

Family First Prevention Services Act

PL 115-123

Stakeholder Informational Meeting Highlights

The Family First Prevention Services Act (FFPSA) was signed into law as part of the Bipartisan Budget Act on February 9, 2018. This act reforms the federal child welfare financing streams, Title IV-E and Title IV-B of the Social Security Act, to provide services to families who are at risk of entering the child welfare system.

North Dakota Department of Human Services (NDDHS) is responsible to implement the federal regulations resulting from FFPSA, manage the Title IV-E State Plan, and administer funding to support these efforts. The department will host Stakeholder Informational Meetings the 3rd Wednesday of each month during 2019. The purpose of the monthly meetings is to engage with Stakeholders and inform on progress, while soliciting feedback and comments related to FFPSA implementation.

DATE	April 17, 2019
FACILITATORS	Pam Sagness, Director – NDDHS-Behavioral Health Division
TOPIC	Legislative Updates on Children’s Behavioral Health

Link to the Behavioral Health Matrix:

Full Behavioral Health Matrix:

<https://www.behavioralhealth.nd.gov/sites/www/files/documents/Behavioral%20Health%20Matrix%20-%204.6.19.pdf>

Children’s Behavioral Health Matrix:

<https://www.behavioralhealth.nd.gov/sites/www/files/documents/Copy%20of%20Behavioral%20Health%20Matrix%20-%202.26.19%20-%20Children.pdf>

Highlights of ND Legislation on Children’s Behavioral Health:

- **SB 2012:** This is the DHS Budget Bill. Refer to the matrix (link provided above) for the behavioral health continuum descriptors addressed during the 2019 Legislative Assembly and included in the DHS budget bill.
 - **1915(i) (Home and Community-Based State Plan Option) Medicaid Plan Amendment:** Amendment to the Medicaid State Plan was proposed which would provide additional services to adults with a serious mental illness, substance use disorder, or brain injury (i.e. employment, education, transitions out of homelessness/institutional living, housing, peer supports, etc.). SB 2298 was introduced by Senator Lee to include a 1915(i) for children with a serious mental illness, substance use disorder, or brain injury (i.e. respite, peer supports, transitional supports, supported education, housing, transportation for non-medical purposes, family training/supports, etc.). The Senate combined, into one line item, the 1915(i) for BOTH adults and children. It was then added into SB 2012 (DHS budget). There were no proposed changes on the House side, so we are optimistic that we will be implementing a 1915(i) in the 2019-2021 biennium. The 1915(i) will be included in the Medical Services budget.
 - **Human Services Research Institute (HSRI) Study:** Originally SB 2030, it appropriates \$300,000 in the DHS budget bill to continue the work of the HSRI. We completed the initial

study and brought forward 13 key recommendations, which have moved into an implementation plan. It's important to note that the HSRI is broader than the department, in that it has strategies that involve law enforcement, community partners/providers, etc.

- **Peer Support Certification:** Originally SB 2032. State general funds were secured to develop a peer support certification program. This is vital as we look at implementing the 1915(i) so that we can develop specific criteria for peer support and therefore reimburse for those services. Additionally, state general funds were included in the DHS budget so that peer support would be available to others who would benefit from the service, but don't qualify under 1915(i).
- **Free Through Recovery (FTR) Program Expansion:** Originally SB 2029. The Free Through Recovery program began after last session by taking \$7,000,000 from the Department of Corrections & Rehabilitation (DOCR) budget and use it for community-based behavioral health supports (both for addiction recovery and mental illness). The program has paid for care coordination and peer support for individuals who were coming out of incarceration or were on probation or parole. The expansion involves making these services available to those who are not involved in the criminal justice system, in particular as an effort to divert people from the system (i.e. individuals coming into contact through local jails but not under the care/custody of DOCR, partnering with social service agencies to provide these services to parents struggling with substance abuse so that children wouldn't have to necessarily be removed from their parent's care, etc.). It is an outcome-based model, which means we reimburse providers based on 4 key outcomes – 1) housing, 2) employment, 3) a reduction in criminal justice involvement, and 4) recovery. So, if an individual achieves 3:4 of those outcomes per month, there's an incentive payment provided to them. It is not a 'fee for service' model; rather, it is very individualized so that individuals can identify their actual barriers. For example, if an individual couldn't get employment because they couldn't afford required work wardrobe, we would provide funding to purchase what is needed to obtain employment. So, the FTR expansion would serve a very different population that what is currently being served. We proposed a \$4.5 million budget for that program. The House reduced the budget to \$3.5 million. It includes 6 FTEs located in each of the regions so that we have the ability to provide training and technical assistance as well as make connections with local providers. Originally, they had removed the FTEs, but they recognized somebody has to reconcile outcomes for reimbursement, so they put the FTEs back in, which is vital for outcome-based reimbursement.
- **School Behavioral Health Program Pilot:** During the 2017 legislative session, HB 1040 approved \$150,000 to develop and implement a school-based pilot specific to mental health promotion, mental illness prevention, and early intervention efforts (ultimately awarded to Simle Middle School in Bismarck). Simle M.S. has only had 1 year to develop/implement, so the previous funding will continue to be expended in this pilot site. One of the reasons Simle M.S. was chosen for this pilot was that they had already implemented the Multi-Tiered System of Supports (MTSS). They already had data showing they've changed their culture to decrease the number of suspensions, expulsions, and getting to the root causes of child behavior. We were given an additional \$300,000 through SB 2012 to expand that pilot to a rural or tribal school. The money is not to be used for a clinician; rather, it is targeted for prevention/early intervention work such as: 1) How can we provide an early intervention and connection to services that's needed, and 2) How can we address the 'silent symptoms' in children that are not necessarily identified, or those who don't exhibit externalized symptoms (i.e. the high-achieving child who is suicidal).
- **Substance Use Disorder (SUD) Treatment Voucher Expansion:** Originally SB 2175 & HB 1105. This voucher was introduced 2 sessions ago. Provides reimbursement to providers for services where we have gaps (i.e. Medicaid doesn't reimburse for methadone, so the

voucher provides reimbursement). The request this session (SB 2175) is to include youth ages 14-17 (previously was for 18 and older). The voucher also provides reimbursement for transportation and recovery supports. Our current count is around 2,400 recipients of the voucher. The voucher program continues to grow very rapidly, so we included 2 FTEs to manage this program within the department's budget. We also had a deficit appropriation of almost \$3 million, so that was also included in the budget.

- **Parents Lead Program:** Original appropriation of \$360,000 of state general funds for substance abuse prevention, the only state funds targeted for this purpose, and we receive no state funding for mental illness prevention. Last session it was reduced to \$100,000 so we requested it be increased to \$200,000. The Senate recommended restoring the budget to \$360,000, but the House reduced it back to \$200,000. This program addresses underage drinking, cyber bullying, domestic violence, and other broader behavioral health topics. We also get some federal funding to support this work.
- **Recovery Home Grant Program:** We have \$200,000 to develop a recovery home grant program. This affects children and families indirectly. Currently, individuals unnecessarily end up in a higher level of treatment because we don't have safe recovery housing for social detox, residential services, etc. This program will help us look at how we can expand such services across the state.
- **Suicide Prevention Program:** Originally SB 2198. This funding has traditionally been appropriated to the Department of Health. We made a request in the executive budget to have this program/funding moved to DHS. This amounts to \$1.2 million plus 1 FTE. This is significant as we look across the continuum of care from prevention/community level to intervention services.
- **Crisis Response Services:** In NDCC 50-06 DHS is required to provide crisis response services across the state through field services (i.e. regional human service centers). All regional human service centers currently have 24/7 crisis on-call but only 2 regions have been funded to offer more robust crisis services through mobile crisis response units. We are looking at making this service available in every region of the state. The legislature has approved \$4.2 million and 27 FTEs to the regional human service centers so that this statutory requirement can be met. This will result in a significant change to how crises are managed in the state. It will take time for each regional human service center to assess their needs and develop a plan to build that capacity.
- **Targeted Case Management:** Originally was SB 2031, with the goal of expanding the approved providers to include private providers. The budget includes \$12.2 million in general funds and another \$12.2 million in other funds.
- **7 FTEs:** The Executive budget had originally reduced the FTEs, but the Governor's budget was never adopted. Therefore, you will see these 7 FTEs as "additional" but in reality, these are retained positions because they were never removed.
- **Mental Health Voucher - failed:** Originally SB 2026. This session has been very different. We're typically ending the session excited about the "one big win," when this session we have had many wins. There was only one item removed from the budget by the House, and that was the Mental Health Voucher (\$1 million appropriation and 1 FTE), similar to the SUD Voucher. The Mental Health Voucher would address system gaps for young adults between ages 17-25 with a serious mental illness. Their rationale for not passing this was more about the timing/duplication of effort, since the legislature approved the 1915(i), which will assist with growing availability of mental health services. It appears the mental health voucher may happen through staggered implementation, or it may resurface in a future legislative session.

- **Behavioral Health Prevention and Early Intervention Services:** Originally SB 2028. There was a \$600,000 budget request, with ½ of that funding going to mental illness prevention/mental health promotion. That was reduced to \$300,000, which will be used to develop a behavioral health prevention and early intervention services program.
- **Trauma-Informed Practices Workgroup:** Originally SB 2291. This was to continue the work of the Treatment Collaborative for Traumatized Youth (TCTY). We have funded this work for the past 10 years, but it was inadvertently left out of the budget last biennium. We were able to partner with other temporary funding during that time, but the legislature did include \$200,000 for this work in the DHS budget.
- **School District Behavioral Health Grants:** Originally SB 2300. It is to provide grants to school districts to address student behavioral health needs. Sen Kyle Davison introduced this bill, intended to incentivize schools to bill Medicaid for behavioral health services (i.e. if the school billed \$50,000 to Medicaid, they could come to BHD and request \$50,000 from the department to address behavioral health issues). This passed the Senate, but on the House side there was concern that the bill would only support those already billing Medicaid and wouldn't benefit the rural school districts, as they don't have the expertise to access this resource. The House added \$200,000 to assist those schools not currently billing Medicaid in building the necessary infrastructure. Therefore, the appropriation is now at \$1.5 million, which was moved into the departments budget. There is a one-year delayed implementation so that schools can be notified of the availability, start utilizing Medicaid, and build the program. The intent is to reimburse school districts for behavioral health services NOT covered through Medicaid or otherwise billable through 3rd party payers.
- **Policy bills:**
 - **HB 1105** – relates to treatment services for children with serious emotional disturbances and the voluntary treatment program (VTP), to expand to community-based services rather than strictly residential/out of home placement.
 - **SB 2198** – relates to moving the suicide prevention program to DHS. Also, had to do with syringe services program – individuals accessing the program were NOT to be prosecuted, but law enforcement was charging the individuals with possession, rather than paraphernalia, using the drug within the syringe as the evidence. So, code was updated to include both paraphernalia and possession in the syringe services program.
 - **HB 1100** – gives BHD the ability to charge fees for licensing agencies/facilities.
 - **HB 1103** – related to opioid treatment programs and Medicaid-assisted programs. There are 3 in the state currently, which is quite limiting. We created offsite locations where methadone can be administered safely.
 - **HB 1237** – relates to child sexual abuse education in schools. Would continue the task force.
 - **HB 1442** – relating to sobriety check points. It would make these illegal. It passed in the House but failed in the Senate, so sobriety check points are still a tool local law enforcement can use as a deterrent.
 - **SB 2052** – relating to school districts having safety plans, which passed.
 - **SB 2114** – met yesterday in conference committee relating to any child who has a

Minor In Possession being required to complete an early intervention course. This is already a requirement in juvenile court, but this would expand it to cover youth ages 18-20. There was an error within the previous law, so the technical error was corrected. We currently have 27 people trained to provide the early intervention classes, with interest from community health in offering it as a prevention service. We have written administrative rules listing requirements of those teaching the class.

- **SB 2149** – regarding mandatory instruction for students in mental health awareness and suicide prevention. There were some concerns regarding who within the schools would be providing this instruction, so the bill was amended to say that every school must identify a behavioral health resource coordinator, and in a separate bill, the department has been required to get that information to the behavioral health resource coordinators so that they know what services are available, and how to access services. Sen Joan Heckaman was key in this bill, and it was actually brought forward by a student who testified on her own experiences.
- **SB 2204** was merged with **SB 2313** – relating to the development of a children’s behavioral health infrastructure, with representation from all 3 branches of government, tribal representation, and consumer/family member representation. The goal is to create a true, cross-government focus on children. Another part of the bill was to create a juvenile justice commission brought forward through the justice reinvestment work, to also include children. There is a sunset clause on this, so the juvenile justice commission will be in place for 6 years to review the uniform juvenile court act.
- **SB 2266** failed – relating to schools adopting restraint and seclusion policy.
- **SB 2240** – updated language related to substance abuse disorders.
- **Key legislators in support of the behavioral health bills/budget requests included:** Sen Judy Lee, Sen Kathy Hogan, Rep Jon Nelson, Sen Dick Dever, Sen Kyle Davison, Rep Cynthia Schreiber-Beck, Erin Oban and many more. Also, pivotal this session was our partnership with the Governor and First Lady, in hosting “Recovery Day” at the capitol. We had the majority and minority leadership of both chambers present with us. It is clear that we all agree behavioral health needs attention and action.

NOTE: Kelsey reported that the DHS is still awaiting federal guidance necessary to implement the FFPSA Prevention Plan.

Q & A

It is difficult to find information on the DHS website related to becoming a mental health practitioner. Is ND looking at the possibility of creating this new entity of ‘mental health practitioner’ to expand the pool of applicants?

Most credentialing is handled through licensing boards. The legislature has addressed this over the past couple sessions. There was a bill to create tiers of mental health professionals. They looked at every place in code where the term, ‘mental health professional’ was used and aligned several sections of code. They aligned the tiers to the definitions of various mental health professions. For example, who can do a commitment? Tier 1A and 1B would have the ability to commit. There were some updates made to the tiers, and there has also been discussion during the interim session about having one behavioral health board. There are many differing opinions about that. There have been professional titles created by HR, for hiring, and there have been

professional titles adopted because insurers have stated, “this is what we’ll pay for.” A lot of attention needs to be paid to this, as it presents opportunities.

NEXT MEETING:

May 15, 2019 1:00-2:00PM

TOPIC: Legislative Updates from CFS