this is the On-Site Compliance Review (OSCR) process established to monitor provider compliance and quality of care in the MYPAC and PRTF programs.

[74]Institute of Medicine (2001).Crossing the Quality Chasm. Washington, DC: National Academy Press.

DOM plans to implement an OSCR process across all mental health programs. DMH monitors the quality of services provided to both children and adults through the following mechanisms:

1. Through the provider certification process, DMH ensures a network of credentialed and qualified providers in the state
2. Tracking and resolving both quality of care and access to care/services grievances
3. Tracking and resolving provider serious incidents
4. Conducting on-site compliance/quality assurance reviews both annually and when triggered by grievance/serious incident report data

Provider adherence to regulations is only one of many factors that should be used to evaluate provider performance. Patient experience of care, access, and improvement in youth functioning, are also critically important variables that should be used to evaluate provider and system performance. With the exception of MYPAC and PRTF, Mississippi has not yet deployed a system-wide quality improvement process that uses both qualitative and quantitative data to drive changes to the care delivery process. This type of approach requires data infrastructure and staff resources that DOM and DMH do not appear to have at this time.

TAC/The Institute found that across DOM, DMH, and provider organizations there is limited use of data for planning purposes, to identify service gaps, or to assist managers in making day-to-day operational decisions. There is very little outcome data collected outside of federal grant programs or waivers. The data that is available is often outdated or has significant lags (i.e. claims data) making its utility for making operational decisions limited. With a few exceptions, providers have limited data infrastructure and reporting systems are outdated and continue to rely heavily on paper and pencil reporting methods. In short, our review found there is no systematic way of looking at data across systems to inform statewide planning or to identify quality of care issues requiring attention. There is an obvious need for investments in establishing data collection and reporting mechanisms, identifying key quality indicators and metrics that can be used to evaluate performance, and connecting results to performance improvement activities and initiatives.

In many of our interviews with family members, state agency staff, advocates, and providers, concerns came up with respect to the quality of care. This is an issue described by all constituents- those that fund care, provide care or receive care. Family members and other stakeholders described barriers accessing needed services and supports, delays in obtaining necessary treatment leading to exacerbation in symptoms, lack of coordination among services, and ineffective care resulting in repeated hospitalizations or juvenile justice involvement. Families expressed that their opinions, beliefs, and values were not solicited or considered in the design and development of treatment interventions nor did they feel valued as partners in their child's care. In sum, Mississippi's performance against many of those key indicators of quality described by the IOM, such as timeliness, effectiveness, efficiency, and family-centeredness suggests the need for improvements in multiple areas in order to improve outcomes and care for the youth and families served by its public mental health system.

Recently, DMH was able to hire an Information Technology Director. This role will provide infrastructure and leadership on the identification and analysis of data that will support policy decisions and quality initiatives. Currently, DMH engages the University of Southern Mississippi's School of Social Work (USM) to administer annual client satisfaction surveys for both adult and youth mental health services. (Another entity was used prior to 2012.) In 2014, the third annual client satisfaction surveys were administered and questionnaires were completed by clients in each of the 14 Community Mental Health Center (CMHC) regions. The questionnaires include demographics and lykert style ratings for domains including access to services, treatment participation, appropriateness and quality of services, social connectedness, and skills improvement. Respondents also have the opportunity to answer open-ended questions regarding their satisfaction with the service system. In 2014, A total of 248 Youth Consumer Satisfaction Questionnaires were completed by parents of youth clients receiving services in the 15 CMHC regions in Mississippi.

RECOMMENDATIONS

1. CREATE A CHILDREN'S BEHAVIORAL HEALTH QUALITY DASHBOARD

TAC/The Institute recommends that the state collect and report on a variety of system development measures (i.e. process measures) and program outcome measures that will be used to monitor system performance and determine gaps in the service system for youth. Additional resources will likely be required by DMH and DOM to implement a quality dashboard.

A list of recommended measures is located below. It should be noted that some of the indicators are already being collected in some fashion. What is missing is:

1. the use of the data to inform policy, planning, operational decisions and
2. a single place where relevant information is put together to offer a comprehensive picture about system functioning and performance.

It should also be noted here that publicly reporting on these types of indicators would help create an environment of greater transparency which could build trust among state agency partners and important stakeholder such as families and consumer groups.

To the extent possible data should be reported out by region and broken out by gender and race/ethnicity where relevant. This will help focus attention on one of the areas of quality identified by the IOM, equity. By reporting out by region, race, and gender policy makers can determine if there are variations in quality due to these factors and more readily consider strategies to address inequities. Further, once a baseline report is established these data should be trended across several years to help evaluate progress over time.

Given these data may come from multiple sources, the state may want to contract with an independent entity such as a university or a UM/QIO to analyze the data and prepare a public report that must be presented to the ICCCY on a regular basis but not less than annually. The information from this data dashboard can be used to identify performance improvement projects and other quality improvement initiatives that the state may wish to include in the CCO and UM/QIO contracts. Establishing a set of indicators helps DMH, DOM and other key stakeholders determine where to focus improvement efforts and how to allocate available human and financial resources.

2. OBTAIN REGULAR FEEDBACK FROM YOUTH AND FAMILIES ABOUT SYSTEM PERFORMANCE

An important aspect of changing the culture in Mississippi's children's behavioral health service delivery system is for front line staff and leaders to hear directly from families about the experience of parenting a youth with a serious behavioral health challenge. Greater inclusion of families in this role will enhance the training activities and help build trust between families, providers, and the state.

Understanding how the system is performing from the point of view of those for whom it is intended to help is absolutely critical. Collecting data from multiple informants and through a variety of mechanisms (e.g. claims data, family survey, provider reports, focus groups, etc.) can offer a more complete picture of how the system is working for youth and families. Gathering information from youth and families offers an important perspective on the system and can help "bring life" and a new level of understanding to the quantitative data that is collected. It often can help provide the "why" behind some of the numbers and can also be useful in identifying those issues that require a more thorough investigation or analysis.

Engaging families in the collection of this information is also important. Many families who have had negative experiences with the system may not respond to a survey from the state or a service provider but may feel more comfortable offering honest opinions and feedback to a peer. Thus TAC/The Institute recommends that the state build upon its current survey efforts include: provider responsiveness, improvements in ability to cope with/manage their child's behavior, improvements to overall well-being and quality of life. Understanding families' perceptions of how their opinions, values, and beliefs were solicited and considered throughout the service delivery process should also be assessed as a way of measuring if care is being

delivered in a family-centered manner. We recommend that results be included in the data dashboard described above and presented publicly at an ICCCY meeting and at provider forums; and that results be used to identify possible performance improvement projects.

Additionally, some states use a "secret shopper" approach to better assess access to care issues and wait times for services. Using families to perform these activities is preferred as there is likely to be greater buy-in and trust from stakeholders if the calls and a report of findings are performed by families as opposed to state staff. A transparent approach to this process is key to its success. When done in partnership with providers to inform critical system issues, it provides access to real-time information which is otherwise difficult to obtain. The state could also establish processes to solicit feedback from youth, providers and system partners such as child welfare through structured interviews, focus groups or other survey methods.

Table 23: Proposed Children's Behavioral Health Dashboard Measures

Area (s)	Measure(s)
Effectiveness **Efficiency**	Unduplicated count of youth who receive the following Medicaid services (across FFS and each CCO) • Community support services • Crisis stabilization • Day treatment • Individual, family, and group outpatient psychotherapy • Inpatient hospital • IOP • MYPAC • Mobile crisis • Peer support • PRTF • Psychiatry • Psychosocial rehabilitation (for youth 18-20) • Tele-behavioral health
Effectiveness **Efficiency**	Penetration rates for the following Medicaid services (across FFS and each CCO) • Community support services • Crisis stabilization • Day treatment • Individual, family, and group outpatient psychotherapy • Inpatient hospital • IOP • MYPAC • Mobile crisis • Peer support • PRTF

	• Psychiatry (including tele-psychiatry) • Psychosocial rehabilitation (for youth 18-20)
Effectiveness **Efficiency**	Unduplicated count of youth who receive the following DMH services • Mobile crisis • Pre-evaluation screening for civil commitment • Residential treatment for Substance Abusing Adolescents • Respite • State hospital • PRTF • Therapeutic foster care • Therapeutic group home
Effectiveness **Efficiency**	% of Medicaid dollars spent on community services for youth under 21 % of DMH appropriation spent on community services for youth under 21
Effectiveness **Efficiency**	% of Medicaid dollars spent on day treatment and partial hospital for youth under 21
Effectiveness **Efficiency**	% of Medicaid dollars spent on 24-hour settings % of DMH appropriation spent on 24-hour settings
Effectiveness **Patient/family-centered** **Timely**	Number of grievances (formal complaints) related to: • Access and availability • Effectiveness/appropriateness of care • Quality of care
Effectiveness **Efficiency**	Ability to successfully respond to and manage crises in community settings as measured by: • N of youth reviewed by MAP who are diverted from out-of-home placement • N of youth diverted from 24-hour care (data from mobile crisis teams) • 30 and 180 day readmission rates for acute psychiatric inpatient, state hospital, and PRTF • N of emergency department visits for youth in behavioral health crisis

	• % of mobile crisis for youth under 21 that occur in the following locations:
	  ○ CMHC
	  ○ Group home
	  ○ Home
	  ○ Hospital emergency department
	  ○ Office
	  ○ Other
	  ○ School

Effectiveness
Efficiency
	Ability to provide access to home and community-based services as measured by:
	• # of service units for youth under 21 per month for:
	  ○ Community support services
	  ○ IOP
	  ○ MYPAC
	  ○ Peer support
	  ○ Psychosocial rehabilitation (for transition age youth)

Effectiveness **Efficiency** **Timely**	Number of EPSDT screenings that identify behavioral health Number of referrals for a behavioral health assessment following a positive behavioral health screen in primary care

Efficiency	Average and median length of stay, admission rate, and readmission rate for children discharged from the following settings:
	  ○ Acute inpatient psychiatric facilities
	  ○ Crisis stabilization units
	  ○ Group home
	  ○ PRTF
	  ○ State hospital
	  ○ Residential treatment for Substance Abusing Adolescents

Patient/family-	% of families who report satisfaction with or improvements in:

centered	• Provider responsiveness to treatment request • Ability cope with/manage their child's behavior as a result of the behavioral health services they have received • Overall well-being and quality of life • Improved coping • Family-centered approach to care
Efficiency **Patient/family-centered**	Number of certified family peer-support specialists
Safety	Number of patient deaths in 24-hour settings (state hospital, acute psychiatric inpatient, PRTF, hospital)
Safety	Physical restraint per 1000 patient days for state and acute psychiatric inpatient facilities Physical restraint per 1000 patient days for PRTF facilities
Safety	Average duration of restraint for state and acute psychiatric inpatient facilities Average duration of restraint for PRTF facilities
Safety	Seclusion per 1000 patient days for state and acute psychiatric inpatient facilities Seclusion per 1000 patient days for PRTF facilities
Safety	Average duration of seclusion for state and acute psychiatric inpatient facilities Average duration of seclusion for PRTF facilities
Safety	Patient injuries per 1000 patient days for state and acute psychiatric inpatient facilities Patient injuries per 1000 patient days for PRTF facilities
Safety	Medication errors (i.e. missed dose, incorrect medication given) per 1000 patient days for state and acute psychiatric inpatient facilities Medication errors (i.e. missed dose, incorrect medication given) per 1000 patient days for PRTF facilities
Timely	% of mobile crisis evaluation for youth under 21 that are responded to within 1-hour
Timely	Average time to first appointment for psychiatric clinician
Timely	Average time to first appointment for IOP
Timely	Average time to first appointment for an outpatient behavioral health assessment
Timely	% of youth under 21 who received follow-up appointment within 4days and 14 days for an initial assessment

3. ESTABLISH SYSTEMS TO HELP IDENTIFY YOUTH IN NEED OF SERVICES AND MAKE FAMILIES AWARE OF AVAILABLE BEHAVIORAL HEALTH SERVICES

Many families (and providers) that we spoke with for this assessment were unaware of the types of behavioral health services and supports available to support youth in the community. We also heard examples of providers who were not facilitating referrals for more intensive services and supports such as IOP even when it might have been indicated for the youth. TAC/UMD recommends that the state identify and seek to notify the parent/caregiver of any youth that claims data reveals could potentially benefit from an intensive home and community-based behavioral health service such as IOP. These approaches are being widely adopted through health home and patient-centered medical home approaches but are also applicable to youth behavioral health. Through these approaches, data is analyzed to identify youth that meet certain criteria and then deploying a managed care vendor, provider or a letter from the state Medicaid office to contact families to see if additional services could be helpful.

Indicators or flags that would identify youth include:

- Acute inpatient or PRTF psychiatric admission
- Poly-pharmacy
- Two or more mobile crisis intervention encounters
- Two or more emergency department visits with a primary mental illness or substance use diagnosis on the claim

Additionally, some states routinely notice all family members of youth via letters that provide information on benefits that are available in the Medicaid program. As an example, Vermont has developed specific EPSDT notices tailored to different ages in order to inform families about developmentally appropriate EPSDT screens[75]. These letters, newborn through age 20, are sent yearly, reminding families and youth about specific health issues tailored to their ages. This type of identification and outreach would help raise awareness among Medicaid members about benefits available to youth under 21 as part of the EPSDT benefit and support more timely access to services. It is also a more efficient strategy than relying on providers alone to facilitate referrals. This letter would be in addition to notifications about behavioral health services for youth under 21 made available to families upon enrollment.

Further, given that many families may not necessarily respond to a letter, consideration should be given to how family support partners could be utilized to conduct further outreach to families to help them understand how to access services and supports for their child. As an example, Maryland uses its Family Support workers to serve as system navigators, to outreach and engage families directly. Some families may need this type of personal assistance and system navigation support due to low literacy or cognition or simply because of prior bad experience with behavioral health services. Family support partners could serve as that critical bridge to support engagement in treatment services.

4. REQUIRE THE UM/QIO AND MCOS TO ENGAGE IN AT LEAST ONE CHILDREN'S BEHAVIORAL HEALTH PERFORMANCE IMPROVEMENT PROJECT ANNUALLY

The selection of these projects should be stakeholder informed and data driven and agreed upon by the ICCCY so that the selected projects do not overlap or place undue burden on providers without requisite support. Examples of projects could be facilitating a learning collaborative on engagement and retention strategies in outpatient behavioral health clinics, reducing 30 day readmission rates, developing same-day or urgent capacity at CMHCs, implementing an EBP, or decreasing mobile crisis response times. These projects should include an evaluation component and could be tied to bonus payments for successful completion and/or outcomes.

[75] http://healthvermont.gov/family/toolkit/tools%5CG6%20Summary%20of%20recommendations%20included%20in%20EPSDT%20Informing%20Letters.pdf

5. ESTABLISH AN ON-SITE QUALITY AND COMPLIANCE REVIEW PROCESS FOR STATE HOSPITAL FACILITIES.

As stated earlier, with the exception of MYPAC and PRTF, DMH and DOM's approach to quality has primarily focused on provider compliance. The OSCR process included a review of provider's administrative operations, overall approach to treatment, and an evaluation of how services are working for enrolled youth and families. This process involves not only a review of client records and program documentation but also interviews with staff, observation of child and family team meetings, and interviews with families. At the end of this process, providers are offered a debriefing and if deficiencies are found the provider must submit a corrective action plan. The inclusion of information from multiple sources, the solicitation of feedback from families, and the connection to a quality improvement process in the form of the correction action plan makes the OSCR a model process. TAC/The Institute recommend that this approach be adopted (and adapted) for use in the other institutional settings for youth. The state will need to use some criteria to determine which programs to review first and establish a timeframe for review of all programs using this new framework. For example, those facilities with high rates of seclusion and restraint, longer than average lengths of stay, or other performance issues should be reviewed in the first wave.

6. ESTABLISH STRATEGIES FOR RAPID NOTIFICATION OF CCOS AND PROVIDERS ABOUT ADMISSIONS AND DISCHARGES AT 24-HOUR LEVELS OF CARE

With inpatient behavioral health care carved out of the managed care benefit, CCOs are often not aware when one of their member's is admitted to an inpatient facility. While a report detailing inpatient admissions is generated by the UM/QIO and sent to the CCOs, it relies on claims data creating a long lag time between the discharge and the receipt of the report. In this way, youth may fall through the cracks and not get connected with important aftercare services that could help prevent another hospitalization. If the UM/QIO obtains information about admissions though some mechanism (i.e. notification by the hospital, concurrent review of care) UM/QIO could send a daily report to the CCOs of those members to inform them of inpatient psychiatric admissions. The CCOs could use this information to contact the family and offer support/assistance in connecting the family with needed post-hospital services and supports. This is another opportunity to use family support partners to help families navigate the system and offer a bridge to other treatment services.

TAC/The Institute recommends that DMH and DOM expand its current efforts related to providers crisis management and safety plan. The development and availability of crisis plans is important to diverting crisis placements. As Mississippi's mobile crisis system grows and more children present for that service, the system would benefit from proactive communication about potential crises. Many states with centralized crisis response teams are able to place "on alert" , with guardian permission via a release of information, a crisis safety plan so that if a child presents in crisis, the mobile crisis team that is not familiar with that child, has access to that crisis safety plan. With parent/caregiver permission, this plan should be sent to the local mobile crisis team and the behavioral provider(s) responsible for "after care" prior to discharge, to supply them with information about the youth and family that could be used to stabilize a behavioral health crisis.

7. PUBLISH AN ANNUAL STATEWIDE REPORT OF FINDINGS FROM MAP TEAMS

As the local "eyes and ears" about issues impacting youth with behavioral health challenges and their families, MAP teams are an invaluable resource to identify emerging system challenges and resource needs and solutions. TAC recommends that DMH build upon its quarterly data gathering and report process to include an annual report for submission to the ICCCY detailing the findings from local MAP teams. This report should include information about numbers of youth reviewed and outcomes of these reviews, but more importantly it should discuss the barriers and challenges faced by local teams in supporting youth and families in the community. It should also include examples of best practices or successful strategies used to support families. This report should be used for action planning and to inform state policy makers about system gaps as well as those best practice strategies that have the potential for replication in other areas.

CHAPTER 5: INTERAGENCY COLLABORATION

INTRODUCTION

In this chapter, TAC/The Institute reviewed the extent to which Mississippi's existing policies, structures, and procedures support interagency collaboration and coordination; limitations or barriers to effective interagency collaboration; and the connection between agency level policy priorities and client-level barriers and needs identified at a local level.

Interagency collaboration and governance is a prerequisite for building an effective system of care and ensuring that children and youth have the services and supports necessary for remaining at home and in their communities. Defined as decision making entities with oversight at a policy level that has legitimacy, authority, and accountability, governance structures vary in configuration and may be established in several ways, such as by legislation, executive order, or memoranda of agreement. As with all behavioral health systems in the country, Mississippi's children's behavioral health system is impacted by decisions made in other child-serving systems.

Several questions drove this interagency collaboration analysis. These questions included:

1. To what extent are policy priorities, structures and procedures established across child-serving agencies in Mississippi?
2. Are there limitations or barriers to interagency collaboration?
3. What is the connection between agency level policy priorities and client-level barriers and needs identified at a local level?

Strong governance structures are essential because they establish the strategic direction for activities, tasks, and functions associated with building, implementing, and sustaining systems of care and providing oversight for their implementation. They also provide a mechanism to ensure that systems of care values and principles are communicated and operationalized by all child-serving agencies.

MISSISSIPPI SYSTEM OF CARE FOR CHILDREN AND YOUTH

In 2010, Mississippi enacted legislation to amend Section 43-14-1, Mississippi Code of 1972 to provide for the development, implementation and oversight of a coordinated interagency system of necessary services and care for children and youth, called the Mississippi System of Care (MSCC), for children with serious emotional/behavioral disorders. The legislation defines three primary interagency components along with their membership and functioning requirements, including:

- ***The Interagency Coordinating Council for Children and Youth (ICCCY)*.** Established to serve in an advisory capacity and to provide state level leadership and oversight to the development of the MSCC, the ICCCY invites the participation of the Executive Directors from each child-serving agency, including the Department of Mental Health, Department of Health, Superintendent of Public Education, Department of Human Services, Division of Medicaid, Department of Youth Services, and the Attorney General.
- ***The Interagency System of Care Council (ISCC).*** Also at the state level, the ISCC serves as the management team for the ICCCY and is tasked with developing the MSCC by collecting and analyzing data and funding strategies, coordinating local MAP teams, and applying for grants from public and private sources. The ISCC is comprised of a member from each state agency, a family member representing a family education and support organization, two special organization representatives, and a family member appointed by Mississippi Families as Allies.

- ***Multidisciplinary Assessment, Planning and Resource (MAP) Teams.*** The MAP teams are the local arms of the Mississippi Statewide System of Care required to work with individual cases to ensure children and youth receive services and supports in the least-restrictive setting possible.

Although this legislation provides a clear and impressive framework for establishing a three-tiered interagency governance structure, it has not been implemented with the desired intent at the state level.

There are many examples of ongoing cooperation between DOM and DMH. Both agencies share a commitment to a service system and benefit array that supports children with behavioral health needs and their families. The sharing of policy changes before enactment, regular meetings to address child specific placement issues, interagency agreements and memorandum of understanding are in place. Aside from a shared commitment to improved care for children, agency goals are not always aligned which is impacting the behavioral health system.

Specifically, DOM is under tremendous pressure to manage costs in the Medicaid program. In an effort to meet that across the board directive, certain policies are implemented to meet that goal. However, these can have inadvertent impact on the behavioral health delivery system. DOM can be hampered by directives outside of its agency's control. . As a specific example, DOM is not able to manage a significant cost driver in its program which is institutional care. This creates significant challenges for an agency that needs to control the Medicaid budget; and impacts the ability of DMH and DOM to redirect institutional placements with appropriate home and community based options. As such, DOM is required to control costs but cannot manage a key cost driver for the program. Instead, they manage lower cost services, in which only nominal savings can be achieved. These types of push-pulls on both of these agencies impact the continuum of care.

Looking beyond DMH and DOM, there is disparate administration and financing of major components of the system across child welfare, juvenile justice, education and public health. This has exacerbated the inherent differences between the roles of state agencies, has diffused accountability for the overall performance of the children's behavioral health system, and has perhaps created unintended incentives for cost or care-shifting between systems and providers. These systems influence access to institutional levels of care and purchase other behavioral services and supports. In most instances the same children may be receiving services across all of those entities, common system goals, client goals, clarity on roles and decision-making, and alignment of agency policy and procedures is needed to ensure a systemic approach to home and community based care. The state language regarding the purview of ICCCY to align child specific issues is strong; however, this body has not been implemented per the legislation and the group has not convened since 2012. The state needs to renew its commitment to that legislation, and enact provisions that lead to accountability across the system. In addition, The ICCCY does not have authority to impact policy and funding decisions across all public service sectors. This is an important component to strengthen this coordinating body.

RECOMMENDATIONS

1. ESTABLISH A CHILDREN'S CABINET

It is recommended that Mississippi establish a Children's Cabinet level position to serve as an organizational locus of system of care management at the state level to implement policy, administrative and regulatory changes. A children's cabinet level position can ensure that governmental agency priorities, policies and financial decisions are aligned toward ***one common set of goals for all Mississippi children*** including shared accountability, alignment of spending, development of communication protocols across agencies, and alignment of agency procedures to facilitate access to services, institutional placement redirection and discharges, and provider capacity. This approach offers greater ability to align with Governor established priorities, addresses that some agencies are already cabinet level while others are not; and provides clearer accountability. The role of ICCCY could remain and become the operational group. We understand that

discussions have commenced with the Governor's office to establish a Children's Cabinet and commission a study to inform the right approach for Mississippi. This group should be empowered to develop a comprehensive and uniform purchasing plan for children's behavioral health, and implement system-wide performance measures and quality indicators that could be incorporated into a comprehensive approach.

2. FACILITATE INTERAGENCY COLLABORATION

The State of Mississippi and specifically child-serving agencies must reaffirm their commitment to the 2010 Mississippi Systems of Care statute and develop interagency structures that reflect a shift to a more child-centered, family-focused and youth guided service delivery system .It is recommended that DMH and DOM introduce new legislation to expand current ICCCY language to empower ICCCY to identify and implement one shared set of goals detailing each agency's accountability and responsibilities towards those goals. This offers the ability to capitalize on existing language and to use the ICCCY structure as originally intended. However, given that ICCCY is not operational and appears to have limited coordination and policy influence; changes would be necessary to ensure that ICCCY could fulfill this purview. Revised legislation should be introduced to mandate staffing and resources to support the ICCCY and methods to ensure the accountability of participating agencies, such as a requirement that annual reports be submitted to the Governor and the Mississippi legislature that includes a summary of activities, any statutory reporting responsibilities, proposals to reduce redundancies, highlights of successes, and meeting minutes with rosters of attendees at each ICCCY meeting. To promote transparency, a web-site that shares the activities of the ICCCY and its participants, provides up-to-date, relevant information, and allows community stakeholders to provide input. For an example, see Louisiana's Coordinates System of Care website, located at www.csoc.la.gov.

TAC/The Institute also recommends that Mississippi implements a cross-agency data sharing protocol and interagency agreements that outline system responsibilities, including actions to ensure system representation on local MAP teams, training of respective agency staff, and cross-agency commitments for policies on diversion of children from placement. The potential use of MAP teams for system wide review on placement considerations should also be considered. In addition, it is recommended that Mississippi consider an interagency funding approach to services that cross multiple agency funding streams and to meet the priorities of the ICCCY. Such an approach would ideally require contributions from each participating agency and would be managed via a comprehensive performance-based budget plan to ensure that interagency funds result in benefits for specified target populations. This cross-agency planning and data sharing strategy could also lead to designating funds to help cover the cost of indigent care. Shared goals and priorities, and redirected funds from reduced institutional placements, could be redirected to cover services for youth without insurance.

3. FURTHER EMPOWER MAP TEAMS TO ADDRESS SYSTEM LEVEL ISSUES

DMH, DOM and other agencies recognize the importance of MAP teams to the system. It is recommended that DOM and DMH implement methods to further empower local MAP teams and ensure an effective communication mechanism between the ICCCY/ISCC so that systems of care policy is understood and achieved at all levels.

The MAP teams have served as a source of interagency youth level reviews to address "stuck" situations and coordinate resources across agencies to meet the needs of specific youth. As intensive care coordination using Wraparound is expanded and utilized by more children, the care planning teams for those youth will be the process to address the needs of youth and to coordinate resources. This will allow the MAP teams to focus their expertise on system level issues that can further support the effectiveness of those care plan teams. As the local "eyes and ears" about issues impacting youth with behavioral health challenges and their families, MAP teams are an invaluable resource to identify emerging system challenges and resource needs and solutions. A greater connection between MAP teams and the needs and challenges identified by the care plan teams convened in IOP will further support this work.

TAC/Institute recommends that DMH build upon its quarterly data gathering and report process to include an annual report for submission to the ICCCY detailing the findings from local MAP teams. This report should include information about barriers and challenges faced by local teams in supporting youth and families in the community. It should also include examples of best practices or successful strategies used to support families. This report should be used for action planning and to inform state policy makers about system gaps as well as those best practice strategies that have the potential for replication in other areas.

Given variation in MAP teams, a systematic approach for convening local MAP team members should be devised to promote participation in peer-to-peer learning activities. In addition, DOM and DMH should regularly conduct trainings and webinars and provide written information that communicate proposed and actual changes in policies and recommendations. Finally, with support of the ICCCY and ISCC, MAP teams should engage in a public-relations campaign to promote the activities of the Mississippi System of Care and to educate and encourage the participation of community stakeholders.

CHAPTER 6: REDIRECTING INSTITUTIONAL CARE

INTRODUCTION

This final chapter in the report evaluates the balance of services, access and utilization across community-based and 24 hour services, what system structures, policies, and procedures are in place to monitor appropriate use of restrictive settings, and whether any cross system issues impact the use of restrictive settings over community-based options.

Both Institutional settings and home and community-based settings serve important functions in every behavioral health system. It is essential for Institutional services to be viewed as part of a continuum of care with a defined role. The National Association of State Mental Health Program Directors recently issued a white paper which describes a shared vision for the role that state psychiatric hospitals can play.[76] State hospitals should serve as a treatment setting which assures health and safety for individuals whose symptoms and behavior, resulting from a mental health disorder, cannot be treated and managed safely in a community setting. In addition, the paper states that 'state psychiatric hospitals should not be a solution or default system for an underfunded or fragmented community system.[77] The lack of a fully-developed and adequately-funded community-based system has contributed to an over-reliance on Institutional care for children and youth in Mississippi.

Several questions drove the quantitative and qualitative aspects of the institutional care analysis. These questions included:

1. What is the balance of services, access and utilization across community-based and 24 hour services?
2. What are the system structures, policies, and procedures in place to monitor appropriate use of restrictive settings?
3. Are there any cross system issues that impact the use of restrictive settings over community-based options?

CURRENT CONTEXT

As indicated in chapter one, the current behavioral health system expenditures is weighted towards institutional settings. The majority of DMH dollars and DMH staffing, along with Medicaid and child welfare expenditures, are locked into maintaining institutions. Additionally, institutions require significant capital investment. Facilities tend to become aged and fall into disrepair resulting in quality of care issues. The state will need to continually budget for capital expenditures. Without commitment to dedicate state staff and state dollars towards HCBS, institutional redirection will not occur.

Disproportionate spending on institutional care is not unique to Mississippi. Nationally, about 19 percent of total Medicaid expenditures are for residential treatment settings, accounting for the highest proportion of spending of any service and averaging nearly $22,000 per child per year. Inpatient psychiatric treatment accounts for an additional 5 percent of total Medicaid spending.[78]

Mississippi spends a greater proportion on institutions compared to national Medicaid expenditure data. In State Fiscal Year 2014, expenditures for psychiatric residential treatment facilities accounted for 26 percent

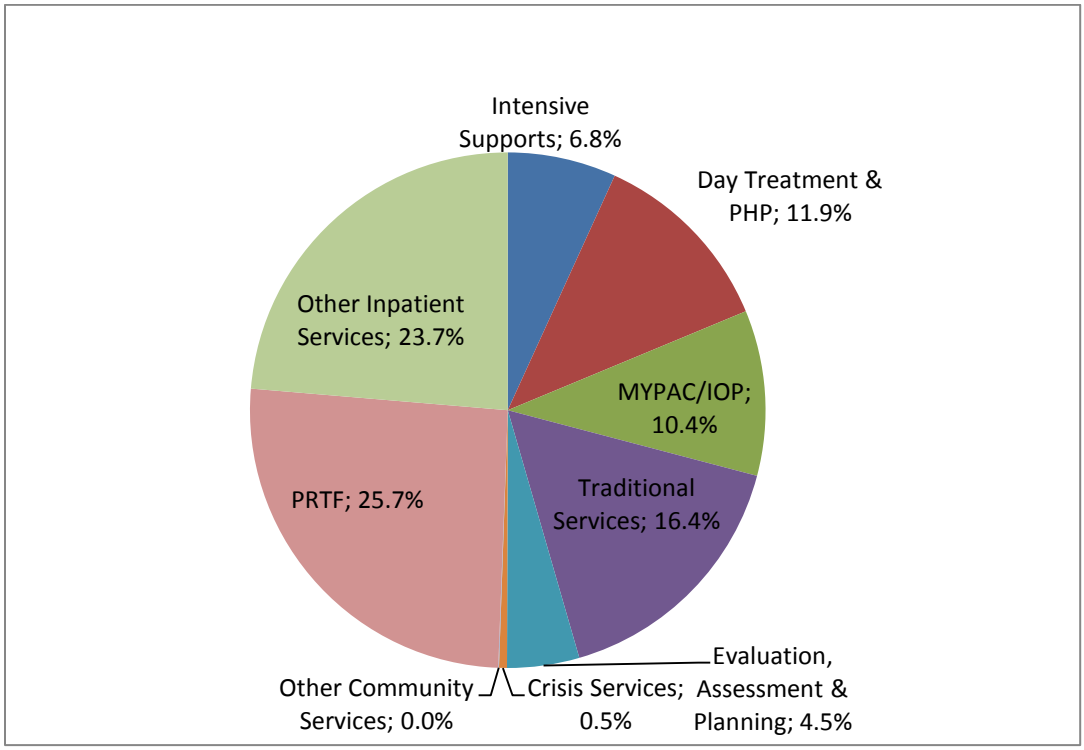
[76] http://www.nasmhpd.org/publications/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf

[77] Ibid.

[78] Center for Health Care Strategies, (2013).Examining Children's Behavioral Health Service Utilization and Expenditures. Retrieved from http://www.chcs.org/media/Faces_of_Medicaid_Examining_Childrens_Behavioral_Health_Service_Utilization_and_Expenditures.pdf

of total Medicaid mental health spending, 7 percentage points higher than the national average. Further, the average cost per user of residential was $49,000 in SFY 2014, more than double the national average. From SFY 2010 to SFY 2014, spending on PRTFs trended upward, increasing by 11 percent. Spending on inpatient psychiatric services (including inpatient medical surgical) was exceptionally greater than the national average, accounting for 24 percent of total mental health Medicaid expenditures in SFY 2014 (compared to 5 percent nationally).

Figure 35: Distribution of Medicaid Payments in FY 2014 (FFS & MC)



Although states spend a significant amount on residential treatment and inpatient care, the evidence base for their long-term effectiveness is mixed. Many states are prioritizing investment in home- and community-based alternatives to ease reliance on institutions, prevent readmissions, and reduce lengths of stay. This trend is influenced by two major factors:

- Greater evidence of cost-savings and better return on investments from home- and community-based interventions, and
- Emerging evidence for the efficacy of a myriad of home and community-based interventions with replicable models.

In states that are purposefully redirecting use of institutional care, expenditures saved by diverting children from residential care into community treatment are often re-allocated to child-serving agencies with the goal of enhancing intensive home and community services.[79]

[79]Ireys H.T., Pires, S. & Lee, M. (2006). Public Financing of Home and Community Services for Children and YOuth with Serious Emotional Disturbances: Selected State Strategies. Retrieved from http://aspe.hhs.gov/daltcp/reports/2006/youthSED.pdf

In their bulletin issued in 2013, SAMHSA/CMCS highlighted the cost-savings potential of home- and community-based alternatives to PRTFs, in which they reference findings from the evaluation of the PRTF-Waiver Demonstration: "The PRTF evaluation showed that state Medicaid agencies reduced the overall cost of care. For example, home and community-based services provided to children and youth in the PRTF demonstration cost 25 percent of what it would have cost to serve the children and youth in a PRTF, an average savings of $40,000 per year per child. State Medicaid agencies' annual costs per child were reduced significantly within the first 6 months of the program."[80] Such savings are prime reinvestment opportunities to enhance the home- and community-based service array.

The SAMHSA/CMS bulletin also pointed to findings from the national evaluation of the Children's Mental Health Initiative (CMHI) that consistently demonstrate improved outcomes and per capita savings across child-serving systems for children and youth with serious emotional disturbance enrolled in systems of care. In 2010, SAMHSA reported a 47 percent decline in inpatient costs and a 42 percent decline in child arrest costs.[81] In 2011, they indicated a 21 percent reduction in psychiatric inpatient costs and a 32 percent reduction in child arrest costs.[82]

More recently in 2013, an expanded analysis was conducted to investigate outcomes and cost-savings among children and youth receiving home- and community-based services in 76 CMHI-funded system of care communities. The analysis found that children enrolled in systems of care, particularly those that incorporated intensive care coordination using a Wraparound approach for high needs children, demonstrated improved outcomes which translated into measurable cost-savings to taxpayers. In particular, decreases in inpatient hospitalizations result in a cost-savings of $37 million, decreases in psychiatric emergency room visits resulted in a cost-savings of $15 million, and decreases in child arrests resulted in a cost-savings of $10 million.[83]

In addition to the national evaluation discussed above, there are a myriad of individual state, community, and provider evaluations that further bolster claims that home- and community-based services reduce costs among children and youth with serious behavioral health needs. For example, Choices Inc., a care management organization that serves children and youth with multi-system needs in District of Columbia, Florida, Indiana, Louisiana, Maryland, and Washington reported that 98 percent of the youth they served were diverted or returned from residential treatment facilities. They found that this resulted in a cost-savings of nearly $36,000 per youth.

Similar savings were demonstrated by an evaluation of PRTF-Waiver youth in Georgia, which found that reductions in inpatient utilization and residential stays due to Wraparound involvement translated into an average annual savings of $44,000 per youth. Further, the cost of serving youth in juvenile correction facilities decreased by 45 percent as a result of Wraparound involvement and recidivism for youth in the juvenile justice system who received Wraparound services was 23 percent lower than the overall rate for Georgia.

In addition to the potential for cost-savings, home- and community-based services are becoming a more attractive option to policymakers due to increasing evidence that they are as or more effective than residential and impatient treatment for similar populations of youth at a lower per capita cost. Although some studies have demonstrated that residential treatment can be successful for many youth, particularly during program involvement, there is a dearth of research that evaluates the effectiveness of specific program components. In addition, the literature lacks operational definitions of residential treatment

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[80]CMCS & SAMHSA. (2013). Joint CMCS and SAMHSA Information Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

[8181]SAMHSA. (2010). The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings – Annual Report to Congress, 2010.

[82]SAMHSA. (2011). The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings – Annual Report to Congress, 2011.

[83]Stroul, B. A., Pires, S. A., Boyce, S., Krivelyova, A., & Walrath, C. (2014). Return on Investments in Systems of Care for Children with Behavioral Health Challenges (Data source: Agency for Healthcare Research and Quality). Retrieved from http://gucchdtacenter.georgetown.edu/publications/Return_onInvestment_inSOCsReport6-15-14.pdf

and success. These factors conspire to make successful residential programs and practices difficult to replicate and scrutinize.[84] In contrast, many evidence-based or promising home- and community-based practices achieve their designations through a highly rigorous practice and are manualized, standardized, replicable, and consistently monitored to ensure fidelity.

Additionally, as the PRTF Waiver Evaluation demonstrated, states are able to achieve similar or improved outcomes to PRTFs with home- and community-based services at lower per capita costs. The national evaluation of the CMHI program also found that home- and community-based services improved outcomes across multiple domains, including improved school attendance and performance, increases in behavioral and emotional strengths, improved clinical and functional outcomes, more stable living situations, improved attendance at work for caregivers, reduced suicide attempts, and decreased contacts with law enforcement.[85]

It is important to reiterate that residential treatment and inpatient care serve a critical need within an overall continuum of care. These services provide care to those children and youth whose needs are too severe to treat at home or those who have not improved via community-based services alone. It is however incumbent upon residential treatment and inpatient providers to take steps to maximize their role within a system of care. This can be accomplished by:

- Ensuring that children and youth who enroll in residential programs are ideally matched to the intervention, preferably through the use of standardized assessment tools. Children with severe levels of functional impairment may be more amenable to residential treatment then their lower-need counterparts, where in some cases residential treatment may be iatrogenic (e.g., due to peer contagion).

- Effectively coordinating discharge from the residential or inpatient program by ensuring the availability of needed services and participating in wraparound child and family teams.[86]

- Creating an internal culture that imbeds a sense of urgency to develop individualized and program-wide strategies to reintegrate youth back into their home sand communities rather than assuming longer lengths of stay

- Adopting systems of care values and principles and tenets of the Building Bridges Initiative (See: CHIPRA Webinar: Reengineering Residential Treatment, available at www.chcs.org).

Many states have closed or dramatically decreased their use of state hospitals for children and adolescents; instead relying on community hospitals for any inpatient care. Unlike in other states where state hospital capacity is directed towards forensic or other special populations, state psychiatric hospitals in Mississippi appear to operate similarly to other acute hospitals in terms of the types of populations described as admitted to the facilities during interviews. Any institutional capacity needs to be integrated with a continuum of robust community services. Some states have pursued inclusion of treatment foster care [87] in their Medicaid benefit array to increase their use of effective practices that better integrate and maintain a child in their community. States are incorporating this service because it is a less-restrictive alternative to

[84]Brown, et al., (2011).Outcomes monitoring after discharge from residential treatment for children and youth. *Residential Treatment for Children and Youth, 28,* 303-310.

[85] SAMHSA/CMCS Bulletin

[86]Lyons, J. S., Woltman, H., Martinovich, Z., & Hancock, B. (2009).An outcomes perspective of the role of residential treatment in the system of care.*Residential Treatment for Children and Youth, 26* (71). 71-91.

[87] Substance Abuse and Mental Health Services Administration. (2013). What does the research tell us about services for children in therapeutic/treatment foster care with behavioral health issues? Report of the SAMHSA, CMS and ACYF Technical Expert Panel, September 27–28, 2012. HHS Publication No. (SMA) 14-4842. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

more restrictive settings such as group care, psychiatric residential treatment facilities, and long-term residential programs. As an example, Montana defines its benefit as:

> *Therapeutic Foster Care (TFOC) is a home based treatment Care alternative for youth with a serious emotional disturbance requiring specific and frequent treatment alternatives and/or supports. TFOC is provided in therapeutic foster homes in two levels: moderate and permanency. TFOC room and board costs are not reimbursed by Montana Medicaid. Medicaid reimburses for 14 therapeutic home visits per state fiscal year for youth in moderate level TFOC. Permanency level TFOC is an intensive therapeutic intervention for the foster family, intended to support the foster placement to become an adoptive home.*

As previously mentioned in Chapter 1, DMH spent $28.6 million on state mental health hospitals for children and youth, compared to a national average of $11 million. Per capita spending for state hospitals was the second highest in the country. In contrast, only $69 million were spend on community-based programs, compared to a national average of $179 million.[88][89]

The average length of stay for children receiving treatment at Oak Circle was 47.2 days in FY 2014 while the average stay for youth receiving psychiatric and substance abuse treatment at the Bradley Sanders Complex in FY 2013 was 125 and 87 days respectively. As reflected in the table below, this level of service utilization exceeds the targeted length of state hospital service in most states. It should be noted that 35 states do not rely on any state hospitalization to treat children and 30 states do not rely on state hospitalization to treat adolescents. For those that do admit children and adolescents to state hospitals, more states target the services for Acute and Intermediate Care as opposed to Long-Term Care in excess of 90 days.

Table 24: Number of States with State Psychiatric Hospitals Providing Specific Inpatient Services by Age and Targeted Length of Inpatient Services

Target Population	Acute Care (less than 30 days)	Intermediate Care (30-90 days)	Long-Term Care (greater than 90 days)
Children	15	13	11
Adolescents	20	20	16

Source: NRI 2013 State Mental Health Agency Profiling System

Currently, admissions to inpatient and other institutional settings that do not involve the Chancery Courts are decided by the institutional provider where the client presents; this provider is frequently rendering decisions based on the presented information, with little or no input from current treaters. The exclusion of inpatient benefits from MississippiCan contributes to this problem. Mississippi is the only state in the country where inpatient care is left out of Medicaid managed care when managed care is utilized. The CCOs have no ability to offer alternatives to, or coordinate the delivery of, the most disruptive and intrusive level of care for children and youth in Mississippi. Not only are the CCOs unable to coordinate inpatient care for their members they are also not funded to create alternative home and community-based services and supports that could help divert youth from unnecessary hospitalization. Many stakeholders and providers report concern that there are no HCBS alternatives that could successfully divert admission/re-admission. Inpatient psychiatric services are provided through the traditional fee-for-service while other home- and community-based behavioral health services are managed by MississippiCAN. Consequently, CCOs are unable to track consumers when they are admitted to inpatient settings in real-time and instead must rely on retroactive reports submitted by UM/QIO. This process substantially limits the capacity for CCOs to prevent unnecessary hospitalizations, coordinate discharges, and arrange warm hand-offs. As previously stated, there are no community-based alcohol and drug residential treatment beds accessible for publicly-funded youth in Mississippi.

[88]Substance Abuse and Mental Health Services Administration. [2012]. Table 15: SMHA-Controlled Mental Health Expenditures at Community-Based Programs, by Age Group and State: FY 2012. Retrieved from http://www.nri-incdata.org/

[89]Substance Abuse and Mental Health Services Administration. [2012]. Table 14: SMHA-Controlled Mental Health Expenditures at State Mental Hospitals, by Age Group and State: FY 2012. Retrieved from http://www.nri-incdata.org/

Access to mobile crisis response and stabilization is an effective mechanism for preventing unnecessary placement in institutions and increasing access to HCBS. While the addition of mobile crisis to the service array is a positive development in Mississippi's system, its potential as an intervention to divert youth from more restrictive settings is underdeveloped. These services are significantly lower in cost, can be developed across the state to address current access issues resulting from the constellation of providers in 2 areas in the state, and allow for closer interaction between CSU team and the IOP. Crisis stabilization units, in addition to mobile response capacity, can also provide observation capacity when it is not known if redirection from inpatient will be effective or when a 23 hour or less placement intervention is appropriate. Mobile crisis services are intended to be delivered where the person in crisis is experiencing the crisis, in order to avoid the individual/family from needing to go to the ED or police department for stabilization. Crisis workers report trying to identify a neutral location where they can meet the person/family but this often ends up being the ED which defeats the purpose of de-escalating and stabilizing the crisis where it is occurring.

Youth and chancery courts were identified as a primary referral source to state and private inpatient facilities**.** In some cases, children involved with the court are committed to a hospital without parental consent or knowledge. In addition, approximately 85 percent of children detained at the state-run detention center, Oakley Training School, have a mental health disorder (not including conduct-related disorders).

Twenty (20) counties in the state have a full-time judge assigned to youth court; however the remaining 62 counties (mostly rural) have part-time "referees" appointed to the chancery's court. These areas lack the capacity for adequate collaboration with mental health providers to inform the courts' recommendations as to whether the youth should be diverted to community services or referred for formal processing to state hospitals or detention centers. As a result, court-involved youth with mental health needs are inappropriately detained or hospitalized.

RECOMMENDATIONS

1. REDIRECT CARE TOWARDS INCREASED USE OF HCBS AND DECREASED USE OF INSTITUTIONS

Residential treatment is the most expensive per episode child and adolescent behavioral health intervention option. Given that total treatment dollars for youth with behavioral health needs are scarce, the more that states spend on residential and other out-of-home care, the less they have for intensive home and community services. As a result, many states recognize that expansion of home- and community-based services is tied to the reduction of the number of residential beds and average lengths of stay in residential settings.

To reduce Mississippi's present overreliance on institutional placements, 24-hour services must be repurposed to build the home- and community-based service array and limit opportunities for restrictive placements. We understand that there is currently a moratorium on PRTF beds, and this should continue. In addition, it is recommended that DHS, DMH and DOM require PRTFs and state hospitals to submit plans for reconfiguring a portion of their beds and redirecting staff and resources towards alternate treatment modalities more conducive to a home- and community-based service array.

In the United States, residential centers are increasingly reengineering their services by re-training staff to provide intensive home and community services. They are also espousing a broader view of their mission, focusing on a range of services that vary in intensity and delivery site while still providing residential treatment. For example, some PRTFs are providing crisis intervention services by reconfiguring their beds to serve as short-term crisis stabilization units. Some are implementing best-practice and evidence-based models to include wraparound and other treatment services provided in the home, school, detention centers, or other community settings.

2. INCLUDE THE INSTITUTIONAL BENEFIT INTO MEDICAID MANAGED CARE STRATEGIES

In order to better manage and coordinate services for children and youth with intensive behavioral health needs, states have implemented managed care plans that include both inpatient and outpatient behavioral

health services. For example, in 2012 Louisiana launched the Louisiana Behavioral Health Plan under a 1915(b) authority that includes the Louisiana Coordinated System of Care. In 2006, Georgia introduced Georgia Families, a managed care plan under a 1932(a) authority that includes primary care, acute, and specialty services including both inpatient and outpatient behavioral health services, dental, and transportation.

Managed care plans that include both inpatient and outpatient services are better able to promote and make available lower-cost alternatives to more restrictive levels of placement. Further, uniting inpatient and outpatient services under one plan will position CCOs/UMQIO to reliably perform independent initial certifications of need and recertification of need for members seeking admission or who have been admitted to a psychiatric inpatient facility or psychiatric residential treatment facility, in which they are able to reasonably determine that:

- Less restrictive, ambulatory care resources available in the community do not meet the treatment needs of the member;
- Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and,
- The services can reasonably be expected to improve the member's condition or prevent further regression, so that the services will no longer be needed.

In addition, including the inpatient services into managed care would enable CCOs/UMQIO to develop and provide daily admission and discharge reports to CMHCs and private providers, developed and provided to CMHCs and private providers to ensure timely notification of service changes and more efficient coordination of care. CCOs should use the information from daily reports to create standards and expectations for care coordination to be implemented by providers. This process would greatly improve continuity of care for children and youth in the behavioral health system.

After carving inpatient care into managed care, it is also recommended that CCOs/UMQIO serve as a single point of accountability for admission to any 24 hour level of care, including acute psychiatric inpatient settings, PRTFs, state hospitals, and CSUs. In addition, CCOs/UMQIO should develop emergency services gatekeeper capacity within the State's current crisis response effort to serve as single point of accountability for screening, redirection from any 24 hour psychiatric placement. This should be firewalled from 24 hour service providers either through separate provider selection or contracting and team composition requirements.

In this regard, there are numerous managed care options to explore including implementing an authorization process for all 24-hour levels of care, care coordination plan for all children presented to crisis team to ensure tracking and immediate connection to services, reporting functions, and quality and network management strategies with its' providers.

It has been demonstrated that integrated managed care approaches that include both home- and community-based services and inpatient services reduce lengths of stay and prevent admissions and readmissions through improved coordination of care and reduced fragmentation. This occurs when the managed care entity also is charged with developing appropriate home and community based service capacity. Without this infrastructure, assigning institutional gatekeeping to managed care vendors can result in children discharged due to lack of medical necessity for the service, without access to appropriate aftercare services in the home and community. This can be particularly problematic for children in child welfare for whom a living arrangement may also be needed. It is anticipated that by following suit with the rest of the country and carving inpatient into their managed care plan, along with other infrastructure, Mississippi could realize cost-savings through the reductions in the excessive use of inpatient services.

3. CONDUCT AN IMMEDIATE REVIEW OF ALL INSTITUTIONALIZED YOUTH

A first step to reducing the number of institutionalized youth is to conduct a review of youth admitted to institutional facilities to determine whether youth are being unnecessarily institutionalized. Given that approximately 6300 children are driving 49% of the Medicaid behavioral health costs, there is significant opportunity to review the clinical needs of these children, and identify systemic opportunities to improve care. A best example of this type of activity comes from New Jersey. They conducted a review targeting children and youth with the longest stays in residential treatment who did not have any clear rationale for being admitted and who were potentially discharge ready. They stratified youth placed in a range of residential placements using two criteria: 1) Exceedingly long length of stay, and 2) Low levels of need according to CANS assessments. The review was focused on children with lengths of stay that were more than three standard deviations above the mean for the specific service type and low levels of clinical and functional impairment according to the CANS, therefore indicating no readily apparent need for continued level of care.

After identifying potentially discharge ready children, lists were provided to care management organizations who then conducted meetings with residential treatment staff, families, and child-welfare workers if necessary to determine whether there was a continued need for residential treatment, and if so, to better understand that need, identify and address barriers to discharge, and develop appropriate discharge plans. At the start of the review in June, 2005, 830 PDR children were in residential placement and at its completion a year later only 38 of those remained, resulting in a 95 percent decrease in the number of potentially discharge ready youth admitted to residential treatment.[90] It is important to recognize that New Jersey had in place a broad continuum of benefits, such as intensive in home and intensive care coordination to help support the movement of children back into the community.

As Mississippi begins its efforts to reduce the number of youth admitted to residential treatment, it is recommended that DOM and DMH implement a similar approach to determine the number of potentially discharge ready youth in residential care and to initiate their transition to home- and community-based services. The review should encompass all youth who are in out-of-state residential care, in-state hospital facilities longer than the average length of stay, and in PRTF facilities longer than the average length of stay to identify barriers to discharge and to develop appropriate transition plans. The CAY and/or the Children's Collaborative could be used to conduct these reviews and a process should be determined for conducting independent reviews of care of all youth who meet the criteria described above. This could be done as part of the statewide MAP team process, the ICCCY, or via contract with the CAY or the Children's Collaborative.

4. CONDUCT ONGOING REVIEWS OF YOUTH AT RISK FOR INSTITUTIONAL PLACEMENT

In addition to conducting an immediate review of youth in out-of-home settings, we recommend that Mississippi develop an identification and referral protocol for those youth who are at risk of an out-of-home placement. The methodology below can be used for two purposes. First, to develop an estimate of the number of youth who could benefit from MYPAC/IOP in each of the 14 CMHC regions. Second, this methodology can be used in an ongoing way to identify those youth who should be screened for MYPAC/IOP eligibility.

Claims and encounter data should first be used to identify Medicaid enrolled youth under 21 with a mental health service need. TAC/The Institute recommends using the definition of mental health service need developed as part of the *T.R. v. Dreyfus* settlement agreement in Washington State. Mental health service need was defined as having one or more of the following:

- A psychiatric diagnosis in the following categories: psychotic disorders, mania and bipolar disorders, depressive disorders, anxiety disorders, adjustment disorders, and other childhood psychiatric disorders including ADHD.[91]
- Filled a prescription for medication in one or more of the following therapeutic classes: anti-psychotic, anti-mania, anti-depressant, anti-anxiety, and ADHD.

[90]Center for Health Care Strategies. (2006). ValueOptions New Jersey: Shortening Residential Care Stays for Teens. Retrieved from http://www.chcs.org/resource/valueoptions-new-jersey-shortening-residential-care-stays-for-teens/

[91] Please see Appendix D of the T.R. v. Dreyfus settlement agreement for a list of the ICD code values within each diagnostic category. The full settlement agreement is located at: https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/cbhtrfullagreement.pdf

- Receipt of a behavioral health service. In Mississippi this would include receipt of any Medicaid behavioral health service or behavioral health screening.

That state also uses a data analytic approach; and has developed algorithm to identify children that could potentially benefit from the states intensive care coordination service. [92] Washington selected a standardized assessment tool called the Child and Adolescent Needs and Strengths (CANS), and developed an algorithm to guide provider decision-making.

Once the larger pool of youth with a mental health service need is defined, the list should be further refined using the indicators below to identify those youth with who should be screened for IOP eligibility using a standardized assessment tool.

- Inpatient psychiatric admission
- PRTF admission
- Psychotropic medication poly-pharmacy where the child was holding at least 4 psychotropic medications. The count of 4 or more includes anti-psychotic, anti-mania, anti-depressant, anti-anxiety, ADHD, sedatives and anticonvulsants.
- Two or more medical inpatient admissions with a primary mental illness on the claim
- Two or more medical outpatient Emergency Department visits with a primary mental illness diagnosis on the claim
- Mental health service use at/above the 90th percentile based on count of outpatient encounters
- Drug overdose diagnosis in a medical claims or encounters
- Anorexia/bulimia diagnosis in medical claim or encounter
- Suicide attempt or self-injury in medical claim or encounter
- Possible suicide attempt or self-injury in medical claim or encounter
- Medical claim or encounter with diagnosis of a substance use disorder

Furthermore, referral protocols with child welfare, juvenile justice, DMH, education, and the CMHCs should be created to promote access to IOP for youth with the following profiles:

- Youth involved with child welfare who have experienced three or more out of home placements
- Youth exiting the Oakley Youth Development Center who have been identified as having a behavioral health condition
- Youth experiencing homelessness as defined by the McKinney-Vento Homeless Education Act (via local school district homeless liaisons)
- Youth reviewed by local MAP teams
- Youth exiting PRTF facilities
- Youth exiting state hospital facilities
- Youth with a mobile crisis intervention encounter

Specific guidance can be developed for partners and stakeholders to assist them in identifying children that may be eligible for IOP (or other needed HCBS services), how to refer and what to expect upon referral. The State of Washington, as part of their recent agreement, will be developing written materials, communication plans and trainings for fifteen different categories of stakeholders including child welfare, education, juvenile justice, primary care. [93]

In order to accommodate those youth identified through the screening process as needing IOP, Mississippi will need to ensure there is adequate provider capacity to deliver the service. Based on the utilization targets, DMH and DOM will need to work closely with the Wraparound Facilitation Training and Coaching Center at the University of Southern Mississippi (USM) and the CMHC providers to create a plan for CMHCs to become

[92] http://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISe%20manual%20v%201.3%20FINAL.pdf

[93] http://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISe%20manual%20v%201.3%20FINAL.pdf

certified IOP providers. Using the methodology described above, DOM and USM should be able to estimate the number of staff who will need to be trained in each region of the state and the approximate timeframe for doing so. This will aide in determining how long it will take for providers to "ramp-up" to full capacity[94] and develop a clear plan for how they will do this.

5. REDIRECT EXPERTISE OF INSTITUTIONAL STAFF TOWARDS NEEDED COMMUNITY-BASED CARE

As states and communities build home- and community-based services and reduce their reliance on institutional care, downsizing of staff in state psychiatric hospitals and residential treatment centers is a common concern. Many states repurpose the traditional roles for state hospital staff as providers of the new types of services being introduced to the system. To this end, state behavioral health authorities are able to expand the availability of low-cost alternatives to psychiatric inpatient placements while capitalizing on the expertise of the professionals currently employed by those institutions.

It is recommended that DMH expand the current and historical functions of staff in its state hospitals to include the provision of home- and community-based services. Given current demands on CMHCs, the services provided by redeployed state hospital staff would complement the role of CMHCs and other providers without duplication. DMH can manage the provision of lower cost alternatives to institutional treatment that CMHCs lack the capacity to provide. For example, the state could redeploy hospital staff to increase mobile crisis response capacity, to provide emergency services and crisis triage functions, to provide one:one crisis stabilization services, and to staff crisis stabilization units. In addition, hospital staff would be ideal for providing in-home therapy, care coordination and warm hand-offs, and for serving special populations such as forensic populations and children placed out-of-state for treatment. Further, psychiatrists currently serving children and youth in state hospitals could be redeployed to enhance access to and capacity for community psychiatric services.

6. PROMOTE MENTAL HEALTH COLLABORATION IN YOUTH AND CHANCERY COURTS

In order to effectively divert youth with behavioral health needs away from detention centers and other restrictive placements, it is necessary for Mississippi to implement a widespread and systematic approach to identifying those needs as they become involved with the court system. Building behavioral health screening and assessment capacity within youth and chancery courts is necessary to identify and respond to behavioral health needs, allowing courts to make informed and appropriate decisions regarding the necessary types of services, proper levels of treatment intensity and degrees of security. Many of these efforts are underway including efforts to adopt a common standardized risk assessment, revisions to state Juvenile Detention Standards, and efforts to improve access to behavioral health services and the collection and use of data with this population of youth. Currently, there are five counties participating in the Juvenile Detention Alternatives Initiative (JDAI), and two more counties are in planning to implement JDAI.

In partnership with DYS, DMH should designate the behavioral health screenings and assessments to be used throughout the state. Some juvenile justice systems employ the CAFAS, which may have utility for Mississippi given that it is currently required to be performed by CMHCs. Depending on the risk assessment instrument used, this may also be a useful behavioral health screening tool.

In addition, DMH should further explore opportunities for expanding Judge Broome's mental health collaboration model beyond Rankin County. This model, which assigns mental health liaisons in-house at Rankin County's youth court, sheriff's department, and detention center, was cited as a best practice in Mississippi that could have utility for other youth courts. Additionally, DMH with its state partners, should continue efforts to promote the lessons learned from current JDAI sites, and seek expansion of such efforts throughout the state.

[94] Full capacity or the utilization target is defined as the number of youth who could benefit from IOP using the methodology described above.

7. REVISIT INCLUSION OF TREATMENT FOSTER CARE AS A MEDICAID BENEFIT

Several states have included treatment foster care in their Medicaid benefits. Mississippi tried to include this service in their benefit array but it was denied by CMS. We recommend they revisit this benefit, and review prior decisions regarding eligible populations for this service. Inclusion of this service is a successful strategy to enhance community based treatment and could help the state divert unnecessary institutional care. We did not review the draft SPA submitted but through dialogue with the state we understand that the SPA was denied as the population defined was restricted to foster care youth only. This service, when implemented with screening and other management strategies to ensure that the appropriate clinical population is identified, will further help the state address the needs of children and reduce use of institutional settings.

CONCLUSIONS

This report has described the Mississippi children's mental health and substance use service systems from a variety of perspectives. As noted in the introduction, the central focus of the report is The Department of Mental Health and the Division of Medicaid. However, these two agencies do not exist in a vacuum, and many of the recommendations contained in the report will require a coordinated effort across all child-serving state agencies, including child welfare, juvenile justice, education and public health.

The report includes quantitative and qualitative information about behavioral health recipients, home and community based services, institutional services, providers and workforce, quality, and interagency collaboration. All of these factors affect the quality and performance of Mississippi's behavioral health system for children.

NOTABLE STRENGTHS

The results of our analyses identified several notable strengths. These are areas that should be built upon and leveraged to further the work of DMH and DOM and other child-serving agencies in meeting its goals and priorities.

AUGMENTATION OF MEDICAID BENEFIT ARRAY IN 2012

In 2012, Mississippi expanded their home- and community-based benefit array to include essential services that are nationally recognized for leading to improved outcomes among children and youth with intensive behavioral health needs. These services include:

- *IOP.* Previously offered as a Demonstration Waiver service, MYPAC, which includes Wraparound facilitation, was migrated to the State Rehab Option. This was an important step to ensure the sustainability of a vital service for children and youth who are at-risk for institutional placement.
- *Crisis Response Services*. DMH has made noteworthy investments towards establishing a robust mobile crisis response and stabilization system in Mississippi. They continue to provide grants, supports, training, and technical assistance to community providers to build this service with the goal of reducing emergency room visits and unnecessary psychiatric hospitalizations. In addition, DOM added crisis response services, which include crisis residential services, to the State Rehab Option in 2012, evidencing a statewide commitment to ensuring the viability of this intervention.
- *Peer Support*. This federally-endorsed service was also added to the State Rehab Option in 2012. While these services are targeted to individuals 18 years of age and older, Peers provide much needed support for youth transitioning to adulthood.

EVIDENCE-BASED AND PROMISING PRACTICE IMPLEMENTATION

Mississippi has made considerable effort to invest in evidence-based, trauma informed approaches. In 2008, Trauma Recovery for Youth and DMH joined forces with the National Center for Child Traumatic Stress to start a statewide Learning Collaborative in Mississippi designed to enhance the implementation of TF-CBT. DMH continues to provide TF-CBT training for clinical staff through the learning collaborative model. As of 2013, there were 90 CMHC staff who completed training in TF-CBT, SPARCS, or other evidence-based practices through Learning Collaboratives. Additionally, the Division has also promoted use of TF-CBT in several of its institutions.

QUALITY MONITORING OSCR PROCESS WITH MYPAC AND PRTF

The Division of Medicaid's On-Site Compliance Review (OSCR) Process for MYPAC providers and PRTFs is a highlight of Mississippi's quality monitoring system; it is very thorough in its scope. The OSCR process consists of a blend of direct observation, document review, staff interviews and participant and family interviews. The robust OSCR tool verifies both that the provider is in compliance with applicable state and

federal requirements for mental health treatment and investigates the quality of treatment being provided to service recipients. The tool also enables compliance reviewers to provide clear, specific feedback regarding findings to provider staff. This process also allows the Division to reliably identify and address non-compliance and enhance the delivery of these important services.

CREDENTIALING OF PEERS

DMH has made considerable investments for training Certified Peer Support Specialists (CPSS). In FY2014, CPSS Trainers held three trainings attended by 62 individuals who identify as a family member or an individual who received or is currently receiving mental health services. Mississippi's CPSS training and certification program prepares specialists for helping families enhance community living skills, community integration, rehabilitation, resiliency, and recovery.

DEVELOPMENT OF STATE TRAINING INFRASTRUCTURE

In 2012, a State Wraparound Council was formed with USM School of Social Work, DMH and DOM to plan for sustainable Wraparound training infrastructure in Mississippi. USM is funded by DMH and DOM to provide High-Fidelity Wraparound training and coaching. As of this writing, there are a total of four certified Wraparound coaches in the state and trainings are planned through December, 2015. Mississippi is well on their way to building a network of certified coaches and trainers as a result of state-level investments and support, which will be vital to ensure adequate capacity for meeting growing demand for wraparound services.

MAP TEAMS

These local multidisciplinary teams have served as a review team concerning children and youth who are at immediate risk for institutionalizing and meet on a monthly basis to identify community-based services and resources that may divert children away from inappropriate out-of-home placements. Families reported satisfaction with the MAP team process, indicating that they have had a positive impact in the system. Because of their local systems knowledge, they can serve an expanded role to address local system level gaps and issues that will improve and support the work of IOP care planning teams.

ICCCY/ISCC STRUCTURES

The legislation enacted in 2010 to provide for the development, implementation and oversight of a coordinated interagency system of necessary services and care for children and youth contains commendable systems of care language. As stated previously, this legislation, which establishes the ICCCY and ISCC structures, provides a clear and impressive framework for establishing a interagency governance structure and appropriately delineates how a statewide coordinated system of care should function. While the ISCC meets regularly and elicits commitment from mid-level agency staff, the ICCCY has not been implemented as intended.

SYSTEM CHALLENGES

The challenges and recommendations identified in the report are intended to focus the state's efforts on both immediate gaps in the system and long-term investments to strengthen and improve the system. Each chapter identifies specific challenges and recommendations related to each of the five content areas: home and community based services, provider and workforce capacity, quality, interagency collaboration, and institutional care. Many of the recommendations are operational in nature, augmenting, modifying or fine-tuning what Mississippi has already built in order to improve its system performance. At the core of recommendations are the following challenges that will impact the state's ability to move forward with the recommendations.

RESOURCES

Mississippi DMH and DOM need additional resources in order to be prudent purchasers of mental health and substance use services. These resources are needed for service delivery and for infrastructure, particularly in the areas of data, quality improvement, and interagency collaboration. While our recommendations do address the need to redirect certain resources from high cost and less-effective care, redirection of funding alone will not provide the resources needed. Both DMH and DOM need the ability to be more nimble, to be able to more rapidly identify system gaps and deploy resources to solve problems. This requires access to data, quality indicators, staff to conduct joint reviews and analysis of outputs and internal flexibility to respond to indicators for needed change.

COORDINATED PURCHASING AND POLICY STRATEGY

Mississippi is hampered by the disparate administration and financing of major components of their children's behavioral health system. DMH, DOM, child welfare, juvenile justice, the courts, education and public health all play a significant role in children's behavioral health. A coordinated effort around system goals, planning and purchasing, as well as policies is needed. A common planning and purchasing approach that addresses critical system functions including results and outcomes for beneficiaries, equity of access to services, best practice benefit array, clarity of responsibilities across state agencies, and improved access to and use of data to guide decision-making are approaches needed to improve the behavioral health system.

PARTNERSHIP WITH YOUTH AND FAMILIES

There is a voiced perception among some stakeholders that Mississippi leadership is disengaged from the voice and will of youth and families. Consequently there is little trust of efforts for system transformation. In order for systems changes to have the desired benefits, decisions by leadership at DMH and other state agencies must align with the goals and values of youth and families. This can only be achieved through sustained outreach, engagement and collaboration with families and advocacy organizations.

REDUCE RELIANCE ON INSTITUIONAL SOLUTIONS

Mississippi leadership has made significant efforts to improve home and community based services however considerable work remains to fully transform a system historically oriented towards institutional care. Institutional options are a known entity and some purchasers and families are comfortable with these services. However, most children and youth can be served effectively and appropriately within their own homes and communities if the right mix and intensity of services is available. Family choice is crucial, but families are not making a true choice when their only option is institutional care or no care. Families, youth, and providers—as well as funders—need to work together to grow Mississippi's service array so that it is comprehensive and based on what national best practice, research, and families have said works. The shift to serving children and youth in the community instead of in institutional settings will not happen overnight; it is a process that will require the collective commitment of all parties to retrain the workforce to provide high quality and effective services to children and youth in their homes and communities. It will also require that the compensation structure that is established for providers is equitable and commensurate with the expertise of their staff and the resources required. This is in no way is to say PRTFs and other institutions will no longer serve an important role in Mississippi's system. Rather, our recommendations will help ensure that Mississippi's limited number of beds are available only to those who need them most.

APPENDIX- INTERVIEW LIST

IN-PERSON INTERVIEW LIST

Name	Organization	Site-Visit
Steven Allen	Boswell Regional Center	Provider
Amy Turner	Catholic Charities	Provider
Angela Griffin	Catholic Charities	Provider
Angela Hudson	Catholic Charities	Provider
Carol Warfield	Catholic Charities	Provider
Linda Raff	Catholic Charities	Provider
Lisa McBride	Catholic Charities	Provider
Michelle Hamilton	Catholic Charities	Provider
Monica Meunger	Catholic Charities	Provider
Nadia Gaynor	Catholic Charities	Provider
Valeria Mapiella	Catholic Charities	Provider
Amanda Keel	Communicare (Region 2)	Provider
Darlene Petit	Communicare (Region 2)	Provider
Kerry McKnatt	Communicare (Region 2)	Provider
KippHeatherly	Communicare (Region 2)	Provider
Meagan Taylor	Communicare (Region 2)	Provider
Melody Copp	Communicare (Region 2)	Provider
Rachel Alcorn	Communicare (Region 2)	Provider
Sandy Rogers	Communicare (Region 2)	Provider
Terri Hall	Communicare (Region 2)	Provider
Tiffany Lewis	Communicare (Region 2)	Provider
Africa Shirley	Community Counseling Services (Region 7)	Provider
Angela Johnson	Community Counseling Services (Region 7)	Provider
Brook Minton	Community Counseling Services (Region 7)	Provider
Carnette Hudson	Community Counseling Services (Region 7)	Provider
Christi Hayes	Community Counseling Services (Region 7)	Provider
Felicia Fort	Community Counseling Services (Region 7)	Provider
Gwen Gray	Community Counseling Services (Region 7)	Provider
Jackie Edwards	Community Counseling Services (Region 7)	Provider
Janice McGee	Community Counseling Services (Region 7)	Provider
Juliette Reese	Community Counseling Services (Region 7)	Provider

Karen Frye	Community Counseling Services (Region 7)	Provider
Kelvin Knowles	Community Counseling Services (Region 7)	Provider
Lakesha Shelton	Community Counseling Services (Region 7)	Provider
Lina Beall	Community Counseling Services (Region 7)	Provider
Lori Latham	Community Counseling Services (Region 7)	Provider
Martha Wallis	Community Counseling Services (Region 7)	Provider
Meomia Gant	Community Counseling Services (Region 7)	Provider
Nikki Nicholson	Community Counseling Services (Region 7)	Provider
Phasun King	Community Counseling Services (Region 7)	Provider
Ray Evans	Community Counseling Services (Region 7)	Provider
Rose Coffee	Community Counseling Services (Region 7)	Provider
Shanta Lawrence	Community Counseling Services (Region 7)	Provider
Sharon Bell	Community Counseling Services (Region 7)	Provider
Stephanie Taylor	Community Counseling Services (Region 7)	Provider
Tiffany Williams	Community Counseling Services (Region 7)	Provider
Toni Jackson	Community Counseling Services (Region 7)	Provider
Trina Cotton	Community Counseling Services (Region 7)	Provider
Trudy Buckhalter	Community Counseling Services (Region 7)	Provider
Amy Winn	Fairland Center	Provider
Stephen Johnson	Fairland Center	Provider
Jaqueline Dedeaux	Gulf Coast Mental Health Center (Region 13)	Provider
Jeff Bennet	Gulf Coast Mental Health Center (Region 13)	Provider
Julie Forrest	Gulf Coast Mental Health Center (Region 13)	Provider
Lisa Crain	Gulf Coast Mental Health Center (Region 13)	Provider
Mary Romero	Gulf Coast Mental Health Center (Region 13)	Provider
Michael Maxey	Gulf Coast Mental Health Center (Region 13)	Provider
Robin Berry	Gulf Coast Mental Health Center (Region 13)	Provider
Shelley Foreman	Gulf Coast Mental Health Center (Region 13)	Provider
Tom Pritchard	Gulf Coast Mental Health Center (Region 13)	Provider
Madolyn Smith	Life Help (Region 6)	Provider
Phaedre Cole	Life Help (Region 6)	Provider
CARES Staff	MCHS	Provider
Cynthia Undesser	MCHS	Provider
Denny Hydrick	MCHS	Provider
Shea Hutchins	MCHS	Provider

Wanda Thomas	MCHS	Provider
BathsheboDompeer	MS Adolescent Center	Provider
Bobby Alsworth	MS Adolescent Center	Provider
Donna Horton	MS Adolescent Center	Provider
Douglas McDonald	MS Adolescent Center	Provider
Henrietta Bey	MS Adolescent Center	Provider
William Gates	MS Adolescent Center	Provider
Amy Baskin	MS State Hospital	Provider
Barbara Fishgrab	MS State Hospital	Provider
Billy Walton	MS State Hospital	Provider
Carolyn Tingle	MS State Hospital	Provider
Chandra Beston	MS State Hospital	Provider
Chris Allen	MS State Hospital	Provider
Deena Mullins	MS State Hospital	Provider
Demetria Horton	MS State Hospital	Provider
Dirk Hosschel	MS State Hospital	Provider
Genevieve Garrett	MS State Hospital	Provider
James Chastain	MS State Hospital	Provider
Jeane Dillon	MS State Hospital	Provider
Kathryn Ford	MS State Hospital	Provider
Kathy Denton	MS State Hospital	Provider
Regina Lacking	MS State Hospital	Provider
Robert Maddux	MS State Hospital	Provider
Rose Casano	MS State Hospital	Provider
Carol Brown	Pine Belt Mental Healthcare (Region 12)	Provider
Donna English	Pine Belt Mental Healthcare (Region 12)	Provider
Felecia Coleman	Pine Belt Mental Healthcare (Region 12)	Provider
Jean Robertson	Pine Belt Mental Healthcare (Region 12)	Provider
Jeanne Baykeu	Pine Belt Mental Healthcare (Region 12)	Provider
NaymudTalakdon	Pine Belt Mental Healthcare (Region 12)	Provider
Rita Porter	Pine Belt Mental Healthcare (Region 12)	Provider
Roger Anas	Pine Belt Mental Healthcare (Region 12)	Provider
Karen Corley	Region One Mental Health Center	Provider
David Cook	Region One Mental Health Center	Provider
Diane Youngblood	Region One Mental Health Center	Provider

Karen Corley	Region One Mental Health Center	Provider
Lisa Phelps	Region One Mental Health Center	Provider
Shane Garrard	Region One Mental Health Center	Provider
Shirley Long	Region One Mental Health Center	Provider
Jody Herring	Southwest MHC	Provider
Karen Graves	Southwest MHC	Provider
Pamela Barman	Southwest MHC	Provider
Sherelene Vince	Southwest MHC	Provider
Steve Ellis	Southwest MHC	Provider
Bryan Vyverberg	Specialized Treatment Facility	Provider
Charles Harris	Specialized Treatment Facility	Provider
Kim Peterman	Specialized Treatment Facility	Provider
Scott Turner	Specialized Treatment Facility	Provider
Shannon Bush	Specialized Treatment Facility	Provider
Stacy Miller	Specialized Treatment Facility	Provider
Stephanie May	Specialized Treatment Facility	Provider
Valerie Joiner	Specialized Treatment Facility	Provider
Bridgett Hancock	Sunflower Landing	Provider
Martinese Fitzpatrick	Sunflower Landing	Provider
Nicole Garrard	Sunflower Landing	Provider
Charlie Spearman	Timber Hills Mental Health Services	Provider
Nikki Tapp	Timber Hills Mental Health Services	Provider
Henry Cooper	Youth Villages	Provider
Jameeka Williams	Youth Villages	Provider
Kayla Virgil	Youth Villages	Provider
Sheneeta Benson	Youth Villages	Provider
Cynthia Eubank	Attorney General's Office	Week One
Patti Marshall	Attorney General's Office	Week One
Lori Garrott	Catholic Charities	Week One
Vivian Walker	Catholic Charities	Week One
Dixie Church	Communicare (Region 2)	Week One
Angie Williams	Department of Human Services	Week One
Kim Shackelford	Department of Human Services	Week One
Sandra McClendon	Department of Human Services	Week One
James Maccarone	Department of Human Services, Division of Youth Services	Week One

Melonie Taylor Gore	Department of Human Services, Division of Youth Services	Week One
Diana Mikula	Department of Mental Health	Week One
Mark Lewis	Department of Mental Health	Week One
Jerri Avery	Department of Mental Health, Division of A&D Services	Week One
Mark Stovall	Department of Mental Health, Division of A&D Services	Week One
Melody Winson	Department of Mental Health, Division of A&D Services	Week One
Sandra Parks	Department of Mental Health, Division of Children & Youth	Week One
Andrew Day	Department of Mental Health, Division of Community Services	Week One
Kris Jones	Department of Mental Health, Division of Quality Management	Week One
Jake Hutchins	Department of Mental Health, Division of Community Services	Week One
Charlene Toten	Division of Medicaid	Week One
David Dzielak	Division of Medicaid	Week One
Sharon Jones	Division of Medicaid	Week One
Will Crump	Division of Medicaid	Week One
Bonlitha Windham	Division of Medicaid, Bureau of Mental Health	Week One
Jennifer Grant	Division of Medicaid, Community Programs	Week One
Joy Hogge	Families as Allies	Week One
Laura Smith	Families as Allies	Week One
Randy Weeks	Grenada Crisis Stabilization Unit (Region 6)	Week One
August Patton	Hinds Behavioral Health Services (Region 9)	Week One
Ophelia Kelly	Hinds Behavioral Health Services (Region 9)	Week One
Angela Ables	Life Help (Region 6)	Week One
Donna Theriot	Life Help (Region 6)	Week One
Jonathon Grostham	Life Help (Region 6)	Week One
Zandrea Ware	MACMHC	Week One
John Damon	MS Children's Home Services	Week One
Al Cervantes	Pine Belt Mental Healthcare (Region 12)	Week One
Mona Gauthier	Pine Belt Mental Healthcare (Region 12)	Week One
Emile Craig	Region 8 Mental Health Services	Week One
Richard McMillan	Region 8 Mental Health Services	Week One
Stephanie Berry	Region 8 Mental Health Services	Week One
Ron Earl	Region One Mental Health Center	Week One
Pamela Bowman	Southwest MS Mental Health (Region 11)	Week One
Sherlene Vince	Southwest MS Mental Health (Region 11)	Week One
Bobby Barten	Warren-Yazoo Mental Health Services (Region 15)	Week One

Suzanne Lancaster	Warren-Yazoo Mental Health Services (Region 15)	Week One
Hon. Tom Broome	Youth Court Judges Association/Rankin County Youth Court	Week One
Amy Adams	Youth Villages	Week One
Katja Russell	Youth Villages	Week One

TELEPHONE INTERVIEW LIST

Name	Organization
Therese Hanna	Center for MS Health Policy
Ann MacLaine	Disability Rights MS
Kristi Plotner	Division of Medicaid
Otis Washington	Division of Medicaid
Charlene Toten	Division of Medicaid
Jennifer Grant	Division of Medicaid
eQHealth Staff	eQHealth
Joy Hogge	Families as Allies
Laura Smith	Families as Allies
Cliff Davis	Human Service Collaborative
Magnolia Staff	Magnolia Healthplan, Inc.
John Damon	MS Children's Home Services
Terry Hight	MS Children's Home Services
Pam Dollar	MS Coalition for Citizens with Disabilities
MS DOE Staff	MS Department of Education
Carnette Hudson	Nfusion
Marshia Moody	Nfusion
Ellen Reddy	Nollie Jenkins Family Center
Jerry Mayo	Pine Belt Mental Healthcare
Mona Gauthier	Pine Belt Mental Healthcare
Elissa Johnson	Southern Poverty Law Center
David Elkin	UMC
United Healthcare Staff	United Healthcare, Inc.
Elizabeth McDowell	USM
Tamara Hurst	USM
Tim Rehner	USM
Katja Russell	Youth Villages

PROVIDER SITE-VISIT LIST

Provider Name
Catholic Charities
Catholic Charities CSU
Community Counseling Services
East MS State Hospital
Gulfport
Hinds Behavioral Health Services
Life Help
MS Adolescent Center
MS Children's Home Services - Lakeland
MS Children's Home Services - CARES Center
MS Families as Allies
MS State Hospital - Adult Psychiatric
MS State Hospital - Oak Circle Center
Pinebelt MHC
Region 1 Mental Health Center (Clarksdale)
Region 1 Mental Health Center (Tutwiller)
Region 8 Mental Health Services
Southern Christian Services (Jackson)
Southern Christian Services (Tupelo)
Southwest MHC
Specialized Treatment Facility
Timber Hills
Warren-Yazoo Mental Health Services
Weems Community Mental Health Center
Youth Villages

MISSISSIPPI BEHAVIORAL HEALTH CONSUMER INTERVIEW TOTALS

These are interviews in addition to the stakeholders listed. These are service recipients, and their names are withheld to protect their confidentiality at their request.

Forum	Number
Provider site-visit	17
Week One site-visit	15
Telephone	6
Total	38

APPENDIX- DOCUMENTS

DOCUMENT REVIEW LIST

Author	Title	Year
eQHealth Solutions	MYPAC Services Provider Manual	2013
Human Service Collaborative	An Assessment and Study of the Mississippi System of Care	2009
Legislature of the State of Mississippi	Miss. Code Ann. § 43-13-107	2014
Legislature of the State of Mississippi	Miss. Code Ann. § 43-14-1(Mississippi System of Care)	2010
MS DMH	A&D ADAPT Project Narrative	2014
MS DMH	Alcohol and Drug Treatment Program Directory	2014
MS DMH	Certified Peer Support Specialist Application	2014
MS DMH	Certified Peer Support Specialist Information Gathering Form	2014
MS DMH	Certified Peer Support Specialist Program: Quick Glance	Unknown
MS DMH	Crisis Intervention Service Utilizaiton, FY 2014	2014
MS DMH	Crisis Stabilization Unit Utilization Totals	2014
MS DMH	Division of Children & Youth Services Directory	2012
MS DMH	DMH State Plan Implementation Report	2013
MS DMH	DMH Strategic Plan, FY15-17	2014
MS DMH	East Mississippi State Hospital Admissions and Discharges, 2010-2013 [Data File]	2014
MS DMH	FY 2014 Adolescent Opportunities Programs	2014
MS DMH	FY 2014 School-Based Services	2014
MS DMH	ICCCY Internal Organizational Procedures	2011
MS DMH	ICCCY Meeting Minutes	2010-2012
MS DMH	ICCCY Membership Roster	2013
MS DMH	ICCCY Memoranda of Understanding (SFY11-12)	2011-2012
MS DMH	IOP Children and Youth Provider Listing	2014
MS DMH	ISCC Meeting Minutes	2010-2014
MS DMH	ISCC Membership Roster	2013
MS DMH	Juvenile Outreach Program Updates	2014
MS DMH	MAP Team and SLCR Youth Served Data	2010-2014
MS DMH	MAP Team Case Summary Form	Unknown

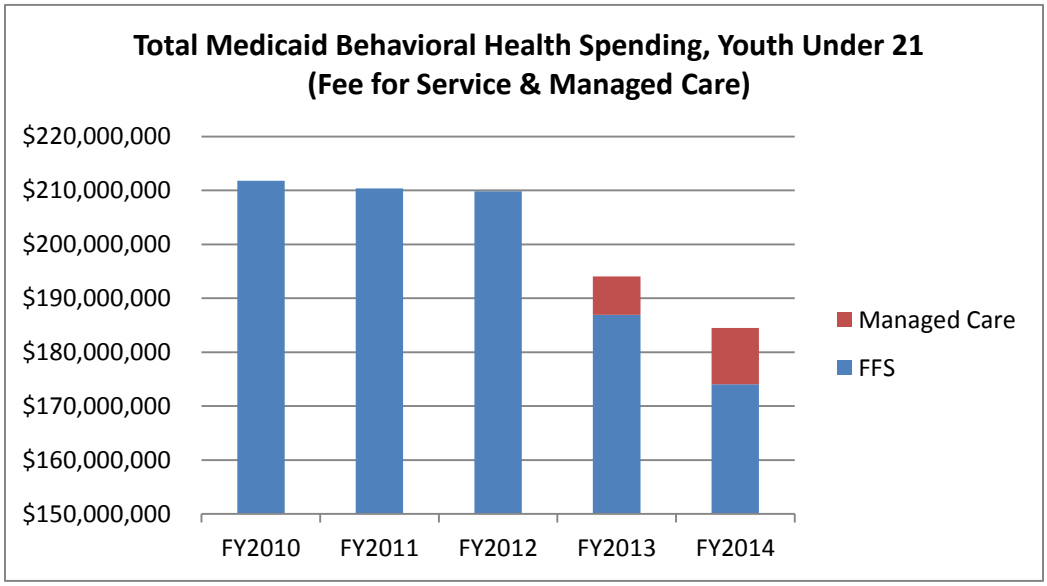
MS DMH	MAP Team Guidance	2014
MS DMH	MAP Team Initial Case Referral Form	2008
MS DMH	MAP Team Monthly Form	2012
MS DMH	MCeRT Utilization Totals (January-September, 2014)	2014
MS DMH	Mississippi Adolescent Alcohol and Drug Services Wish List	2014
MS DMH	Mississippi Mental Health National Outcomes Measures (NOMS): CMHS Uniform Reporting System, 2011-2012	2014
MS DMH	Mississippi State Hospital (Oak Circle Center) Admissions and Discharges, 2010-2014 [Data File]	2014
MS DMH	Mississippi SYT-ED Youth Treatment Workplan	2014
MS DMH	Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers	2013
MS DMH	Peer Support Specialist Professional Standards and Requirements	2012
MS DMH	PRTF Seclusion and Restraint Numbers, January 2012-December 2013 (Southern Poverty Law Center RFI)	2013
MS DMH	SmartTrack Data Brochure	2013
MS DMH	Specialized Treatment Facility Admissions and Discharges, 2010-2014 [Data File]	2014
MS DMH	Therapeutic Group Home and Foster Care Utilization	2014
MS DMH	Wraparound Provider Listing	2014
MS DOH	Mississippi State Health Plan	2014
MS DOM	Acute Facilities - Admissions and Expenditures (SFY10-11) [Data Files]	2010-2011
MS DOM	Administrative Code Title 23, Part 202: Inpatient Hospital	2012
MS DOM	Administrative Code Title 23, Part 206: Mental Health Services	2014
MS DOM	Administrative Code Title 23, Part 300: Appeals	2012
MS DOM	Appeal Request Data, SFY11-13	2014
MS DOM	Application for a 1915c Home- and Community-Based Services Waiver	2007
MS DOM	CMHC Billing Guidelines and Procedure Codes	2012
MS DOM	CMHC Office Address List	2014
MS DOM	CMHC Provider Policy Manual	2001
MS DOM	CMHC Services and Fact Sheets	2010-2011
MS DOM	Contract Between DOM and Magnolia Healthplan, Inc.	2014
MS DOM	Contract Between DOM and UnitedHealthcare of Mississippi, Inc.	2014
MS DOM	EPSDT Anticipatory Guidance	2006
MS DOM	Guidance for Becoming a MYPAC Provider	2013
MS DOM	HCBS FY2016 Budget Request	2014

MS DOM	HSM Year End Reports: Inpatient Programs, SFY10-14	2010-2014
MS DOM	Intensive Outpatient Psychiatric Administrative Code (Draft)	2014
MS DOM	Mississippi Medicaid Fee-for-Service and Managed Care Claims Encounter Data, SFY10-14 [Data Files]	2010-2014
MS DOM	MSCAN Provider Surveys	2014
MS DOM	MYPAC Critical Incident Reporting, SFY10-14	2014
MS DOM	MYPAC Freedom of Choice Form	2010
MS DOM	MYPAC Initial Screen Form	2014
MS DOM	MYPAC Legislative Report	2008-2012
MS DOM	MYPAC On-Site Compliance Review (OSCR) Tool	2009
MS DOM	MYPAC Provider Policy Manual (prior to Administrative Code - Title 23, Part 206, Chapter 2)	2009
MS DOM	MYPAC vs. PRTF Reports	2010-2013
MS DOM	OSCR Summary for MYPAC Demonstration Waiver	2013
MS DOM	Provider Reference Guide for MYPAC	Unknown
MS DOM	PRTF Administrative Code (Draft)	2014
MS DOM	PRTF Incident Reporting Requirements	Unknown
MS DOM	PRTF Incident Reports: Numbers and Types (SFY10-13)	2014
MS DOM	PRTF Provider Policy Manual	2009
MS DOM	Request for Proposals: Utilization Management and Quality Improvement Services	2008
MS DOM	Sample MYPAC OSCR Exit Interview Documents for Provider	2013
MS DOM	Sample MYPAC OSCR Notification Letter	2013
MS DOM	Sample MYPAC OSCR Status Letter to Provider	2013
MS DOM	Sample MYPAC Provider Corrective Action Plan	2013
MS DOM	SPA04-012: Title XIX Inpatient Hospital Reimbursement Plan	2005
MS DOM	SPA08-063: Inpatient Psychiatric Services	2008
MS DOM	SPA10-006: Rate Computation for State-Owned PRTFs	2010
MS DOM	SPA12-003: Rehabilitative Services	2012
MS DOM	SPA12-009: Outpatient Hospital Services	2012
MS DOM	SPA14-005: Treatment Foster Care Services	2014
MS DOM	SPA14-016: Title XIX Inpatient Hospital Reimbursement Plan	2014
MS DOM	Substance Use Disorder Treatment Administrative Code (Draft)	2014
MS DOM	Therapeutic and Evaluative Mental Health Services for Children Provider Policy Manual	2009

MS DOM	Therapeutic and Evaluative Mental Health Services: Legislative Data (2010-2013)	2013
MS DOM	Updated Billing Guidelines for Therapeutic and Evaluative Mental Health Services for Children	2014
MS Families as Allies	Family Survey	2010
MS Families as Allies	Focus Group Findings	2013
MS Families as Allies	Letter to the Governor	2014
Specialized Treatment Facility	Admission, Discharge, and Continued Stay Policies	2010
University of Southern Mississippi	Evaluation of MYPAC Participant Outcomes and Family Satisfaction	2014
University of Southern Mississippi	Evaluation of MYPAC Wraparound Fidelity	2014
University of Southern Mississippi	Mississippi Youth Programs Around the Clock: Final Evaluation	2012
University of Southern Mississippi	Mississippi Youth Programs Around the Clock: Local Evaluation Report #1	2010
University of Southern Mississippi	Mississippi Youth Programs Around the Clock: Local Evaluation Report #2	2011
Youth Villages	MYPAC Program: Length of Time from Referral to Program Placement	2014
Youth Villages	MYPAC Program: Parent Satisfaction at Discharge	2014
Youth Villages	Telemedicine Consent Form and Policy	2014

APPENDIX DATA REFERENCED IN CHAPTER 1

FIGURE 1: TOTAL MEDICAID BEHAVIORAL HEALTH SPENDING (FFS & MC), FY10-FY14



Note: Lower totals in FY 2014 may be attributed to claim lag.

TABLE 2: TOTAL MEDICAID COVERED LIVES, YOUTH 0-21

	FY10	FY11	FY12	FY13	FY14
Fee for Service	455,064	466,559	467,891	463,588	447,295
Managed Care*	N/A	N/A	N/A	70,655	91,966
Total	455,064	466,559	467,891	534,243	539,261

*CCOs did not include outpatient mental health services until late 2012.

FIGURE 2: TOTAL MEDICAID COVERED LIVES, FY10-FY14

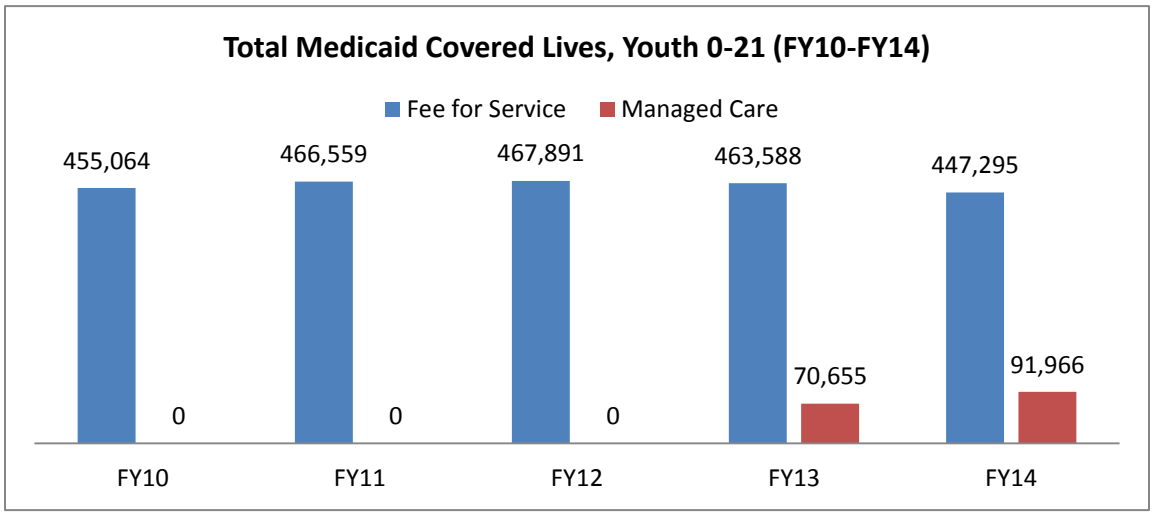


TABLE 3: COVERED LIVES & UTILIZATION

	FY10		FY11		FY12		FY13		FY14	
	Covered Lives	Utilizers (% CL)	Covered Lives	Utilizers (% CL)	Covered Lives	Utilizers (% CL)	Covered Lives	Utilizers (% CL)	Covered Lives	Utilizers (% CL)
FFS	455,064	164,103 (36%)	466,559	177,429 (38%)	467,891	189,446 (40%)	463,588	165,137 (36%)	447,295	134,607 (30%)
MC	0	0	0	0	0	0	70,655	16,580 (23%)	91,966	21,917 (24%)
Total	455,064	164,103 (36%)	466,559	177,429 (38%)	467,891	189,446 (40%)	534,243	181,717 (34%)	539,261	156,524 (29%)

TABLE 4: AVERAGE LENGTHS OF STAY (DAYS) IN MISSISSIPPI STATE PSYCHIATRIC HOSPITALS AND STATE-OPERATED PRTF FOR CHILDREN AND YOUTH (0-18)

	FY10	FY11	FY12	FY13	FY14
Oak Circle Center (MSH)	45.1	45.2	48.9	42.9	47
Specialized Treatment Facility*	142.6	175.2	182.5	170.1	184.4
Bradley Sanders Complex (EMSH)	120	127	120	125	N/A

*PRTF Source: Mississippi DMH State Hospital Admission and Discharge Data

TABLE 5: ALOS (DAYS) IN PSYCHIATRIC ACUTE INPATIENT FACILITIES FOR CHILDREN AND YOUTH UNDER 21

	FY10	FY11	FY12	FY13	FY14
Brentwood Acquisition INC	15.29	14.37	14.53	12.91	12.49

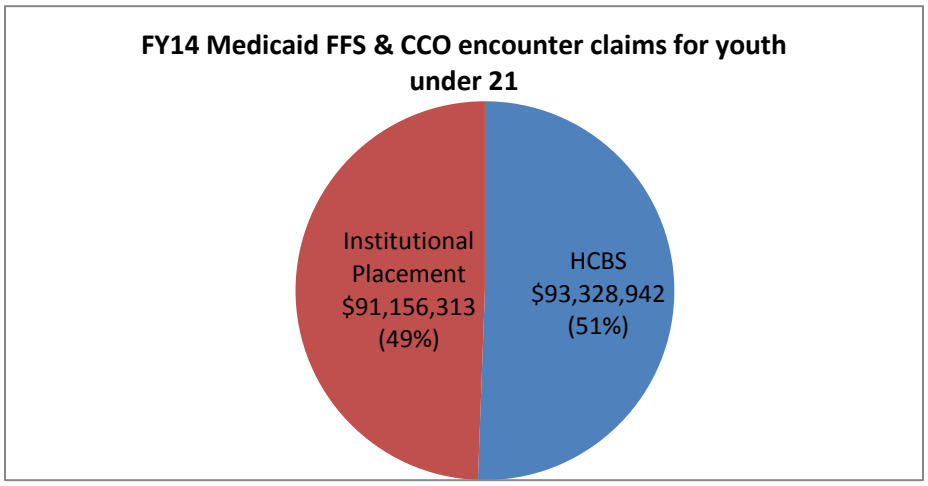
Crossroads Regional Hospital*	15.77	13.55	13.05	13.97	N/A
Diamond Grove Center	22.27	22.63	21.84	15.09	11.83
Lakeside Behavioral Health Systems*	15.35	15.44	14.15	15.83	15.55
Liberty Healthcare Systems*	7.08	7.54	10.12	10.78	10.09
Oak Circle Center	28.71	33.95	29.84	31.24	36.48
Parkwood Behavioral Health System	14.60	14.30	13.92	12.79	13.06

*Out-of-State Facility Source: Division of Medicaid Acute Inpatient Facilities Data

TABLE 6: FY14 FFS & CCO CLAIMS

FY14 FFS & CCO, Youth Under 21	Total Encounter Claims ($)	% of Total Medicaid BH Spending	% of Total Medicaid BH Claims	Number of Medicaid Beneficiaries Utilizing Services[95]
Institutional Placements	$91.2 million	49%	1.4%	6,394
HCBS	$93.3 million	51%	98.6%	150,130

FIGURE 3: MEDICAID FFS AND CCO ENCOUNTER CLAIMS FOR YOUTH UNDER 21



[95] The utilizer figures are likely duplicated by services, with a youth counted each time he or she accessed a different HCBS or institutional service. Data were unduplicated *within* service types only and in aggregate, so a child-level analysis is not possible.

TABLE 7: TOTAL MEDICAID SPENDING, INSTITUTIONAL & HCBS, BY SERVICE, FEE FOR SERVICE & MANAGED CARE

Service Category	FY2010	FY2011	FY2012	FY2013 (MC & FFS)	FY2014 (MC & FFS)
Assertive Community Treatment (FY2010-2011, MIMS service)	$325,903.45	$285,484.50	$168,269.76	$2,557.50	$7,375.50
Assessment	$5,101,559	$5,579,513	$5,876,878	$5,450,954	$5,047,024
Community Support Services#	N/A	N/A	$6,568,173	$12,276,726	$10,591,244
Crisis Residential #	N/A	N/A	$228,214	$687,158	$546,475
Day Treatment	$38,142,091	$27,715,326	$24,308,241	$20,386,276	$21,975,081
Electroconvulsive Therapy*	$0	$0	$0	$1,130	$224
Evaluation and Management	$7,913,792	$8,120,609	$8,155,530	$5,480,911	$2,980,184
Family Therapy	$5,818,368	$6,344,031	$6,562,359	$6,706,638	$6,240,469
Group Therapy	$1,001,014	$1,430,785	$1,862,678	$2,842,947	$3,018,738
Individual Therapy	$15,640,281	$18,237,131	$18,700,398	$20,034,952	$20,631,898
Individual Therapeutic Support*^	$32	$64	$124	N/A	N/A
Inpatient Medical Surgical Hospital	$35,161,427	$32,588,874	$32,194,633	$21,367,994	$17,479,844
Inpatient Psychiatric Hospital	$24,576,115	$25,017,217	$24,580,512	$27,243,428	$26,159,344
Intensive home-based treatment (MYPAC)	$11,535,974	$15,863,100	$18,568,700	$21,061,611	$18,947,865
Intensive Outpatient Psychiatric (CMHC/PMHC service) #	N/A	N/A	$6,582	$5,741	$102,637
Interactive Complexity%	N/A	N/A	$4	$16,669	$72,119
Medication Management$	$1,864,820	$2,271,746	$2,692,499	$1,217,019	$139,087
Mobile Crisis Service#	N/A	N/A	$40,403	$166,414	$367,802
Outpatient Hospital	$8,947	$6,551	$11,851	$15,099	$15,515
Partial hospitalization	$38,002	$97,439	$69,402	$19,411	$8,735
Peer Support #	N/A	N/A	$689	$17,354	$45,520
Pharmacotherapy (including Medication Assisted Treatment)	$6,218	$8,593	$10,864	$143,187	$266,957
Prolonged Service*	$9,511	$24,239	$66,892	$78,503	$4,876
Residential Psychiatric Treatment Facility	$42,851,133	$44,153,413	$45,535,965	$46,374,799	$47,501,610
Respite (MYPAC)&	$150,400	$343,600	$426,000	$403,600	$80,400
School Based Services^	$2,033,266	$2,482,602	$2,122,565	N/A	N/A
Screening and Brief Intervention for Tobacco Cessation*	$0	$0	$0	$0	$21
Service Planning	$641,528	$697,306	$565,472	$327,224	$315,160
Skill Building	$1,483,440	$1,939,699	$1,777,801	$1,242,798	$909,216

Specialized evaluations (Neuropsychological Evaluation)*	$12,700	$12,550	$10,830	$23,043	$8,197
Targeted Case Management	$17,488,464	$17,140,844	$8,589,530	$464,186	$1,021,638
Therapeutic Foster Care*+	N/A	N/A	$153,888	N/A	N/A

*Indicates a service that was not included in graphs depicting HCBS claims, utilization or services below

^Indicates a service that ended in FY2012

# Indicates a service that began in FY2012

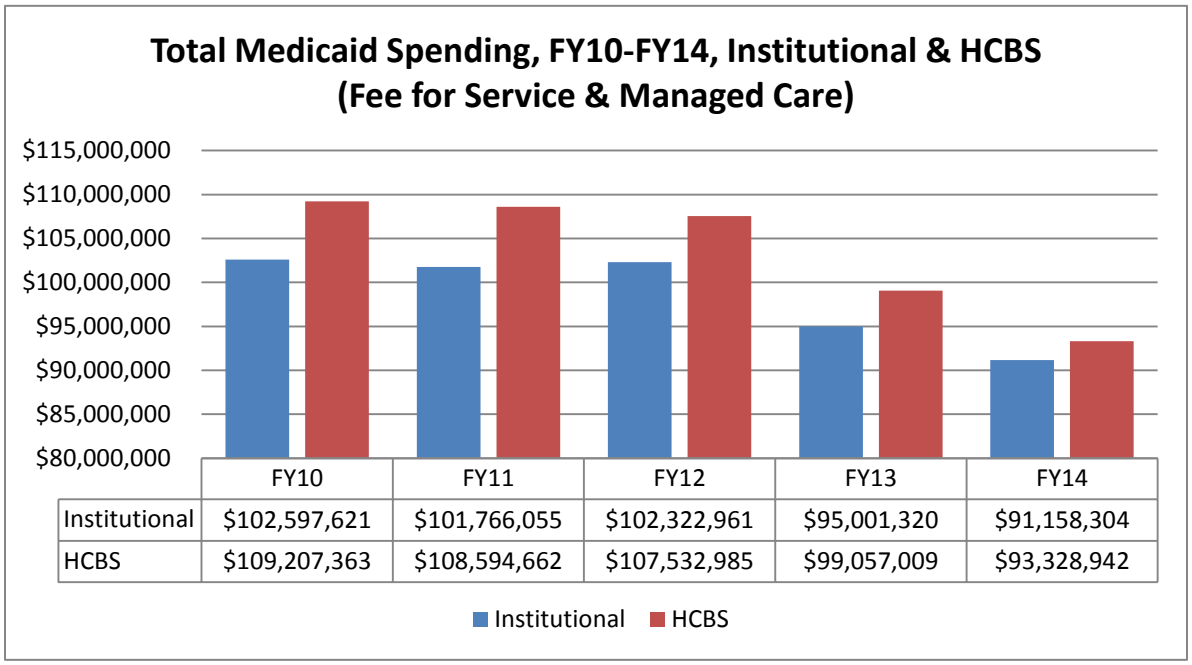
%Indicates a service that began in FY2013

$CMS removed the procedure code in FY2014. Services provided as an E&M code or as a HCPS code.

&MYPAC respite did not continue for newly enrolled MYPAC recipients for admission dates after 9/30/2012. This was only allowed for CA-PRTF Demonstration Waiver participants.

+ Treatment Foster Care (TFC) was opened in FY2012 for billing while DOM requested approval of the service in the Rehab Option of the State Plan Amendment (SPA). Based on informal questions received from CMS, DOM felt the service would not be approved and requested providers stop billing TFC until approval or denial was received from CMS. Although various revisions were made to this draft SPA TFC was ultimately denied by CMS.

FIGURE 4: TOTAL MEDICAID SPENDING BY CATEGORY OF SERVICE



	FY10	FY11	FY12	FY13	FY14
Institutional	$102,597,621	$101,766,055	$102,322,961	$95,001,320	$91,158,304
HCBS	$109,207,363	$108,594,662	$107,532,985	$99,057,009	$93,328,942

FIGURE 5: TRENDS IN MEDICAID INSTITUTIONAL SPENDING

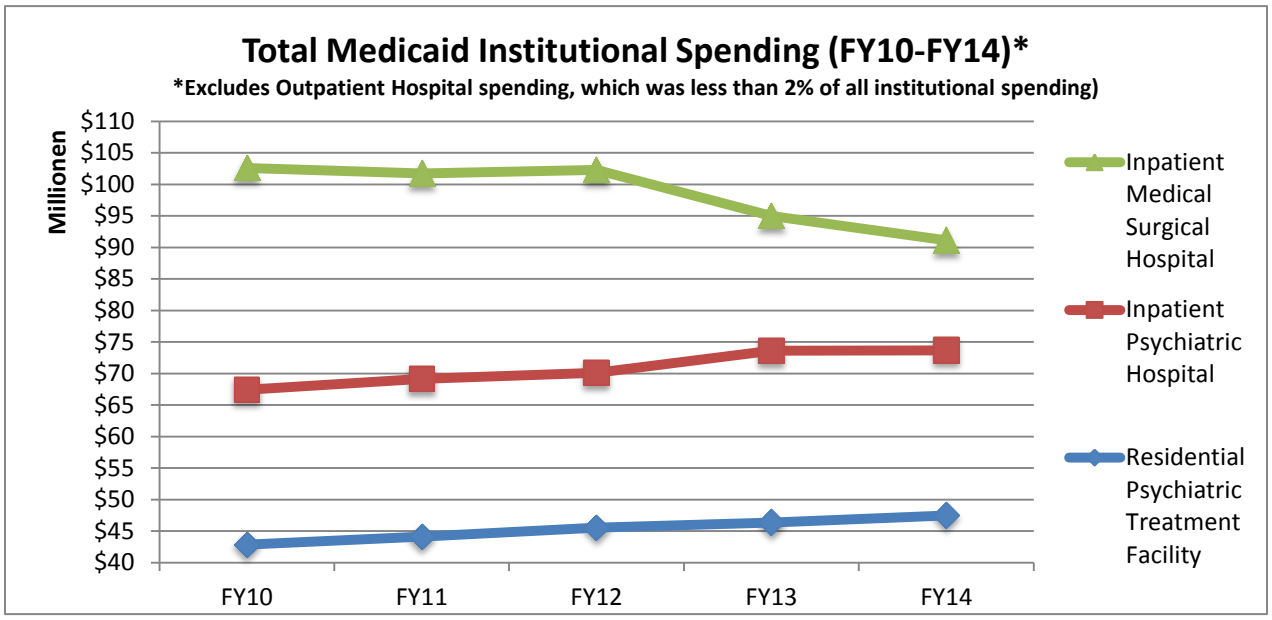


FIGURE 6: TRENDS IN HCBS MEDICAID SPENDING, FY10-14 (SERVICES WITH $1 MILLION OR MORE IN A GIVEN YEAR)

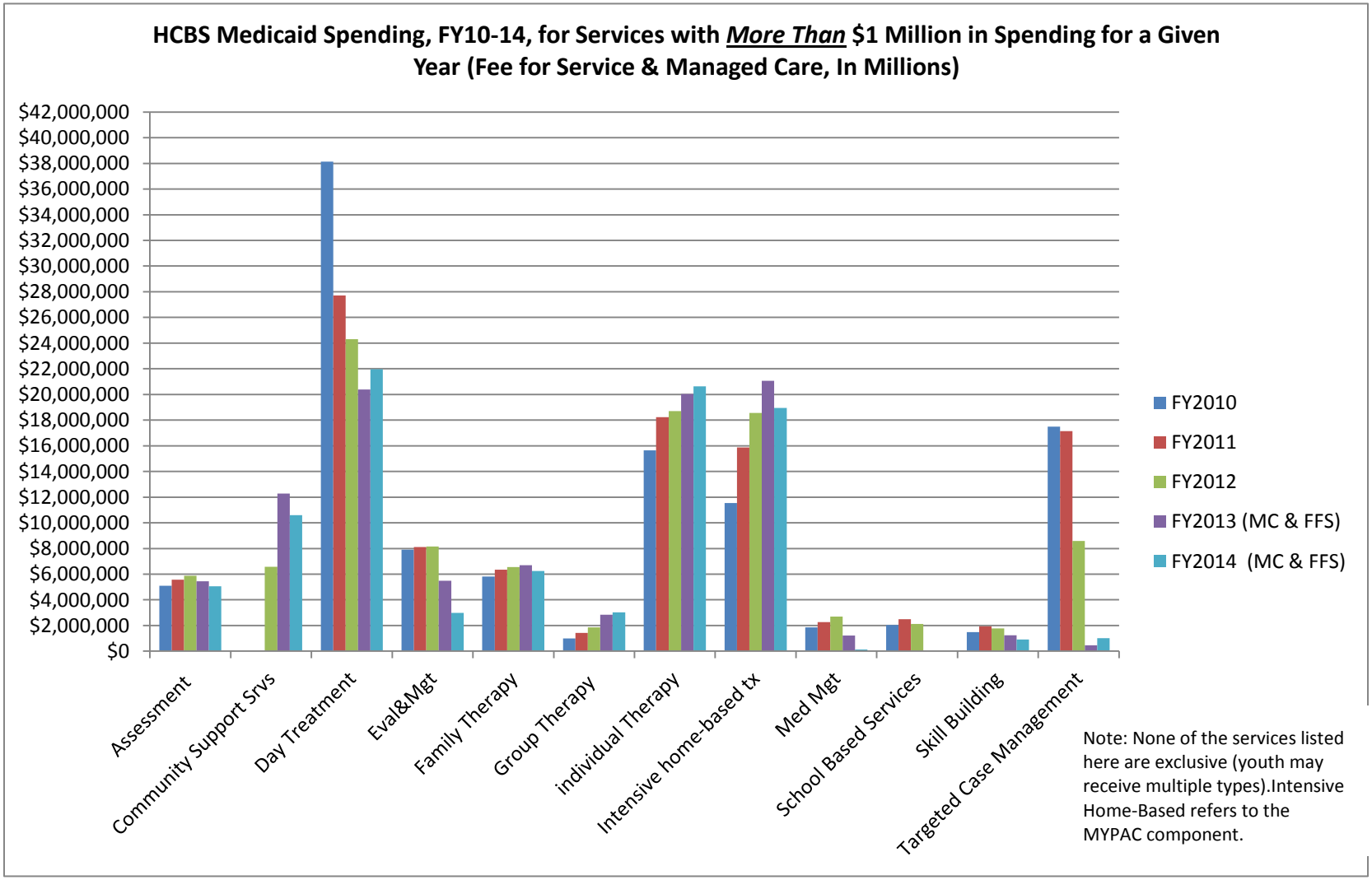
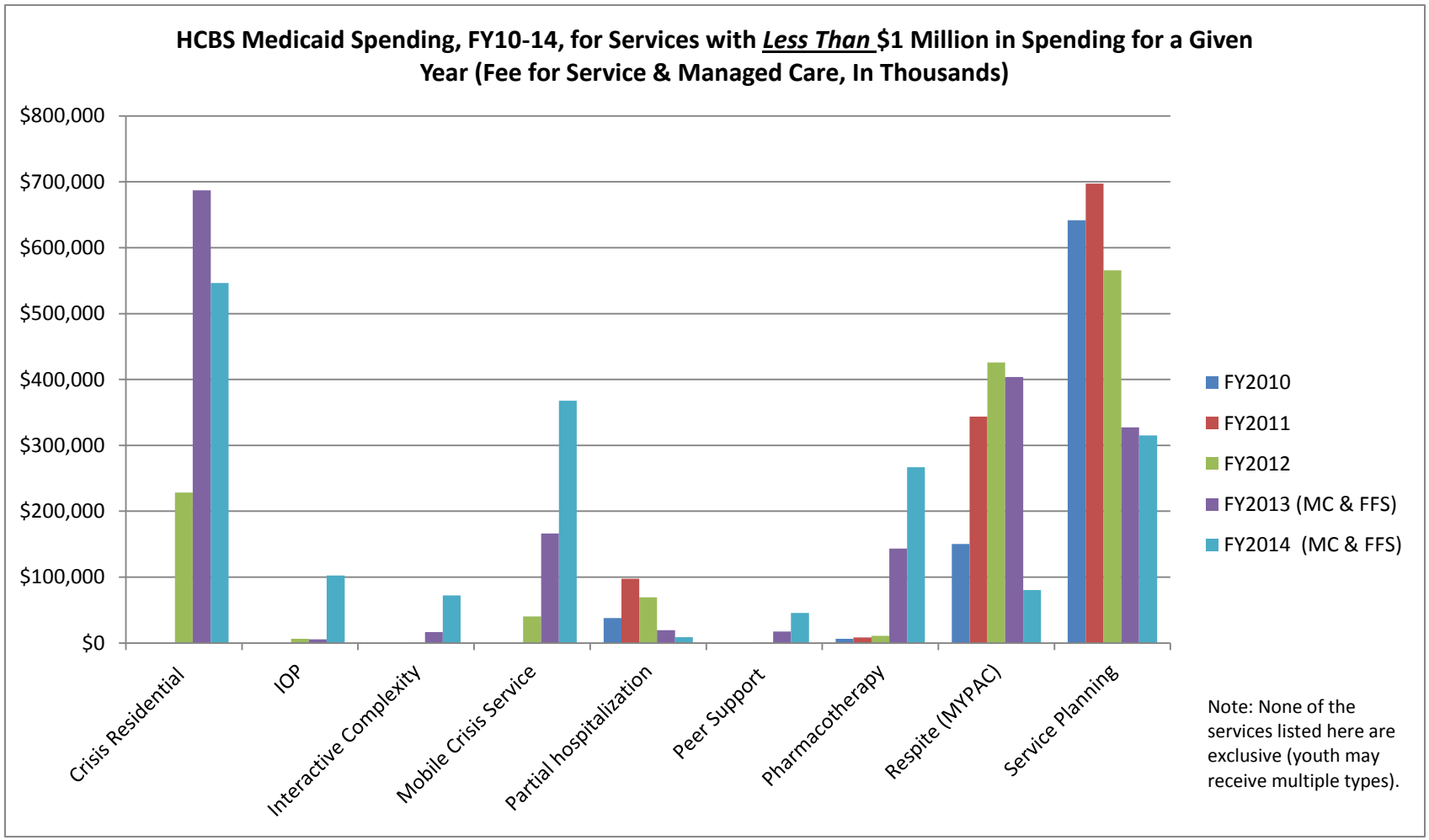


FIGURE 7: TRENDS IN HCBS MEDICAID SPENDING, FY10-14 (SERVICES WITH LESS THAN $1 MILLION IN A GIVEN YEAR)



Note: Although the data provided to TAC by DOM grouped Institutional, Inpatient, and Outpatient Hospital services together, it was not DOM's intent to have hospital outpatient service considered as institutional services. Hospital Outpatient services are considered the same type services that would be provided in an office setting, such as psychiatrist, LCSW, or CMHC, therefore should not be considered inpatient or institutional.

TABLE 8: BEHAVIORAL HEALTH SERVICES UTILIZED BY THE HIGHEST PERCENTAGE OF MEDICAID ENROLLEES[96]

Top Services	FY2012 FFS	FY2013 FFS	FY2013 Managed Care	FY2014 FFS	FY2014 Managed Care
1	Evaluation & Management (6.8%)	Evaluation & Management (6.4%)	Individual Therapy (4.8%)	Individual Therapy (5.8%)	Individual Therapy (4.9%)
2	Individual Therapy (6.1%)	Individual Therapy (6.1%)	Assessment (3.6%)	Assessment (5.6%)	Assessment (4.2%)
3	Assessment (5.7%)	Assessment (5.7%)	Evaluation & Management (3.4%)	Family Therapy (4.3%)	Evaluation & Management (3.6%)
4	Family Therapy (4.4%)	Family Therapy (4.4%)	Community Support Services (3.2%)	Evaluation & Management (3.2%)	Family Therapy (3.1%)
5	Medication Management (3.5%)	Medication Management (2.6%)	Family Therapy (2.8%)	Community Support Services (2.7%)	Community Support Services (2.6%)
6	Service Planning (3.3%)	Community Support Services (2.9%)	Service Planning (1.6%)	Service Planning (2.1%)	Service Planning (1.9%)

TABLE 9: NUMBER OF CLAIMS PER SERVICE, FY10-FY14, INSTITUTIONAL & HCBS

Service Category	FY2010	FY2011	FY2012	FY2013 (MC & FFS)	FY2014 (MC & FFS)
Assessment	76,363	80,995	87,548	85,948	81,098
Community Support Services#	N/A	N/A	108,311	196,744	169,944
Crisis Residential#	N/A	N/A	354	879	709
Day Treatment	337,541	268,264	261,438	210,019	174,508
Electroconvulsive Therapy*	0	0	0	7	2
Evaluation and Management	82,893	83,399	85,600	68,417	46,850
Family Therapy	64,420	68,981	74,579	82,420	86,073

[96]Based on % of Enrollees Receiving Service

Group Therapy	29,661	38,379	48,227	63,312	76,659
Individual Therapy	191,415	217,076	231,528	251,255	235,372
Individual Therapeutic Support*^	1	2	4	N/A	N/A
Inpatient Medical Surgical Hospital	2,928	2,935	2,826	2,834	2,820
Inpatient Psychiatric Hospital	4,086	4,137	4,130	3,967	3,908
Intensive home-based treatment (MYPAC)	2,873	3,913	4,553	5,472	6,549
Intensive Outpatient Psychiatric (CMHC/PMHC service)[#]	N/A	N/A	43	44	280
Interactive Complexity[%]	N/A	N/A	1	3,063	10,985
Medication Management[$]	40,273	44,586	51,517	24,917	3,170
Mobile Crisis Service[#]	N/A	N/A	310	1,256	2,251
Outpatient Hospital	199	165	156	164	151
Partial hospitalization	350	880	615	178	59
Peer Support[#]	N/A	N/A	21	648	1,346
Pharmacotherapy (including Medication Assisted Treatment)	978	995	974	1,301	1,308
Prolonged Service*	107	162	203	422	49
Residential Psychiatric Treatment Facility	4,837	4,849	4,934	5,000	4,923
Respite (MYPAC)[&]	57	144	186	188	37
School Based Services^	33,735	40,742	36,038	N/A	N/A
Screening and Brief Intervention for Tobacco Cessation*	0	0	0	0	4
Service Planning	34,637	37,650	30,442	17,780	16,029
Skill Building	21,258	28,516	27,210	17,165	8,926
Specialized evaluations (Neuropsychological Evaluation)*	24	35	25	51	25
Targeted Case Management[!]	238,705	236,568	120,355	20,614	39,709
Therapeutic Foster Care*[+]	N/A	N/A	60	N/A	N/A

*Indicates a service that was not included in the graphs
^Indicates a service that ended in FY2012
[#] Indicates a service that began in FY2012
[%]Indicates a service that began in FY2013
[$]CMS removed the procedure code allowed for Medication Management in FY2014. Services were to be provided as an E&M code or as alternate HCPS code that DOM implemented.
[&]MYPAC respite did not continue for newly enrolled MYPAC recipients for admission dates after 9/30/2012. This was only allowed for CA-PRTF Demonstration Waiver participants.
[+] Treatment Foster Care (TFC) was opened in FY2012 for billing while DOM requested approval of the service in the Rehab Option of the State Plan Amendment (SPA). Based on informal questions received from CMS, DOM felt the service would not be approved and requested providers stop billing TFC until approval or denial was received from CMS. Although various revisions were made to this SPA and multiple follow-up questions from CMS were answered, TFC was ultimately denied by CMS.
[!]SFY '10. '11 and '12 included traditional Case Management services during this time. Community Support Services was added in FY2012 to distinguish managing the case from managing the person.

FIGURE 8: MEDICAID CLAIMS FOR INSTITUTIONAL SERVICES, FY10-14

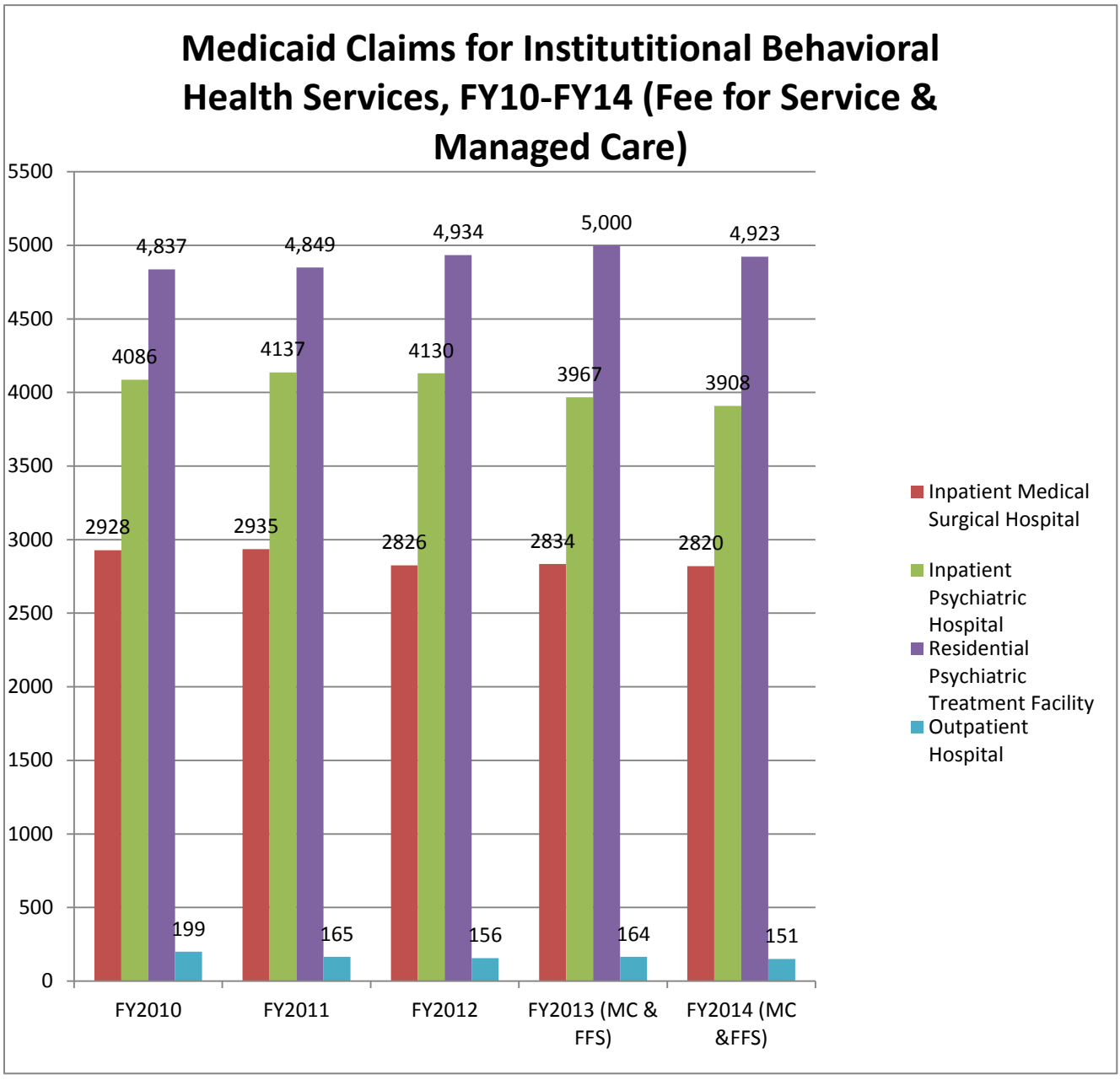


FIGURE 9: HCBS MEDICAID CLAIMS, FY10-14: SERVICES WITH GREATER THAN 10,000 CLAIMS

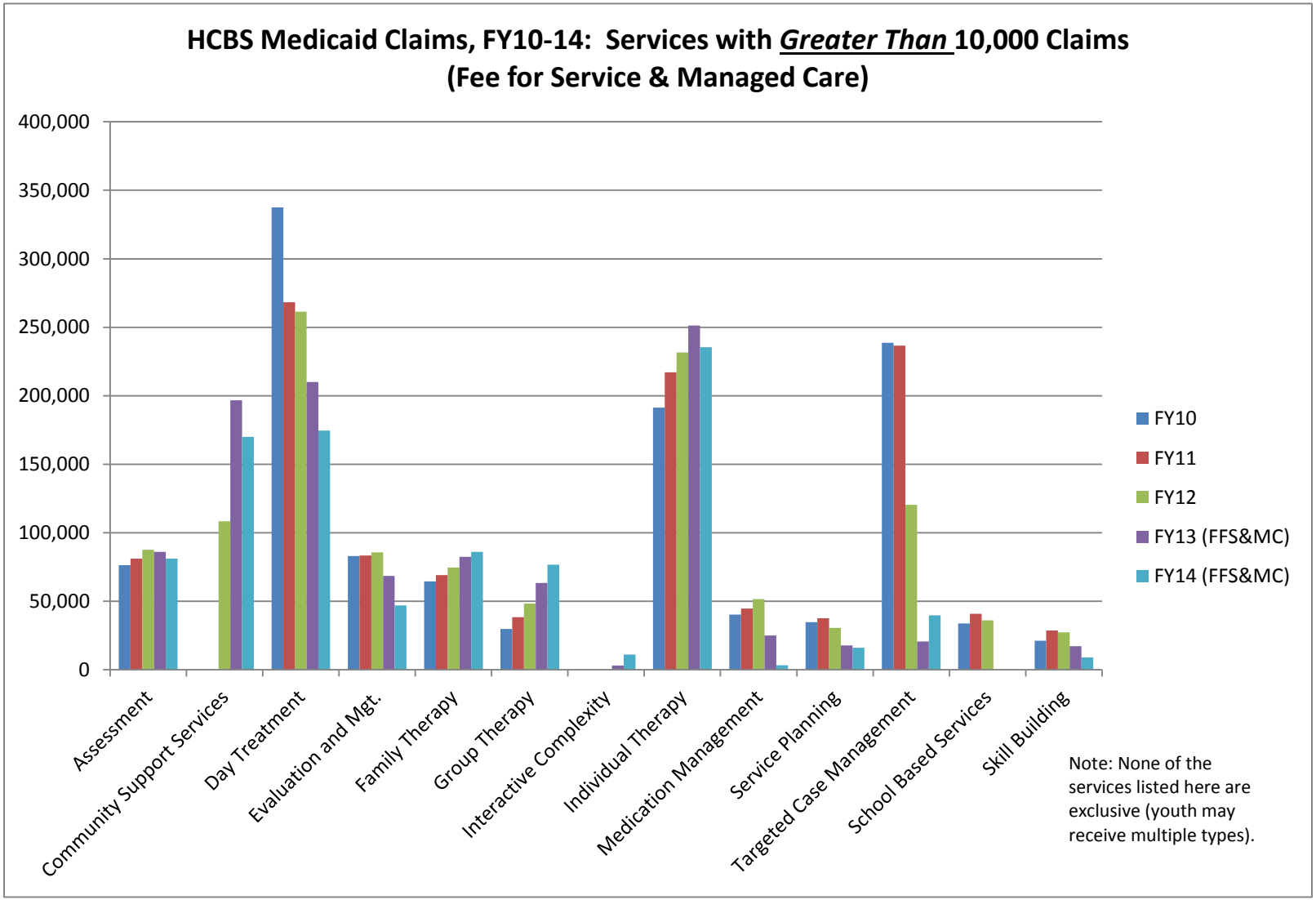


FIGURE 10: HCBS MEDICAID CLAIMS, FY10-14: SERVICES WITH FEWER THAN 10,000 CLAIMS

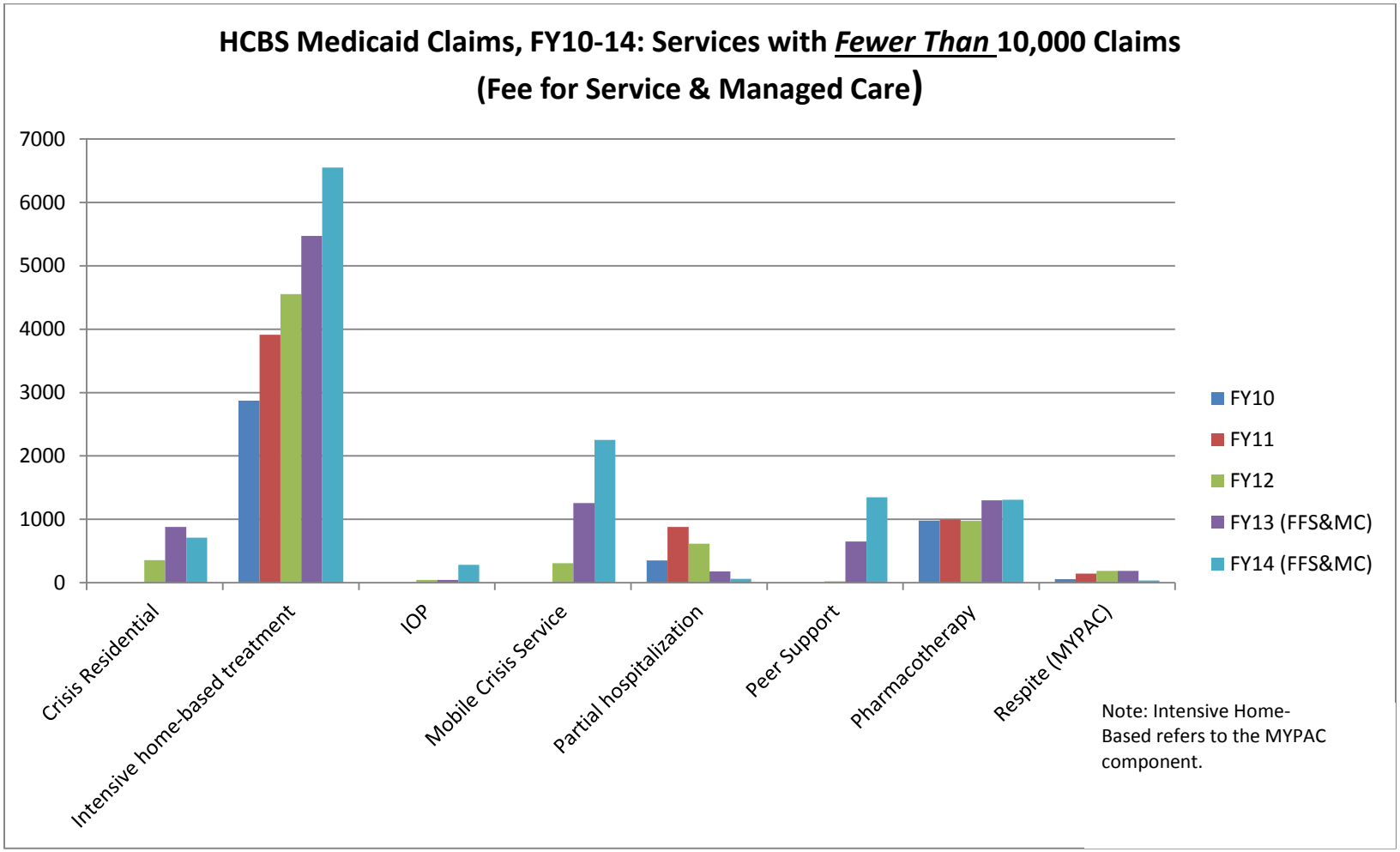
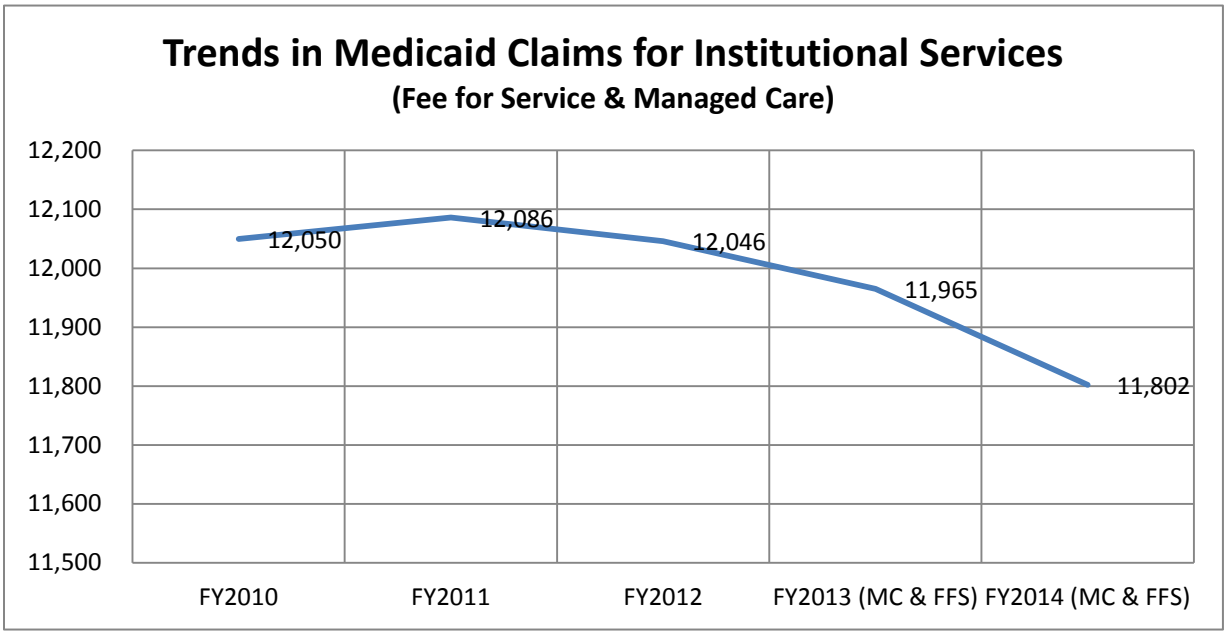


FIGURE 11: TRENDS IN MEDICAID CLAIMS FOR INSTITUTIONAL SERVICES



Note: Although the data provided to TAC grouped Institutional, Inpatient, and Outpatient Hospital services together, it was not DOM's intent to have hospital outpatient service considered as institutional services. Hospital outpatient services are considered the same type services that would be provided in an office setting, such as psychiatrist, LCSW, or CMHC, therefore should not be considered inpatient or institutional.

FIGURE 12: TRENDS IN MEDICAID CLAIMS FOR HCBS

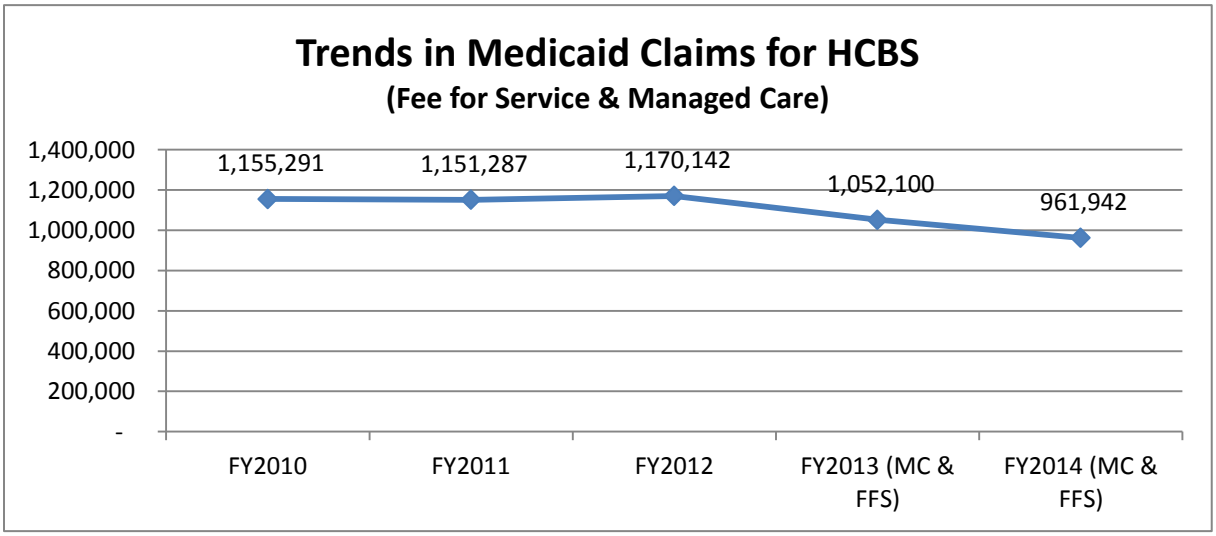


FIGURE 13: UNDUPLICATED COUNT OF UTILIZERS, INSTITUTIONAL SERVICES, FY10-FY14

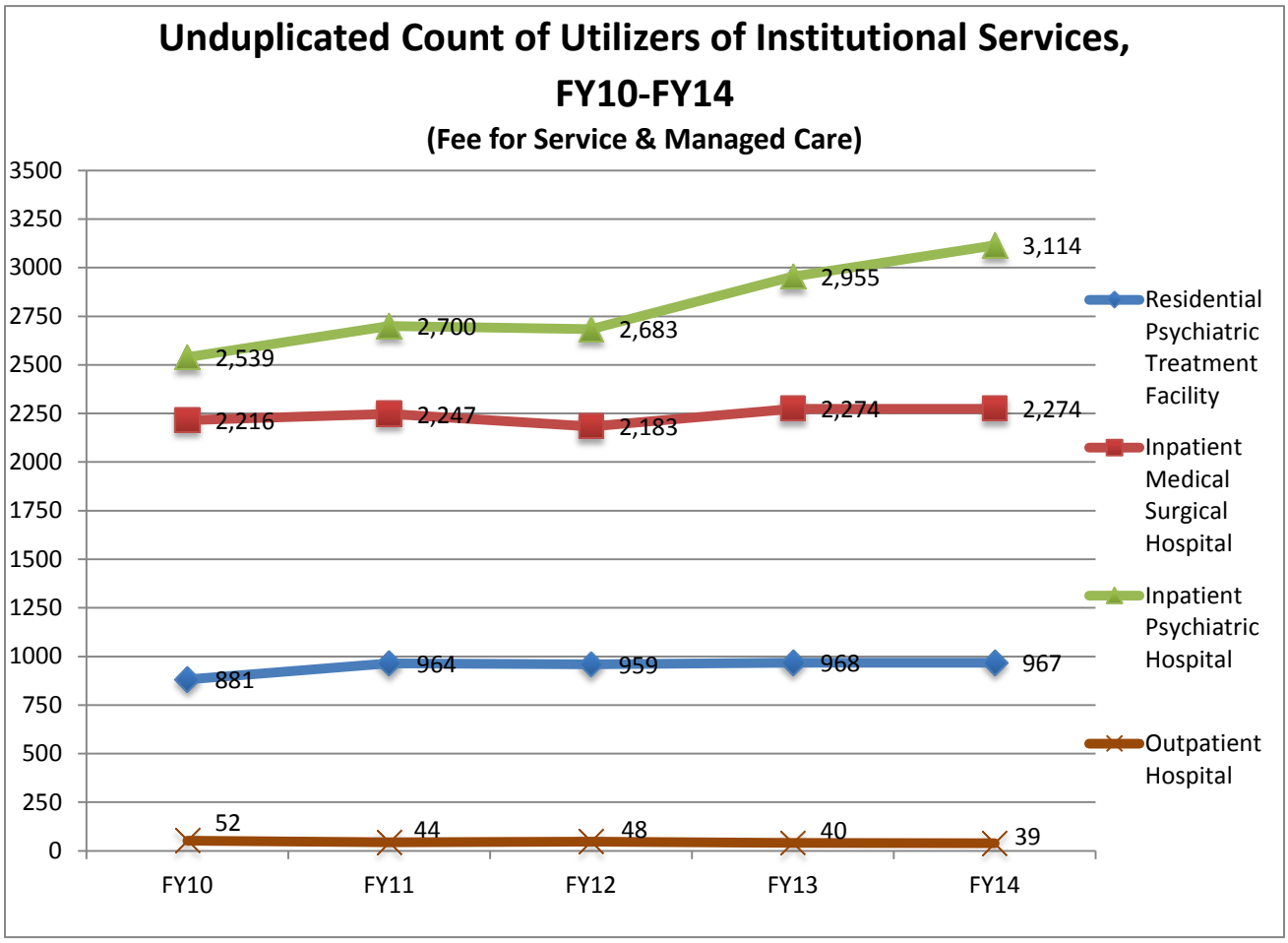


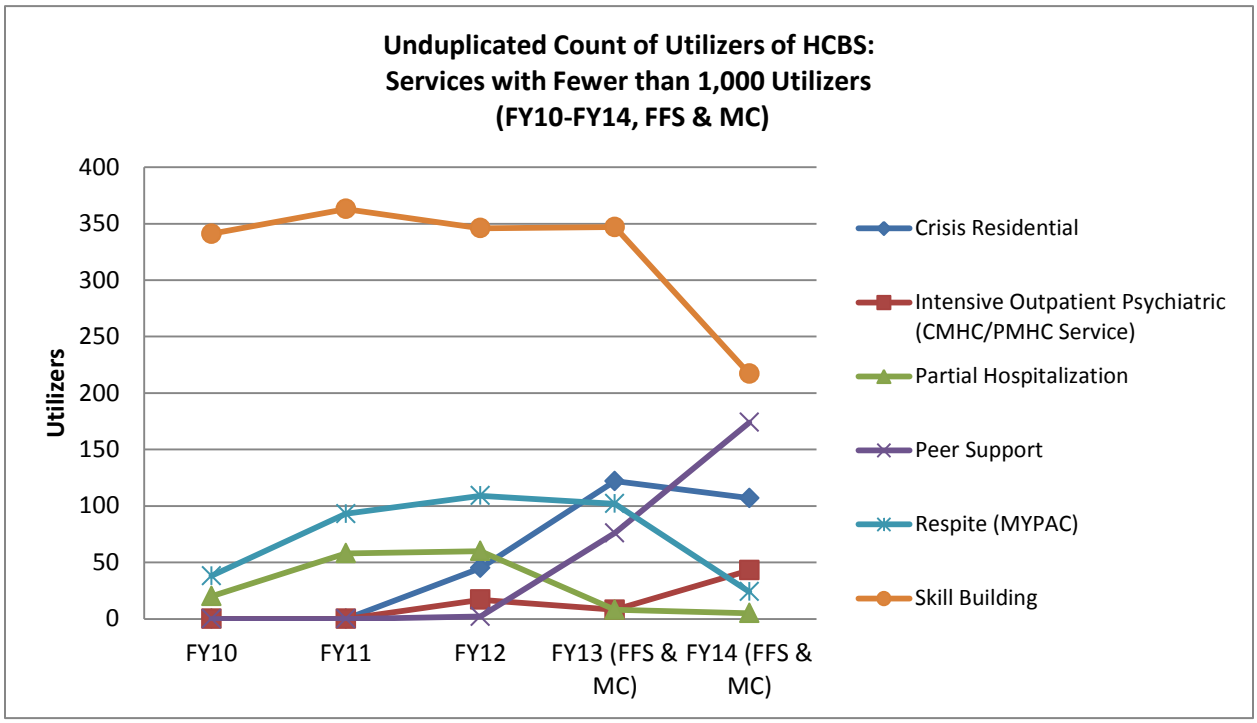
TABLE 10: CHANGES IN UTILIZATION, HCBS, FY10-FY14

Service	**% Change from FY10-FY14**
Assessment	**18%**
Community Support Services	**26%***
Crisis Residential	**138%***
Day Treatment	**-27%**
Evaluation & Management	**-41%**
Family Therapy & Group Therapy	**-39%**

Individual Therapy	**22%**
Intensive home-based treatment (MYPAC)	**111%**
Intensive Outpatient Psychiatric (CMHC/PMHC Service)	**153%***
Interactive Complexity	**69%~**
Med Management & Pharmacotherapy	**451%**
Mobile Crisis Service	**360%***
Partial Hospitalization	**-75%**
Peer Support	**129%***
Respite (MYPAC- Waiver)	**-37%**
School Based Services	**-100%**
Service Planning	**-22%**
Skill Building	**-36%**
Targeted Case Management	**-46%**

*Indicates service that was not available until FY12; % change is calculated from FY12-FY14
~Service began on 1/1/13, but only 1 youth utilized it in FY12; calculation was for FY13-FY14.

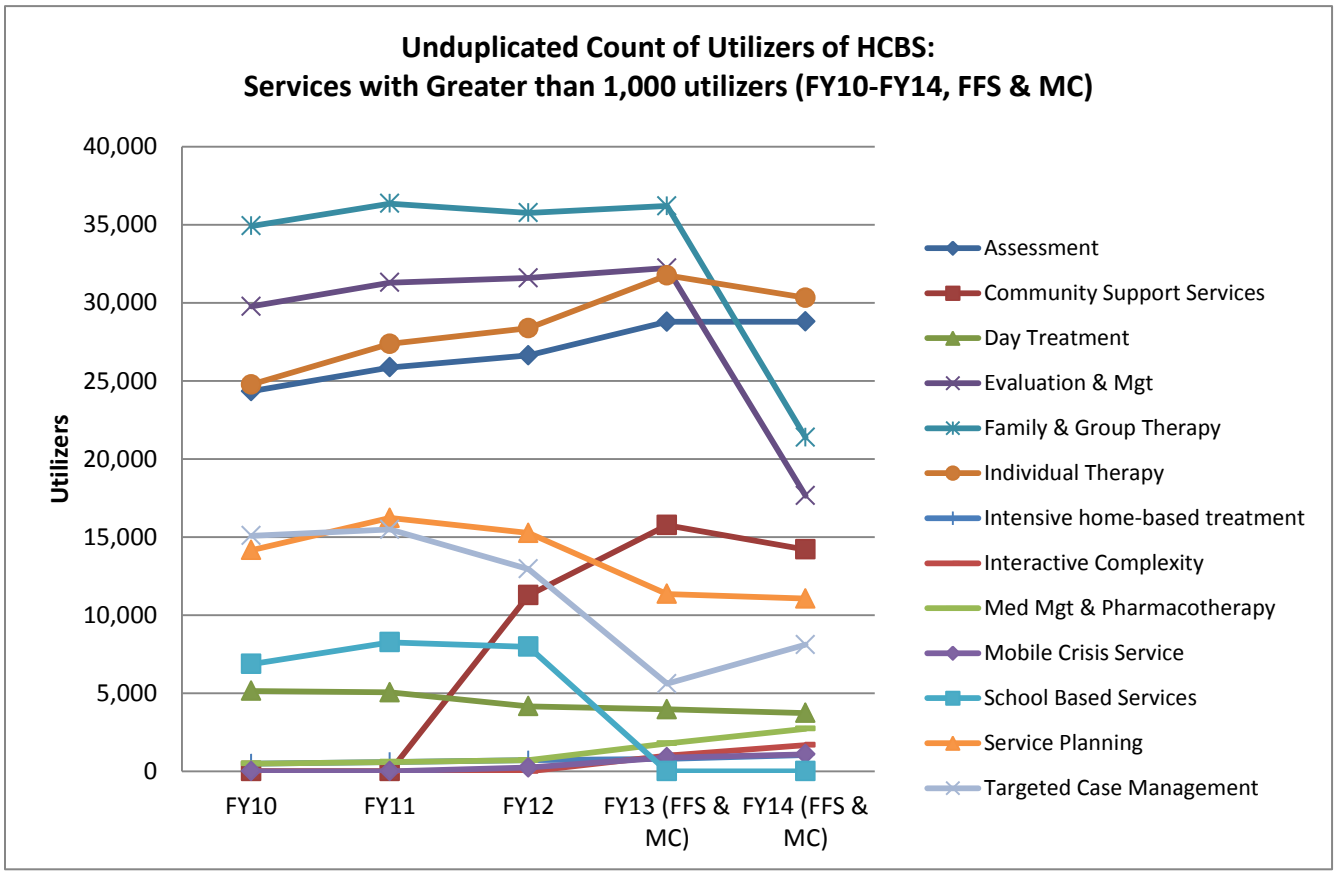
FIGURE 14: UNDUPLICATED COUNT OF UTILIZERS-HCBS WITH FEWER THAN 1,000 UTILIZERS



	FY10	FY11	FY12	FY13 (FFS & MC)	FY14 (FFS & MC)
Crisis Residential	N/A	N/A	45	122	107
Intensive Outpatient Psychiatric (CMHC/PMHC Service)	N/A	N/A	17	8	43
Partial Hospitalization	20	58	60	8	5
Peer Support	N/A	N/A	2	76	174
Respite (MYPAC)	38	93	109	102	24
Skill Building	341	363	346	347	217

Note: Crisis Residential, IOP and Peer Support were not available until FY2012. In FY2013 and FY2014, respite was only available to participants still enrolled in the CA PRTF Demo (MYPAC Demo).

FIGURE 15: UNDUPLICATED COUNT OF UTILIZERS OF HCBS WITH GREATER THAN 1,000 UTILIZERS

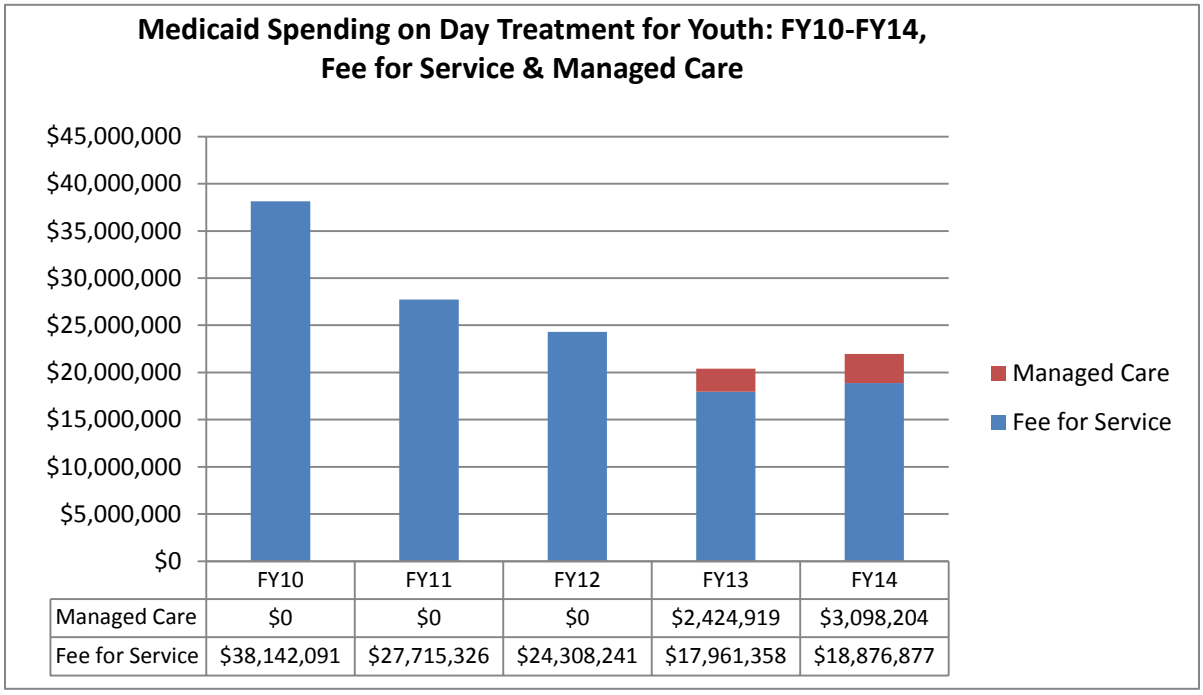


	FY10	FY11	FY12	FY13 (FFS & MC)	FY14 (FFS & MC)
Assessment	24,341	25,873	26,635	28,794	28,797
Community Support Services	N/A	N/A	11,274	15,769	14,208
Day Treatment	5,147	5,059	4,168	3,970	3,735
Evaluation &Mgt	29,777	31,302	31,597	32,236	17,649
Family & Group Therapy	34,924	36,361	35,765	36,206	21,384
Individual Therapy	24,769	27,374	28,382	31,760	30,329
Intensive home-based treatment (MYPAC)	495	601	713	790	1,043
Interactive Complexity	N/A	N/A	1	998	1,686

Med Mgt& Pharmacotherapy	495	601	714	1,788	2,729
Mobile Crisis Service	N/A	N/A	237	881	1,090
School Based Services	6,873	8,267	7,980	N/A	N/A
Service Planning	14,169	16,227	15,263	11,354	11,062
Targeted Case Management	15,089	15,483	12,961	5,605	8,113

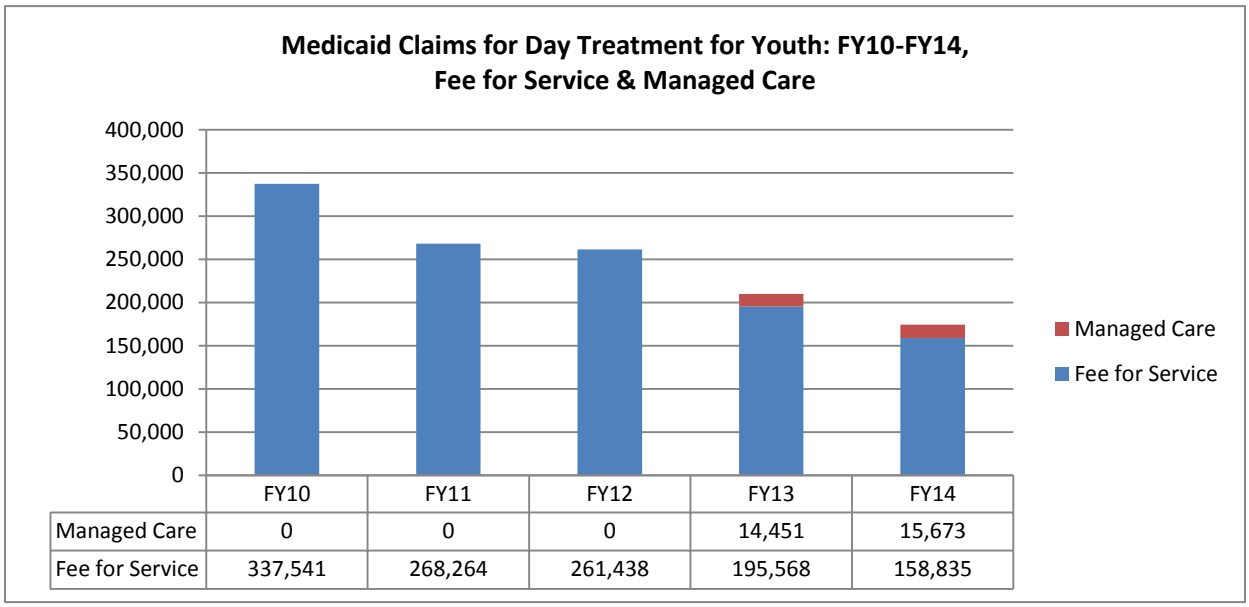
Note: Community support services and mobile crisis services began in FY2012. Interactive complexity began in FY2013. School-based services ended in FY2012.

FIGURE 16: DAY TREATMENT MEDICAID SPENDING



	FY10	FY11	FY12	FY13	FY14
Managed Care	$0	$0	$0	$2,424,919	$3,098,204
Fee for Service	$38,142,091	$27,715,326	$24,308,241	$17,961,358	$18,876,877

FIGURE 17: MEDICAID CLAIMS FOR DAY TREATMENT



	FY10	FY11	FY12	FY13	FY14
Managed Care	0	0	0	14,451	15,673
Fee for Service	337,541	268,264	261,438	195,568	158,835

FIGURE 18: UNDUPLICATED UTILIZERS OF DAY TREATMENT

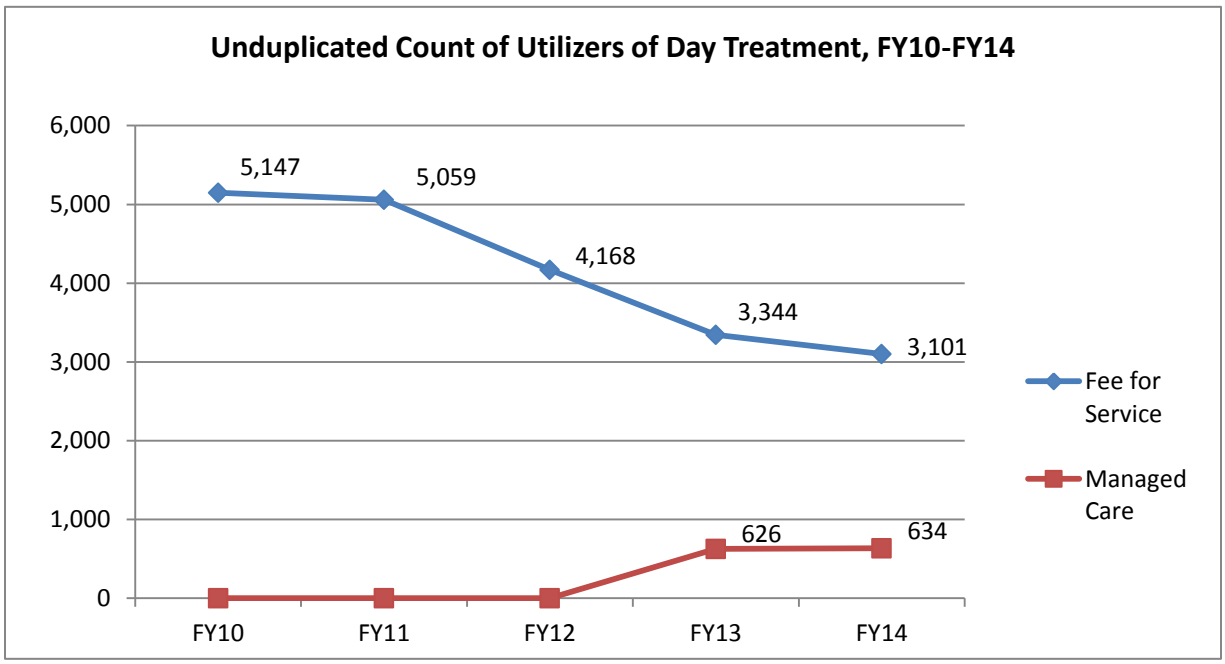


FIGURE 19: MEDICAID CLAIMS FOR CRISIS SERVICES

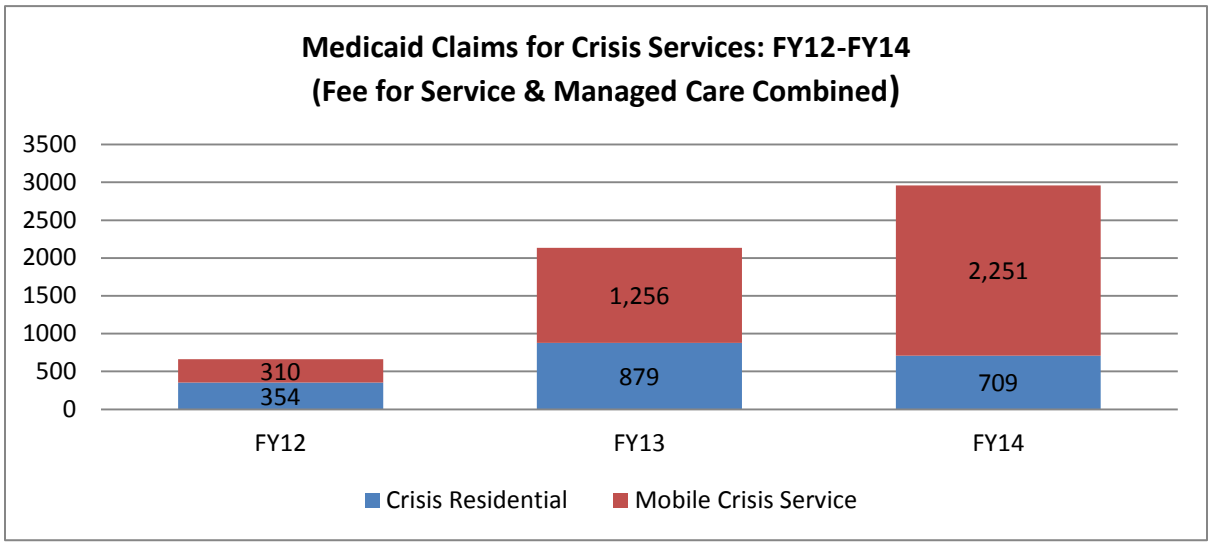


FIGURE 20: MEDICAID SPENDING ON CRISIS SERVICES

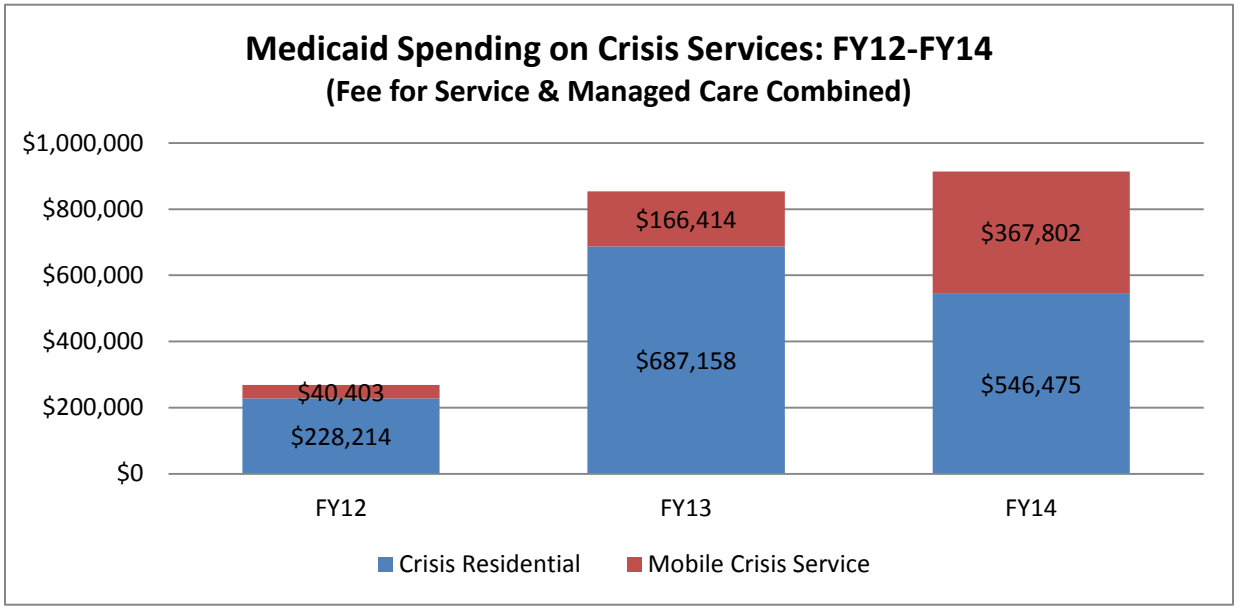
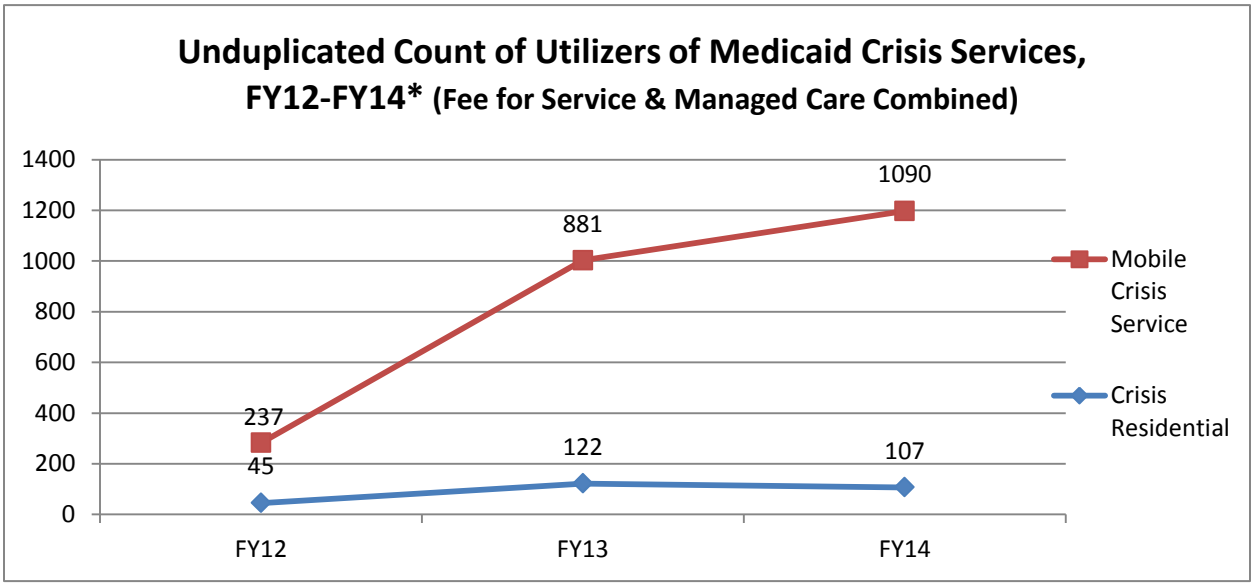
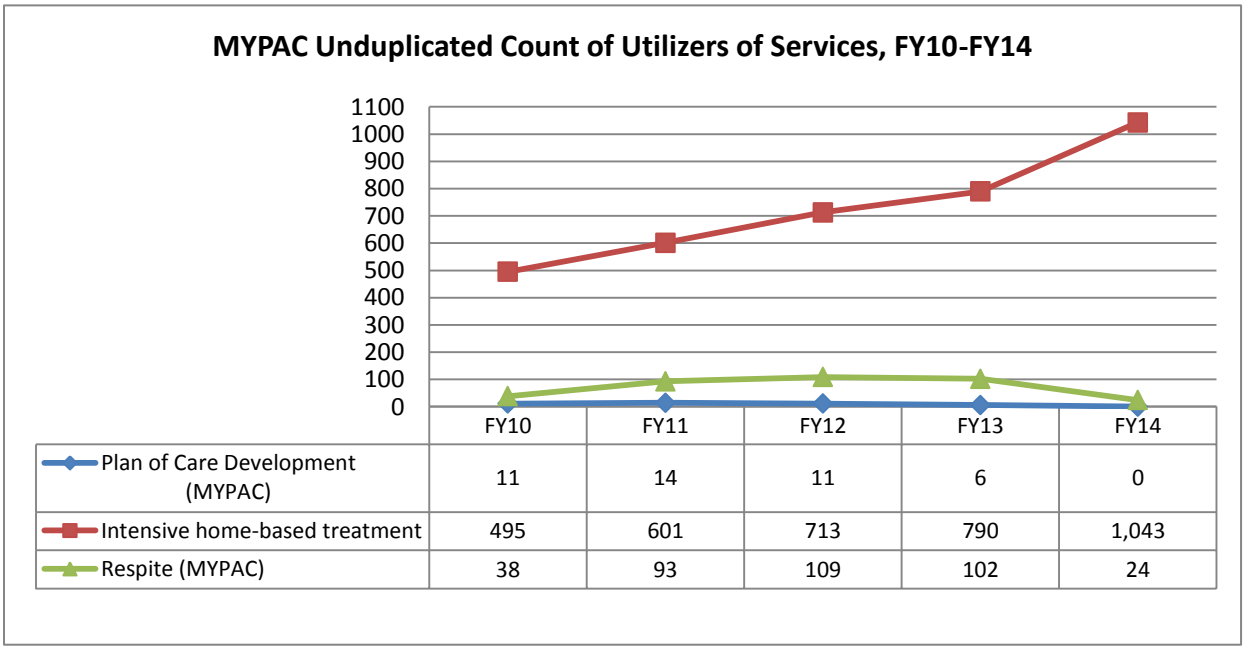


FIGURE 21: UNDUPLICATED COUNT OF UTILIZERS OF MEDICAID CRISIS SERVICES



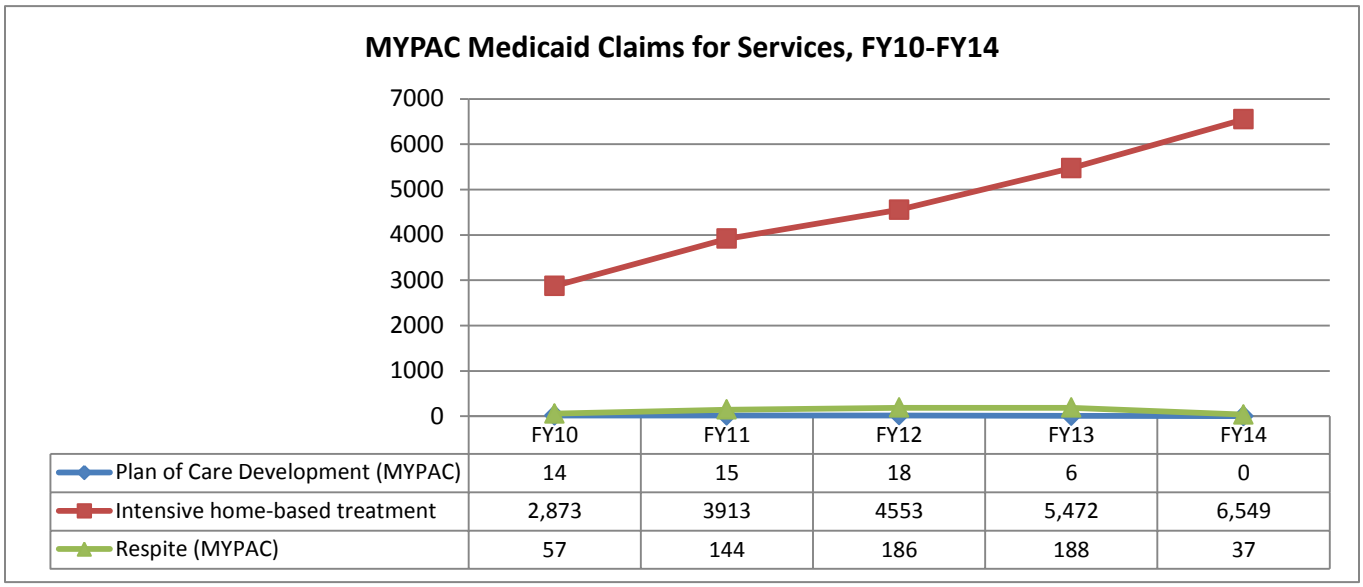
*Youth are unduplicated within each of the services but may be duplicated across services.

FIGURE 22: MYPAC UNDUPLICATED COUNT OF UTILIZERS OF SERVICES, FY10-FY14



	FY10	FY11	FY12	FY13	FY14
Plan of Care Development (MYPAC)	11	14	11	6	0
Intensive home-based treatment	495	601	713	790	1,043
Respite (MYPAC)	38	93	109	102	24

FIGURE 23: MYPAC MEDICAID CLAIMS FOR SERVICES, FY10-14



	FY10	FY11	FY12	FY13	FY14
Plan of Care Development (MYPAC)	14	15	18	6	0
Intensive home-based treatment	2,873	3913	4553	5,472	6,549
Respite (MYPAC)	57	144	186	188	37

FIGURE 24: TOTAL MEDICAID SPENDING ON PLAN OF CARE DEVELOPMENT (MYPAC), FY10-14

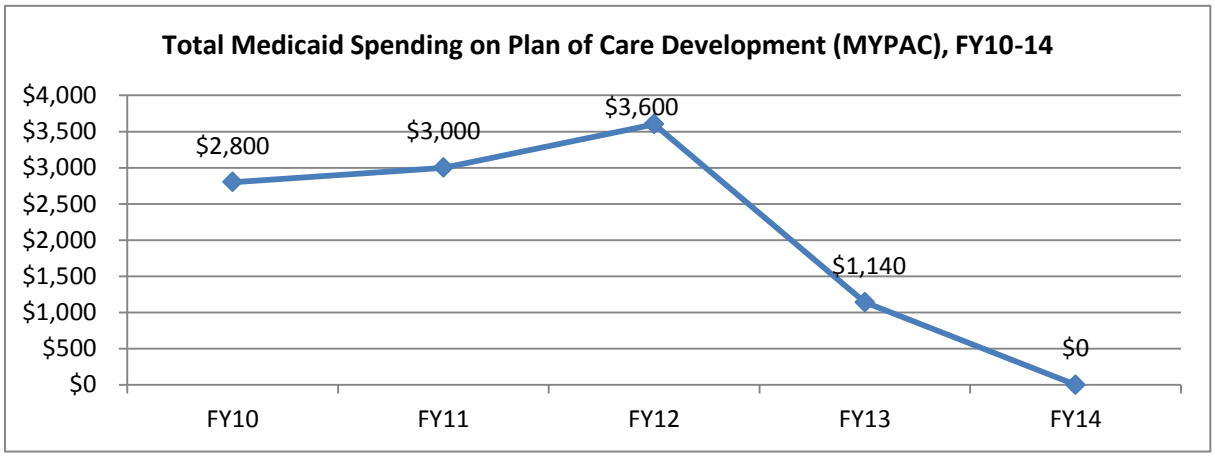


FIGURE 25: TOTAL MEDICAID SPENDING ON MYPAC INTENSIVE HOME-BASED TREATMENT COMPONENT, FY10-14

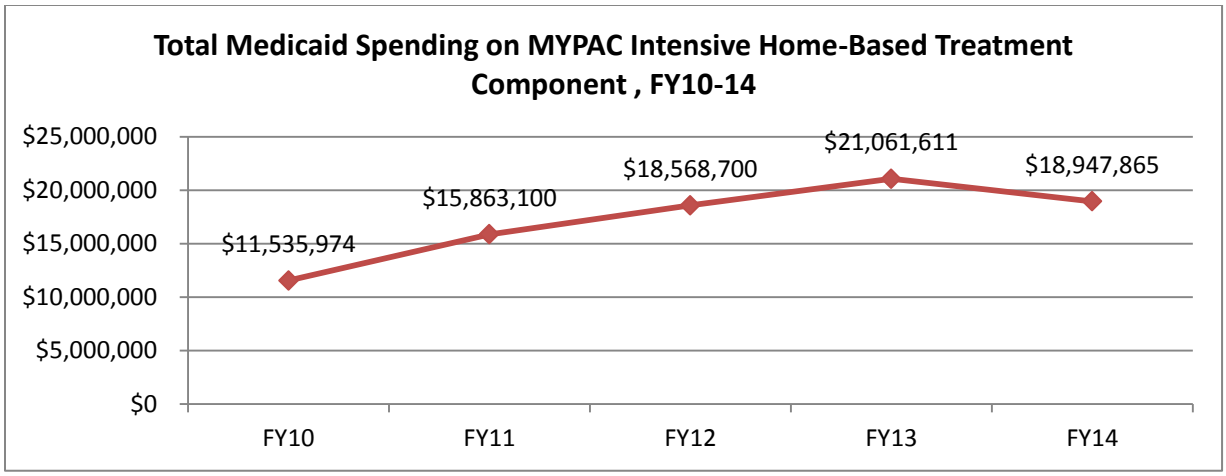


FIGURE 26: TRENDS AND DISTRIBUTION OF MEDICAID SPENDING FOR INTENSIVE HOME-BASED TREATMENT, FY10-14

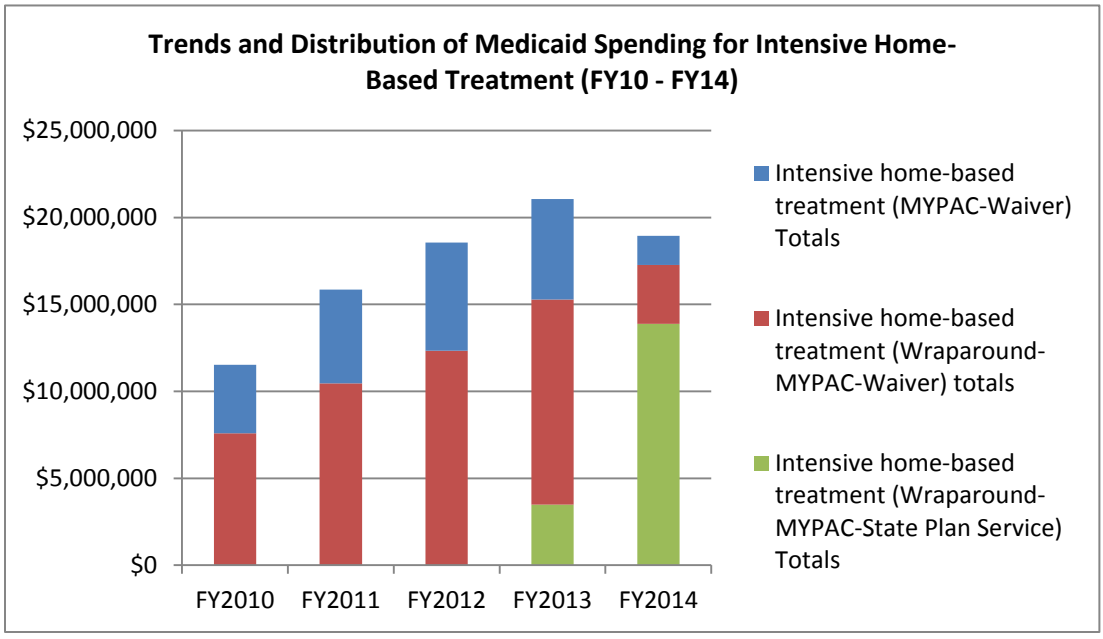


FIGURE 27: TOTAL MEDICAID SPENDING ON RESPITE (MYPAC), FY10-14

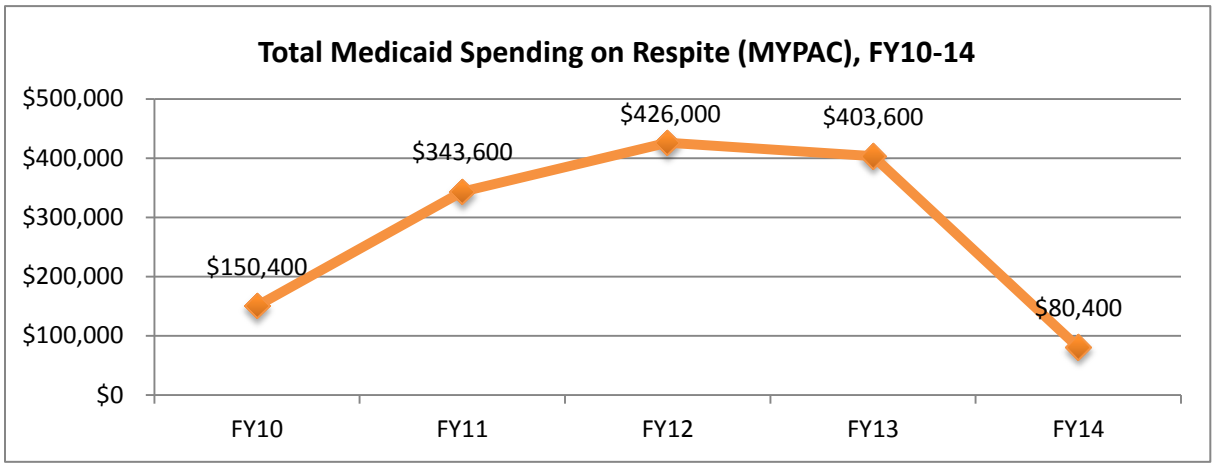


FIGURE 28: MEDICAID SPENDING BY PLACE OF SERVICE, 2013, FEE FOR SERVICE

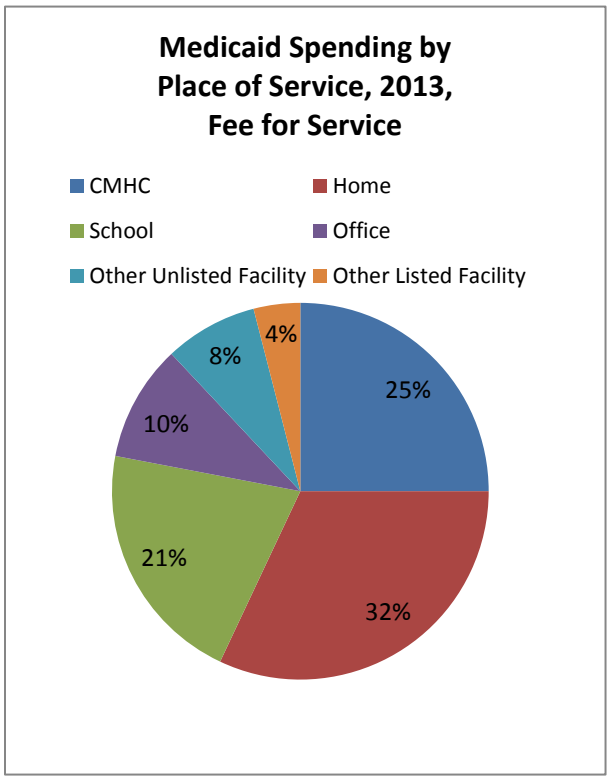


FIGURE 29: MEDICAID SPENDING BY PLACE OF SERVICE, 2013, MANAGED CARE

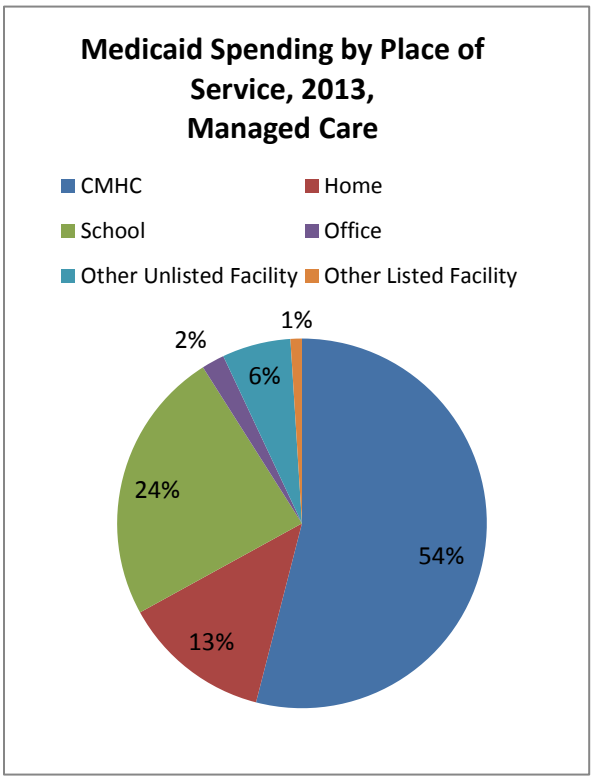


FIGURE 30: MEDICAID SPENDING BY PLACE OF SERVICE, 2014, FEE FOR SERVICE

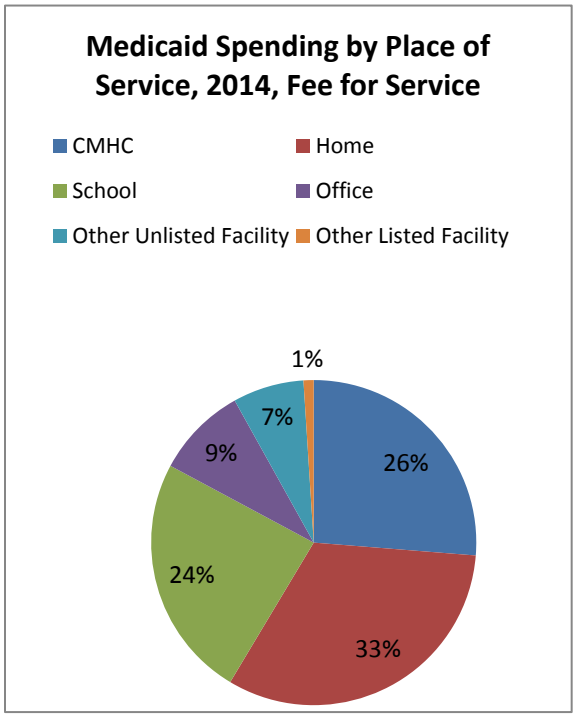


FIGURE 31: MEDICAID SPENDING BY PLACE OF SERVICE, MANAGED CARE

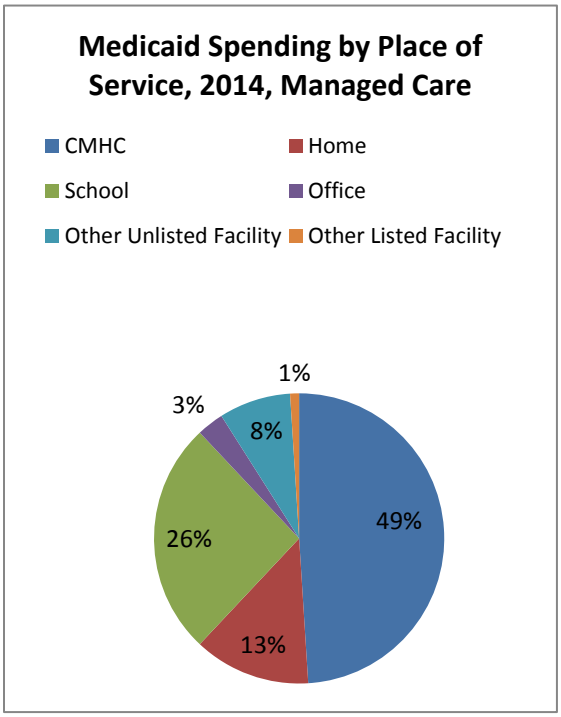


FIGURE 32: MEDICAID SPENDING BY PLACE OF SERVICE (FY10-FY14, FFS)

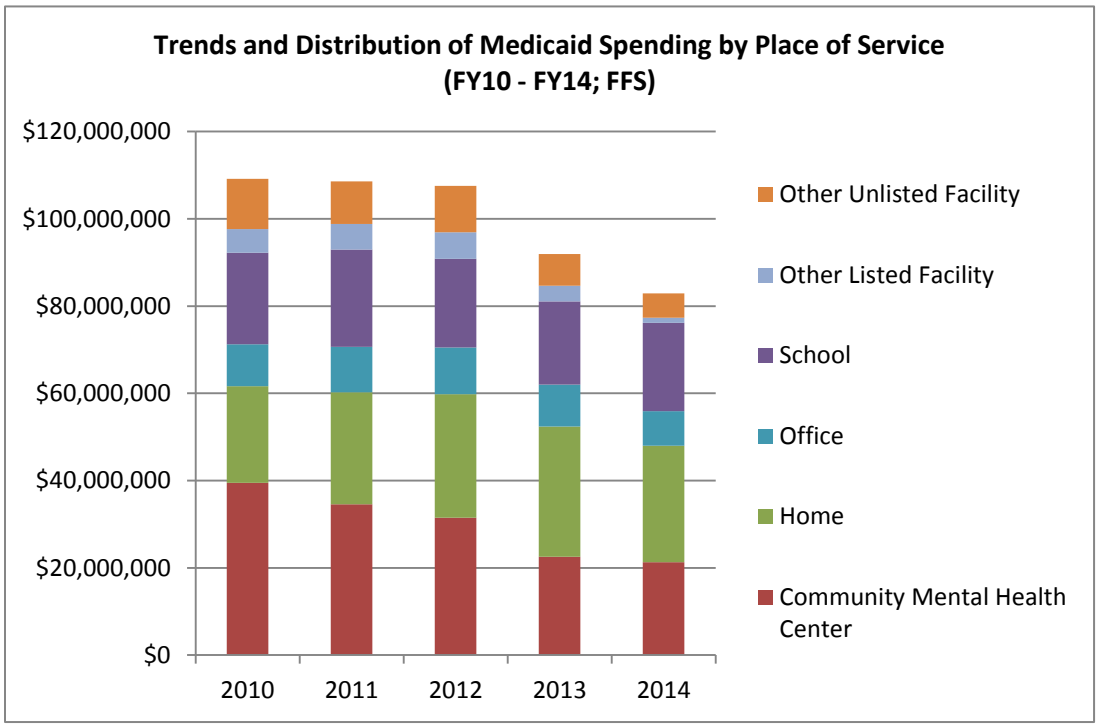


TABLE 11: TRENDS AND DISTRIBUTION OF MEDICAID SPENDING BY PLACE OF SERVICE (FY10 - FY14; FFS)

	2010		2011		2012		2013		2014		
Place of Service	$	%	$	%	$	%	$	%	$	%	% Change
CMHC	$39,494,802	36%	$34,554,020	32%	$31,526,328	29%	$22,535,039	25%	$21,334,225	26%	-46%
Home	$22,123,785	20%	$25,705,136	24%	$28,251,918	26%	$29,876,149	32%	$26,692,396	32%	21%
School	$21,012,544	19%	$22,295,783	21%	$20,290,712	19%	$19,117,966	21%	$20,256,613	24%	-4%
Office	$9,630,947	9%	$10,393,878	10%	$10,734,836	10%	$9,577,245	10%	$7,862,400	9%	-18%
Other Unlisted Facility	$11,577,276	11%	$9,735,032	9%	$10,629,400	10%	$7,252,938	8%	$5,583,861	7%	-52%
Other Listed Facility	$5,368,009	5%	$5,910,814	5%	$6,099,791	6%	$3,586,275	4%	$1,168,003	1%	-78%

TABLE 12: TRENDS AND DISTRIBUTION OF YOUTH SERVED BY PLACE OF SERVICE (FY10 – FY14; FFS)

Place of Service	2010	2011	2012	2013	2014	% Change
CMHC	76,090	82,710	86,439	80,355	68,593	-10%
Office	44,715	46,471	47,622	42,203	26,903	-40%
School	30,621	34,289	32,968	31,760	36,234	18%
Home	24,281	25,042	30,531	25,187	25,329	4%
Other Unlisted Facility	15,982	21,691	25,780	18,364	13,916	-13%
Inpatient Hospital	5,705	6,185	5,935	3,822	1,275	-78%
Outpatient Hospital	4,232	4,696	4,133	2,885	3,177	-25%
Rural Health Clinic	2,630	3,718	4,120	2,995	358	-86%
Inpatient Psychiatric Facility	2,125	2,625	3,007	1,985	1,068	-50%
Federally Qualified Health Ctr	367	223	314	224	140	-62%
Psychiatric Resident TrmtCntr	255	262	291	286	135	-47%
Group Home**	13	29	30	84	114	777%
Skilled Nursing Facility	18	43	36	9	23	28%
Emergency Room Hospital	27	33	28	29	7	-74%
Nursing Facility	11	24	42	25	2	-82%
Urgent Care Facility	36	16	7	9	3	-92%
Res. Substance Abuse TxCtr	1	8	3	20	36	3500%
Mobile Unit	6	5	17	12	16	167%
State Local Public Hlth Clinic	12	12	14	10	2	-83%
Independent Laboratory	21	4	4	5	11	-48%
Independent Clinic	4	4	3	1	31	675%
Prison/Correctional Facility	0	2	5	19	15	650%
Tribal 638 Provider-based Fac	12	6	1	0	0	-100%
Assisted Living Facility	2	2	5	3	6	200%
Intermediate Care Facility-MR	0	1	0	4	12	1100%
Psych Facility Partial Hosp	0	0	5	1	6	20%
Pharmacy	2	1	0	2	0	-100%
Ambulance Land	0	0	0	1	4	300%
Ambulatory Surgical Center	2	2	0	0	0	-100%
Homeless Shelter	0	0	0	0	4	N/A
Custodial Care Facility	0	1	0	1	1	N/A
Tribal 638 Free-standing Fac	0	1	0	0	1	N/A
Comprehensive OP Rehab Faci	0	0	0	0	2	N/A

Walk-in Retail Health Clinic	0	2	0	0	0	N/A
Temporary Lodging	0	0	0	0	1	N/A
Ambulance Air or Water	0	0	0	0	1	N/A
IHS Provider-based Facility	0	1	0	0	0	N/A
IHS Free-standing Facility	0	0	0	0	1	N/A

**Services included from group home and below in this table comprise the "Other Listed Place of Service" category in the graph.

FIGURE 33: MEDICAID SPENDING BY PLACE OF SERVICE, FY13-FY14, MANAGED CARE

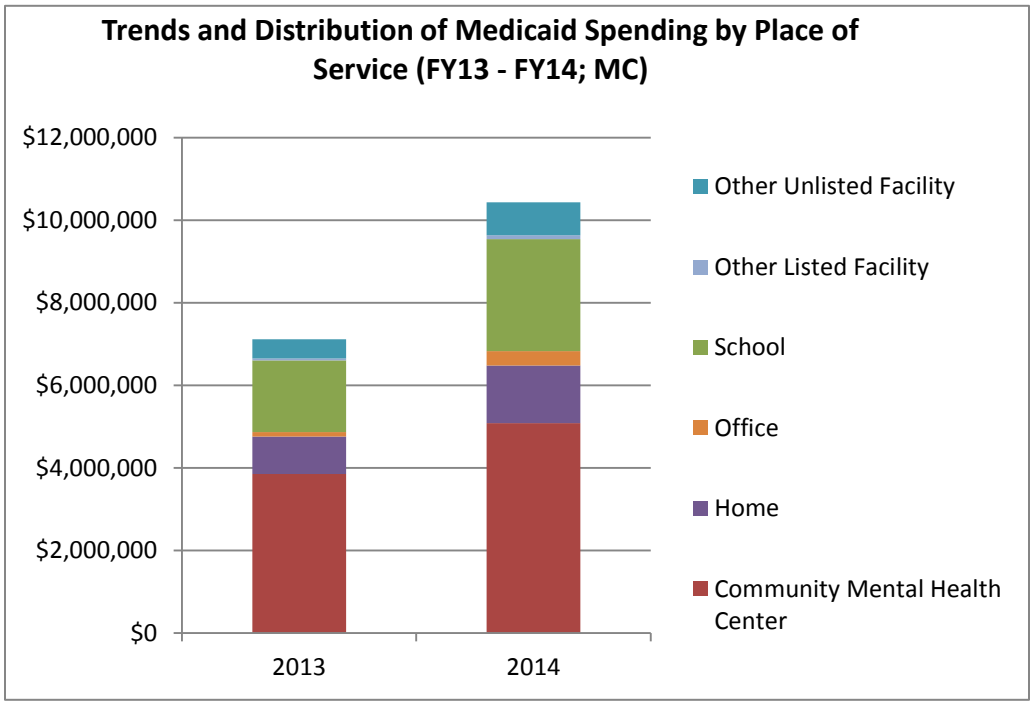


TABLE 13: TRENDS AND DISTRIBUTION OF MEDICAID SPENDING BY PLACE OF SERVICE (FY13 - FY14; MC)

	2013		2014	
Description	**Total Medicaid Payments**	**%**	**Total Medicaid Payments**	**%**
Community Mental Health Center	$3,850,050	54%	$5,080,401	49%
School	$1,738,958	24%	$2,707,561	26%
Home	$906,262	13%	$1,400,921	13%
Other Unlisted Facility	$457,952	6%	$798,201	8%
Office	$110,685	2%	$348,213	3%
Other Listed Facility	$47,490	1%	$96,148	1%

TABLE 14: TRENDS AND DISTRIBUTION OF YOUTH SERVED BY PLACE OF SERVICE (FY13 – FY14; MC)

Place of Service	**FY2013**	**FY2014**	**2-Year Average**
Community Mental Health Center	10,982	14,390	31%
School	3,754	5,499	46%
Home	3,321	4,666	40%
Other Unlisted Facility	1,504	2,095	39%
Office	809	1,838	127%
Inpatient Hospital	134	242	81%
Inpatient Psychiatric Facility	101	182	80%
Outpatient Hospital	29	152	424%
Rural Health Clinic	19	27	42%
Federally Qualified Health Ctr	6	27	350%
Group Home	1	25	2400%
ResdntlSbstnceAbseTrmtCntr	5	7	40%
Skilled Nursing Facility	3	5	67%
Emergency Room Hospital	2	1	-50%
Mobile Unit	0	2	N/A
Assisted Living Facility	0	1	N/A
Nursing Facility	1	0	-100%

Table 15: Number of Claims by Point of Service: Day Treatment

DAY TREATMENT	2010		2011		2012		2013		2014		% Change
	n	%	n	%	n	%	n	%	n	%	
CMHC	197,145	58%	153,530	57%	145,814	56%	108,763	52%	93,085	53%	-53%
Group Home		0%		0%		0%	2	0%	0	0%	N/A
Home	182	0%	886	0%	55	0%	34	0%	293	0%	61%
Independent Clinic		0%	1	0%		0%	0	0%	0	0%	N/A
Independent Laboratory		0%		0%		0%	0	0%	2	0%	N/A
Inpatient Psychiatric Facility		0%	3	0%		0%	0	0%	0	0%	N/A
Intermediate Care Facility-MR		0%		0%		0%	0	0%	4	0%	N/A
Office	673	0%	40	0%	41	0%	0	0%	1	0%	-100%
Other Unlisted Facility	53,695	16%	21,579	8%	21,133	8%	19,752	9%	13,937	8%	-74%
Outpatient Hospital		0%	2	0%		0%	0	0%	0	0%	N/A
Psych Facility Partial Hosp		0%		0%	1	0%	1	0%	1	0%	N/A
Psychiatric Resident Treatment Center	1	0%	1	0%		0%	0	0%	6	0%	500%
School	85,878	25%	92,194	34%	94,395	36%	81,464	39%	67,185	38%	-22%
Skilled Nursing Facility	9	0%	37	0%		0%	4	0%	0	0%	-100%
Total	**337,583**		**268,273**		**261,439**		**210,020**		**174,514**		

TABLE 16: NUMBER OF CLAIMS BY POINT OF SERVICE, MOBILE CRISIS

MOBILE CRISIS	2012		2013		2014		% Change
	n	%	n	%	n	%	
CMHC	222	72%	835	66%	987	44%	345%
Emergency Room Hospital		0%	12	1%	2	0%	N/A
Group Home		0%		0%	1	0%	N/A
Home	17	5%	93	7%	424	19%	2394%
Independent Laboratory		0%		0%	1	0%	N/A
Mobile Unit		0%		0%	2	0%	N/A
Office		0%	17	1%	36	2%	N/A
Other Unlisted Facility	47	15%	141	11%	358	16%	662%
School	24	8%	158	13%	447	20%	1763%
Total	**310**		**1,256**		**2,258**		

TABLE 17: NUMBER OF CLAIMS BY POINT OF SERVICE, COMMUNITY SUPPORT SERVICES

COMMUNITY SUPPORT SERVCIES	2012		2013		2014		% Change
	n	%	n	%	n	%	
CMHC	31,299	29%	42,091	21%	23,218	14%	-26%
Group Home		0%		0%	1	0%	N/A
Home	39,651	37%	86,519	44%	80,228	47%	102%
Nursing Facility		0%	1	0%		0%	N/A
Office		0%		0%	35	0%	N/A
Other Unlisted Facility	15,571	14%	25,715	13%	21,667	13%	39%
School	21,790	20%	42,414	22%	44,824	26%	106%
Skilled Nursing Facility		0%	4	0%		0%	N/A
Total	**108,311**		**196,744**		**169,973**		

TABLE 18: NUMBER OF CLAIMS BY POINT OF SERVICE, FAMILY THERAPY AND GROUP THERAPY

FAMILY THERAPY & GROUP THERAPY	2010		2011		2012		2013		2014		% Change
	n	%	n	%	n	%	n	%	n	%	
CMHC	21,347	23%	24,412	23%	23,946	19%	24,665	17%	27,796	17%	30%
Federally Qualified Health Ctr	19	0%	4	0%	6	0%	3	0%	2	0%	-89%
Group Home		0%		0%		0%		0%	6	0%	N/A
Home	23,340	25%	22,601	21%	24,784	20%	29,650	20%	32,544	20%	39%
Inpatient Hospital	23	0%	17	0%	24	0%	11	0%	2	0%	-91%
Nursing Facility		0%		0%	18	0%	4	0%		0%	N/A
Office	20,903	22%	25,646	24%	30,480	25%	44,983	31%	56,356	35%	170%
Other Unlisted Facility	6,902	7%	11,633	11%	19,915	16%	18,538	13%	14,851	9%	115%
Outpatient Hospital	494	1%	945	1%	619	1%	513	0%	912	1%	85%
PRTF	20	0%		0%		0%	3	0%	1	0%	-95%
Psychiatric Resident Trmt Cntr		0%		0%		0%		0%	1	0%	N/A
Rural Health Clinic	386	0%	393	0%	493	0%	319	0%	243	0%	-37%
School	20,681	22%	21,723	20%	22,536	18%	27,075	19%	30,022	18%	45%
Skilled Nursing Facility		0%	11	0%	3	0%	1	0%	1	0%	N/A
Total	93,729		107,385		122,824		145,765		162,737		

Response from Mississippi Department of Mental Health and Division of Medicaid

DMH is providing this draft report to The Clarion Ledger in response to a public records request. The attached draft document is an assessment of the state's adult behavioral health system developed by the Technical Assistance Collaborative (TAC) is the unedited, incomplete and in some areas inaccurate draft as it existed in 2015. It is the only draft of this report that was submitted by TAC. Because this document is an incomplete draft, DMH would like to clarify some of the information. No feedback was ever given to TAC by any of the agencies referenced. There is no appendix, no references, some information is inaccurate, and information is missing. For example: page 22 annual report data comparing 2014 and 2012 is inaccurate because this comparison includes duplicated numbers. Another factor to consider when reviewing the draft report is that the data hasn't been updated and doesn't reflect the current system. For example: in 2016 Mississippi had 16.2 inpatient beds per 100,000 people. In 2010, we had 39 inpatient beds per 100,000 people. At that time, Mississippi ranked number one in inpatient beds according to the Treatment Advocacy Center. In 2016, Mississippi ranked between 9 and 10.

- The State of Mississippi, as part of ongoing negotiations with the Department of Justice (DOJ), agreed to contract with TAC in 2014 to develop an assessment of the state's mental health system for adults. This assessment was to be used in those negotiations related to the DOJ. However, when DOJ walked away from the negotiations, the draft report was never completed.

- The draft TAC report is a review of: 1) Division of Medicaid (DOM) and Department of Mental Health (DMH) adult beneficiary/participant characteristics, and paid claims by DOM for behavioral health services for adults, and 2) programmatic documents provided by DMH and DOM, as well as information gathered during site visits and interviews conducted by TAC with stakeholders, adult consumers, family members, providers, associations, advocacy groups, and state personnel.

- This draft report reflects information that was gathered nearly three years ago. Since the draft TAC report was developed, the state has made strides in all five recommendation areas listed on page 4. On page 33 of the draft, it states that "there have been changes to the array of behavioral health services and supports as a result of DMH initiatives as well as modifications to the Medicaid program." Further, the landscape of the Medicaid program has changed rather significantly since the draft report was developed, specifically in regards to managed care.

- The state is expanding community-based services and will continue to in the future. DMH's focus will remain on the mission of the agency and building up direct services in the community through partnerships with Community Mental Health Centers, advocacy groups, and other providers to ensure capacity is available to reduce the reliance on inpatient institutional services. However, this is a process. Over the last 10 years, the number of adult psychiatric beds at Mississippi State Hospital (MSH) and East Mississippi State Hospital (EMSH) has been reduced by 500.

- Over the last five years, many new community-based services have been expanded including Mobile Crisis Response Teams, PACT Teams, Supported Employment, Wraparound Facilitation for children and youth, Adolescent Intensive Outpatient Programs, increase in ID/DD Home and Community Based Wavier slots, and others.

Mississippians should have the opportunity to live and be included in their community. Services must be provided on a continuum of care that addresses a person's current health and their current needs. Those needs may range from outpatient therapy, to case management, to crisis services or, as a last resort, commitment to a behavioral health program. In all of these areas, we must keep our focus person-centered.

Below are highlights of progress made that is directly related to areas in the TAC report. This progress has been a joint collaboration between DMH, DOM, Department of Corrections, Community Mental Health Centers, Mississippi Home Corporation, and other partners.

- **Crisis Services:** DMH provides grant funding to all 14 Community Mental Health Centers (CMHCs) for Mobile Crisis Response Teams to serve children and adults. These teams also use funds for community education and outreach to schools, youth courts, and other community organizations. In FY17, the teams provided 15,668 face-to-face interventions and responded to a total of 23,168 calls. These teams provide crisis response services to everyone, children and adult, regardless of insurance or ability to pay.

- **Crisis Services:** Through a federal grant, DMH was able to pay for Crisis Intervention Training (CIT) for up to 40 law enforcement officers from throughout the state each year from 2015 through 2017. In FY16, three classes of officers were trained, resulting in 38 officers receiving certification in Crisis Intervention Training.

- **Certified Peer Support Specialists:** There are approximately 149 Certified Peer Support Specialists (CPSS) currently in Mississippi's public mental health system. CPSSs have been included on Mobile Crisis Response Teams, PACT Teams, Supported Employment pilot sites, and other areas throughout the public mental health system. A CPSS is an individual or family member of an individual who has self-identified as having received or is presently receiving behavioral health services. A CPSS has successfully completed formal training recognized by DMH and is employed by a DMH Certified Provider. These individuals use their lived experiences in combination with skills training to support peers and/or family members with similar experiences.

- **Peer Bridger Project:** The Recovery Peer Bridger Project was started in the fall of 2015 in North Mississippi to improve the transition process from inpatient care to a community based level of care. The pilot project has three objectives: decrease the need for readmissions; increase the number of individuals who attend follow-up appointments by offering insensitive crisis peer support services through the use of Peer Bridger; and help individuals transition back into their communities.

- **Programs of Assertive Community Treatment:** Prior to FY15, Mississippi had only one PACT team. DMH used legislative funding to add five PACT Teams and Balancing Incentive Program funding for two PACT Teams. Mississippi now has eight PACT Teams operated by Community Mental Health Centers. PACT is a mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient/community services. Clinicians and community support specialists from multidisciplinary backgrounds compose the PACT teams, and every team member shares responsibility for addressing the needs of the individuals served. The PACT teams are mobile and deliver intensive services in the community that are tailored to each individual to address his or her goals and

preferences. In FY16, there were 85 new admissions to PACT Teams in addition to the 164 already being served. In FY17 (as of May 31, 2017), 387 were served by PACT teams.

- **Housing:** In 2015, the Mississippi Home Corporation received funding from the Mississippi Legislature to partner with DMH to develop an integrated permanent supported housing project. This project helps ensure people with a serious mental illness who are housed as a result of permanent supportive housing have the opportunity to live in the most integrated settings in the community of their choice by providing an adequate array of community supports/services. This program began implementation in March 2016. Known as CHOICE—Creative Housing Options in Communities for Everyone—it provided housing vouchers to 48 people during FY16. Through the first half of FY17, 92 people were housed under the CHOICE program.

- **Housing:** Cooperative Agreement to Benefit Homeless Individuals (CABHI) is a three-year grant from SAMHSA to enhance/develop the infrastructure of Mississippi and our treatment service system to increase capacity to provide accessible, effective, comprehensive, coordinated, integrated, and evidence-based treatment services; permanent housing; peer supports; and other services to individuals who experience homelessness. Twelve of the state's 14 Community Mental Health Centers participate in CABHI, which served 454 people in FY16.

- **Supported Employment:** In January 2015, DMH provided funding to develop four pilot sites to offer Supported Employment to 75 individuals with mental illness. In FY16, the DMH Supported Employment Pilot Program assisted 108 individuals on their road to recovery by helping them to become employed in the openly competitive job market. An additional two pilot sites were funded in FY17. Supported Employment, an evidenced-based way to help people diagnosed with mental illnesses secure and keep employment, begins with the idea that every person with a serious mental illness is capable of working competitively in the community.

- **Jail Diversion:** DMH and the Department of Corrections has developed the Second Chance Reentry Program aimed to reduce recidivism by addressing untreated co-occurring substance use and mental health disorders in offenders under community supervision. It allows the two departments to improve identification of inmates with co-occurring substance use and mental health disorders, provide training to staff, integrate individualized treatment plans and track participant outcomes. As the program begins, it will focus on non-violent offenders returning to Hinds County. Current plans are to serve 90 individuals during the three-year pilot program in order to develop a program model that can be replicated statewide with the receipt of additional federal grant funding.

In addition, the State has made progress to expand community-based services using Balancing Incentive Program (BIP) funding to improve access to long term services and supports (LTSS). Below are some of the efforts.

- **Supported Decision-Making Model:** The Arc of Mississippi developed the Supported Decision-Making Model in response to findings from the Department of Justice highlighting the common practice in Mississippi for individuals with ID/DD to waive all of their decision-making rights to a guardian, regardless of the individual's level of cognitive function. The Arc of Mississippi sought to develop

resources for individuals with ID/DD that enable them to retain as much choice and control as possible over the decisions in their lives. The Supported Decision-Making Model provides ongoing, case-by-case support to individuals with ID/DD so that they have a continuing resource to ensure informed decision-making.

- **DETECT:** DMH used funding to create DETECT, a program that provides educational, training, and clinical support services to providers in addition to helping patients with ID/DD find community-based healthcare providers. DMH developed DETECT due to concern that the medical providers in the state were not equipped to treat the growing number of individuals with ID/DD moving out of institutions into the community. DETECT provides various support services to any type of medical or dental provider in Mississippi interested in caring for patients with ID/DD. Support is provided through webinars, live presentations, and clinical consultations. DETECT has also created partnerships with medical residency programs in Mississippi to strengthen resident training. Additionally, individuals with ID/DD or their caregivers can utilize DETECT services to locate healthcare providers in their community who are equipped to meet the special needs of patients with disabilities.

- **Expanding Community LTSS:** DOM has transitioned 503 people as of June 30, 2017 from institutional settings into home and community based settings since February 2012. This was done through the Money Follows the Person Grant known as Bridge to Independence in Mississippi. This program was designed to offer people choice, provide empowerment and improve quality of life, while in turn, shifting LTSS spending from institutional to Home and Community Based Services.

  Under the Balancing Incentive Program, DOM has directly expanded access to community LTSS through additional waiver slots and services under 1915(i). Of the $76.3 million award, more than $44 million has been spent on service enhancements. The Elderly and Disabled Waiver, the largest waiver, increased the number of people served from 16,060 in 2012 to 18,758 in 2014. The ID/DD Waiver grew from 1,843 people served to 2,357 as of April 30, 2016, under the Program. Mississippi also established a 1915(i), which provides day habilitation and prevocational services. As of March 2016, approximately 230 individuals were receiving services under 1915(i). Mississippi's largest challenge in opening these slots and launching 1915(i) was contracting additional case managers to oversee care plan implementation.

- **Developing Innovative Community LTSS Programs:** DOM is using BIP funds to develop a variety of innovative community LTSS programs. Some of these programs, such as the Children's Collaborative, the Autism Pilot, and the Program of Assertive Community Treatment (PACT), are intended to support direct services and improve care coordination. Other programs, such as the Developmental Evaluation, Training and Educational Consultative Team (DETECT), and the Supported Decision-Making Model, are designed to expand the resources available to individuals seeking community LTSS and enhance the quality of those services.

- **Children's Collaborative:** A University of Mississippi Medical Center (UMMC) team developed the Children's Collaborative with the financial support of the Balancing Incentive Program to improve the fragmented and difficult-to-navigate children's behavioral healthcare system in Mississippi. The Children's Collaborative aims to increase access to community LTSS for children by combining specialized behavioral health services into a single system of care. To achieve this aim, the Children's Collaborative has formed partnerships with several organizations that employ licensed behavioral

therapists throughout Mississippi. The expertise of the UMMC team and the reach of these therapists help children throughout the state, regardless of their insurance status, receive the care they need in a coordinated manner.

Patients enter the Children's Collaborative at UMMC, where they are treated by a "dyad," composed of a physician and a clinical psychologist. The dyad assesses the patient's full range of needs and then refers the patient to relevant partnering organizations for further treatment to address those health needs. An example of a partnering organization is Mississippi Children's Home Services (MCHS)—an organization that provides care and therapy to children and families in their homes and other familiar community settings. Partner organizations use standardized care models, developed by PracticeWise, with oversight of UMMC. Through March 2016, the Children's Collaborative had served more than 1,000 children.

- **Autism Pilot**

  The Autism Pilot provides specialized behavioral therapy geared toward children with autism. The Autism Pilot was created by MCHS in response to the lack of early intervention services for youth on the autism spectrum in Mississippi. The pilot, which first began in February 2014, is designed to serve up to 60 children. Participants can receive anywhere from a few hours of community-based assistance a week to 20 hours a week of intensive one-on-one behavioral therapy in a clinical setting. MCHS used BIP funding to support the Autism Pilot by acquiring a clinic to house the program, hiring staff, and providing ongoing education and training to the clinical team.

All of these examples above, as well as others not mentioned, speak to the progress Mississippi has made since the TAC report was written.

Introduction

Overview and purpose

In 2011 the U. S. Department of Justice (DOJ) launched an investigation of the State of Mississippi's system for delivering services and supports to individuals with mental illness and/or developmental disabilities. Their review found that the State of Mississippi failed to meet its obligations under Title II of the American with Disabilities Act (ADA), 42 U.S.C. § § 12131-12134, and its implementing regulations, 28 C. F. R. pt. 35, by unnecessarily institutionalizing individuals with mental illness or developmental disabilities in public and private facilities and failed to ensure that they are offered a meaningful opportunity to live in integrated settings consistent with their needs. Specifically, DOJ found the state in violation of Olmstead v. L.C., 527 U.S. 581 (1999), which requires that individuals with mental illness and developmental disabilities receive services and supports in the most integrated setting appropriate to their needs.

Following receipt of DOJ's findings, the Mississippi Legislature appropriated $10 million in FY 2014 and $16.1 million in FY2015 to the Department of Mental Health (DMH) to expand the provision of community-based services for individuals with serious mental illness and for individuals with Intellectual and Developmental Disabilities. In addition, DMH retained the Technical Assistance Collaborative (TAC) in the spring of 2014 to develop a strategic plan to expand permanent supportive housing (PSH) in Mississippi for persons with mental illness and other disabilities and high need populations. TAC is a national nonprofit organization that provides policy leadership, technical assistance and consultation for many federal, state and local government agencies on such topics as mental health, substance use, developmental disabilities, homelessness, and affordable housing systems, and is recognized for its expertise in working with states to facilitate the development of systems designed to support community integration for persons with disabilities.

As part of the strategic planning process, TAC reviewed various community-based housing sites and interviewed a wide spectrum of key informants about the housing needs of individuals with disabilities in Mississippi. Just prior to issuing the final report, *A Statewide Approach for Integrated Supportive Housing,* the Mississippi Office of the Attorney General and DOJ signed an agreement (August 29, 2014) designed to provide a framework for the parties to reach a resolution on all issues. Among the commitments in the letter, the State of Mississippi agreed to provide expanded services for adults with mental illness and people with intellectual and developmental disabilities.

Per the letter, the State retained TAC to "…provide technical assistance to the State at the State's direction and in collaboration with the Department of Justice…," and to perform "assessments of existing services, guidance on program development, and recommendations related to program improvement," with a focus on the following:

- The development of permanent supportive housing and the dedicated permanent supported housing fund;
- The transition of individuals with serious mental illness from institutions to the community using permanent supported housing; and
- The implementation of intensive supports for individuals with serious mental illness in permanent supported housing, including Assertive Community Treatment.

TAC has continued to provide technical assistance and support for the development and funding of PSH. In addition, staff has conducted a thorough assessment of the services and system that support adults with serious mental illness and addictive disease. The purpose of this report is to inform negotiations between the State of Mississippi and DOJ. This report presents TAC's findings based on culmination of extensive information gathering and analysis, and identifies several recommendations to increase the availability of and accessibility to services and housing in Mississippi for individuals with serious mental illness and intellectual and developmental disabilities.

Our review is consistent with various reports identified throughout this document that have reviewed and ranked Mississippi's mental health system at or near the bottom on many measures. It is clear that there are many well intentioned and committed individuals working in the system, but until there is collective ownership of the problem, many individuals with mental illness will continue to fall through the cracks and end up in costly state hospitals or jails, or live in homelessness or substandard housing. It is our opinion that responsibility and accountability for successful reform of Mississippi's public mental health system must not fall solely on the shoulders of DMH, and must be acknowledged and shared by all involved, including DOM, State housing, transportation, employment agencies, the Mississippi Legislature, county government, CMHCs and other providers, and consumers and families.

Methodology

Mississippi DMH engaged TAC to conduct an assessment of Mississippi's adult behavioral health system and to identify recommendations to assure ready access to an array of services needed for individuals to live successfully in permanent supportive housing. Per the Augusts 29 letter between Mississippi and DOJ, the adult services assessment was commissioned concurrently with a similar assessment of Mississippi's behavioral health system for children and adolescents. To perform the children's assessment, TAC subcontracted with the University of Maryland, Institute for Innovation and Implementation (The Institute) with system expertise in successfully serving children with significant behavioral health needs in community settings. Since both assessments involved many of the same agencies and stakeholders, TAC and The Institute staff parceled out a number of on-site visits and conducted analysis of both children and adult services at these locations.

The adult services needs assessment was conducted between October, 2014 and February, 2015. TAC's approach to information gathering for this assessment was twofold: 1) A quantitative analysis of Mississippi Division of Medicaid (DOM) and DMH participant characteristics, claims, and encounters; and

2) An in-depth qualitative analysis of all relevant documents, site visits and interviews with stakeholders, adult consumers, family members, providers, associations, advocacy groups, and state personnel.

TAC applied a multifaceted approach to gathering information, including conducting a literature review, synthesizing quantitative and qualitative data, interviewing stakeholders and key informants, and applying TAC's extensive expertise analyzing similar data in other states. Specifically, methods included:

- Data analysis of populations served, service utilization, Medicaid claims, quality data, and other system indicators from DOM and DMH.
- National and state document reviews.
- Site visits to state operated services and Community Mental Health Center (CMHC) programs.
- Key informant interviews.
- CMHC surveys.

The state provided quantitative data from DMH and DOM. Data from DMH included state operated services utilization, crisis services utilization, Uniform Reporting System reports and DMH certified providers. Community Mental Health Center data included selected adult services utilization and funding information.

DOM provided five years of Medicaid fee for service claims data (2010-2014) and two years of managed care data (2013-2014) which coincided with implementation of managed care in the State. This data included Medicaid enrollment, utilization, place of service and expenditures for behavioral health services.

TAC reviewed documents and literature from a variety of sources, including DMH, DOM, and the Department of Health as well as the CMHCs. The State identified and provided numerous legislative and other reports, policy, quality, and procedural documents for review. CMHCs provided program literature, service descriptions and budget information. In total, XX number of state documents were provided or researched from DMH, DOM and DOH; CMHCs provided XX additional sources of information. These documents offered details on system indicators and issues being tracked by the programs, and policy and quality issues identified and monitored by leaders in various state agencies as well as the CMHCs. A listing of documents provided or researched can be found in Attachment XX.

A significant part of the qualitative analysis involved engaging and interviewing a broad array of stakeholders. TAC conducted interviews with over XX people individually and in small focus groups. These individuals included adult consumers and families, state personnel, DMH Board members, Medicaid Coordinated Care Organizations (CCOs) and the Utilization Management/Quality Improvement Organization (UM/QIO), CMHC executive leadership and direct care staff, advocates, and associations. State officials and DOJ identified an initial group of key informants for each of the identified topic areas and this initial group of informants identified additional subject matter experts. Interviews were confidential and were not conducted in the presence of DMH or DOM staff with the exception of the CCO and Central Mississippi Residential Center interviews. A complete listing of Adult Services key informants can be found in Attachment XX to this chapter. Please note that names of consumers and

some family members are not included in order to maintain their confidentiality as service recipients; however, they are included in aggregate numbers.

Interviews with key informants took place in person, telephonically and via onsite-visits. The first onsite-visit occurred from October 21st to October 23rd and included meetings with state leadership from DMH, DOM, mobile crisis and stabilization providers, advocates and CMHC leadership. The second site-visit took place from November 10th to November 13th and consisted of visits to a statewide sample of behavioral health service providers, including state hospitals, CMHCs, crisis services, psychosocial rehabilitation programs and mental health and Alcohol and Drug (A&D) residential programs. In all, TAC and The Institute staff visited XX total providers and XX provider sites located throughout the state. Please refer to the map below and Attachment XX for a complete listing of the providers visited. The themes that emerged from these meetings, interviews and reviews of written materials are included throughout this report.

TAC used the information learned during the environmental scan, empirical knowledge of best practices, systems expertise, and analysis of Mississippi data to develop a list of actionable recommendations for Mississippi to implement. These recommendations include:

1. *Assuring an Effective Array of Services for Adults.* Recommendations in this chapter focus on implementing and financing an effective array of covered services across Medicaid and DMH, focusing on services and supports necessary to help individuals succeed in permanent supportive housing. This chapter identifies methods to enhance services available under Mississippi's Rehab option, including Program for Assertive Community Treatment teams (PACT), mobile crisis response and stabilization services, Psychosocial Rehabilitation, Community Support Services and Peer Support services based on national models, as well as adding the Evidence-based practice of Supported Employment to the continuum.
2. *Expanding Capacity/Enhancing Services.* This chapter addresses the impact of inadequate funding for behavioral health services, including disparities in access to Mississippi's Core Services for Adults; limitations of service provision; workforce shortages; workforce competencies; and explores provisions to expand and improve provider capacity.
3. *Improving and Monitoring Quality*. This chapter identifies quality priorities, and necessary processes and measures to promote quality across adult behavioral health services.
4. *Promoting interagency collaboration*. This chapter addresses governance structures, interagency priorities and processes to build an effective system that eliminates barriers, builds bridges and promotes access to life in the community with Recovery supports.
5. *Defining the role for institutional care*. This chapter identifies several factors contributing to Mississippi's over-reliance on state hospital services, and provides a framework for establishing a clear role and expectations for state operated services within a continuum of care for adults with behavioral health disorders.

State context

Mississippi is a predominantly rural state, the fourth most rural state in the country with about 51 percent of its population living in a rural area (compared to 19 percent nationally).[1] Only three cities in the state have populations in excess of 50,000 including Jackson, the state capitol; Gulfport, a center for tourism along the Coast; and Hattiesburg, home of the University of Southern Mississippi. According to information from Northeast Mississippi Area Health Education Center at Mississippi State University, as of April 2012, approximately 2.1 million Mississippi residents reside in a mental health professional shortage area with an estimated 1.1 of those residents considered "underserved."[2] In addition to its rural nature, the state is one of the poorest in the nation, ranking 4th in Poverty. The unemployment rate among adults is about 9 percent, the third highest in the country[3] and 32 percent of high school students do not graduate on time, the second highest rate in the country[4]. The state ranks nationally at or near the bottom for most health indicators.[5]

The state continues to recover from the devastation incurred by a number of natural disasters, most notably Hurricanes Katrina and Rita. Tornadoes have also devastated communities, including one within the past year which destroyed one of the region's only mental health programs. Even with Federal assistance, the need to re-build its economy has taken precedence for the state, compromising its ability to strengthen its community-based health and social services. Yet these same crisis incidents have increased demand for these community services which were already woefully underfunded.

In FY 2013 Mississippi's public community mental health system served 73,244 adults, ages 18 and older; 88 percent met the federal criteria for Serious Mental Illness. [6] In 2013, Mississippi's mental health authority, the Department of Mental Health (DMH), spent about $163 million on mental health services for children and adults, compared to a national average of $190 million. Nationally, state mental health authorities (SMHAs) spent an average of 71.1% of their total budgets on community-based programs for adults and 25.7% of their total budget on state mental hospitals. Conversely, DMH spent 77% of its mental health budget on state mental health hospitals for adults and 21% on community services; only seven other states in the country have similar spends. Mississippi was one of only 8 states that spent more on state hospital services than community-based care in 2013. Mississippi ranked 49th lowest in the country for community-based mental health expenditures for adults.[7]

[1] U.S. Census Bureau. [2010]. Urban, Urbanized Area, Urban Cluster, and Rural Population, 2010: United States.

[2] Northeast Mississippi Area Health Education Center at Mississippi State University. (n.d) Healthcare Infrastructure Shortage Areas. Retrieved on November 17, 2014 from: http://nemsahec.msstate.edu/?page_id=437

[3] U.S. Department of Labor, Bureau of Labor Statistics (BLS). Local Area Unemployment Statistics, Annual Average, "Unemployment rates for states, [2013]

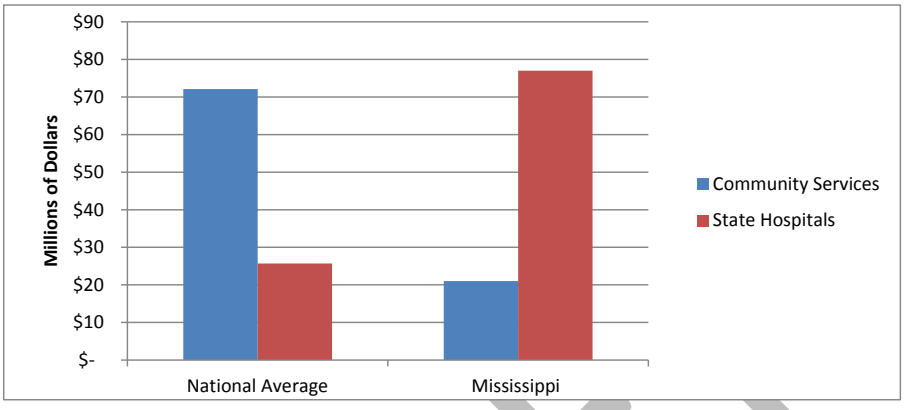
[4] Population Reference Bureau, analysis of data from the U.S. Department of Education.
U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), State Dropout and Completion Data, accessible online at http://nces.ed.gov/ccd/drpcompstatelvl.asp

[5] http://cdnfiles.americashealthrankings.org/SiteFiles/AnnualDownloads/Americas%20Health%20Rankings%202014%20Edition.pdf

[6] http://www.samhsa.gov/data/sites/default/files/URSTables2013/Mississippi.pdf

[7] http://www.nasmhpd.org/docs/TAC%20Assessment%20PDF%20Report/Assessment%2010%20-%20Expenditures.pdf

Figure 1: State Mental Health Authority- Controlled Mental Health Expenditures at State Psychiatric Hospitals and Community-Based Programs for Adults



In addition to DMH funding, the Division of Medicaid is a significant financer of community-based care for individuals eligible for Medicaid health insurance. In FY 2014, Medicaid fee-for-service and managed care claims accounted for $64.3 million for outpatient (non-hospital) mental health services for adults ages 21 and older. Mississippi has strict Medicaid eligibility criteria for adults, though people with a serious mental illness who meet Social Security Disability criteria are eligible. Nationally, states spend on average $16,643 per Medicaid enrollee with a disability while Mississippi spends $10,450.[8]

Key State Agencies

The Department of Mental Health and the Division of Medicaid are the predominant programs responsible for administering and funding Mississippi's behavioral health system for adults. While other agencies interact with the behavioral health system and helped to inform findings and recommendations throughout this report, the scope of this study did not include an assessment of behavioral health services administered by agencies other than DMH and DOM.

Department of Mental Health

Mississippi's public behavioral health system is administered by the Department of Mental Health (DMH). DMH is organized into three components: The Board of Mental Health, the DMH Central Office, and DMH-operated Programs and Community Services Programs. The Board of Mental Health is responsible for governing DMH and includes a physician, a psychiatrist, a clinical psychologist, a social worker with relevant experience, and citizen representatives. The Central Office oversees administrative functions of DMH and implements policies set forth by the State Board of Mental Health. The DMH Central Office is divided into six bureaus, including the Bureau of Administration, the Bureau of Mental

[8] http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/?state=MS

Health, the Bureau of Community Mental Health Services, the Bureau of Alcohol and Drug Services, the Bureau of Intellectual and Developmental Disabilities, and the Bureau of Quality Management.

Established within the Bureau of Community Services, DMH's Division of Adult Services has the primary responsibility for developing, implementing, expanding, and monitoring a comprehensive continuum of services for adults with serious mental illness, as well as to assist with the care and treatment of persons with Alzheimer's disease/other dementia. The Division also allocates financial resources and coordinates the establishment of programs. Some federal and state funds for direct community mental health services for adults are provided by grants between the DMH and the regionally organized CMHCs and/or other public or private non-profit mental health service providers.

The components of the behavioral health delivery system include: DMH-operated programs, regional community mental health centers (CMHCs), and other nonprofit/profit service agencies/organizations that provide community services and/or institutional services.

State-operated programs.

The Department of Mental Health administers and operates five behavioral health programs for adults. Four of the programs provide inpatient services for adults with serious mental illness and substance abuse; and one program provides supported living and crisis stabilization:

- East Mississippi State Hospital in Meridian provides 120 acute, intermediate and continued psychiatric care beds; and 25 alcohol and drug treatment beds.
- Mississippi State Hospital in Whitfield provides 315 acute, intermediate and continued psychiatric care beds; and 80 alcohol and drug treatment beds.
- North Mississippi State Hospital in Tupelo provides 50 acute psychiatric care beds.
- South Mississippi State Hospital in Purvis provides 50 acute psychiatric care beds.
- Central Mississippi Residential Center in Newton provides 48 supervised living, 24 supported living and 16 crisis stabilization beds.

In addition, Mississippi State Hospital and East Mississippi State Hospital provide Nursing Home Services, and MSH provides Medical/Surgical Hospital Services and Forensic Services. The majority of state hospital psychiatric beds are identified for acute psychiatric care, though MSH and EMSH provide continued care beds. Mississippi ranks first in the nation for the number of state psychiatric inpatient beds, adjusted per total population.[9]

Table 1: 2010 Public Psychiatric Beds/100,000 Total Population

State	Number of beds 2010	2010 beds/ 100,000 total population	State ranking per capita (highest to lowest)
Mississippi	1,156	39.0	1
South Dakota	238	29.2	2
New York	4,958	25.6	3
Kansas	705	24.7	4
Alabama	1,119	23.4	5

[9] http://tacreports.org/tables

Delaware	209	23.3	6

Table 2: Rate of Admissions for SMI Population

State	State Psychiatric Hospital Admissions 2012 (1)	State SMI Rate (2)	Adults w/ SMI (3)	Rate of SMI admitted to state psychiatric hospitals (4)		
US	125,321	3.97	9,637,318	1%		
MS	3,073	4.69	105,671	3%		
GA	7,034	3.66	274,722	2.50%		
LA	1,964	3.56	124,896	1.50%		
NC	2,676	3.92	296,508	0.90%		
IA	793	4.12	97,592	0.80%		
OR	821	4.6	141,300	0.58%		
PA	1,125	4.06	408,390	0.30%		

1. SAMHSA URS Tables; Most recent 2012

2. NSDUH 2014 Rate of SMI

3. Based upon US Census Adult population Data (2013)

4. Number of admissions divided by number of SMI in state.

Table 3: Number of Adult Admissions and Average Length of Stay in Days by State Hospital, 2014

Facility	Admissions		Ave Length of Stay	
	MH	A&D	MH	A&D
East Mississippi State Hospital	589	316	41	26
Mississippi State Hospital	1,093	754	99.03	37.21
North Mississippi State Hospital	475	N/A	34 (acute only)	N/A
South Mississippi State Hospital	632	N/A	27 (acute only)	N/A
	T = 2,789	T = 1,070		

As stated in Section 159 of the Mississippi Constitution, admission to a state hospital for both mental health and substance abuse treatment beds is dictated by order of a Chancery Court Judge. There are 20 Chancery Court districts and 49 Chancery Court judges in Mississippi. The number of chancery judges per district ranges from one to four. Chancery Court judges are selected in non-partisan elections to serve four-year terms. While it is the role of the Court to determine if an individual meets the standard for involuntary mental health commitment, the court may or may not engage the regional behavioral health authority in an attempt to divert an individual from inpatient care.

Community Mental Health Centers

The Regional Commission Act provides the structure for Mississippi's mental health service system and program development by authorizing the 82 counties to form multi-county regional commissions on mental health. Regional commissions are authorized to plan and implement mental health and intellectual or developmental disability programs in their respective areas, delivered through community

mental health centers (CMHCs). There are currently 14 CMHCs operating in the State, funded by a combination of local, state, and federal dollars, forming the backbone of Mississippi's public, community behavioral health service delivery system. DMH certifies the centers to provide services and monitors state and federal dollars allocated to them via DMH. The primary goals of the CMHCs are to:

- Provide accessible services to all citizens with mental illness, and emotional and substance use disorders
- Reduce the number of initial admissions to the state hospitals
- Prevent re-admissions through supportive aftercare services

CMHCs operating under the authority of regional commissions must provide the following core services for adults in each county in the CMHC's entire catchment area:

Table 4: Medicaid and DMH funded behavioral health services for adults

Outpatient Therapy
Community Support Services
Psychiatric/Physician Services
Emergency/Crisis Services
Inpatient Referral
Pre-Evaluation Screening for Civil Commitment
Peer Support Services
Targeted Case Management Services
Support for Recovery/Resiliency Oriented Services
Substance Abuse Outpatient
Prevention Services
Primary Residential Treatment Services

Private behavioral health providers

The use of private providers in the public behavioral health system outside of CMHCs is very limited in Mississippi. A few private mental health providers are certified by DMH and receive DMH funding to provide targeted services for adults or services in targeted geographic areas. Two providers offer Core services in Jackson, and another offers Core services to individuals with Cognitive impairments. DMH also contracts with private for acute care partial hospitalization and specialized mental health holding beds.

Division of Medicaid

The "Mississippi Administrative Reorganization Act of 1984," established the powers and responsibilities of the Division of Medicaid in the Office of the Governor. The Division of Medicaid is the single state agency designed to administer the Medicaid Program. The duties of the Division of Medicaid Agency are set out by State and Federal legislation and the approved Mississippi State Plan and include setting regulations and standards for the administration of the Medicaid programs, with approval from the Governor, and in accordance with the Administrative Procedures Law.

DOM's Office of Mental Health oversees mental health programs and it is comprised of two divisions, the Mental Health Services Division and the Special Mental Health Initiatives Division. The Mental Health Services Division is responsible for:

- Acute freestanding psychiatric facilities
- Community/private mental health centers
- Outpatient mental health hospital services
- Pre-admission screening and resident review
- Psychiatric units at general hospitals

The Special Mental Health Initiatives Division administers:

- Federally qualified health centers and rural health clinics
- In-patient detoxification for chemical dependency
- Intellectual disabilities/developmental disabilities
- Psychiatric services by physician or nurse practitioner

In 2011, Mississippi implemented a coordinated care program for Mississippi Medicaid beneficiaries called the Mississippi Coordinated Access Network (MississippiCAN) under a 1932(a) State Plan Authority. Managed by the DOM Bureau of Coordinated Care, MississippiCAN employs two coordinated care organizations (CCOs), Magnolia Health Plan and United Healthcare that offer the full range of Medicaid benefits to enrollees, including all outpatient mental health services and excluding inpatient hospital services, Waiver services, and transportation services. MississippiCAN is available in all 82 counties, and covers 45 percent of Medicaid beneficiaries, primarily adults.

Services that are not covered under MississippiCAN (inpatient hospital services, Waiver services, and transportation services) are provided through Mississippi Medicaid's traditional fee-for-service system. Both non-managed care enrolled Medicaid beneficiaries and fee-for-service benefits are managed by eQHealth Solutions (eQHealth), which serves as the state's Utilization Management and Quality Improvement Organization (UM/QIO). The eQHealth conducts prior authorizations and quality of care reviews for beneficiaries enrolled and services covered in the fee-for-service system.

As of December 31, 2014, there were 340,326 adults enrolled in Mississippi Medicaid. Of this total, 185,307 (54%) were enrolled in the state's managed care program and 155,019 (46%) were enrolled in the traditional fee-for-service program. Of those adults enrolled in Medicaid, 33,626 used some type of behavioral health service in SFY 2014. This number is a combined number across both managed care and fee for service thereby representing some duplication in the count of total utilizers.

Assuring an Effective Array of Services

The Affordable Care Act (ACA)" recognizes that prevention, early intervention and when necessary, treatment of mental and substance use disorders are an integral part of improving and maintaining overall health. In articulating how these conditions should be addressed in a transformed and integrated

system, in 2010 SAMHSA released a brief describing a "good and modern" mental health and substance abuse system[10]. As outlined in this brief, a modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. A modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective.

The vision for a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. The goal of a "good" and "modern" system of care is to provide a full range of high quality services to meet the range of age, gender, cultural and other needs presented in order to maintain individuals in their communities. The interventions that are used in a good system should reflect the knowledge and technology that are available as part of modern medicine and include evidence-informed practice; the system should recognize the key role of community supports with linkage to housing, employment, etc. A good system should improve the lives of Mississippians.

Table 5: Elements of a Good and Modern System for Adults

Health Homes	Prevention / Wellness	Engagement	Outpt/ Med Mngmt	Community Supports	Intensive Supports	Other Living Supports	Out of Home Res	Acute Intensive	Recovery Supports
Access to medical care Care coordi-nation	SBIRT Warm Lines Relapse Prevention Wellness Recovery	Motivational Interviewing Assmnt Service Plng Including Crisis Plng	Individual EBTs Group Therapy Family Therapy Med Mngmt Pharma-cotherapy Med Assisted Therapy	Psychosocial Rehab (skill-Building) Case Mgmt Supported Employment Permanent Supported Housing Recovery Housing	PACT Partial Hospital Programs Intensive Outpt Intensive Case Mgmt	Trans Recreation Social Activities Interact Commun Technolog Devices	Crisis Residence Crisis Stabilization A&D Res Treatment	Mobile Crisis 24/7 Crisis Phone Line 24-hr Clinical Care	Peer Support Recovery Coaches Peer Run Drop In Self Directed Care

Expanding Beyond Core Services

Core services provide a system framework but are not comprehensive, flexible, intensive or accessible enough to meet the needs of many individuals with SMI, and do not include the service array as identified by SAMHSA's Good and Modern System. As a result, the insufficiency of core services to

[10] http://www.samhsa.gov/healthReform/docs/good_and_modern_4_18_2011_508.pdf.

support adults in PSH and other integrated community settings results in an over-reliance on crisis oriented and institutionally-based care. In addition to the Core Services, CMHCs are able, but are not required, to request certification from DMH, to provide more comprehensive services to address additional needs of adults they serve. Additional non-core services may include acute partial hospitalization, psychosocial rehabilitation services, supported employment and Community Living Services. Every CMHC provides psychosocial rehabilitation services and about half of the CMHCs provide Community Living Services; No CMHC provided Supported Employment for adults with serious mental illness. In order for individuals to live successfully in their communities, TAC asserts that the array of services should be expanded in order to provide the necessary supports for individuals with mental health disorders and addictive disease regardless of which county/region they reside. Among the services that should be expanded include the following.

Program of Assertive Community Treatment

In an effort to create readily accessible treatment for individuals with frequent utilization of inpatient and Crisis Services, in 2011 DMH approved Regions 6 and 15 to re-allocate existing funds to create Program of Assertive Community Treatment (PACT) teams. Each region created the multi disciplinary team, had team members participate in extensive training and has conducted repeated Fidelity reviews. These initial teams have experienced marked reductions in inpatient utilization and increased residential stability with persons served. However, the Teams were both established in rural areas of the state, creating multiple challenges to implementing, delivering and sustaining the full benefits of the service. Neither team is operating at full capacity, based on the Rural PACT team staff to client ratio. The inability or unwillingness of the CMHCs to expand the territory served by the Teams has resulted in underutilization of the service, with less than 50 persons supported by each team. Team Leaders report that attempts to engage individuals, especially persons with significant histories of substance abuse, often are unsuccessful. In addition, it is reported that adults with distrust of agencies are not willing to have Team members in their homes at the level of frequency required for Fidelity. The low numbers of persons served, coupled with the costs associated with the multidisciplinary team (Region 6 identified that the agency must pay $100/hour for psychiatric time, including travel time to and from Memphis and Jackson), equates to a cost per person of about $14,000 annually which is within the “reasonable” range of cost for PACT teams.

Several rural states and communities have encountered similar challenges in implementing PACT teams. However, states including Washington, Oklahoma and South Carolina have been able to operate teams with smaller caseloads to accommodate the travel time required in a rural territory. These teams have also maintained a focus on co-occurring mental health and substance use disorders through treatment team meetings and cross-training team members.[11] [12] [13]

While PACT services may be more costly than other community-based behavioral health services in Mississippi, Figure 2 below illustrates several outcomes for individuals served by the original PACT

[11] http://nashp.org/sites/default/files/Washington_ACT_Porter_09.pdf

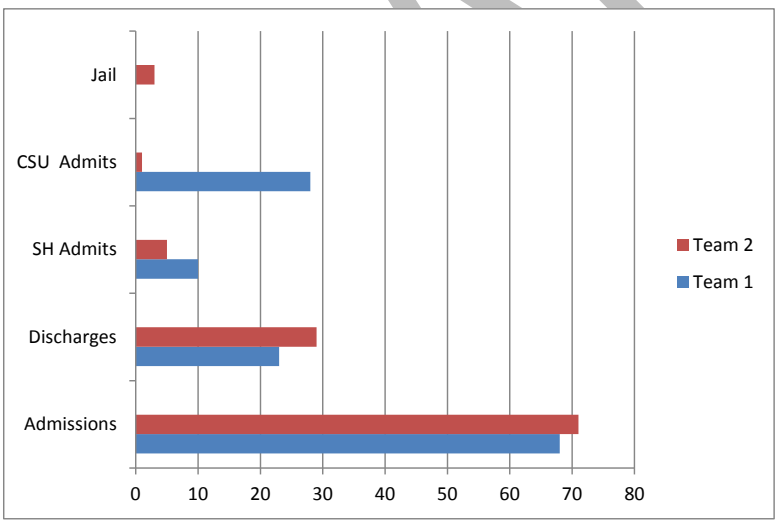
[12] http://www.ncbi.nlm.nih.gov/pubmed/7641003

[13] http://www.red-rock.com/Services/PACT.html

teams. The over-arching benefit of PACT is the team's holistic approach to working with individuals to meet their needs. A good example is the teams' work in assisting recipients to obtain benefits. Team members reported working with several adults who, as a result of multiple transitions between the state hospital and the community, were never successful in being determined eligible for Medicaid. Once assigned to PACT, teams worked with the state hospital staff to initiate applications for benefits, and followed the process through into the communities where the individuals were discharged. Reportedly, most if not all of the individuals were found to be Medicaid eligible, providing coverage for ongoing behavioral health services including medications. By maintaining the stability achieved from their hospitalization, the teams report noticeable reductions in re-admissions.

Building on this momentum, DMH has secured and targeted additional funding to expand services. In December, two new teams supported with DMH grants began providing services in the Hattiesburg and Gulf Coast Regions. In February a third team started providing services in the Jackson Metro area, and a fourth team will start serving individuals in DeSoto County as soon as all Team members are hired. Since these teams are in more populated areas there should not be issues with operating at full capacity. In January, the Division of Medicaid identified funding for DMH to add two more PACT teams which will expand the service into a total of 8 regions. These additional teams should be targeted to serve regions where integrated community housing efforts are being developed.

Figure 2: Legacy PACT Team Outcomes



Commented [SS1]: Cyndi and Diana – this chart reflects the data that Andrew sent me a few weeks ago. It doesn't really make the case however, of the impact of PACT because there are no 'bars" depicting each measure pre-PACT. Is that info available?

Mobile Treatment and Services

Statewide accessibility to PACT teams is important for individuals who need and are willing to participate in this intense level of support, but the service is not intended for everyone. Medication

management and individual, group and family therapies are available within each region for individuals and families who need less intensive treatment and are able to get to the CMHC. However, since the termination of Mental Illness and Monitoring Services in June, 2012, Mississippi lacks an interim level of support for individuals who need individualized treatment and support but who lack the ability, or are unwilling, to make regular visits to a provider. Small teams with a licensed professional able to monitor medication compliance, access to a psychiatrist/physician or Advanced Nurse Practitioner for consultation, a CSS and/or Peer Support Specialist, and mobile capacity to deliver services in the home or other community-based locations would fill a gap in the current continuum. These mobile teams would not include the number of professionals or frequency of contacts as required for fidelity to PACT, and would make the service more affordable. DMH would need to establish eligibility criteria and standards for services including mobility; the service isn't intended to be merely a less costly alternative with reduced requirements but should be structured to deliver appropriately defined treatment and support.

Innovative approaches that bridge the service gap between PACT teams and clinic services have proven successful in other states include the Chronic Users System of Care in Mendocino County, CA[14]; the Mobile Medication Program for Patients with Mental illness in Lawrence County, PA[15]; and the ASPIN Network Community Health Worker Program in Indiana[16].

Strengthening Psychosocial Rehabilitation

Prior to 2012, many individuals with serious mental illness participated in daily activities at "clubhouse" programs operated by the CMHCs. The services reportedly lacked skill-building and evidence-based approaches, focusing more heavily on socialization. However, four regions reported investing considerable resources into obtaining national certification of their clubhouses with a focus on supported employment. As a result of on-site reviews and audits, the Division of Medicaid determined that the services were not being delivered in accordance with the state plan amendment (SPA) and discontinued funding of clubhouse services in 2012. With the loss of Medicaid reimbursement and no DMH funding to support the service, clubhouses were forced to close and were replaced with Psychosocial Rehabilitation services (PSR).

The SPA indicates that reimbursable PSR services include "…skill-building groups focusing on social skills training, coping skills, daily living skills and time and resource management." Two separate services are used to facilitate development of these skills – Psychosocial Rehabilitation and Day Support Services. The Table below identifies important characteristics of the two services.

Table 6: Comparative Analysis of Psychosocial Rehabilitation and Day Support Services

Service	Purpose	Activities	Staff Qualifications	Med FFS Rate

[14] http://www.raconline.org/success/project-examples/783

[15] http://www.raconline.org/success/project-examples/742

[16] http://www.chwcrs.org/

Psycho Soc Rehab	Participants learn about their illnesses, how to manage symptoms, and the importance of adhering to their treatment plan.	Clinically focused and employ the evidence based practice of Illness Management and Recovery Structured and goal-oriented	Services provided under the supervision of a licensed Master's level professional. Program Director or MH Therapist must be on site at least 5 hours/week	$3.87/15 min. unit Or $15.48/hr
Day Support Service	Participants develop skills necessary for independent living	Focus on social skills development, activities of daily living and time and resource management	At least 1 staff with a Master's degree and prof license; Others under the supervision of a Master's level licensed professional	$2.70/15 min. unit Or $10.80/hr

This rate differential provides incentive for the CMHCs to provide more PSR services than Day Support. By creating separate services, individuals with SMI are not benefiting from the full array of skill-building opportunities. PSR programs should focus on 'living, learning, working and socializing'… essential domains for community inclusion.

In addition, skill acquisition developed through facility-based PSR programs is limited if the service participants are not given the opportunity to apply them "in vivo." The lack of an off-site, mobile PSR service prevents individualized training and practice in real life situations for recipients. This is especially important for individuals moving into integrated community living. Based on 2014 Medicaid fee-for-service and managed care claims data, PSR services were only provided "In home" to 6% and 7% of service recipients respectively, illustrating the lack of mobile psychiatric rehabilitation services.

The change from clubhouses to PSR programs was reported as positive for many service recipients, but not so positive for others. Participants attending various PSR programs who were interviewed indicated they were benefiting from the group sessions and topics, as well as the increased structure of the service. Program directors pointed out, however, that attendees have shifted and that some individuals with more chronic conditions have stopped participating in PSR due to their inability to sit through the focused group discussions or their lack of interest in the topics. Absent alternative opportunities for meaningful daily activities and social interaction, many of these individuals are isolated at home, or spend their days walking the streets in their communities to pass the time.

Peer Run Drop–In Centers

In Mental Health America's s 2015 report on the State of Mental Health in America, Mississippi's mental health system ranked at or near the bottom of states on several measures including access to care.[17] Ironically, in spite of its rural nature, the state ranked 4th highest in the nation for Social Connectedness.[18] The Clubhouses may not have provided a robust Medicaid reimbursable service but it appears that they may have provided an opportunity for individuals with serious mental illness to make and meet with friends.

Isolation is one of the key contributors to decompensation for individuals with serious mental illness and addictive disease. As Oxford University researcher Tom Burns describes what is known to be effective in

[17] Parity or Disparity: The State of Mental Health in America 2015, Mental Health America
[18] Ibid.

keeping people with serious mental illness in the community, "… insuring… a person's social life is stabilized reduces the rate of relapse substantially." [19] The elimination of Clubhouses without an alternative opportunity for socialization and connectedness has created a void in the continuum of supports for adults with serious mental illness in Mississippi.

Peer run drop-in centers are an evidence based practice recognized by SAMHSA[20]. The benefits from Peer run services are two-fold: Individuals with mental health disorders have the opportunity for socialization, empowerment and advocacy; and individuals with mental health disorders direct and operate the services, building the skills and self-confidence which increase the potential for future employment opportunities. There is only one Peer run drop-in center in Mississippi. The Opal Smith Consumer Center is supported with DMH funding as well as a SAMHSA grant awarded to the Mental Health Association of South Mississippi. The center employs 3 Peer specialists who oversee the Advisory Council made up of 100% consumers, assist in the organization and planning of center activities and programs, lead sessions such as Wellness Recovery Action Plan development and provide individualized Peer support. The lack of stringent requirements and structures allow attendees to benefit from the socialization and support provided by the center while maintaining jobs, going to school or just participating for the part of the day that they can tolerate.

In addition to "stigma-busting," the center is initiating a Leadership Academy designed to prepare consumers for roles as future leaders in the mental health system in Mississippi. The center has reached its capacity however (the space funded can only accommodate a finite number of people) and cannot serve the number of individuals who want to participate, resulting in a waiting list.

Supported Employment

According to a recent study by the University of Minnesota, in Mississippi, 49.3% of adults with a disability live in poverty.[21] Disability can be a significant factor in an individual's ability to earn a living wage and to meet their basic needs. For most adults employment provides the primary means to achieve economic independence and self-sufficiency, and provides a source of identify and self-esteem. Yet individuals with disabilities are often challenged to access the labor market due to a variety of social, cultural, and economic barriers. Even those who do find employment may work in facilities that pay below the minimum wage. Therefore despite being employed they cannot achieve economic independence.

Supported employment is another evidence-based approach recognized by SAMHSA.[22] Employment specialists help people find jobs in the open labor market that pay at least minimum wage and that anyone could have, regardless of their disability status. Employment specialists help people look for jobs soon after they enter the program, eliminating the need for sheltered employment or vocational

[19] www.latimes.com/.../la-oe-morrison-burns-20140723
[20] http://store.samhsa.gov/shin/content/SMA11-4633CD-DVD/TheEvidence-COSP.pdf
[21] http://rtc.umn.edu/prb/251/
[22] http://store.samhsa.gov/shin/content//SMA08-4365/TheEvidence-SE.pdf

readiness. Once a job is found, employment specialists provide ongoing support, as needed. Choices about work are based on a person's preferences, strengths, and experiences.

Unlike sheltered workshops, supported employment integrates individuals with disabilities into their communities and leads to greater independence. Mississippi is on target by no longer funding sheltered workshops for individuals with serious mental illness. In January, DMH provided funding to develop four pilot sites that will offer Supported Employment to a total of 75 individuals with mental illness. The sites will be located in Community Mental Health Center Regions 2, 7, 10 and 12 and are expected to deliver services with fidelity. DMH is to be commended for identifying funding for the pilots with the goal of submitting a 1915i state plan amendment for expansion of supported employment initiatives statewide.

Housing

A good and modern mental health system must include emphasis on safe, affordable and integrated living environments. The likelihood for individuals to focus on and maintain their recovery absent residential stability is poor. Yet, there is lack of emphasis in Mississippi on housing related services designed to help individuals secure and maintain housing and gain the skills necessary to live in integrated settings. Nor has there been an emphasis on developing integrated, affordable housing opportunities for individuals with mental illness. It is important to note that the burden of affordable housing development should not fall upon the disability service system, and the State's approach to affordable housing should include individuals with mental illness and other disabilities.

Table 6 below summarizes the residential services supported by the 14 CMHCs.

Table 7: CMHC Funded Adult Residential Services

	MH Group Home	MH Supervised Living	MH Supported Living	A&D Primary Residential	A&D Transitional
# of CMHCs Providing Service	6	5	5	11	9
# of CMHC Beds	135	73	198	354	209

Analysis of the residential data indicates that in spite of DMH's efforts to promote Supervised and Supported Living, 6 CMHCs continue to support "group homes," a model that is unnecessarily restrictive and segregates adults with serious mental illness from full integration in their communities. DMH reports that the group homes were funded with grants allocated many years ago and that they have little ability to impact how the CMHCs use the funding. The CMHC data indicates that the lengths of stay in the group homes average "many years."

The Supervised and Supported Living programs that do exist tend to be provided in congregate living settings and in apartment buildings or complexes where more than 20% of the residents are persons with disabilities. Occupancy rates for all mental health residential options run consistently at 90% or above with several CMHCs reporting 100% occupancy. As shown above in Table 2, less than half of the CMHCs offer community living programs for individuals with SMI. More CMHCs provide residential services for individuals with alcohol and drugs (A&D) abuse disorders; 11 CMHCs provide A&D Primary

Residential beds and 9 provide A&D Transitional Living beds. Occupancy rates in A&D residences are much lower, however, averaging 69.9% in Primary and 61.4% in Transitional programs.

DMH also operates the Central Mississippi Residential Center (CMRC) in Newton. DMH has operated the CMRC since 1996 to provide extended housing and treatment for individuals discharged from long-term treatment received in a Mississippi state hospital. Since the residents are discharged from the state hospital the CMRC has been viewed as a tool to reduce state hospital bed capacity. Currently the campus provides 4 twelve-bed Supervised Living residences with 24-hour staff supervision and 12 two-bedroom Supported Living apartments where staff monitors individuals as needed. The CMRC is the only formalized residential support for residents of the Weems Region; its Board declined the offer from DMH to take over the campus and has not developed alternative residential options as the Board does not view mental health residential services as aligning with its mission. Individuals from the Weems Region comprise 50% of persons served at the CMRC while individuals referred from other state hospitals and CSUs comprise the remaining 50%.

Of adults discharged from Mississippi state hospitals in 2014, 74.5% returned home, 5.2% went to a group home and 8.5% went to live in a board and care home. While that 74.5% return home rate is notable, it has not meant stable or quality living options for all of these individuals. Given the lack of sufficient community living options, adults with mental illness and addictive disease often live in less than optimal situations. Stakeholders provided examples of individuals living with aging parents; some living with family and "friends" who reportedly rely on their SSI income to support the household; and others living in board and care homes, many of which are not licensed and reportedly take the residents' SSI checks and leave little if anything for the individuals' personal spending.

Even more tragic is the number of homeless individuals with disabilities, including serious mental illness and addictive disease, in Mississippi. According to current Mississippi Homeless Management Information System (HMIS) data, as published in the 2013 Annual Homeless Assessment Report (AHAR) to Congress, Mississippi's data has a total of 2,403 homeless individuals. Of that total, 1,320 or 54.9% were unsheltered, the 5th highest rate of unsheltered homeless people in the country. When the 2013 Homeless Point in Time Survey was conducted on a single night in January, Mississippi had more than 80% of chronically homeless people who were unsheltered. Of the total number of homeless individuals, 475 (20%) were chronically homeless and 498 (21%) were identified as having a substance use disorder.[23] DMH took the initiative to apply for, and was awarded, a Cooperative Agreement to Benefit Homeless Individuals grant from SAMHSA to help address this crisis. The purpose of the initiative is to address the housing and support service needs of 297 persons who are experiencing chronic homelessness with substance use or co-occurring substance use and mental health disorders.

[23] Mississippi Department of Mental Health, MS Housing 4 Recovery (MH4R) Initiative proposal

The lack of safe and affordable housing in Mississippi was captured in detail in TAC's October 2014 report *A Statewide Approach for Integrated, Supportive Housing in Mississippi*[24] and TAC has provided technical assistance throughout this process to DMH and the Attorney General's Office to move forward legislation supporting the creation of a Special Needs Housing Council and the funding for bridge rental subsidies. In addition, DMH has committed CABHI resources to help reduce the reliance on inpatient, including state hospital, beds. However, the need for PSH is far greater than the number of units that can be supported with the proposed resources.

Recommendations

TAC proposes that the community-based service array for adults with serious mental illness and/or addictive disease in Mississippi should be enhanced in order to better support a life in the community.

PACT/Mobile Treatment

In addition to assuring fidelity, DMH should support and require all PACT Teams to receive training and technical assistance on Recovery, community integration and housing supports, and how that translates into services that add to recipients' quality of life. Teams have focused on reducing hospitalizations, CSU admissions and incarcerations with positive results. Teams have provided less focus on developing natural supports and use of community alternatives to traditional CMHC programs. The PACT team members clearly care about the individuals they support, but they describe their relationship with consumers as caregivers and caretakers, some in fact referred to themselves as the consumer's "family." PACT is intended to help service recipients use and develop natural supports, not replace them.

DMH must require the legacy teams to begin billing Medicaid for eligible recipients/services. As part of this process, DMH and DOM staff should meet with the Teams to understand their concerns with paperwork and prior authorization and streamline administrative requirements to maximize time spent in service delivery. Spending 100% state funding on a service which is Medicaid eligible and thereby reduces the state's funding by about 70% for MA eligibles is not a sound financing strategy.

DMH and DOM should work together to estimate the number of individuals who could be eligible for PACT and plan accordingly. Estimates have ranged from .06% to .1% of the total adult population to upwards of 20% to 40% of the adult SMI population.[25] State funds could be used to start-up new teams and then re-allocated as teams begin to generate Medicaid revenue for eligible services. In addition to expanding and shoring up PACT services, DMH and DOM should assess the potential for implementation of an alternative to PACT for individuals who may not meet the stringent eligibility criteria but who would benefit from mobile treatment and support. In-home therapy with medication management and Peer Support has proven to be successful as well as Medicaid reimbursable in other states.

[24] http://www.dmh.ms.gov/wp-content/uploads/2014/10/A-Statewide-Approach-for-Integrated-Supportive-Housing-in-Mississippi3.pdf

[25] Cuddeback, Gary, Morrissey, Joseph, and Meyer, Piper. *How many assertive community treatment teams do we need?* Psychiatric Services, December 2006. Vol. 57, No. 12.

Psychosocial Rehabilitation/Day Support

Defining these services separately may be advantageous for billing, but absent a vision and framing of the services to meet that vision, providers appear to be focused on delivering services that generate the highest revenue. DMH should issue policy for the delivery of comprehensive PSR and Day Support services for skills development and attainment, including the expectation for billable off-site services to encourage practicing and monitoring of skills attainment. The need for skill development, practice, measures and timelines for attainment should be included in individualized service plans based on the needs and choices of service recipients and should not be driven by the Medicaid rate. DMH monitoring should include an assessment of the delivery of person-centered PSR and Day Support services as indicated by a reviewed sample of service plans.

Expand Peer Run Drop-In Centers

DMH should identify, or request additional funding, for Peer run drop-in centers that follow the evidence-based practice as outlined in SAMHSA's toolkit. In addition, DMH must articulate and model a vision for Recovery that includes consumer empowerment and leadership. Peer support should also be required across the continuum of services, including inpatient, emergency rooms, mobile and other crisis-oriented services, warm lines, PSH, PACT and other traditional services.

Implement and Further Develop Supported Employment

DMH should implement a strong evaluation component with the 4 newly awarded grants for Supported Employment. The evaluation should assess both the process followed, as well as the outcomes for individuals, as outlined in SAMHSA's toolkit for evaluating supported employment services.[26] Lessons learned and results of the projects should serve to inform the use of Medicaid reimbursement, such as for a 1915i State Plan Amendment.

DMH should identify or request additional funding to provide additional grants for start-up costs to further expand Supported Employment initiatives, building on the successes and lessons learned from the pilot projects.

Adults with serious mental illness and addictive disease should also have access to job training and supports that are available to other adults with disabilities in Mississippi. DMH should work with the Mississippi Department of Rehabilitation Services to establish benchmarks for job training and employment services for adults with serious mental illness and/or addictive disease.

Housing

Implement and Expand Permanent Supportive Housing

Per the agreement outlined in the August 29, 2014 letter, Mississippi should implement the project-based rental assistance program for 50 individuals in FY 2015 with serious mental illness being discharged from state hospitals or who have histories of state hospital or frequent admissions to CSUs; and a minimum of an additional 150 adults in FY 2016.

[26] https://store.samhsa.gov/shin/content/SMA08-4365/EvaluatingYourProgram-SE.pdf

TAC recommends that DMH establish eligibility criteria for PSH as outlined in the October 2014 Housing report and develop a methodology to determine the need for PSH in Mississippi. This will inform the budget decision making process regarding the number of affordable housing units, state funded rental subsidies and services that are needed. An option is to use a methodology devised by TAC for other states to project the need for both affordable and permanent supportive housing (PSH) among persons with serious mental illness (SMI) and serious and persistent mental illness (SPMI) living within Mississippi.[27] People with disabilities including mental illness are overrepresented among those in poverty and have a need for affordable housing. To project this need, 2010 U.S. Census Bureau and Social Security Administration data would be examined to obtain basic demographic, poverty, and Supplemental Security Income (SSI) utilization information. Prevalence estimates from DMH's most recent SAMHSA Block Grant application would then applied to project the state's adult population with mental illness living in poverty and therefore the supply of affordable housing that should be available.

Since not all people in need of affordable housing would necessarily choose to live in or meet the definition of being in need of PSH, the number of individuals with mental illness who have the unmet, highest priority need for PSH would also be estimated. This estimate would include: a) the number of non-elderly people with mental illness receiving SSI disability payments, which is considered a reliable proxy of the need for both public sector human services and affordable housing; and b) the number of homeless individuals with mental illness identified through Mississippi's homeless Continuum of Care's (CoC) 2014 point-in-time (PIT) count who are likely not yet enrolled but qualify for SSI. This estimate would then be applied to the number of consumers currently served in supportive housing and other residential programs to reach a projected need for DMH housing.

Based on this assessment and with the input, review and approval of the Permanent Supportive Housing Committee, DMH should develop a 5-year plan for the ongoing expansion of PSH in Mississippi. Expansion should be targeted to regions where the public housing agencies are willing to target housing vouchers for adults with serious mental illness and/or addictive disease. Treatment and support services must also be assessed to assure a comprehensive array of services and supports are readily accessible.

Transform/Align Current Housing

DMH should work with the CMHCs to continue transforming all remaining MH group homes. All residents in group homes should be assessed to move into PSH. Some vacancies in group homes created as a result of these transitions, could serve individuals with complex needs in the community, avoiding unnecessary admissions to, or days spent in, state hospitals, such as those with co-occurring mental illness and complex medical needs. However, as individuals move into PSH, not all existing group home beds will need to be backfilled, resulting in an opportunity to re-allocate group home funds to more integrated housing and services. The funding made available as a result of the transformation should be used to expand or enhance support services for individuals living in permanent supportive housing.

[27] District of Columbia, Department of Behavioral Health. Supportive Housing Strategic Plan, 2012 – 2017. September 2012.

DMH should work with CMHCs to bring all HUD funded congregate living programs into compliance with *Olmstead,* as well as recently published guidance for home and community based services by CMS[28], by no later than 2020.

Policies

DMH should issue a policy prohibiting any state hospital from discharging a patient to a shelter or un-licensed board and care home and provide community education about the policy.

DMH should require CMHCs to provide regular and ongoing assessment of the housing stability of persons served. Individuals who are in less than optimal housing should be informed of other housing alternatives.

Expanding Provider Capacity and Enhancing Existing Services

Assessing the adequacy of services

Ready access to individualized services and supports has proven key for successful PSH initiatives throughout the country. Recovery from mental health and substance use disorders is not linear; individuals are likely to need more and less support at times, and the level of need can change quickly. Services need to be flexible and responsive to increase: 1) the likelihood for individuals to remain stable in their housing; and 2) the willingness of housing providers to continue offering units to individuals with mental health disorders.

Mental health and housing stakeholder interviewees expressed concerns about the lack of readily accessible and responsive services to support individuals in PSH, particularly individuals with challenging behaviors. Yet little data was available to confirm these observations. According to Mental Health America's 2015 report (based on 2012 data),[29] the assessment of service adequacy found that:

- Mississippi ranks 50th in the nation for access to Mental Health Care; and
- Only 34.9% of adults with any mental illness in Mississippi receive treatment

DMH confirmed that access continues to be a concern in its own 2014 Annual Report, estimating that 165,000 Mississippians were in need of mental health treatment[30] but only 57,797 adults were served. Not only were less people served than in need, but the number represents a decrease from 69,474 adults served in 2012.

[28] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html
[29] Parity or Disparity: The State of Mental Health in America 2015, Mental Health America.

[30] http://www.dmh.ms.gov/wp-content/uploads/2012/07/DMH-FY14-Annual-Report1.pdf

TAC had access to data and indicators such as the number of licensed mental health and alcohol and drug service providers or certified practitioners, and the units of service financed by Medicaid, however it's unclear if these measures reflect past *practice*, or the actual *capacity* for the system to serve and support individuals. In addition, the number of licensed programs or practitioners doesn't indicate the degree to which those programs offer, or staff are trained in delivering, evidence-based or promising practices. Stakeholder interviews and site visits offered key insights to round out the assessment of service capacity.

Accessibility and adequate capacity is especially relevant for key Core services such as outpatient and psychiatric treatment, crisis intervention services and Peer Support services.

Outpatient Therapy/Psychiatric Services

CMHCs are legislatively mandated, but operate under the authority of a local board of commissioners and not the Department of Mental Health. As previously stated, CMHCs are required to offer core services for all residents within their regions; however, the degree to which services are available varies considerably. In Region 8, a full continuum of readily accessible services is available at a CMHC in every county served by the Region. Intake appointments and psychiatric appointments can be accessed within 24 hours of contact if the need is identified as a "crisis." Likewise, appointments can be accessed within a day at Region 15. At the opposite end of the spectrum, residents of counties within the Gulf Coast Region may wait as long as 4-6 weeks for an intake appointment and 6-8 weeks for a psychiatric appointment. Over half of the CMHCs identified at least a three week wait, and often longer, for a psychiatric appointment. Please see Appendix XX for all CMHC survey responses. The lack of readily accessible treatment, including medications, compromises the ability for individuals with serious mental illness to maintain successful lives in their communities.

Access to medications is a challenge for individuals ineligible for Medicaid or private insurance. CMHCs report using Pharmaceutical Assistance programs, samples, grants and some are able to provide a small amount of funding to support limited access to medications. However, the inability to fully access needed medications is a contributing factor to hospital readmissions and involvement with crisis services. Medicaid pays for psychotropic medications included in its formulary but has recently changed its procedures for certain agents. CMHCs are now required to purchase injectible medications and store them for administration when the recipients come to the Center for their injection. This practice, referred to as "buy and bill," incurs up-front costs for the CMHCs which they must then recoup by billing for administration of the medication to each recipient.

Formularies also present challenges for individuals in accessing medications. Neither the state hospital or DOM staff who were asked could say if the medications prescribed to individuals being discharged from the state hospitals were on Medicaid's or the CCOs' formularies. The state hospital physician may prescribe the most effective medication for a patient upon discharge, but the individual may not have ongoing access to the medication. State hospital physicians prescribing practices and the availability of medications in the community must be aligned for persons being discharged to facilitate successful transition.

Crisis Intervention Services

Emergency/Crisis Services are identified by DMH as Core services. It appears, however, that not all components of Crisis Services are available and readily accessible statewide.

Expanding Crisis Stabilization Units

Mississippi relies on nine (9) Crisis Stabilization Units (CSUs) to divert admissions from acute psychiatric and state hospitals. Once operated by DMH, all but one CSU is now operated by a Community Mental Health Center (CMHC). CSUs provide 24-hour treatment and supervision in facilities with no more than 16 beds.[31] While CSUs are able to admit individuals under involuntary commitment, they do not typically provide the level of security or safety features required for individuals with highly threatening or violent behaviors[32]. In addition, CSUs are not hospitals nor are they located on hospital grounds, and are not able to admit individuals with significant health care needs.

The number of admissions and longer average length of stay compared with typical acute inpatient stays of approximately 7 days suggests that individuals fall to the acute part of the system absent more robust community services. In FY 2014, CSUs admitted 4,251 adults; 33.6% were referred from Chancery Courts and 25.4% were self-referred or referred by family. The average length of stay was 9.58 days. Medicaid funded treatment for 35.8% of all admissions, Medicare and private insurance covered about 8%, and DMH grant funds supported treatment for 55.4% of admissions who had no health care coverage or ability to pay for their services. One-third of admissions had previously been admitted to a CSU, though data is not available on the timeframe or number of the prior admissions. Discharge data indicates that only 12.5% of admissions were referred for further treatment at a state hospital.

In addition, not all individuals who would have been appropriate for admission to a CSU were referred. Chancery Courts have the authority to commit individuals directly to a state hospital for treatment. While DMH does not capture data on these occurrences, staff reports that some Courts continue this practice in spite of their efforts to educate the judges on the purpose and benefits of CSUs.

CSUs were effective at keeping most people served out of the state hospital, but not all referrals to the CSUs were admitted; 1,174 referrals could not be served due to:

- No beds at the time of referral – 21.6%
- Severity of medical issues - 16%
- Behavior too violent – 13.3%

While all CSUs are required to adhere to the same DMH standards, there is variability across the CSUs. For example, CSUs reported referrals from a variety sources with the exception of Corinth, which reported referrals only from Chancery Courts and Self/family. Tupelo reported serving 38% of all Medicare eligibles served by CSUs. Brookhaven reported being unable to admit the highest number of

[31] Gulf Coast CSU is the exception.
[32] Gulf Coast CSU has the ability to admit individuals whose behaviors may cause harm or injury to others

referrals due to the lack of a bed at the time of referral, while Grenada reported the most frequent inability to admit individuals due to Medical complexity and violent behaviors Table 3 below indicates the range of variability across the CSUs for selected data elements. Please refer to Appendix X for a summary of all data elements reported by the CSUs.

Table 8: Select Data Elements Reported by CSUs

CSU Facility	Admissions	Involuntarily Committed	Chancery Court Referral	Law Enforcement Referral	CMHC Referral	Days in Jail Pre-Admission	Previous CSU Admission	Discharge to DMH Hospital
Lowest	345 Cleveland	16% Newton	.2% Gulfport[33]	0 Batesville, Corinth, Grenada	0 Corinth	0 Brookhaven	21% Corinth	0 Laurel
Highest	668 Newton	81% Tupelo	81% Tupelo	25% Newton	42% Brookhaven	602 Gulfport	54% Gulfport	25% Gulfport

Five of the fourteen regions do not have a CSU and residents must travel to another region for the service. When any CSU is at capacity, subsequent referrals are re-directed to the closest CSU with an empty bed or to a state hospital. Since CSUs serve as the primary diversion from state hospitals communities without ready access to this resource are more likely to look to the state hospital for admission. DMH staff expressed no interest in investing resources into building additional CSU facilities but would prefer instead to locate/co-locate beds in existing facilities or structures.

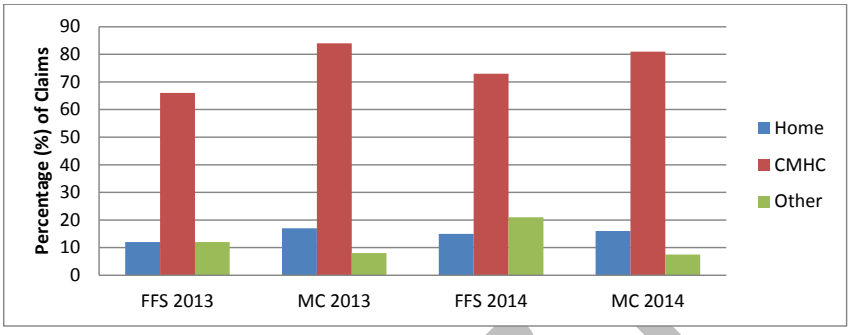
Enhancing Mobile Crisis Emergency Response Teams

The rural nature of Mississippi and pervasive poverty are contributing factors to the lack of ready access to treatment. Formalized transportation does not exist outside of the major metropolitan areas and many living in the poorest regions do not have personal transportation. In 2012 DMH issued grant funds to the regions to develop Mobile Crisis Emergency Response Teams (MCERT), intended to respond to a person experiencing a behavioral health crisis at the location where the crisis is occurring, in order to provide assessment, stabilization and alleviation of the crisis situation.

All of the CMHCs received DMH grant funding to implement MCERT. Teams are typically "dispatched" based on an assessment of need by a supervisor at the CMHC or an on-call Crisis Supervisor after-hours. While the teams are intended to go to the location of the crisis, Medicaid claims data indicates that most mobile crisis services were delivered at the CMHC offices.

Figure 3: Medicaid Claims for Adult MCERT by Place of Service

[33] In Gulfport, CSU staff are "deputized" to involuntarily commit



MCERT members interviewed identified "safety Issues" as preventing teams from going into the homes of individuals new to their agency. While law enforcement can be accessed at times to accompany a team on a call, this support can be especially difficult to obtain in the more rural counties. According to DMH data, of the 4,344 face-to-face contacts in FY 2014, only 549 involved accompaniment by law enforcement[34]. In order to address safety concerns Crisis team members reported that they attempt to identify a "neutral" location to meet the individual or family member but it appears that the majority of contacts occur at the CMHC offices. Several states have addressed these concerns through enhanced training and dispatching two staff when necessary.

Another challenge for MCERT is educating "the system" and individuals in crisis about the availability of the service. CMHCS were allowed to spend up to 10% of their grant funding on educating the community about the service; several shared various strategies including posters and pamphlets showcasing the service and toll free contact numbers, attending health fairs and public events, running public service announcements, and placing ads in local publications. Yet, numerous family stakeholders, advocates, and non-CMHC behavioral health providers that we interviewed stated that they were not aware of the mobile crisis service. If individuals who could benefit from mobile crisis are not aware of the service, people in crisis and their family members are likely to resort to past practice for seeking help.

There are several examples of rural states and communities that operate mobile crisis response teams including the Appalachian Community Services Crisis Management program in North Carolina[35], The Eastern Shore Mobile Crisis Teams in Maryland[36], the Washington County Mobile Crisis Service in Vermont[37] and the Mobile Crisis Response Teams operating throughout Tennessee[38]. These teams have common characteristics:

- Centralized 24-hour telephone access for screening/triage;

[34] 2014 DMH Report of Mobile Crisis Emergency Response Team Data
[35] http://www.ncbi.nlm.nih.gov/pubmed/22779153
[36] http://mdruralhealth.org/2014conf/ESMC.pdf
[37]https://www.wcmhs.org/crisis-access.html
[38] http://tn.gov/mental/recovery/crisis_serv.shtml

- Capacity for face-to-face intervention with trained crisis professionals in a safe and secure location within 1 hour of contact;
- Access to a continuum of services and interventions aimed at stabilizing the crisis without inpatient admission, as well as access to inpatient when needed; and
- Access to referral for follow-up care, typically within 24 hours.

The teams report investing considerable time and effort in establishing community relationships and linkages, which serve to identify potential/emerging crisis situations and to provide safe places for crisis assessment and interventions to occur. Their communities have also invested in Crisis Intervention Teams that work hand in hand with the Mobile Crisis Response Teams.

DMH staff acknowledges that MCERT is a work in progress and that introducing mobility for crisis services in Mississippi has been a major undertaking. DMH reports investing considerable time and resources into sponsoring training for the teams to build skills in crisis de-escalation and stabilization as opposed to assessing for commitment, and at providing services at locations outside of the CMHCs.

Enhancing Crisis Telephone and Walk-in Services

During business hours these functions appear to be carried out by an available therapist or clinical services manager at the CMHC. Stakeholder interviews depict these services as predominantly assessment for inpatient civil commitment whereas their purpose should emphasize crisis stabilization or inpatient diversion. Expanding the telephone service to include Peer and Family Mentor operated "warm lines" has been an effective strategy utilized in other states to provide support to individuals before they reach a psychiatric crisis. Peer and family mentors can offer a listening ear, empathy and support for an individual or family member who is struggling, as well as share successful tools and resources for managing a crisis and avoiding an inpatient admission. Peers and Family mentors are also effective in sharing coping strategies and offering support in crisis walk-in settings.

Expanding Peer Support Services

Peer Support is one of the more recent EBPs implemented by DMH. While DMH has supported the training and certification of Peer specialists, the Division of Medicaid is the primary funding source for the service. Identified as a Core service, the disparities among CMHCs is clearly evident with accessibility to Peer Support. In FY 2014 the number of Peer Support positions ranged from a low of 1 in two regions (with one region having a vacancy) to a high of 12 in one region with all positions filled. The number of individuals receiving Peer Support ranged from 3 in one region to 350 in another. A challenge CMHCs identified in delivering the service was the ability to keep positions filled with full-time employees. Several CMHCs have created part-time positions to minimize the stress of full-time employment on the Peers which appears to be a successful solution. In addition, Mississippi has a Peer Support Coalition to provide networking opportunities and support for the Peers.

One explanation for the lack of service provision is likely to be the low rate of reimbursement. At a rate of $ 7.83 a quarter hour of service, CMHCs are not incentivized to expand peer service delivery. Other contributing factors include the stigma associated with mental illness and very little buy-in to the idea that people can and do recover from serious mental illness and/or addictive disease.

DMH recognizes that a sub-population of the individuals in the system have had repeated CSU and state hospital admissions, do not respond to traditional community-based services and have not responded with interest in PACT team support. Peer Support Specialists have proven to be effective in establishing relationships with individuals with serious mental illness and with addictive disease who lack trust in professional staff. DMH is considering the targeted expansion of Peer Support Services in an effort to engage this hard to reach population. As stated earlier, peer delivered services should have a place at multiple intercepts throughout the system.

In addition, DMH could do more to support the development of an informal network of peer supports. Strong peer support coalitions in several states provide an additional level of peer support, and also empower consumer influence at the policy and provider level.

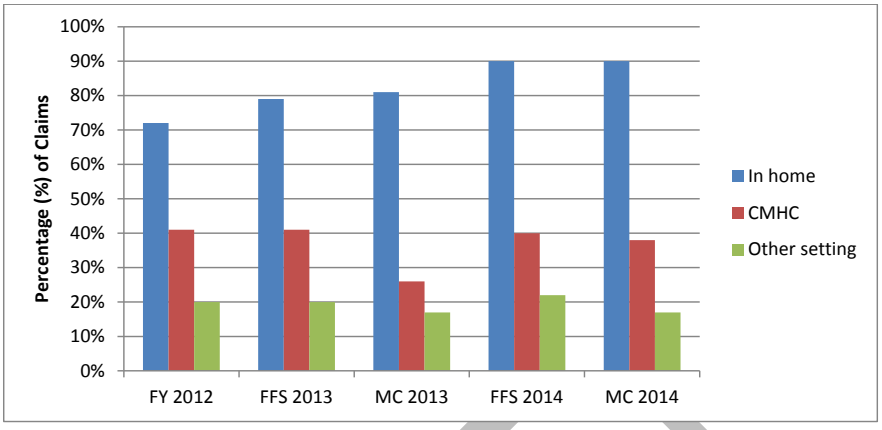
Enhancing Targeted Case Management/Community Support Services

Community support services (CSS) were established in 2012 in Mississippi as an alternative to Targeted Case Management (TCM). Mississippi included CSS as a Medicaid covered service under the Rehab Option to define hands-on direct service provision apart from the clinical and administrative targeted case management functions.

As currently defined, TCM is intended to provide the independent development and monitoring of an individual's treatment plan, to ensure that treatment team members complete tasks that are assigned to them, that follow up and follow through occur and to help identify when the treatment team may need to review the treatment plan for updates if the established plan is not working. TCM must be delivered by a Licensed Social Worker or a Registered Nurse. CSS is intended to support individuals in their communities, outside of the office-based setting, to make sure that individuals are receiving the services and supports identified in their service plan, and to assist with skill building and service navigation. CSS can be delivered by a bachelor's level staff person.

Based on Medicaid claims data CSS appears to be delivered out of the office as intended; twice as many adults received services in their home than at the CMHC and twice as many units of service were provided in-home as opposed to the CMHC. In addition, services were billed for the location "other" which is not a CMHC.

Figure 4: Medicaid Claims for CSS by Place of Service



Medicaid data also indicates that more adults are receiving CSS than TCM; FY 2014 FFS and MC data reflect CSS billing for about twice as many adults as for TCM . This data appears to conflict with the State's intended relationship between the two services – that 'TCM manages the plan and CSS manages the person.' When asked why so many more recipients received CSS than TCM services, DMH explained that 'clients and families have the right to refuse TCM or not add it to their treatment plan.' When an individual doesn't have an independent TCM, the "primary service" provider typically manages the service plan/services, i.e. the individual and their therapist, community support specialist, or the clinician providing day services or therapy services. This practice may be a practical solution but it doesn't align with the objective of TCM…to have an unbiased party monitoring a recipient's care. Other explanations provided for the lower numbers of TCM recipients included the Medicaid payment limits on TCM, which can end Medicaid billing for the service while individuals continue to receive other services, and the credentialing requirements make it difficult for CMHCs to attract sufficient TCM staff.

An inherent limitation of both TCM and CSS services is the inability to bill for either service while a recipient is in the state hospital. The predominant funding source for both TCM and CSS is Medicaid and the current payment rules do not allow for billing until the individual is discharged from the state hospital back into the community. Effective discharge planning needs to begin at the time of admission, especially when the average length of stay in state hospital acute care beds is around 30 days. The lack of a guided transition or "warm hand-off" from the state hospital often results in individuals leaving the hospital and falling through the cracks. As discussed in the previous section on PACT, individuals with chronic conditions and little resources aren't able to make the transition on their own; this often results in inadequate aftercare, decompensation and readmission to a CSU or state hospital setting.

The lack of an alternative funding source for CSS during this crucial time of transition limits an important potential benefit of the service. DMH has recently responded to this dilemma by allowing CMHCs to re-direct 10% of MCERT funding previously identified for service promotion to funding for Making a Plan (MAP) Teams for adults. Based on this successful approach for children, MAP teams' responsibilities for adults include facilitating the provision and coordination of services and continuity of care for individuals

with repeated use of high-end services. Allowing more flexible use of funding is a positive step for DMH to take, however diverting funding from MCERT does not appear to be the ideal solution given that MCERT services are in need of further development.

Recommendations

The following are recommended strategies to enhance the availability and effectiveness of Core services.

Outpatient Therapy/Psychiatric Services

DMH should establish and enforce access standards for routine and urgent appointments for intakes and psychiatric evaluations, for all payer sources. Waiting for weeks, and in some cases months, for an appointment disrupts the engagement of individuals with newly emerging disorders,the smooth transition from CSU or inpatient care, and for those who may be experiencing psychiatric crisis. Managed care industry standards are an option to consider.

DMH must work with DOM, providers and universities to increase access to community-based psychiatric capacity. Options to explore include:

- Supporting and enforcing the use of telepsychiatry in every region. TAC understands that Tele-behavioral health is available currently in Mississippi via the Medicaid rehab option state plan amendment and that DOM is implementing new policies and procedures to provide Tele-behavioral health services across the state. DMH should use its certification process to insure that CMHCs take advantage of this opportunity to meet access standards.
- Allocating a portion of each DMH psychiatrist's time to provide on-site work at a CMHC and/or to provide consultation for primary care providers. Sharing resources would not only illustrate DMH's commitment to providing community-based services, it would increase continuity of care for individuals who are served by the same psychiatrist in both the state hospital and in the community, and help to address workforce shortage issues.
- Developing a community psychiatry residency rotation where psychiatric residents are rotated through the CMHCs. The residency rotation would provide additional psychiatric support to the CMHCs and expose residents to the rewards of working with individuals with serious mental illness and additive disease. In addition, residents may be more likely to stay and practice in Mississippi if the state were to fund and implement the loan forgiveness program approved by the legislature.
- Establish an expectation for each CMHC to set aside a minimum amount of funding annually to provide medication assistance to adults when *no other resources* are available. Given some CMHCs already do this, it can be done.

Crisis Services

Mississippi must improve access to community-based services as a way to reduce the need for crisis-oriented services such as inpatient, emergency rooms and crisis stabilization units. Crisis services should approach service delivery with an emphasis on community preservation and inpatient diversion.

MCERT should be required to deliver mobile services in the community 24/7/365. Enforcing standards and implementing performance measures are tools which should be utilized to ensure the delivery of MCERT services geared toward de-escalating and stabilizing crisis situations in lieu of inpatient admission and in locations other than CMHCs. DMH should assess potential opportunities and the resources needed to develop a centralized 24-hour hotline for access to consistent screening and triage. In addition, each team should adopt the strategies that other states' mobile crisis teams have found to be successful: developing strong relationships with a variety of linkages in the community; use of Urgent Care Centers, Federally Qualified Health Centers and Rural Health Centers to conduct medical clearances when needed; access to Mobile Teams across county and regional lines if closer and more accessible for the person in crisis; and establish at least one Crisis Intervention Team in each Region.

Mississippi should strengthen its crisis residential/respite capacity. A facility such as a mental health group home could be converted into a crisis residential program by enhancing staff, utilizing a peer-run model, and making minor physical plant modifications. Several successful peer-run crisis residential/respite programs exist throughout the country.[39] Crisis residential/respite capacity could also be situated in small apartment settings with accessible staff and/or peer support. MCERT could function as a gatekeeper to these beds to ensure that the most appropriate individuals access this level of service. In addition, many individuals can benefit from crisis related supports in their own home. Services, whether through MCERT, PACT, or CSS, for example, should have the capacity to intensify support to individuals in their own home during crisis periods in order to help alleviate the crisis and preserve the housing placement.

While TAC Supports DMH in not wanting to *build* additional CSUs, there are alternative approaches to offering acute psychiatric stabilization, especially in regions where capacity is limited. A number of CSU beds, based on the need from analysis of commitment data, could share space in an existing setting within a region. Yet another approach would be to negotiate access to existing acute care psychiatric beds in the community for individuals with no health care coverage. These options are likely to require DMH funding.

In addition to expanding capacity, Mississippi would benefit from enhancing the capacity for existing CSUs to admit and safely treat individuals with non life-threatening medical needs/conditions, and enhancing the staffing and interventions for CSUs to accommodate individuals with challenging behaviors. In addition, DMH should attempt to address those Chancery court judges that continue to order adults directly to a state hospital bed, bypassing the CSU as a diversion. An option that has worked in another state is to identify an influential judge to champion the positive impact of CSUs with fellow judges who are reluctant to use the service.

Peer Support Services

DMH should work with consumers, families and providers to establish a minimum threshold for the employment of Peer Support Specialists throughout the service continuum due to their effectiveness

[39] National Empowerment Center website. Crisis Alternatives. http://power2u.org/crisis-alternatives.html

and to help alleviate the workforce shortage. Employing Peer Specialists allows licensed practitioners to focus on the delivery of clinical services, and promotes recovery for individuals with lived experience as well as the persons they serve. DMH should follow through with staff's observations that Peer Specialists could be effective with engaging adults who are unwilling to receive support from PACT teams. Peers are also known to be effective in assisting individuals in the transition from institutional to community-based settings such as "Peer Bridgers,"[40] and can also be successful in helping individuals with important housing supports such as preparing application, housing search and household set-up. Finally, DMH should work with DOM to assess the adequacy of the Medicaid rate to ensure the rate supports service delivery and to insure that service limitations do not prevent individuals from receiving the amount of service for as long as Peer Support is needed.

TCM/CSS

During on-site monitoring of TCM, DMH should review a sample of TCM and non-TCM cases to insure treatment/service plans are developed with the consumer and fully address the recipient's preferences and needs. DMH should work with DOM to identify the impact of TCM and CSS service limitations on the adequacy of services available for recipients, and either revise the limits or develop an exceptions process as warranted. The CSS Medicaid rate should also be assessed to determine if the rate presents a barrier to adequate service delivery.

DMH should provide funding for providers to deliver case management services to individuals with serious mental illness during hospitalization, incarceration, or admission to CSUs in order to ensure continuity of care and to facilitate effective transition back to integrated community-based settings. Individuals and their families are often not able to navigate these transitions themselves and would benefit from case management assistance and support. DMH is considering the allocation of funding for additional adult MAP teams which could serve to bridge this gap. This may serve as an interim solution but will not provide the continuity that the TCM and CSS workers would provide.

Finally, DMH should require all CSS staff to participate in annual training on recovery-oriented practices, expectations of DMH regarding business practices and clinical interventions that support community integration, integrated settings and person-centered planning. Providing services Monday through Friday during typical business hours, based on a professionally driven treatment/service plan does not meet the objective of the person-centered care necessary to support successful, integrated community living.

Is there ready access to services and are the services available consistent with a good and modern mental health system?

[40] National Empowerment Center website. Creating Replicable and Sustainable Peer Supprt Services. http://www.power2u.org/creating-replicable-sustainable-peer-support-services.html

As mentioned earlier in this report DMH requires that CMHCs offer certain "core services" to any one in need of the services who resides within the region. However, as evidenced by the variability in access to Peer Support and psychiatric appointments for example, designating a service as "core" does not necessarily mean adults will have ready access to the service, particularly for adults who are not Medicaid eligible. Access to most mental health and substance use services is dependent upon available funding, and for individuals enrolled in MississippiCan, approval of service authorization requests by the Coordinating Care Organizations. There is a wide gap between requiring services to be offered and people actually receiving those services in Mississippi.

There is also a gap between the Core services and the breadth of services needed to support adults in their recovery. In April 2013, DMH and the Strategic Planning and Best Practices Committee, established as part of the Rose Isabel Williams Mental Health Reform Act, conducted a survey of external stakeholders to identify needed or desired revisions to the Core services that CMHCs and other DMH approved and certified mental health service providers offer. While survey respondents indicated that the existing Core services should be maintained, they also recommended additional core services for adults including: employment related services; transportation; supportive housing options; expanded crisis services, including Crisis Intervention Teams and additional CSU beds; increased PACT teams; and supportive services such as money management, Peer Support, family education and respite.

While most of these services have not been added to the list of Core services, DMH has or is in the process of, implementing several of the recommendations. Four CMHCs responded to a recently released RFP from DMH for grants to provide Supported Employment Services. Grantees will receive technical assistance provided by NASMHPD and funds to initiate services with fidelity to the Dartmouth Approach beginning January 1, 2015. In response to the TAC report on PSH and compliance with the DOJ agreement letter of August 29, 2014 DMH is requesting funds to create 50 bridge rental subsidies with housing support services in FY 2015 and an additional 150 subsidies in 2016, targeted for individuals with serious mental illness with histories of state and community hospitalizations, arrest and incarceration and homelessness. DMH has provided training and continues to support the East Mississippi Crisis Intervention Team (CIT). Finally, four new PACT teams came on line and started building caseloads in December 2014 and DOM recently identified funding to start-up two more teams for a total of eight.

Are there limitations or barriers to expanding community-based provider capacity?

Lack of State investment in community-based services

DOJ's findings with respect to the lack of community-based services resulting in the over-utilization of state hospitals for adults are well documented in its December 22, 2011 letter to then Governor Barbour and will not be discussed in detail here. Since the findings letter was written, there have been changes to the array of behavioral health services and supports as a result of DMH initiatives as well as modifications to the Medicaid program. The development and expansion of PACT teams should decrease, and reduce, the over-reliance on inpatient treatment. The development of mobile crisis teams is conceptually on target, though greater benefits from the service should be realized when DMH holds the CMHCs to the MCERT standards. The development of permanent supportive housing units through federal initiatives such as the Balancing Incentive Program and CABHI, and newly requested funding from the Legislature

will create safe and affordable housing capacity. DMH has made progress in developing home and community based services and supports for adults with serious mental illness and/or addictive disease but there continues to be significant unmet need.

The Impact of Inadequate Funding

According to 2012 URS Tables, DMH served 107,277 adults and children. Of that number:

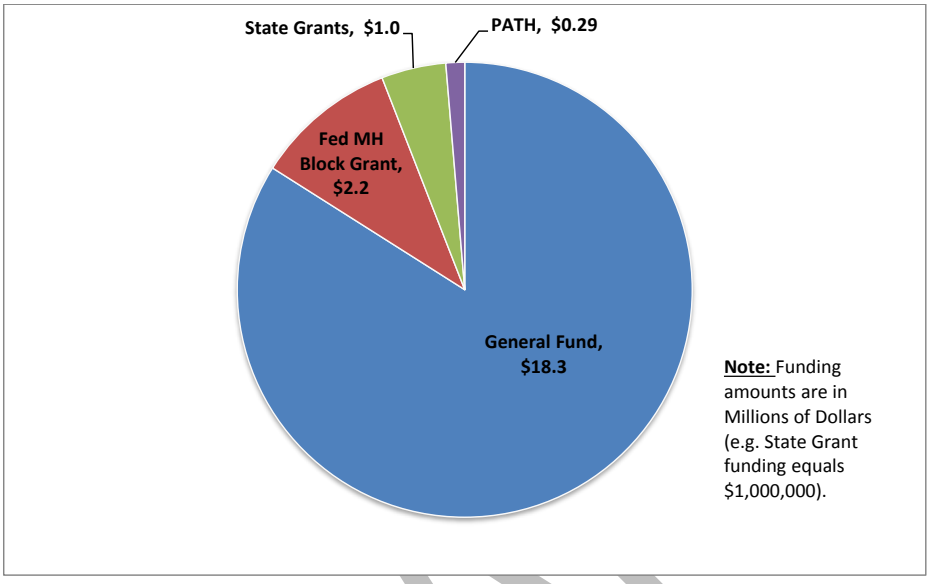
- 41,628 received no Medicaid funded service
- 11,360 received service but Medicaid status was not available
- 17,941 received both a Medicaid and non-Medicaid funded service
- 36,248 received only Medicaid funded service.

Of the total number served in 2012 about half received only DMH funded service and an additional 16.7% received both DMH and Medicaid funded service. Only about one-third of service recipients were solely Medicaid funded. In addition, of all adults served, only 13.2% were employed and *may* have had health insurance to cover any part of their treatment; Mississippi ranks 50th in the nation for the percent of adults with mental illness and no health insurance.

Based on this data it's likely that more than half of persons served in the behavioral health system in 2014 received only DMH funded or uncompensated care. The graph below depicts adult community mental health services funding in 2014.[41]

Figure 5: Adult Community Mental Health Services Funding

[41] http://www.dmh.ms.gov/wp-content/uploads/2012/07/DMH-FY14-Annual-Report1.pdf



Funding for community services pales in comparison to funding for the state hospitals – $206.2 million in 2014. The bulk of DMH funding is used to support state-operated services, including the state hospitals and Central Mississippi Residential Center. Even when funds became available in 2014 for re-direction to the community, DMH elected to continue using the resources for state hospital operations. According to a June 2014 report released by the Mississippi Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER), regarding the closure of the Mississippi State Hospital's (MSH) Community Services Division, that by not, "….eliminating any of the division's positions and the plan to transfer its employees to MSH inpatient care positions, the department has forgone the opportunity to redirect resources yielded from closure of the division into providing community-based mental health care."[42] When asked about these plans, "officials of the Department of Mental Health (DMH), the department's and hospital's staffs perceived that the Community Services Division was outside the hospital's primary mission and believed that redirecting resources from community mental health services to acute inpatient care at the Mississippi State Hospital (MSH) was the best use of resources."[43]

The amount available for CMHCs to cover care for individuals not eligible for Medicaid is *very* small. So small that when asked, CMHCs indicated the funding was exhausted within the first few months of the fiscal year. In spite of DMH's requirement that the CMHCs serve everyone in need, businesses must have sufficient revenue to cover costs. The CMHCs reported they are struggling to serve the large number of individuals who lack Medicaid or insurance coverage. The lack of revenues limits their ability

[42] Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER). (June, 2014). A Review of the Closure of the Mississippi State Hospital's Community Services Division, Report #584. Retrieved on November 17, 2014 from: http://www.peer.state.ms.us/reports/rpt584.pdf
[43] Ibid.

to hire additional psychiatric coverage and licensed professional staff, impacting access to, and longer wait times for, services which can ultimately result in decompensation and admission to a CSU or state hospital bed.

CMHCs provided several examples of how the funding contributed by the state and the counties to cover community-based care for youth and adults with behavioral health challenges who lack health insurance does not adequately cover the costs of delivering these services. One CMHC served 1,240 adults and children without insurance in FY 2014 alone. Between FY 2010 and FY 2014, this Region saw a total funding decrease of over $3 million as a result of a combination of Medicaid managed care service denials and decreases in available federal block grant dollars. This funding decrease led to staff reductions. At the same time the number of service referrals increased, resulting in large caseloads for staff. Funding from DMH grants and county contributions only accounted for 4.4% and 1.1% of the Region's budget in 2014, respectively. Another CMHC reported providing behavioral health services to over 1,000 adults and children without insurance in FY 14, equating to almost $780,000 in indigent care. Yet another Region reported closing its crisis stabilization unit due to budget constraints and described experiencing significant losses, with auditors reportedly writing off approximately $8 million as a result of uncompensated and under-compensated care.

Table 8: Indigent Costs FY 2010 – FY 2014, as Reported by seven (7) CMHCs

Total Indigent Costs	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	CMHC 5 Year Total
Region A	$1,462,365	$1,039,834	$1,056,899	$818,274	$779,938	$5,157,310
Region B	$1,273,866	$1,268,382	$1,136,902	$1,134,321	$856,268	$5,669,739
Region C	$900,000	$1,800,000	$2,500,000	$2,699,221	$0	$7,899,221
Region D	$2,517,777	$2,660,346	$2,023,108	$2,059,193	$1,669,626	$10,930,050
Region E	n/a	n/a	$1,400,000	$1,400,000	$1,500,000	$4,300,000
Region F	$620,740	$720,329	$775,341	$460,292	$252,113	$2,828,814
Region G	$892,350	$779,283	$521,377	$630,166	$1,498,323	$4,321,499
Average Costs Each FY Year	$638,925	$689,015	$724,125	$707,805	$504,328	**Total from FY 10-14**
Total Costs Per FY Year	$7,667,098	$8,268,174	$9,413,627	$9,201,467	$6,556,268	**$41,106,633**

The lack of State funding has also inhibited further development of successful initiatives. **Crisis Intervention Teams** are an example. As a result of a growing number of individuals involved with mental illness interfacing with the criminal justice system, in 2012 Meridian and its surrounding communities came up with local funding to implement a Crisis Intervention Team (CIT). CIT provides specialized training for law enforcement officers to interact with individuals experiencing a mental health crisis. In addition to the training, the mental health system is prepared to respond promptly when an officer brings a person in mental health crisis to their attention, allowing the officer to return to his or her primary duties. CIT helps keep people with mental illnesses out of jail, and gets them into treatment instead.

In 2014, the Meridian Police Department and Lauderdale County Sheriff's Department responded to 189 crisis mental health calls through the East Mississippi Crisis Intervention Team (CIT). As a result of a coalition, including law enforcement, Weems Community Mental Health Center, Central Mississippi Residential Center, NAMI and other health care providers, only five of the calls responded to by law enforcement resulted in arrest (3%). The responding CIT officer was able to defuse the situation and/or make a referral for follow-up in 48% of the calls. 46% of the calls resulted in immediate transport and access to assessment and evaluation through the Crisis Stabilization Unit in Newton. As a result, approximately 177 individuals were diverted from the criminal justice system and provided immediate access to care. In spite of CIT's success most other communities have not followed suit, likely due to the lack of funding to cover the costs. CIT requires each officer to commit to 40 hours of training; most departments have to pay other officers overtime to cover the shifts of fellow officers while away from the job. With implementation of the Meridian CIT various community partners each contributed to the costs for start-up of the team. Most communities aren't willing or don't have the resources to do that. DMH could entice interest by issuing small grants to communities who could substantiate local buy-in to the approach.

Medicaid Cost Containment

CMHCs reported that Medicaid accounted for an average of 64% of total revenues in FY 2014.[44] CMHCs continue to struggle with the implementation of Medicaid managed care and fee-for-service (FFS) cost containment efforts.

Managed Care

Several CMHCs attributed significant revenue losses to discrepancies in eligibility and the frequent changes in CCO plan enrollment of individuals receiving their services. Reportedly, state level representatives for Medicaid, Cenpatico, and UHC all have acknowledged discrepancies in eligibility files. In Mississippi managed care enrollees may change health plans at any time. CMHCs reported it is not uncommon to receive denial of payment for services by the CCO from which they have a current authorization for treatment but the person served is no longer a member. Most CMHCs do not check recipient eligibility at every visit due to the increased costs that would be incurred from hiring additional administrative staff.

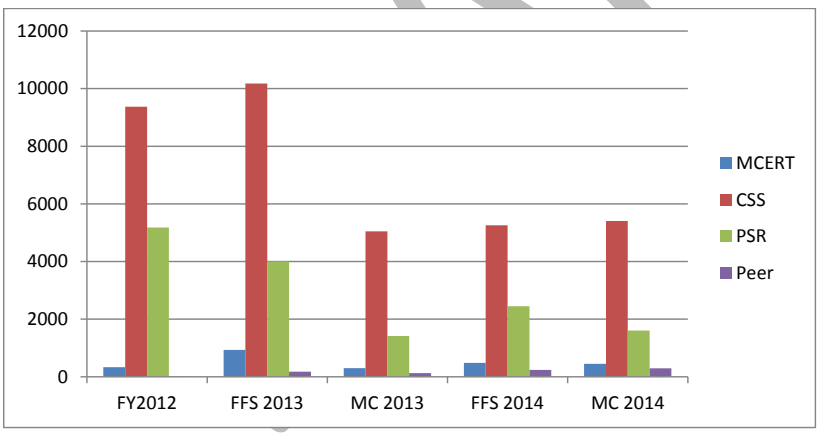
CMHCs reported that even when they do confirm a service recipient's eligibility, obtain a service authorization and provide the services, a recipient's eligibility can be changed and back dated. CMHCs reported examples of retroactive eligibility changes of several months. The CMHCs were then expected to return the "over-payment" to the CCO with the amount due deducted from a future payment, resulting in the CMHC providing uncompensated services. The CMHCs reportedly do not have any recourse or dispute resolution process.

[44] CMH Association data, absent Regions 8 and 11, 2014.

Mississippi is one of five states in the country operating a Medicaid managed care program (excluding Primary Care Case Management) that carves out inpatient behavioral health services from the managed benefit package[45]; inpatient services are covered under fee-for-service. A primary benefit of implementing managed care is to insure that the highest cost, most intrusive services are only provided to individuals who meet medical necessity criteria for the level of care or type of service, or when a less intensive alternative that could meet their need is not available. Managed care plans are typically afforded greater leeway in creating new and enhancing existing less intensive services in order to prevent covered recipients from needing to rely on the deep-end services such as hospital-based care. With inpatient excluded from the managed care contracts, there is no ability for CCOs to divert individuals from admissions to inpatient care, they are typically not informed when a member is admitted to inpatient care and they have no incentive to create alternative solutions. The only way for CCOs in Mississippi to realize savings is to reduce authorization and payment for community-based services.

The implementation of managed care has had mixed results for behavioral health services. Figures 6 through 11 below illustrate the impact of managed care implementation on several key community-based mental health services, from pre-managed care implementation in Fiscal Year 2012 to full implementation for covered populations in FY 2014.

Figure 6: Number of Medicaid Users of Select Community Based Services



[45] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-profiles.html

Figure 7: Average Claims Per User of Select Community Based Services

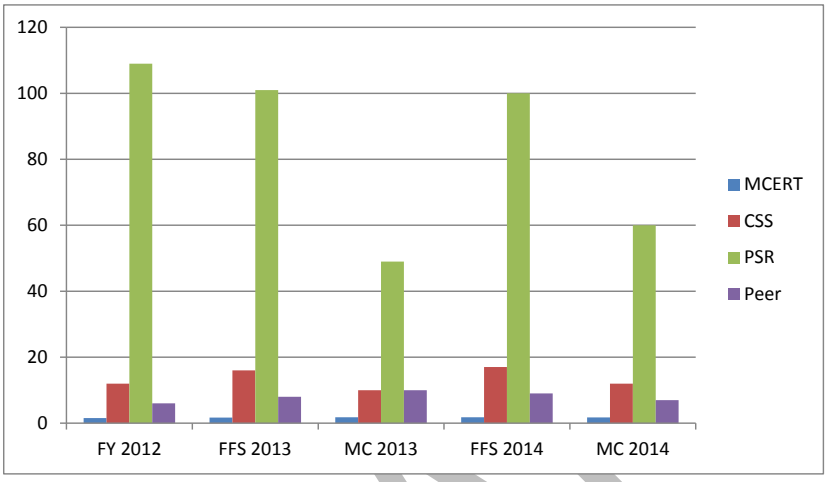
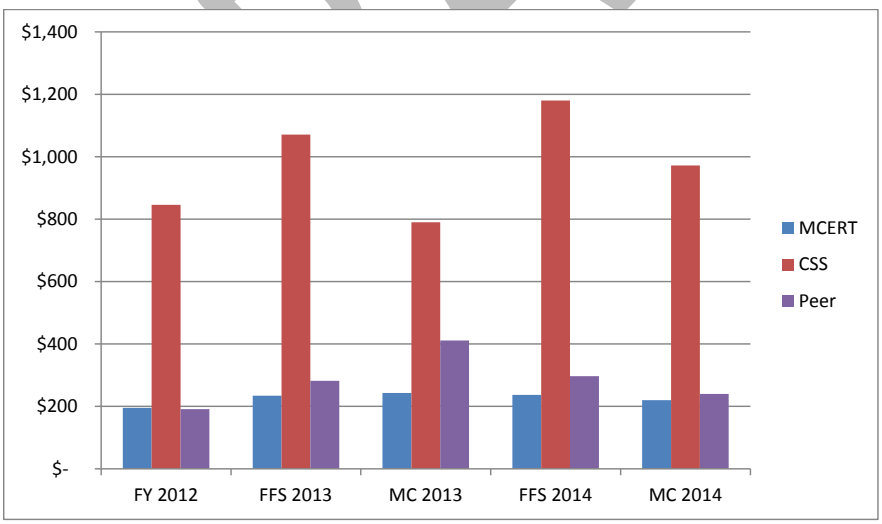


Figure 8: Average Paid Claim Per User of Select Community Based Services[46]



[46] CCOs are required to pay the same rates for services as Medicaid fee-for-service

Figure 9: PSR Average Amount Paid Per User

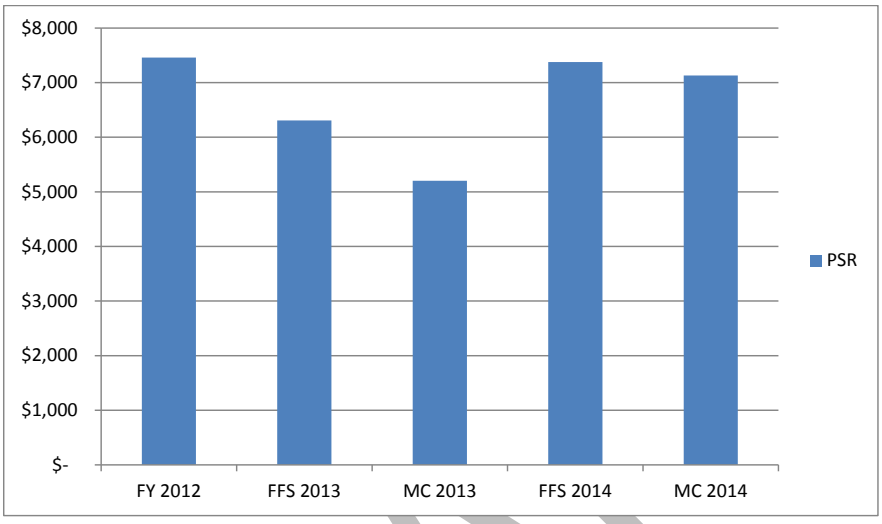


Figure 10: Total Medicaid Expenditures for PSR and CSS

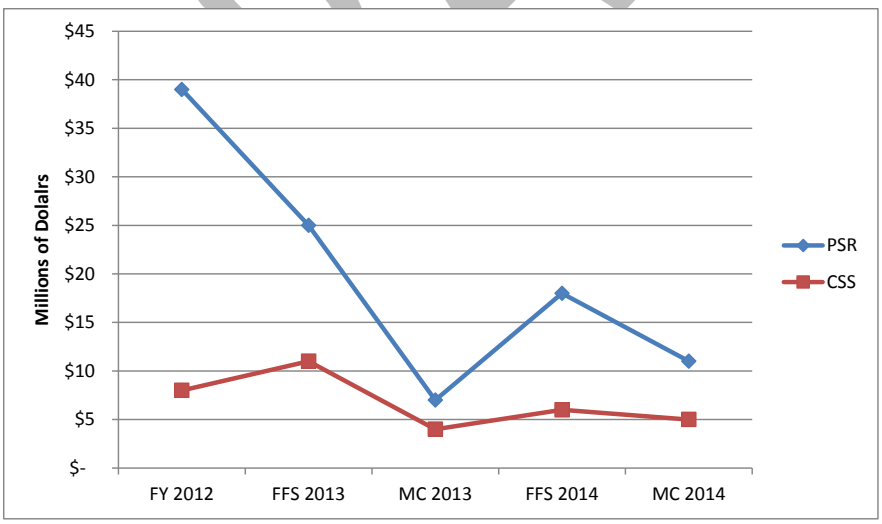
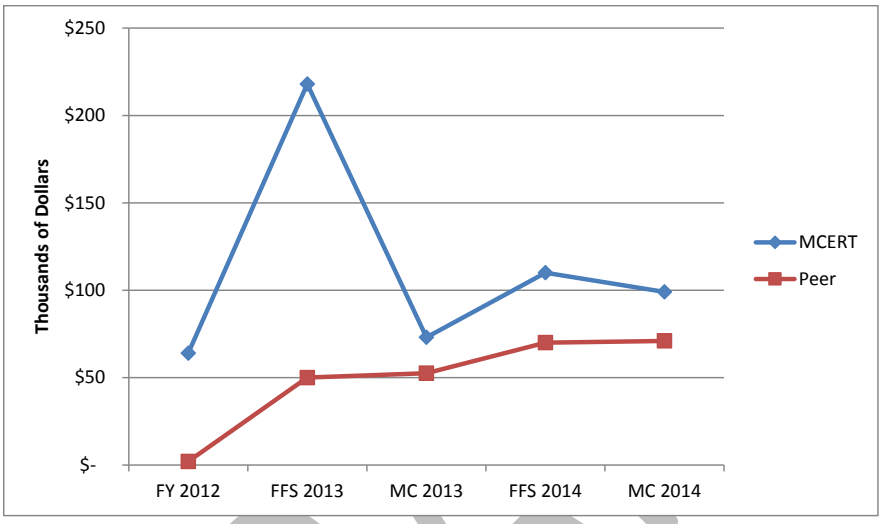


Figure 11: Total Medicaid Expenditures for MCERT and Peer



One of the most striking impacts of implementing managed care is on the funding of PACT services. PACT is intended to serve those individuals who are difficult to engage, utilize high cost services, and have poor treatment outcome - factors which may contribute to a preference by managed care organizations to increasingly rely on prior authorization. CMHCs described the prior authorization process for PACT services as "restrictive" and "burdensome," re-directing the team members from providing intensive services to recipients to completing paperwork. The teams were originally funded with DMH grant funds with the intent to bill Medicaid as the services matured. Figures 12 and 13 depict the opposite picture.

Figure 12: Users of Medicaid Reimbursed PACT Services

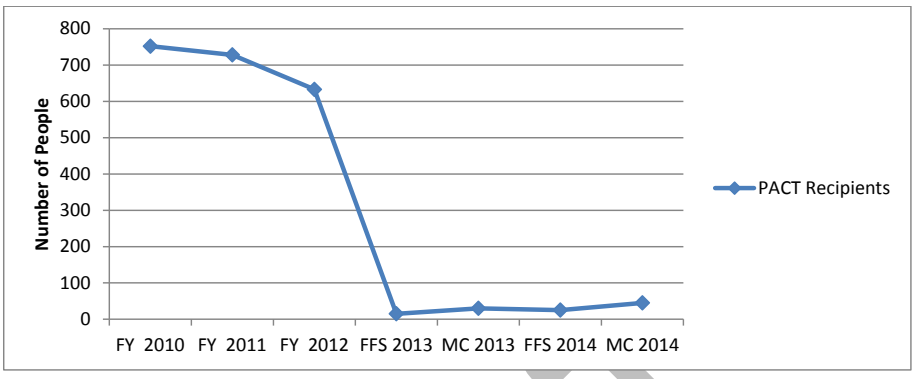
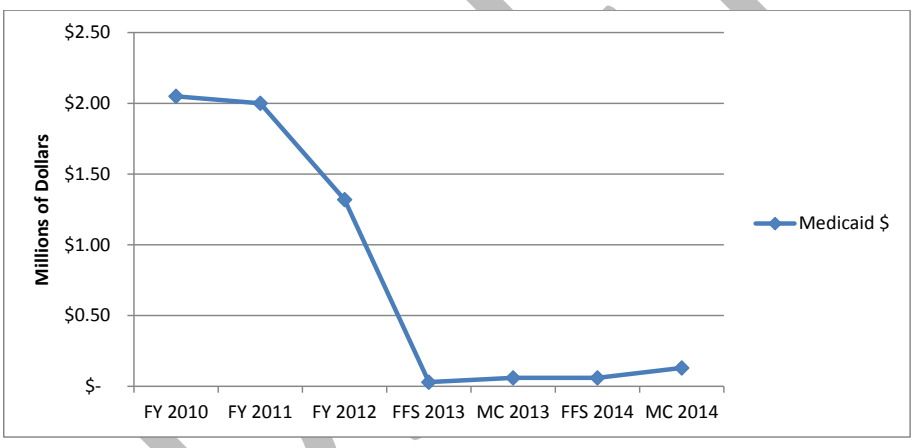


Figure 13: Medicaid Expenditures for PACT Services



The reportedly stringent authorization requirements and burdensome paperwork have resulted in CMHCs continuing to rely on DMH grant funding to provide PACT services to a limited number of adults rather than bill Medicaid for services and use DMH funding to expand the service to others in need.

Since the inception of managed care there are less Medicaid funds supporting community based mental health services.

Table 9: Total Medicaid Spend for Community MH Services in Millions

Commented [SS2]: The years dropped off the chart

	2010						
	FFS	FFS	FFS	FFS	MC	FFS	MC
				$54	$19.7	$34.2	$30.1

All Outpatient	$73.7	$81.1	$82.6	$73.7	$64.3

Service Limits

Payment limits on services such as PACT, Mobile Crisis Response, and Peer Support are contradictory to best practice since these services help to support individuals in the community and reduce over-reliance on more costly institutional or acute care. PACT is intended to be a long-term service that is available at the intensity and for the duration that meets the individual's needs. Mobile Crisis and Peer Support are intended to assist individuals by providing additional hands-on support in effort to mitigate admission to inpatient. There is no *clinical* rationale to arbitrarily impose service limits on these types of service that are more cost effective and have proven efficacy for their use. DOM does not maintain an Exceptions Process whereby additional services can be requested for individuals with documented need for continued treatment and support. Several CMHCs in fact indicated that they continue to provide care for individuals in need of service with no reimbursement after Medicaid limits have been reached.

Finally the inability to bill for more than one procedure on the same day creates a barrier to care. Many individuals who lack transportation struggle to get to a CMHC for an appointment and find it especially difficult to make a second trip for a service that they couldn't receive due to same day billing restrictions. This is especially problematic for the most rural areas of the state.

Rates

Medicaid reimbursement rates were also identified as problematic by the CMHCs. Rates are paid at 95% of the established fee, which creates an immediate shortfall. Additionally, rates do not take travel time or the rural nature of the state into account. An example is the rate for TCM and CSS – the rate for both services is the same. TCM is office-based; CSS is intended to be provided in the community in natural settings for the recipient and not in an office. Yet, there is no rate adjustment to account for the travel time from the CMHC to a recipient's home.

With Medicaid serving as the primary source of CMHCs' revenue, cost containment efforts impact accessibility to services for all. As described in the Children's Behavioral Health assessment, there are examples of ongoing cooperation between DOM and DMH. The sharing of policy changes before enactment, interagency agreements and memorandum of understanding are in place. However, agency goals are not always aligned which is impacting the behavioral health system.

Similar to the funding issues faced in serving children and youth with behavioral health needs, DOM is under tremendous pressure to manage costs in the Medicaid program. In an effort to meet that across the board directive, certain policies and rate decisions are implemented to meet that goal. However, these can have an inadvertent impact on the behavioral health delivery system and more importantly, on the individuals who are dependent on support from both DMH and DOM for their recovery

Workforce challenges

Workforce challenges facing both mental health and substance use are detailed in Chapter 3 of the Children's Report and will not be repeated here. As previously stated in this report, as of April 2012,

approximately 2.1 million Mississippi residents resided in a mental health professional shortage area with an estimated 1.1 of those residents considered "underserved."[47] In 2013 Mississippi ranked 46th in the nation for workforce availability.[48]

There are limited opportunities to support community settings in the recruitment and retention of psychiatrists in Mississippi. For example, psychiatry is not included as one of the medical specialties eligible for the Mississippi Rural Physician Scholarship program. In addition, telehealth in Mississippi has grown with respect to its use in primary care and other medical specialties, but is not being used to increase access to community psychiatric care. At the time of this writing, only one of the 14 CMHCs was actively utilizing telepsychiatry. Most CMHCs were not aware that there is grant funding available for the purchase of telehealth hardware or that codes have been established for billing the Medicaid program for telepsychiatry services. Finally, while Advanced Registered Nurse Practitioners are able and being used in Mississippi to augment psychiatric services, there appear to be some restrictions that limit their utility. ARNPs must have a collaborative agreement with a licensed psychiatrist and can only practice at a site pre-approved by the state Board of Nursing. [49]

DMH has responded to the shortage of licensed mental health clinicians by creating a certification process for non-licensed individuals working within the "state mental health system." The DMH Professional Licensure and Certification (PLACE) program was a creative attempt to appropriately respond to the shortage and should be applauded. Table 7 shows the number of individuals holding a DMH professional credential as of October 2014. The numbers below include staff with specific experience and interest in working with adults with serious mental illness as well as children with serious emotional disturbance.

Table 10: Number of individuals holding a DMH professional credential

Credential	Number as of 10/14/14
Mental health therapist	1,276
Community support specialist	964
IDD therapist	231
Licensed DMH administrator	79
Addictions therapist	111
TOTAL	**2,661**

Not all stakeholders view PLACE positively however; the Mississippi Psychiatric Association views the process as allowing services to be provided by "unqualified" staff. Absent the influx of more licensed professionals, DMH must either use this process to insure programs have sufficient staffing or face even greater issues with access to care in the public mental health system due to closures.

[47] Northeast Mississippi Area Health Education Center at Mississippi State University. (n.d) Healthcare Infrastructure Shortage Areas. Retrieved on November 17, 2014 from: http://nemsahec.msstate.edu/?page_id=437
[48] Parity or Disparity: The State of Mental Health in America 2015, Mental Health America
[49] http://www.msbn.ms.gov/Documents/AdministativeCode.pdf

To what extent are adults with mental health disorders and in recovery from addictive disease being utilized in the provision of mental health and substance use services?

DMH's peer support specialist certification program is a positive area of workforce development. Use of persons with lived experience in the provision of services is a strategy more states are using to augment traditional mental health services and support better engagement in treatment. Growing this underutilized workforce is a key to developing greater capacity to serve adults and families with behavioral health challenges. The certification process established by DMH and the inclusion of peer support in the state's rehabilitation option offers a positive opportunity for adults with lived experience. We do note however that the current peer support specialist application is complex and burdensome and the associated fees and training costs may hinder expanded capacity of this service.

In 2014, 62 individuals graduated from DMH sponsored Peer Support training.[50] The CMHCs reported providing Peer Support Services to 1,710 adults, but as indicated earlier in this report, there is considerable variation in the number of Peers hired across the CMHCs. While some providers report great success with the use of peer support in substance use residential programs, crisis stabilization, and mobile crisis services, others identified the low reimbursement rate for this service as a barrier to increasing service capacity, particularly for providers serving more rural areas. The Director of the Central Mississippi Residential Center has called upon Family advocates as well to augment her professional staff. Family advocates have been especially helpful in engaging families of residents who lack trust in the system to act in the best interest of their loved one. State-operated services would also benefit from employing Peer Specialists and Family Mentors to enrich their service delivery.

Finally, there is little to opportunity for mental health consumers and individuals in recovery from addictive disease to provide input into the behavioral health system. By statute , the nine-member DMH Advisory Board consists of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and one citizen representative from each of Mississippi's five congressional districts (as existed in 1974). These members are appointed by the Governor and approved by the state senate. While the current citizen representatives include parents of consumers, those most directly impacted by the service system do not have a voice at the table. Consumer input and influence at the state and provider decision-making levels are sorely missing throughout Mississippi's adult behavioral health system

Recommendations

A good and modern mental health service system provides ready access to an array of effective and efficient high quality services that support individuals in their communities and thereby alleviate the over-reliance on institutional care. Below are several recommendations intended to support and enhance provider capacity.

Address the inadequacy of funding for non-Medicaid eligible persons and services

The report identifies numerous examples of service inadequacy and barriers to care due to inadequate funding for community-based services and supports.

[50] http://www.dmh.ms.gov/wp-content/uploads/2012/07/DMH-FY14-Annual-Report1.pdf

Absent a decision to expand Medicaid eligibility and enhance coverage, DMH should request that the Mississippi Legislature provide additional state funding, and/or establish a threshold of funding to be re-directed from state operated services, resulting in an increase in state general funding for CMHCs or other providers capable of providing services. States that have made progress strengthening their systems have done so through increased state funding and a re-allocation of institutional resources as the emphasis of care is shifted to the community. DMH should limit expenditure of the funds to expand service capacity as evidenced through data analysis.

In addition to seeking additional funding, DMH should assure that existing funds are spent properly. DMH should require CMHCs to bill Medicaid for all eligible services and recipients, and work with DOM to reduce excessive administrative burden. DMH should re-direct the funds made available toward expanding non-Medicaid eligible services. Similarly, DMH should establish an expectation that CMHCs re-direct any funds made available through the conversion of MH group homes or implementation of PSH back into funding for non-Medicaid eligible services/recipients.

If the State's policy is to continue to assign some financial responsibility to the counties, it should consider the need to increase the counties' contribution for mental health and substance use disorder services to ensure that residents have access to mental health services and related supports.

Promote Interagency Collaboration and Use of Data for Budgeting, Policy and Program Development

The Legislature should designate a responsible authority to oversee funding, policy and planning for both DMH and DOM, insuring that any decision takes into account the impact on both agencies to meet the needs of individuals. DOM has implemented a number of cost containment initiatives since 2010, resulting in approximately $10 million in *overall* savings to the Medicaid Program. Mississippi has the second highest rate of Federal Medicaid Participation (FMAP) in the country, about 73%. While the state saved about $3 million in state expenditures, it lost about $7 million in federal revenues. During this same time, as a result of initial DOJ findings in Mississippi, the Mississippi Legislature appropriated increases of $26 million to DMH, 100% state funds, for service expansion in 2014 and 2016. As a net result, Mississippi incurred increased state spending of $23 million and the loss of $7 million in federal revenue. While TAC is not advocating for generating federal revenues for the inappropriate delivery of services, this funding approach illustrates the absence of an effective strategy for the mental health system and for Mississippi taxpayers.

TAC is aware that DMH is hiring for a newly established Data Manager position. Adding this capacity is crucial for the agency. Informed with data, DMH and DOM should jointly review monthly service delivery and expenditure reports, monitoring for cost drivers that may need immediate attention. DMH should use data to assess the adequacy of Medicaid rates to incent community-based service delivery, thereby reducing the over-reliance on state hospitals. Documented evidence of insufficient rates impacting the availability of services must be addressed despite provider concerns. Finally, DMH should use data to assess the impact of service limits on the termination of, or reduced access to, needed services as well as the amount of uncompensated care provided by CMHCs. Documented evidence of

insufficient access to care must be addressed. At minimum there must be an Exception's Process to seek FFS authorization for needed services when limits have been exhausted.

DMH and DOM should collaborate with stakeholders and work together to establish a process and indicators to assess the quality of services funded across both agencies. DMH should be the state agency responsible for driving mental health policy for the State, and should be empowered to ensure that community service providers are held accountable for providing quality services that are consistent with best practices.

Address Workforce Challenges

DMH should expand the use of Peers to help in addressing the severe workforce shortages by allowing professional staff to devote their time strictly to the delivery of clinical services.

Mississippi should address the requirement that APRNs must establish individualized collaborative agreements with physicians. This issue was described in detail in the Children's assessment. In a rural state with few physicians such as Mississippi, collaborative agreements, especially those with proximity requirements, can significantly impede APRNs' ability to provide care. APRNs cite difficulty finding collaborating physicians that the Board of Medical Licensure would approve and that are located within a 40-mile catchment area of their practice. While Mississippi has made strides to ease these requirements in recent years, including an amendment to authorize a 90-day grace period for APRNs who cannot secure a collaborative physician, the geographic component of collaborative agreements is a major barrier that limits access to care.

DMH should explore opportunities or behavioral health internships to retain professionals in Mississippi post graduation. To address the need for behavioral health services and shortage of providers in rural Appalachian communities, Virginia established a behavioral health internship that is a partnership of two universities and a community health center. As of October 2014, the Stone Mountain Health Services Behavioral Health internship is into its fourth year of interns and has:

- 5 licensed clinical psychologists, including an assessment clinical psychologist
- 2 clinical psychology interns
- 2 licensed clinical social workers
- 1 masters' social worker, a product of the internship
- 1 social work intern
- 1 adult psychiatric nurse practitioner [51]

Quality

Consistent with the assessment of Mississippi's children's mental health system, our review of the adult services system also determined the lack of an approach to quality or quality improvement. DMH and

[51] http://www.raconline.org/success/project-examples/772

DOM gave consistent responses that they did conduct oversight of services and providers, consisting mainly of adherence to standards and requirements. However, these provider reviews were done for the purpose of assessing compliance as opposed to assessing the quality of care. The exception to this is the On-Site Compliance Review (OSCR) process established to monitor provider compliance and quality of care in the MYPAC and PRTF programs. The purpose for the OSCR process is not only to assure compliance with state and federal requirements for Medicaid reimbursed mental health treatment, but to also assess services through direct observation, document review, staff interviews and interviews with service recipients and their families. DOM provides clear and specific feedback regarding their findings in order to enhance ongoing services. DOM plans to implement an OSCR process across all mental health services.

PACT serves as a case in point as to why compliance with requirements alone is not enough. PACT is an evidence-based approach and DMH monitors to insure that services are being delivered with high fidelity to service requirements. However, there are concerns with implementation of the service in Mississippi. The strict adherence to Fidelity appears at times to overshadow whether the service is improving the overall quality of life for recipients; the persons served appear at times to get lost in meeting the requirements.

As an example, one of the Legacy teams described a young woman who had participated in another service provided by the Region prior to agreeing to participate in PACT; she had established friendships and enjoyed the other programming but was assigned to PACT to reduce her repetitive inpatient admissions. Since assignment to PACT, the young woman has spent far fewer days in a psychiatric inpatient setting. But she is no longer able to attend the day programming that she enjoyed or to visit with her "friends." Her daily activities include free time, during which she now sits outside of the previously attended program and watches others inside. This team provides services with high fidelity to PACT standards and has significantly reduced inpatient utilization, but the recipient has lost a significant source of her social connectedness. Perhaps through the use of OSCR, strategies would be identified to enhance consumers' experiences with services.

Similarly to the Children's system review, TAC found that across DOM, DMH, and provider organizations there is limited use of data for planning purposes, to identify service gaps, or to assist managers in making day-to-day operational decisions. There is very little outcome data collected outside of federal grant programs or waivers. The data that is available is often outdated or has significant lags (i.e. claims data) making its utility for operational decisions limited. With a few exceptions, providers have limited data infrastructure and reporting systems are outdated and continue to rely heavily on paper and pencil reporting methods. In short, our review found there is no systematic way of looking at data across systems to inform statewide planning or to identify quality of care issues requiring attention. There is an obvious need for investments in establishing data collection and reporting mechanisms, identifying key quality indicators and metrics that can be used to evaluate performance, and connecting results to performance improvement activities and initiatives.

In many of our interviews with family members, state agency staff, advocates, and providers concerns came up with respect to the quality of care. This is an issue described by all constituents, including those

that fund care, provide care or receive care. Stakeholders consistently described barriers to accessing needed services and supports, delays in obtaining necessary treatment leading to exacerbation in symptoms, lack of coordination among services, and ineffective care resulting in repeated hospitalizations, homelessness and criminal justice involvement. Apart from the MHS of Southern Mississippi's consumer-run drop-in center, there was little evidence that service recipients have meaningful input about the services they receive.

A positive development in Mississippi's system is that in 2012, DMH engaged the University of Southern Mississippi's School of Social Work (USM) to administer annual client satisfaction surveys for both adult and youth mental health services. In 2014, the third annual client satisfaction surveys were administered and questionnaires were completed by clients in each of the 14 Community Mental Health Center (CMHC) regions. The questionnaires include demographics and Likert style ratings for domains including access to services, treatment participation, appropriateness and quality of services, social connectedness, and skills improvement. Respondents also have the opportunity to answer open-ended questions regarding their satisfaction with the service system. In 2014, a total of Consumer Satisfaction Questionnaires were completed by clients receiving services in the 14 CMHC regions in Mississippi.

While positive in approach, there appear to be limited benefits from the surveys. The number of respondents is low… while 47.5 % of adults *receiving* surveys responded, that number represents 441 of 5,474 adults served on any given day. Using Peer Support specialists to assist with survey dissemination and collection may help to increase responses. More important, there is no indication of how the results are used to improve or enhance services. Service recipients may be more inclined to complete surveys if they know that their feedback will be used to enhance future service delivery.

Recommendations

Mississippi must improve its efforts to ensure: 1) the quality of services provided to individuals; and, 2) that services are consistent with best practices. Efforts must also empower DMH to hold providers accountable based upon performance measures, and to make decisions based on data. Following implementation of the Patient Protection and Affordable Care Act, the Center for Health and Human Services was charged with developing a National Quality Strategy (NQS), the purpose of which is to better meet the promise of providing all Americans with access to health care that is safe, effective, and affordable. In March 2011, the Secretary of HHS reported to Congress on a National Strategy for Quality Improvement in Health Care. Using the NQS as a model, the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed the National Behavioral Health Quality Framework (NBHQF). The NBHQF provides a mechanism to examine and prioritize quality prevention, treatment, and recovery elements at the payer/system/plan, provider/practitioner, and patient/population levels. The NBHQF is aligned with the National Quality Strategy in that it supports the three broad aims of better care, healthy people/healthy communities, and affordable care. However, it was specifically broadened to include the dissemination of proven interventions and accessible care. SAMHSA offers the NBHQF as a guiding document for the identification and implementation of key behavioral health quality

measures for use in agency or system funding decisions, monitoring behavioral health of the nation, and the delivery of behavioral health care.[52]

The NBHQF is built around 6 measures of care: Effectiveness; Patient/Family/Community Centered, Coordinated; Healthy Living; Safe or Reduced Adverse Incidents; and Affordable/Accessible. The indicators within each measure are evolving and the subject of ongoing refinement. While not exhaustive, the following indicators would serve as a good starting point for DMH to consider.

Table 11: National Behavioral Health Quality Framework Measures of Care

Measures of Care	Indicators
Effectiveness	# of providers delivering EBPs, # of EBPs offered by each provider, # of individuals receiving EBPs
Patient/Family/Community Centered	# of individuals participating in satisfaction surveys, % of recipients participating in satisfaction surveys, % of providers sharing results with staff, # of actions taken in response to survey results, % of service recipients with documented assessment of housing needs, % of identified service recipients receiving assistance with accessing housing, % of service recipients with documented assessment of employment/education needs, % of identified service recipients receiving assistance with employment/education, % of individuals reporting social connectedness
Coordinated	post-discharge follow-up within 7 and 30 days, % of individuals discharged from any inpatient setting who's transitional care plan was shared with an aftercare provider, % of service recipients with medication reconciliation post discharge, % of individuals with documented assessment for a co-occurring mental health/substance abuse disorder
Healthy Living	% of service recipients with a WRAP, % of service recipients receiving basic health screens (such as weight, heart rate, blood pressure) at their BH provider, % of BH service recipients with at least annual encounters with a primary care provider and OB/Gyn for women, % of consumers who smoke offered cessation assistance
Reduced Adverse Incidents	hours of restraint, hours of seclusion, # of individuals discharged from any inpatient on more than 1 antipsychotic, % of service recipients assessed for exposure to trauma, % of identified recipients receiving trauma-informed care, % of service recipients assessed for suicide risk, & of service recipients with a crisis plan, % of service recipients receiving illness self-management
Affordable/accessible	# of individuals who decline to participate in treatment due to inability to pay; % of individuals who access treatment within standards for urgent, emergent and routine; % of individuals who access treatment without requiring involuntary commitment

[52] http://www.samhsa.gov/data/national-behavioral-health-quality-framework

Redefining the Role and Responsibilities for state hospital services in Mississippi

Viewing State Hospitals within a Continuum

While state hospitals are a significant provider of service in Mississippi, they operate as if apart from the rest of the mental health system. Interviews with treatment staff and the administration revealed a sense of "we" versus "them" when discussing the state hospital and the community. Hospital leadership conveyed pride in the scope and quality of services they provide to patients, and are of the opinion that individuals are not likely to obtain as comprehensive an array of accessible and high quality services in the community.

Similarly, CMHC staff described having little to no relationship with the state hospitals. Some send case management or crisis staff to the hospitals to participate in discharge planning for individuals known to their Centers, but others don't provide any services to individuals while hospitalized since they can't bill for the service and may have significant staff downtime due to travel.

There appears to be little communication between the state hospital administration and the CMHC Directors. State hospital staff reported that they don't hold meetings with the CMHCs and there appeared to be little interest in working with the CMHCs or to understand their strengths and needs. Staff indicated that CMHC Directors were too busy and would not travel to the state hospital for a meeting. Most of the hospital staff had little familiarity with the county-based services or the challenges CMHCs face in providing services. Absent communication there is no opportunity to discuss gaps that hospital staff may see in the community or the potential for sharing successful strategies and resources. Given its role as the state mental health authority, DMH should require this to occur.

As the agency responsible for the mental health system, DMH should articulate a vision for the state hospitals within the continuum of care. It is commendable that the hospital administration and staff take pride in their services, but it's unfortunate that they don't see the lack of access to comparable services in the community as a problem. Admission to a state hospital removes an individual from his or her home, family, friends and community, causes disruption in his or life and carries stigma. Many key informants throughout the system described the hospital as the "safety net"…the place where people with no health care coverage can receive mental health inpatient or substance abuse residential treatment. The hospital should be the last line of defense in stabilizing a mental illness or addiction, not the primary option for treatment.

Reducing Re-admissions

DMH has worked over the past few years to significantly reduce the length of stay for admissions, especially individuals served on the Receiving Units. This trend mirrors states across the country and is considered a best practice when the comprehensive array of community-based services and supports are readily available. Absent home and community based services, individuals may not transition well to the community, with little engagement and follow through with aftercare services. Using a point in time count for the hospital census in November, 2014, data on the number of state hospital patients who had a

previous state hospital admission reveals that the state hospital serves as a "revolving door" for many adults.

Table 12: Per Cent of Census on November 30, 2014 on Receiving and Continued Stay Units with a State Hospital Readmission(s)

	MSH		EMSH		NMSH		SMSH	
	Recvg	Cont St	Recvg	Cont St	Recvg	Cont St	Recvg	Cont St
1 readmission	15.53	14.47	50.00	0.00	15.00	N/A	17.00	N/A
2-5 readmissions	28.16	40.79	44.00	0.00	15.00	N/A	34.14	N/A
6-10 readmissions	16.02	17.11	6.00	0.00	2.00	N/A	4.87	N/A
10+ readmissions	11.65	13.16	0.00	0.00	17.00	N/A	0.00	N/A

The role of Private Psychiatric Hospitals and Psychiatric Units in Med Surge Hospitals

According to the 2013 Report on Hospitals from the Mississippi Department of Health, Division of Health Facilities Licensure and Certification[53], there were 588 adult psychiatric beds in Mississippi located in free-standing psychiatric hospitals and on psychiatric units of med/surge hospitals. In addition, there were 238 adult chemical dependency beds. Reportedly, these beds are only accessible for individuals with health insurance or the ability to private-pay leaving a large number of uninsured individuals without access to this service; with occupancy rates of 55.97% and 23.24% respectively there is bed capacity to treat more individuals in the community if there was a funding source. The lack of Medicaid coverage for substance abuse services is a clear barrier to accessing community treatment. The inability to access inpatient acute care psychiatric beds and alcohol and drug residential treatment beds in the community, especially for individuals presenting with challenging behaviors and no healthcare coverage, results in the state hospitals serving as the only option for treatment.

Workforce Issues for State Hospitals

While there is an obvious shortage of psychiatrists working in community mental health settings, particularly in more rural areas, State hospital administrators also cited challenges with maintaining staffing levels required for accreditation. The hospitals compete with the Veterans Administration and state prisons for psychiatrists, and in turn, the CMHCs compete with the hospitals. State hospital psychiatrists lamented the inability to hire additional psychiatrists via the federal loan forgiveness program, an option that was available in the past and enticed some of the current staff to their positions. Recruitment and attainment of direct care workers is also an issue for the hospitals. As one administrator pointed out the salaries for direct care staff are barely above minimum wage, yet these staff spend the most time with the patients, some who present with extremely challenging behaviors.

Funding

Advocates within the community perceive the state hospitals as flush with funding, which administrators were quick to challenge. Hospital budgets have also seen reductions in recent years. Mississippi's state hospital capacity was reduced by 286 beds from 2005 to 2010, from 49.7/100,000 population to

[53] http://msdh.ms.gov/msdhsite/_static/30,0,83.html

39/100,000.[54] The state still had the highest bed capacity per capita; South Dakota was second with 29.2 beds per 100,000 population. While operating budgets have been reduced, the grounds and facilities are deteriorating and have required extensive funding for repairs. The Legislature has secured more than $80 million in financing for needed capital construction and improvements. However, reliance on institutional care is inconsistent with best practices, and is fiscally unsustainable due to the significant expense of providing clinical care and maintaining aging facilities.

Recommendations

DMH must define the role and responsibilities for state hospitals within Mississippi's continuum of mental health service delivery. State hospitals should not be viewed apart from the community mental health system or as an adversary to CMHCS. Facilitating quarterly meetings/conference calls between state hospital administration, treatment teams and CMHC Leadership should help to enhance communication and problem solving for patients with complex needs and/or repeated hospital admissions. In Pennsylvania State Hospital Service Areas plan for requesting and using resources to enhance services and supports in both the communities and the hospital.

DMH has indicated support for the development of an accessible, community-based system. States that have committed to this have also committed to reducing reliance on long and short term inpatient care thus reducing state spending on institutional care. Several states have received "bridge funds," a significant investment in community-based services allocated by the legislature over a period of time (e.g. 1 – 5 years) with the intent to downsize and reduce appropriations to state hospitals as beds are utilized less. Savings are not realized by a reduction of one bed, but savings can be realized as increased numbers of vacant beds materialize. Key in this process is commitment to community services and hospital diversion, and to not unnecessarily fill state hospital beds as other patients move into community-based settings.

DMH must assure that if state hospitals are going to continue as part of the service continuum, services must be delivered in safe settings, availing current technology and staffed by qualified individuals who are adequately compensated. Direct care staff should receive wages and benefits sufficient to promote retention and afforded opportunities for advancement. Buildings which present safety concerns as well as inefficient and undesirable environments should not be used for patients. However, securing $80+ million is bonds for capital improvements in lieu of funding community-based care is hard to justify.

By creating a variety of opportunities for state hospital psychiatrists to serve as consultants for family physicians and other primary care providers, DMH will enhance the community's capacity to evaluate and treat adults with SMI. Project Echo[55], adapted from the model that originated in New Mexico, has proven very successful in enhancing the expertise of primary care providers in treating individuals with mental health disorders in rural communities. Other states and health plans have experienced similar success through regularly scheduled "grand rounds," where specialists conduct regularly scheduled case reviews with general practitioners, increasing their comfort level and expertise in treating more challenging, complex cases.

[54] http://www.tacreports.org/trends-in-availability
[55] http://www.rwjf.org/en/grants/grantees/project-echo.html

DMH should also look to address state hospital workforce issues through pursuing the loan forgiveness program as approved by the Legislature, and the hiring of Peer Support Specialists and Family Mentors to support the clinical staff.

DMH and DOM should crosswalk the state hospital, Medicaid and third-party formularies and address discrepancies. DMH should work with DOM to develop a process to advocate for access to high-cost medications when proven to be the only agent successful for treating an individual's mental illness. DMH should also explore bulk purchasing with the CMHCs to obtain reduced pricing for more costly medications.

DMH should assess the impact of issuing a policy prohibiting the admission of any individual directly to a state hospital if a CSU bed is available, can meet the clinical needs of the individual and assure the safety of the individual as well as the community. While DMH may not be able to control the decisions made by Chancery Court Judges they can take a stand on the rights of individuals to access less restrictive alternatives to care when available. In addition to assuring individuals have access to CSU beds when appropriate, DMH should also identify funding to negotiate for access to acute care beds when available in the community.

In order to address readmissions, DMH and DOM must resolve the inability to pay for TCM and CSS services while adults are inpatient, the use of mobile services capacity and "peer bridgers," and the timeliness, frequency and intensity of services for individuals who are in crisis or just transitioning from inpatient to community-based living. DMH should also conduct a thorough analysis of individuals with high numbers of readmissions to identify potential gaps in aftercare for the individuals, as well as the community based system. Addressing those factors should significantly reduce the revolving door.