MONTANA LEGISLATIVE BRANCH

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MINUTES
HJR 35 SUBCOMMITEE

Wednesday, March 8, 2000
Helena, Montana

The fourth meeting of the House Joint Resolution (HJR 35) subcommittee was called to order by Senator Chuck Swysgood, Chairman, on March 8, 2000 at 8:45 a.m., in Room B-7 of the Federal Building. The following HJR 35 members were present:

Senator Swysgood, Chairman	Representative Taylor, Vice-Chairman
Senator Waterman	Representative Soft
Senator Franklin	Representative Barnhart
Senator Keenan	

Representative McCann was excused.

Approval of Minutes

Senator Waterman moved that the minutes of the January 20 and 21, 2000, meeting be approved as presented. The motion carried unanimously.

Montana State Hospital Construction

Lois Menzies, Director, Department of Administration (DOA), Randy Triem, Project Manager, Montana State Hospital (MSH), and Tom O'Connell, Administrator, (DOA) answered questions regarding the construction of the new facility. Ms. Menzies reported that the completion date planned was for June 27, 1999 but the new building is not yet complete. The construction company has claimed that some of the delays are the result of state action or the action of consultants, unforeseen circumstances, labor strikes, and bad weather. DOA is negotiating with the construction company for the assessment of penalties and fines for delays. DOA currently holds in retention about $1.0 million in payments. That amount would be enough to assess liquidated damages for the delay when a determination is made.

Senator Swysgood asked when the hospital would be completed. Ms. Menzies stated that the hospital is close to completion. Ms. Triem stated that it would be completed by the end of the month.

Senator Waterman asked if the hospital would be fully operational at the end of the month. Ms. Triem stated that the hospital would not be. The contractor will be finished with the contract obligations by the end of the month. There is approximately a two-month period to get staff and patients moved in. **Senator Waterman** also asked when the remaining things that were not included in the contract would be completed, how much those will cost and if the sewer has been fixed. Ms. Triem said that the remaining list of items will be worked on at the same time staff is moving in. The cost should be under $50,000. Ms. Triem also stated that the sewer has been connected.

Senator Waterman commented that she is concerned with the design of the new hospital, the long hallways and places to stash contraband. Mr. O'Connell responded that the design process for the new facility involved working with a planning committee, which included doctors, nurses, a psychologist, and administrators from Warm Springs in an attempt to build more of a hospital facility than a correctional facility. Mr. O'Connell also reported that the sewer that was destroyed went to the multipurpose building and during construction got crushed or removed. It's not the sewer to the new facility.

Ms. Triem responded that there are long hallways but the building has a security camera system in all of the hallways. The strike line between the block walls in the patient rooms meets a rubber base cove on the floor where contraband could be stuffed and that is going to be fixed.

Senator Swysgood commented that he hopes the state will take a firm position during negotiations with the contractor in regard to the completion date being almost a year behind schedule.

MAP Jail Survey

The Montana Advocacy Program (MAP) is a private non-profit organization, which advocates for the rights of people with disabilities and is appointed by the State of Montana to act as the protection and advocacy organization for people with mental illness and developmental disabilities in Montana.

Alexandra Volgerts, Attorney, MAP summarized statues and case law regarding treatment of persons in jails and prisons. Prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care, including mental health care. Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997a et seq., authorizes the Attorney General to conduct investigations and litigation relating to conditions of confinement in state or locally operated institutions (the statute does not cover private facilities). The standard of care the U.S. Supreme Court has set is that prison officials may not exhibit deliberate indifference to the serious medical needs of inmates. These standards were taken from a lawsuit filed against Los Angeles county in the late 1980s. The U.S. Attorney General considers failure to provide reasonable medical care constitutes unnecessary and wanton infliction of pain contrary to contemporary standards of decency. The Attorney General's Guidelines state that the essential components of a prison or jail mental health system should include the following:

- Inmates must be screened for mental health and medical problems in a confidential setting.
- The facility must screen upon admission in order to identify inmates with mental illness.
- Inmates must be monitored throughout their incarceration in the event they develop signs or symptoms of mental illness.
- A range of meaningful medical modalities must be provided to inmates identified as having a medical disorder.
- Psychotropic medication must be made available, if needed.
- Individual and group therapy must be made available, when appropriate.
- Inmates with a history of mental illness should not be disciplined without consulting the mental health staff.
- The facility should provide sufficient and qualified staff to provide treatment consistent with contemporary standard of care.
- Access to an adequate number of psychiatrists, psychologists, or other mental health professionals must be provided for the number of people in the facility with mental illness.
- Prison psychiatrists should have caseloads of no more than 125 to 150 inmates and jail psychiatrists should not exceed 75 to 100.
- The facility must have a special needs unit and inpatient hospitalization to provide more intensive treatment and supervision should the number of inmates in their facility justify it.
- The facility must keep accurate, complete, up to date, and well organized medical and mental health records. They must be kept confidential and separate from the penal records.
- The facility must ensure continuity of care after release. They must provide inmates with medical prescriptions as well as the right to follow-up services in the community mental health centers.
- Prisoners with serious mental illness must be provided with an equal opportunity to have success in the community.
- The facility must have a quality assurance plan to assure that inmates receive competent care.

Alexandra Volgerts, discussed the results of the MAP Jail Survey (Exhibit 1). MAP conducted a survey of 22 jails or detention centers in Montana to determine the standard of mental health care in jails, what problems are being faced by both the inmates with serious mental illness (SMI) and the detention staff.

Response Rate

After 5 months, 15 out of 22 of the jails surveyed completed and returned the survey. The respondents comprised just over 33 percent of all jails in Montana.

Summary of Findings

- 75 percent of the responders estimated 1 to 5 percent of their inmates suffer from SMI. The remaining 25 percent of the respondents estimated from 6 to 10 percent of inmates had SMI.
- Almost 50 percent of responders thought they were seeing more inmates with SMI than 5 years ago.
- Native Americans make up more than 10 percent of the population in over half of the responders, with 20 percent reporting Native American populations of 25 to 34 percent
- Approximately half of the jails reported using some form of screening tool at booking to identify mental health issues and such tools used no more than 3 to 5 questions.
- Approximately 60 percent of the jails provided very few inmates with psychotropic mediation during incarceration. Few jails made arrangements to ensure that inmates' medication could be continued once the inmate was released.
- Approximately 87 percent of the responders had 24-hour crisis services available in their community but 80 percent indicated there were no in-patient hospital beds available in their community for crisis or treatment.
- One-third of responders admitted they had detained a person with SMI on no charges or on petty charges to protect the person or the community.
- 87 percent of the jails can provide alcohol abuse counseling, 66 percent can provide alcohol and illegal drug counseling, and 15 percent have no access to any form of substance abuse counseling.
- Discharge planning is nominal, with 50 percent stating they provide none.
- Two jails had 1 to 5 inmate deaths last year. Almost half of the respondents had 1 to 5 suicide attempts last year.
- All respondents identified 2 to 7 special problems created by incarcerating people with SMI. One-third of respondents were aware of inmates with SMI who had either been victimized by other inmates or had victimized other inmates within the last year.
- Nearly all respondents reported responsibility for transporting persons to MSH for commitment or diversion. Respondents cited the inconvenient timing, distance, frequency, cost and staff demands as problems.

Senator Franklin expressed concerned that the survey does not define the problem, is not statistically valid, and that it may lead to the wrong solution. Ms. Volgerts agreed and stated that the results are more reflective of the perceptions of the detention center staff then of the actual

conditions. There were a number of recommendations that staff made. The detention center staff and sheriffs said that when the mental health system fails, they are the system of last resort and they don't have the resources, training and funds to deal with mental health issues

Kathleen Mauer, a licensed Nurse Practitioner, currently provides care at Ravailli County jail two half days per week. Ms. Mauer raised concerns regarding withholding medications from prisoners and the lack of follow-up treatment when they are released. About 90 percent of the people in the local jails suffer from some type of mental health problem including drug and alcohol abuse. She has encountered some opposition when ordering medications for the prisoners. Ms. Mauer reported that after Dr. Jones (from the Department of Corrections - DOC) visited with local jail personnel that it seemed to her that it became more difficult to get permission to obtain psychotropic medications. Through the Access to Care Program, Ms. Mauer can obtain free medications by writing and sending a prescription to them.

Senator Franklin asked Ms. Mauer if she had any personal conversations with Dr. Jones about his approach to mental health care. Ms. Mauer stated that she did not. She attended a meeting that Mr. Jones spoke at.

Senator Franklin expressed concern regarding Ms. Mauer's remarks regarding Dr. Jones and asked that he be allowed to address the subcommittee.

Dr. Jones, Medical Health Director, DOC and Montana State Prison responded that there is a lot of misinformation publicly. Prisoners are not taken off their medications when they arrive at the prison. Anyone who is on medications will continue until they are evaluated whether it is for medical or mental health. Once they are evaluated the clinician makes a determination as to which mediations should be continued. A lot of confusion comes from the fact that many times people who come to the prison are withdrawing from other substances that were not prescribed to them. Each person that comes into the prison is screened within the first 4 to 12 hours regarding on-going treatment and current treatment. There are three levels of mental health screening that take place, which allows for referral or appropriate evaluation follow-up.

Representative Barnhart asked if medical records follow the person from the jail to the prison. Dr. Jones stated that many times persons are transferred without much information. DOC is in the process of establishing a computerized medical record system.

Senator Keenan provided a copy of the Disclosure and Consent for Services form and the Level 1, 2 and 3 screening for mental health services from the Montana State Prison (Exhibit 2).

Senator Waterman reported that the subcommittee on law enforcement of the Mental Health Oversight Advisory Council is working with the sheriffs and police officers at their request, to develop a screening and intake form.

Great Falls Campus College of Nursing

Sharon Howard, Assistant Professor Montana State University (MSU) Bozeman, distributed a packet outlining the service delivery in Great Falls at the regional detention center (Exhibit 3). The project is a partnership between MSU and Cascade County. The health service at the prison is an integrated service involving physical and mental health of all inmates, employee health and environmental safety. The complex in Great Falls is a 360-bed facility and houses county, federal and state inmates. Inmates are of all races with significant populations of Native Americans, Hispanics and African Americans. Many inmates are developmentally and physically disabled, pregnant, abused, intoxicated, battered, and mentally ill, and have chronic illnesses and infections. The nursing staff average 200 face to face contacts with inmates a day. One-third of the population will receive medications every day. There are 6,000 health requests evaluated by registered nurses each year. Sick call clinics are conducted 5 times per week for 4 half days per week. There are 80 to 100 inmates seen in clinics each week. Medication costs average $10,000 per month and laboratory costs average $1,000 per month.

Senator Swysgood asked Ms. Howard how much training law enforcement officers would need to be better able to handle persons with mental illness. Ms. Howard stated that preferably a day and a minimum of four hours.

Senator Franklin identified some key issues: on-going mental health training for detention officers; potential statutory changes; professionalizing case management; and records management.

Standing Agenda Items

Mental Health Access Plan (MHAP) Claims - Jacqueline Lenmark, representative for Magellan Behavioral Health, distributed two handouts: a Summary of Transition from MHAP to the Mental Health Services Plan (MHSP) (Exhibit 4) and a three page document containing Magellan Behavioral Health Claims Adjudication Summary, Summary of Appeals and Disputes, and Administrative Expenses for Montana Operation (Exhibit 5).

In late March 1999, Magellan entered into a termination agreement with the state of Montana to close MHAP.

- Magellan established three active work teams with representation from Magellan, Department of Public Health and Human Services (Department), and related state vendors.
- Magellan agreed to authorize and manage all Medicaid mental health inpatient cases through July 1, 1999.
- Magellan managed claims payment for eligible members for dates of service through June 30, 1999.
- Magellan maintained clinical and enrollment staff through September 1999.
- Magellan currently maintains two full time claims customer service staff to address the processes associated with claims questions, appeals and dispute resolution.

Page 1 of the claims adjudication summary contains information about the financial status of the program for February 1, 1999 through January 31, 2000. Billed and paid data is organized by month. The last several months of the program claims activity significantly dropped off so those months were consolidated. The denial data does not tie directly to the paid and billed data. The reason for that is when a claim is denied it may still be paid at a later time after review. When a claim is denied initially the provider has the opportunity to appeal that denial through an appeal process. In addition, as part of the termination agreement, Magellan and the state collaboratively developed a dispute resolution process that allowed denied claims to be brought back for reevaluation. The table at the bottom of page 1 contains by claim line and by percentage the most common denial reasons.

Senator Waterman asked what was the amount still in dispute at the end of January. Ms. Lenmark stated it is the amount that is either denied and the denials have been upheld or it is claims that are still working through the appeal process.

Senator Swysgood asked how much money is in the reserve. Ms. Lenmark stated that there are no funds left in the reserve. The entire reserve was paid out during the period of time for claims with dates of service prior to April 1. The state assumed risk May 1, 1999. Magellan contracted with the state to process claims with dates of service from May 1 through June 30, 1999 even though the payment would come from the state.

Senator Waterman posed several questions to Ms. Lenmark regarding charges paid by the state and payments to Magellan. Ms. Lenmark stated that charges that were billed in May and June, and processed by Magellan, were paid by the state. She would not guarantee that claims in that period of time were not paid from the reserve. Magellan was not permitted to use the reserve for any claims until all unappealed claims with dates of service prior to April 1 were paid. Checks were cut for providers for dates of service prior to April 1 and they were forwarded to the state, and Magellan was reimbursed from the reserve fund for those claims. Claims with dates of service after that were processed and paid from Magellan funds. If the claim was for services from May 1 to June 30, 1999 then that dollar amount was submitted to the state and the state reimbursed Magellan.

Ms. Lenmark also stated that Magellan received its last capitation payment for the month of April. Magellan was compensated for claims processing work for the months of May and June but did not receive any additional payments from the state for services. The reserve fund was monies that had already been paid to CMG as security for execution of the contract. The reserve fund was used only for payments to providers and was never used for administrative service. Other funds from Magellan paid and continue to pay for claims.

Senator Waterman also asked if any of the $13 million in claims are subsequently determined to be valid claims will be the responsibility of Magellan. Ms. Lenmark stated that if the claims are for dates of service prior to May 1 than Magellan would pay them. If they are for dates of service May 1 or later than it will first be determined whether they should be paid. If the determination is made that the claim should be paid then it is the state that will pay that claim.

Senator Swysgood asked how much of the $13 million in claims are for the months of May and June. Ms. Lenmark did not know the amount but would try to see if it is possible to get that information and provide a report at the next meeting.

Senator Waterman asked who is handling the appeals and negotiations and does someone know what the amount is that the state will be responsible for. Ms. Lenmark stated the appeals and the dispute resolution for all claims with dates of service through June 30 are handled by Magellan.

Senator Swysgood asked Ms. Lenmark to clarify page 2 of the handout, which is a summary of appeals and disputes. Ms. Lenmark explained that the number of appeals filed since Magellan assumed MHAP management is 30,010 and the number of providers using the appeal process is 874. The 874 may be the same provider filing more than one claim. **Senator Swysgood** also asked if the 19 open appeals correspond to the $13 million on page 1 and if not, why. Ms. Lenmark stated that the dates don't correspond and there are still claims on page 1 that may not have started the appeal process.

Representative Barnhart asked if some of the providers are resubmitting the same bill month after month. Ms. Lenmark responded that she is not aware of providers continually resubmitting bills if they are denied. Sometimes the certification does not reach the system before the bill for the service so it will be automatically denied. The appeals process would be the most efficient way to get the bill paid. Ms. Lenmark also stated that there are some claims that Magellan is not going to pay under this program. If the patient is not eligible, if the service is not an authorized service, if the necessary pre-authorization or certification is not obtained, the claim will not be paid. If it is not billed at the contracted rate or the correct non-participating rate, the claim will not be paid.

MSH population - Mr. Anderson, Administrator, Addictive and Mental Disorders Division, Department, referred to the January report on the MSH (Exhibit 6). The January report indicates the average daily population (ADP) to be 148. Mr. Anderson reported that the population for February is still at 148. The population is significantly below where it was last year at this time. Mr. Anderson stated the population will be further reduced through expansion of the PACT program.

Senator Swysgood asked what the forensics population is. Debra Dirkson, CEO, MSH stated there are 42 forensic patients on the unit now. There are 2 or 3 other patients that are residing on less restricted units. There are 8 of the 42 patients that can be placed on one of the lesser

restricted units. If they moved into the new facility today every bed in the forensic unit would be full.

PACT update – Randy Poulsen, Bureau Chief, Mental Health Services Bureau, Addictive and Mental Disorders Division, Department, reported on the PACT Program. Mr. Poulsen referred to the packet containing the reports for the Helena and Billings PACT programs for the month of January and the Department summary figures for the PACT programs (Exhibit 7 and Exhibit 8). PACT implementation in both communities is on schedule and proceeding well. The Helena team has asked to hire two more paraprofessional staff to use for daily routine errands and helping clients shop. The Department has told them to proceed with hiring those people. The Billings team has requested an additional registered nurse position to help with the clients they have now. Once the program has stabilized in June, the additional position would allow them to further expand the number of clients they can take. Currently they are scheduled to take 40 clients as opposed to the Helena team, which is going to take 60 clients. The Department is continuing to work with the teams to find out what is needed to make the programs successful.

Senator Waterman expressed concern that the teams are only at half capacity and will additional staff be needed in order to reach the total team sizes. Mr. Poulsen stated that when the teams are stabilized in June, the PACT teams feel they will have adequate staff to run the programs.

Representative Barnhart asked how the evaluation of the two teams is working. Mr. Poulsen stated that the Department does not have data at this time but the PACT teams are collecting baseline data and ongoing assessment data for future comparisons. **Representative Barnhart** also asked if the evaluations will be done within the Department. Mr. Poulsen stated that the evaluations will be done within the Department but also each of the individual PACT teams will be assessing how well they are doing and how well the clients are doing. The Department does not have plans to have an independent assessment. Mr. Anderson added that the data they are collecting will be public data so everyone will be able to evaluate the program.

Senator Sywsgood asked what is the average daily cost of the PACT teams. Mr. Anderson responded that it is about $1,100 per month.

Expenditures compared to appropriation – Mr. Anderson referred to the memo regarding the January FY00 Mental Health Budget Report (Exhibit 9) and the memo regarding the December Budget Status Report for the Department (Exhibit 10). The Department budget status report includes the entire division including chemical dependency programs. The Department is projecting a $1.4 million general fund deficit but a surplus in state special revenue partially offsets that. The biggest portion of the remaining deficit in general fund is attributable to the delay in being able to move into the new hospital building.

Senator Swysgood asked where the increase is in state special revenue that helps offset the general fund deficit at the state hospital.

Bob Mullen, Bureau Chief, Fiscal Division, Addictive and Mental Disorders Division, Department, responded that the increase is remaining MHAP revenue that was collected in FY99.

Senator Swysgood posed several questions to Mr. Mullen regarding the amount the state may be liable for MHAP claims between May and June of 1999, where the money would come from to pay for those claims, and who is monitoring the situation. Mr. Mullen stated the amount of those claims is unknown and he does not know of anyone in the Department that has the information at this time. Mr. Mullen also stated that the Operations and Technology Division is monitoring the situation.

Senator Waterman stated that if the Department is operating under the Magellan contract, May and June bills should be submitted by the end of September and the Department should have a dollar amount of what potentially might be owed on those claims.

Senator Swysgood requested Mike Billings provide a total budget expenditures report for FY99 and for FY00 to date for the whole Department for the next meeting.

Response to Dr. Marlin's Letter – (Exhibit 11) Mr. Anderson reported that the person referred to in Dr. Marlin's letter requires services from the Disability Division (DD) and the mental health system. It is not infrequent that if a person has not been in DD services while growing up they do sometimes end up at MSH. Because the DD system is funded on a slot basis there is a

waiting list for services. The state hospital should be able to deal with mental illness and developmental disability. Once the mental illness becomes stabilized then the hospital will look at a discharge plan. The patient is eligible for DD services in her home community and is also being evaluated by the mental heath center.

Mental Health Oversight Advisory Council Recommendations/Actions – **Senator Waterman** reported there are no recommendations from the Mental Health Oversight Advisory Council. **Senator Keenan** mentioned the news release from the Council and the Department to the public asking for input on a draft mission statement that will guide their work to enhance the delivery of public mental health services in Montana (Exhibit 12).

Mental Health Ombudsman Report

Bonnie Adee, Mental Health Ombudsman, reported that she hears regularly from providers requesting information about how to get paid. **Senator Waterman** asked if the questions are about payment from Magellan or an ongoing problem with payment from the state. Ms. Adee stated that it is both. Ms. Adee also reported on discussions with the Department about how someone leaving the correctional system accesses mental health services. Prisoners have access to case management 60 days prior to discharge but many are not using that service, which may represent a systemic problem. There is intent on the part of DOC to work on it. There will be a follow-up meeting in May. Ms. Adee also reported she hears regularly from family members or case managers on behalf of people with dual diagnosis but is concerned about those people who don't have an advocate. Because DD services are difficult to access a person is more likely to be served in the mental health system which tends to be a more intermittent need, not constant, where DD needs are everyday.

Other issues are:

- Access to mental health services.
- Re-enrollment eligibility.
- Access to psychiatry, particularly for children.
- Lack of school based services and family based services.

Recommendations:

- Look at how to increase access to mental health services for those in need.

- A system to notify people and their provider about the need to re-enroll needs to be accurate and consistent.
- More consumer run services.
- More drop-in services.
- More vocational opportunities.
- More transitional care services.

Senator Waterman asked Ms. Adee what are some ways to increase access to mental health services. Ms. Adee recommended the Department proposal to increase financial eligibility to 200 percent of the federal poverty level. Children with severe disabilities should be covered regardless of income test. Early intervention and prevention will pay off.

Training for Law Enforcement Officers

Susan Fox, Research Analyst, Legislative Services Division, (LSD) provided the subcommittee with a copy of Chapter 375 MCA [HB 580] (Exhibit 13). This bill aids with the scope of practice and licensure of any health professional that works in the correctional field. It does not solve the law suit issue. Correctional health care providers can still be sued in state or federal court. It protects the licensure procedure and adds a review process. A report prepared by Susan Fox and Valencia Lane on Correctional Standards and Limitations on Confinement was provided for the record (Exhibit 14) and copies are available if any of the subcommittee members are interested.

Ms. Fox briefly discussed her report on Training for Law Enforcement Officers on Mental Health Issues (Exhibit 15). The Department of Justice (DOJ) has the power and duty to determine the curriculum and methods of training for officers and other individuals attending the academy. The Montana Board of Crime Control (MBCC), which is administratively attached to DOJ, has discretionary authority to establish minimum qualifying standards for employment of peace officers, detention officers, probation and parole officers, and corrections officers. State law requires a peace officer, including a deputy sheriff, undersheriff, police officer, highway patrol officer, fish and game warden, park ranger, campus security officer and airport police officer, to attend and successfully complete an appropriate peace officer basic course certified by the MBCC. Continuing education is not required. Advanced training is available but not required.

The MLEA Basic Training Course (Exhibit 16) is a 12-week program for law enforcement officers, adult and juvenile detention officers, and correctional officers. The Basic Training 109 class that began on January 9, 2000, is the first training group to receive specific training on mental health. Thirty-five hours of instruction are in police function and human behavior and two of those hours are in mental health. The last week of basic training also includes scenario-based training that includes some specific mental illness issues. There is no specific legal instruction to rights of the mentally ill.

The Mental Health Oversight Advisory Council Subcommittee on Criminal Justice has recommended regional training for Montana law enforcement. The subcommittee also recommended that the Department develop the described training and request funding through the EPP process.

Ms. Fox distributed copies of the statute on local government that discusses health and safety of prisoners (Exhibit 17).

Lois Steinbeck, Senior Fiscal Analyst, Legislative Fiscal Division (LFD), introduced Pat Gervais, the new Associate Fiscal Analyst for LFD.

Flexibility in Funding Mental Health Services

A report prepared by Lois Steinbeck and Pat Gervais, was presented to the subcommittee on Funding Flexibility for Mental Health Services (Exhibit 18). The primary purpose of the report is: 1) to find ways to lessen or eliminate funding barriers; 2) identify alternative funding sources; and 3) compliance with federal Medicaid criteria. Persons testifying before the Subcommittee have suggested several alternatives to increase funding flexibility and therefore access to services: 1) fund services with a capitated or case rate; 2) create ways to fund wrap around services that may be outside the scope of services covered by a traditional fee-for-service system; 3) increase general fund to cover service gaps not funded by other programs; and 4) allow each community flexibility to develop programs suited to its needs.

There are three major funding sources currently supporting state mental health services: 1) general fund; 2) Medicaid; and 3) CHIP. General fund is the most flexible funding source, but is limited. Medicaid is the most significant source of funds, but states that opt to participate in the

Medicaid program must abide by federal criteria. States can apply for waivers of certain Medicaid program criteria. Waivers can be used to create flexibility but impose additional workload to design and administer. A prepaid health plan - PHP - can offer a great deal of flexibility. A PHP allows states to use a capitated reimbursement method. A PHP may contain services in addition to those authorized in the Medicaid state plan and may contain services that cannot be funded by Medicaid. The philosophy of a PHP is to provide appropriate services at the appropriate time, to achieve savings by preventing placement or shortening length of stay in higher end, more expensive services.

Senator Waterman asked if you could create a plan with a capitated rate for community services and could it also be written to address the needs of children that are seriously mentally ill regardless of income level. Ms. Steinbeck stated that a PHP could be designed to accomplish what Senator Waterman described and that you can make gateways into a PHP through medical necessity criteria.

CHIP - Ms. Steinbeck reported on using federal CHIP funds for MHSP services to offset current general fund costs. Most children eligible for MHSP are probably also eligible for CHIP. The income eligibility criteria are the same. The state plan is written to allow CHIP funds to follow the child and offset 80 percent of the MHSP costs for dual eligible children. CHIP is funded from a fixed federal grant and any federal funds used for MHSP reduces the federal funds available to potentially cover additional children. Using federal CHIP funds would increase funding flexibility and allow more general fund for innovative services. A separate carve out program could be established so it wouldn't impact the CHIP premium.

Temporary Assistance for Needy Families Block Grant (TANF) - Ms. Gervais reported on TANF Block Grant. The final rules for TANF became effective October 1, 1999. The final regulations placed more restrictions on the use of unspent federal TANF funds carried over from pervious grants, while at the same time increased the flexible use of TANF funds for services that fit the definition of "nonassistance". These changes would allow TANF funds to be used for some types of mental health related services for families and children. If TANF funds are not combined with MHSP, general fund supporting MHSP services for some families and children may be able to be counted toward the TANF Maintenance of Effort (MOE). MOE is the amount that the state is required to spend in order to receive the federal TANF block grant. Counting

MHSP expenditures toward the TANF MOE could free up general fund to be used for other priorities or purposes.

Federal TANF regulations do not explicitly define medical services. The definition of medical services is important because although federal TANF funds cannot be used to pay for medical services, MOE funds spent in a separate state program, such as MHSP, can be used to pay for medical services. The most recent budget status report prepared by the Department anticipates general fund shortfalls in the TANF MOE of about $400,000 and in mental health services of about $1.5 million. Using MHSP expenditures toward the MOE would help resolve the projected MOE shortfall and depending on the amount of MHSP expenditures that could be counted toward TANF MOE, it could free up general fund to offset the mental health services shortfall. It should be noted that state funds used to match or draw down other federal funds cannot be counted toward TANF MOE, with the exception that state MOE for the child care block grant can be counted toward TANF MOE. If MSHP general fund were to be used to match CHIP funds, it could not also be used to draw down TANF.

The rules and regulations of the TANF program are complex; therefore, creative uses of TANF and MOE funds require that programs be carefully crafted to assure compliance with all applicable regulations. Statutory and rule changes would be needed to use TANF funds for MHSP or to count MHSP expenditures toward TANF MOE. DPPHS would also need to amend the state TANF plan.

Medicaid criteria - Ms. Steinbeck addressed the subcommittee regarding compliance with federal Medicaid criteria. The compliance issues is raised because House Joint Resolution 35 that authorizes the study by this interim committee directs that it consider imposition of fines and penalties. There are two separate issues related to the Medicaid compliance. The first is funding pilot or demonstration projects that limit provider participation and the number of service slots without receiving a waiver of federal Medicaid criteria and without complying with provisions of federal procurement guidelines. The second issue is the status of the two pilot and demonstration projects currently funded from general fund and Medicaid funds.

Senator Swysgood asked Mr. Anderson to address Medicaid compliance as it relates to the two new pilot projects and why the Department feels it was not necessary to obtain a waiver. Mr.

Anderson responded that the PACT program was developed in cooperation with the providers. The Department knew that if another provider wanted to participate they would have to let them but the providers were willing to wait and see how the pilots would work.

Senator Swysgood also asked Mr. Anderson if HCFA was aware of the fact there was no competitive bid process offered for the two pilot projects. Mr. Anderson stated that the issue was never discussed with HCFA. Mr. Poulsen stated that HCFA knew that the pilots were limited to the two provides. A competitive bid was not discussed because the Department was not bidding a contract. They were negotiating a cost based rate with the providers.

Senator Waterman asked if the Department signed a contract with each of the mental health centers. Mr. Poulsen stated that they did. **Senator Waterman** also asked if the Department signs individual contracts with providers for services. Mr. Anderson stated that it would not be the same type of contract. One of the reasons for a contract for the two providers is because the Department does not have administrative rules that define the requirements of PACT.

Senator Swysgood asked the Department if they were comfortable with the decision not to obtain a waiver to implement the PACT, which uses Medicaid funds to pay the providers. Mr. Anderson responded that they are comfortable with the decision. **Senator Swysgood** expressed concern on jeopardizing Medicaid funding. He also mentioned that there were providers (from a previous meeting) that wanted to participate in the PACT program and weren't given the opportunity to bid on the program. He asked Mr. Anderson to explain how this makes the service available to other providers. Mr. Anderson replied that it was clear to the Department and the providers from the beginning that if other providers insisted on participating that the Department could not have prevented them from doing so. Mr. Anderson also stated that he does not recall any significant issues over the pilot sites that were selected. Mr. Poulsen stated that the Region V mental health center in Missoula expressed dismay that they did not have the opportunity to be one of the pilot sites. He also stated that he does not view what the Department did as limiting access to the program. He views it as making a service available where it wasn't before. The Department has taken a proactive role in deciding what is needed, who can provide it and who the Department will assist. The Department chose two providers to assist but they did not limit other providers. If another mental health center came forward with a PACT model and if it met the Departments standards, the Department would reimburse those services. **Senator**

Swysgood asked if the Department is restricted by the amount of money they have available to spend. Mr. Anderson stated that they are restricted by the amount of money that the Department has in the budget. The Department is hopeful that PACT will reduce spending in other areas so the Department can provide other PACT services.

Ms. Steinbeck commented that the issue of Medicaid compliance was not raised primarily because of the two pilots that are operating, it was raised for future applications. If it is legal within Medicaid to limit provider participation, then it can be done in any program and there would be no supplemental. It's a policy budget management issue for the Legislature and the budget office to consider.

Hank Hudson, Administrator, Human and Community Services Division, Department, briefly responded on TANF, CHIP and MOE funds. The Department did have an opportunity to review the report and most of their comments were included. Mr. Hudson added that to receive TANF funds a person must be TANF eligible. People who are TANF eligible are also Medicaid eligible. Within the mental health system, everyone who is TANF eligible is being served with Medicaid funds. TANF money can be used to provide non-medical services to TANF eligible people.

Ms. Gervais commented that the research she did indicates that under TANF and MOE states could set different income eligibility standards for different benefits and services.

Public Comment

Anita Rosseman, Montana Advocacy Program, commented on the importance of consumer run services and the need for peer support networks.

Direction to Staff

Senator Waterman requested a copy of the Performance Audit on medical services at the state prison.

Senator Swysgood directed staff and the Department to continue working on the issues related to PHPs and alternate funding sources. **Senator Swysgood** also directed staff to make sure any new programs are in compliance with regulations and funding is not jeopardized.

Senator Swysgood requested a report from Jacqueline Lenmark on the potential liability of the state on the appealed claims.

Senator Waterman reported that the Law Enforcement Subcommittee of the Mental Health Oversight Advisory Council is working on a recommendation to this subcommittee.

Representative Barnhart asked for a list of the important issues the subcommittee has discussed.

Next HJR 35 Subcommittee Meeting

The subcommittee agreed on a one-day meeting on May 11th. There will either be another meeting between May and August or a two-day meeting in August.

Adjournment

Meeting adjourned at 4:55 p.m.

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Sen. Chuck Swysgood, Chairman

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Diane McDuffie, Committee Secretary