August 2022

Children, Families, Health, and Human Services Interim Committee

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FINAL REPORT TO THE 68TH MONTANA LEGISLATURE

MENTAL HEALTH STUDIES: SJR 14, HJR 35, AND HJR 39

This report is a summary of the work of the Children, Families, Health, and Human Services Interim Committee on the three mental health studies assigned to the Committee during the 2021-2022 interim as outlined in the Committee's work plan and Senate Joint Resolution 14, House Joint Resolution 35, and House Joint Resolution 39. This report highlights key information presented during the interim and the decisions made by the Committee. Members received additional information and public testimony on the study topics. To review that information, including audio minutes and exhibits, visit the Committee's website, www.leg.mt.gov/cfhhs, and pages specific to each study:

- SJR 14 Study: Adult Mental Health System
- HJR 35 Study: Children's Mental Health System
- HJR 39 Study: Involuntary Commitment of Individuals with Dementia

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INTRODUCTION

The 2021 Legislature decided to take a magnifying glass to the state's mental health system, passing three study resolutions that called for examination of many facets of the system:

- Senate Joint Resolution 14 requested a study of the state's publicly funded mental health system, with particular attention to reviewing the ways in which it has changed in recent years and identifying any gaps in the system. The study ranked fourth out of 28 study resolutions in the post-session poll of legislators.

- House Joint Resolution 35 asked for a review of the children's mental health system, with a focus on the use of out-of-state facilities to treat some children. It ranked 12th in the poll.

- House Joint Resolution 39 asked for a study of the use of involuntary commitments for people with dementia and of alternatives to placing those individuals at the Montana State Hospital, the state-run psychiatric hospital. It ranked 17th in the poll.

Setting – and Changing – Priorities

The Legislative Council assigned all three studies to the Children, Families, Health, and Human Services Interim Committee (Committee), which had to balance how much time it could spend on each of the mental health studies, as well as on three assigned studies related to child protective services. Each of the assigned studies could have – on its own – occupied most of the Committee's time and attention. Thus after hearing broadly about the mental health system and issues of importance to stakeholders, Committee members narrowed their focus to the topics of greatest concern.

At the start of the interim, members decided to devote the most time to the SJR 14 study of the adult mental health system, followed by the HJR 35 study of the children's mental health system. Members agreed to devote only a few hours of meeting time to the HJR 39 study and expected to hear only some statistical information and a panel presentation on alternatives to commitment.

Each mental health study could have, on its own, taken most of the Committee's available time.

However, midway through the interim, the Committee heard from numerous Montana State Hospital employees who were concerned about staffing matters and patient care. Shortly after that, the federal government identified patient safety concerns at the hospital and issued a notice of Immediate Jeopardy. The hospital subsequently lost its federal Medicare and Medicaid funding for failure to meet Medicare's basic health and safety requirements.

The turn of events prompted the Committee to devote more time to looking at ways to reduce the use of the Montana State Hospital for people suffering from Alzheimer's disease, other dementias, or traumatic brain injury.

Recommendations

During the interim, the Committee heard wide-ranging presentations that focused on, among other things:

- Medicaid payment models;
- the effects of past budget cuts;
- crisis services;
- workforce education, recruitment, and retention matters; and
- availability of in-state treatment for children.

Based on that information, Committee members decided to introduce the following legislation in the 2023 session:

- LC 156,* to increase Medicaid reimbursement rates for a 4-year period for any in-state psychiatric residential treatment facilities and therapeutic group homes that serve children who meet age or acuity levels identified by the Department of Public Health and Human Services (DPHHS) each year;

- LC 157, to require psychiatric residential treatment facilities and therapeutic group homes that receive enhanced Medicaid rates to submit a plan of care for each child who is at risk of being placed out of state for services;

- LC 158, to change the involuntary commitment laws for people with primary diagnoses of Alzheimer's disease, other dementias, or traumatic brain injury and to require DPHHS to begin transitioning those individuals out of the Montana State Hospital and into community services;

- LC 159, to require DPHHS to share reports of abuse and neglect at the Montana State Hospital with the state's protection and advocacy program for people with mental illness;

- LC 160, to allow behavioral health providers who are licensed in another state to become licensed in Montana if they have been licensed in the other state for at least 1 year and the license is in good standing; and

- LC 271, to require DPHHS to implement the Certified Community Behavioral Health Clinic (CCBHC) model by January 1, 2024, and to allow CCHBC services to be covered by the state Medicaid program if DPHHS adopts rules to do so.

**All bills can be followed in the legislative bill-tracking system before and during the session using their LC numbers. Actual House or Senate bill numbers will be assigned when the bill is introduced.*

OVERARCHING ISSUES: BUDGETS AND WORKFORCE

Although the three mental health studies touched on separate aspects of the state's mental health system, many topics cut across all the studies and influenced the Committee's work. Stakeholders pointed to two issues as key to the cracks that have appeared in Montana's system of services:

- budget cuts made 4 years ago when state revenues fell short of expectations; and
- workforce shortages that have been exacerbated in recent years by the COVID-19 pandemic and increasing competition for a smaller pool of workers.

2019 Biennium Budget Cuts: Immediate and Long-Term Effects

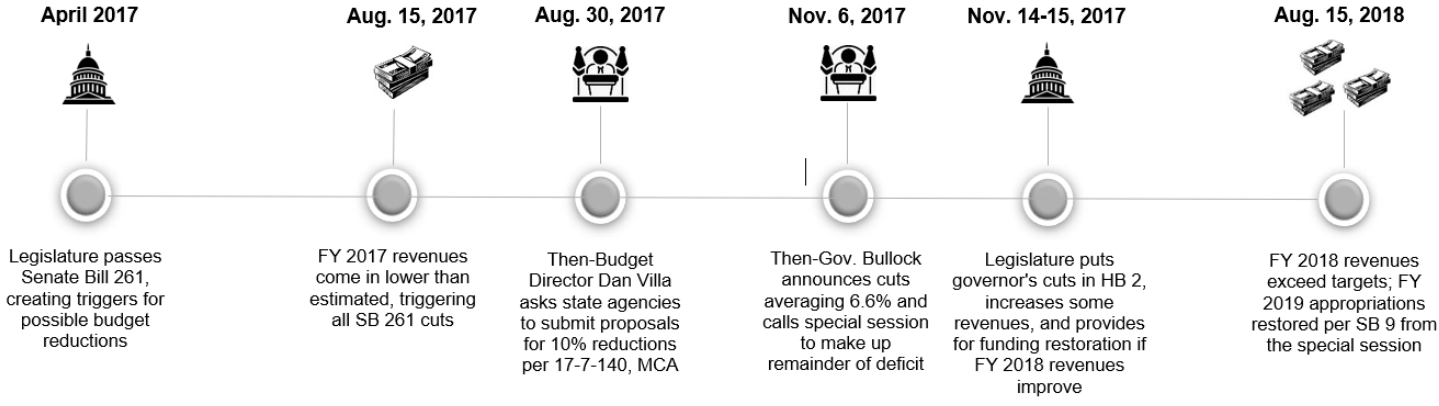
Members learned about the effects of budget cuts that the 2017 Legislature pre-approved to go into effect in fiscal year 2018 if revenues fell short of projections. When revenues didn't come in as expected, mental health providers were hit with a triple whammy: a 0.5% reduction in the DPHHS budget, an additional 1% across-the-board cut for all Medicaid providers, and specific cuts of $965,000 to the budgets for both adult and children's mental health targeted case management services.

Cumulatively, the cuts resulted in a 2.99% rate decrease for all Medicaid services in FY 2018 and a cut of more than 50% in targeted case management rate.

The Legislature also met in special session in November 2017 to take up revenue proposals from the governor. During the session, lawmakers also incorporated into House Bill 2 an additional 6.6% decrease in spending that the governor had ordered earlier in the month, to maintain the ending fund balance at the level required by law. That decrease resulted in additional reductions in mental health services.

Revenues rebounded in the following fiscal year, triggering a reversal of budget cuts that had been approved for the second year of the biennium. However, agencies were not required to use the restored funding to reinstate all the cuts that the governor had made. Not all mental health cuts were reversed, resulting in effects that have lingered on for the mental health system.

The graphic below represents the budgetary ups and downs experienced during the 2019 biennium.



Workforce Woes: A Challenging Situation Worsens

The fields of health care and human services have long relied on a wide range of workers, from physicians and mental health professionals to direct-care workers who assist people with daily tasks and needs. Problems in recruiting and retaining direct-care workers, who are at the lower end of the pay scale, have long plagued Medicaid providers of all types. The Legislature has taken steps in the past to try to alleviate direct-care workforce pressures, including passing bills to increase wages and to encourage health care coverage for the workers.

This interim, the Committee heard from providers that workforce shortages now exist at all skill and pay levels. As a result, some providers have had to shutter mental health group homes and crisis services. Other providers can't see as many patients or have had to hire traveling, temporary staff at a higher cost to make sure they can continue to provide services.

Speakers offered a number of reasons for the increased level of vacancies, including Medicaid reimbursement rates that don't allow for pay increases that can keep up with the costs of housing and child care. They also noted that the work is difficult, and many people may be able to earn more money at jobs that are both less physically demanding and less emotionally draining.

Speakers discussed efforts underway to assess and address workforce needs and to encourage providers to work in Montana, particularly in underserved areas of the state. Those efforts included:

- the 2020 assessment prepared by the Montana Office of Rural Health/Area Health Education Center on Montana's health and behavioral health paraprofessional workforce;
- the different behavioral health education programs offered on Montana University System campuses and at tribal colleges; and
- incentive programs for physicians and for other health care professionals.

The Provider Rate Component

As the Committee was carrying out its work, a separate review of Medicaid reimbursement rates was underway. DPHHS contracted with Guidehouse Inc. to conduct the review, which was required under legislation approved by the 2021 Legislature.

Guidehouse presented its preliminary findings to the Committee in June 2022. The results showed that rates were 11% lower, on average, than the actual costs incurred by children's mental health providers and 17.5% lower for adult mental health providers. The difference between rates and actual costs ranged from about 7% to 63% depending on the specific type of service being provided.

Noting that the governor's budget proposals won't be known until November 2022 and that any rate increases would be dependent on legislative action in 2023, Committee members agreed in June to send the governor a letter asking the administration to look for funding to raise rates before the next biennium begins. A DPHHS response indicated all Fiscal Year 2023 funds had been obligated or spent.

SJR 14: Rethinking Care Delivery and Licensing

During the SJR 14 study of the adult mental health system, the Committee focused on two changes designed to address the payment and workforce concerns raised by stakeholders. Members considered:

- a new method of delivering mental health services that advocates say would improve crisis response, better coordinate physical and mental health care, and reimburse providers for the actual costs of care; and
- a way to speed up licensing of behavioral health providers who have already been licensed in another state, so they can begin practicing more quickly in Montana.

CCBHCs: A New Model of Care

The Committee heard throughout the interim about the Certified Community Behavioral Health Clinic (CCBHC) model of care. This model couples mental health and substance use disorder services with physical health care services to provide patients with a single point of entry to the range of services they may need. The services are reimbursed at a higher Medicaid payment rate that takes into account the total cost of providing care, including administrative and care coordination costs. Montana currently uses a fee-for-service system in which a mental health provider is reimbursed for each unit of care that is provided; many care coordination activities are not reimbursable.

Under federal law, CCBHCs must also provide mental health crisis response services, including mobile crisis response and short-term stabilization services. Stakeholders told the Committee that Montana's system of crisis services has fractured in recent years, with many crisis facilities closing their doors and leaving people with few alternatives to placement at the Montana State Hospital.

The graphic below, part of a presentation to the Committee by the National Council for Mental Wellbeing, summarizes (in blue) the services that CCBHCs must provide directly and (in green) provide either directly or through an arrangement with another entity.

The committee decided in August to introduce a bill requiring DPHHS to implement the CCBHC model by January 1, 2024. LC 271 also would allow, but not require, the state Medicaid program to cover CCBHC services. DPHHS would have to adopt rules to include that model of services in the Medicaid program.

License Reciprocity: Quicker Entry Into the Montana Workforce?

In examining workforce shortage issues, the Committee learned not only about efforts within the educational system to address workforce needs but also about actions that states can take to allow providers licensed in one state to more easily provide care in other states. Those actions include:

- compacts, in which a state agrees to abide by the licensing terms set by a national organization; and
- reciprocity, in which a state accepts the license issued by another state as valid authority to practice a profession in that state.

Montana already allows license reciprocity for health care providers, if the licensing standards in the other state are substantially equivalent to or higher than the standards for licensure in Montana. However, the Behavioral Health Alliance of Montana suggested that the Committee also consider pursuing – for behavioral health licensees – a bill modeled on legislation in Arizona. That legislation allowed licensing of a new provider if the person had held a license in any state for 1 year, regardless of the other state's licensure standards.

The Committee in May reviewed a bill draft making similar changes to Montana's licensing laws for behavioral health care providers. Members agreed in June to introduce the measure, LC 160, in the 2023 legislative session.

HJR 35: Focusing on School and In-State Services

As the Committee learned about the mental health treatment services available to children, members focused attention on two specific areas: school-based services and the in-state residential services needed to keep children with the most intensive needs from being sent out of state for treatment.

School-Based Prevention, Screening, and Treatment

Committee members learned about a variety of methods by which mental health services are provided to children in the school setting, ranging from the prevention programs offered in the K-12 system and the use of depression screening in some middle schools and high schools to the transition of a longstanding program that provides mental health treatment services to children in the school setting.

Monitoring the CSCT Transition

The HJR 35 study unfolded against the backdrop of a significant change in the administration of a school-based mental health program. The Comprehensive School and Community Treatment (CSCT) program was for years administered by DPHHS. Participating schools received Medicaid funding to provide mental health services to Medicaid-eligible children at school or in the community. The state used in-kind expenditures by the schools as the state's match for federal Medicaid funds.

The Centers for Medicare and Medicaid Services notified DPHHS in 2016 that it would no longer approve the use of in-kind expenditures as the state's match. DPHHS negotiated an extension of that payment model until June 2020 and then used general fund dollars for the state's match after that. In 2021, the Legislature passed HB 671 directing DPHHS and the Office of Public Instruction (OPI) to develop a new funding mechanism for the program.

That new model requires schools to provide a cash match to OPI for the school's share of the program costs. OPI transfers the funds to DPHHS, which in turn uses the money to draw down federal Medicaid funds. DPHHS then reimburses the schools at the published reimbursement rate for the services, which includes both the state share that the school districts paid up front and the drawn-down federal funds.

The transition got off to a rocky start, prompting several interim committees to monitor how the changes were affecting school district participation in the program. DPHHS statistics showed that the number of students receiving CSCT services dropped from a high of 5,129 in FY 2017 to 3,027 in FY 2021. The number of participating school districts dropped from 97 to 77 during that same time period. By the end of the 2021-22 school year, 58 school districts had completed a Memorandum of Understanding with OPI to participate in the program.

Other In-School Screening, Prevention, and Treatment Options

The Committee also learned about other efforts to support student mental wellness, including:

- the multi-tiered systems of support approach to student wellbeing that is used in many Montana schools;
- partnerships between federally qualified health centers (FQHCs) and school districts for school-based health centers, which can provide physical, dental, and behavioral health services to students either in school, through telehealth, or at a mobile unit on the school campus.
- efforts undertaken by the state's suicide prevention program to support prevention efforts in the schools; and
- recommendations related to universal depression screening in the schools, along with DPHHS's plans to begin funding that type of screening in schools that choose to undertake it.

Intensive Services for High-Needs Children

The Committee spent much of the interim reviewing the factors that have caused an increasing number of children to be sent out of state for the highest levels of care.

Under legislation passed in 2009, DPHHS is required to report to the Committee on the number of children placed out of state for psychiatric residential treatment facility (PRTF) or therapeutic group home (TGH) care. Those reports show that 126 youth were placed out of state in FY 2009. By FY 2020, the number had increased to 411. It dipped to 373 in FY 2021.

Members heard from in-state providers of residential services that they were unable to treat the children for a variety of reasons. Workforce shortages played a key role in the decision by some providers to close group homes or to reduce the number of beds available in PRTFs. Providers also said that very young children or children with intensive or specialized needs usually require higher staffing levels and may need to be separated from other children in the facility. However, only a small number of children need those intense services, often making it cost prohibitive to offer the services.

Committee Legislation

In an attempt to increase access to in-state care, the Committee approved a pair of bills designed to work in tandem:

- LC 156 would, for a 4-year period, provide enhanced Medicaid reimbursement rates to in-state PRTFs and TGHs that serve children who meet age or acuity levels identified by DPHHS each year.

- LC 157 would require PRTFs and TGHs that receive enhanced Medicaid reimbursement rates to submit a plan of care for each child who is at risk of being placed out of state for services.

HJR 39: ALTERNATIVES TO INVOLUNTARY COMMITMENT

In conducting its HJR 39 study of the involuntary commitment of individuals with dementia, the Committee heard from DPHHS about the number of people with dementia who had been committed to the Montana State Hospital in recent years.

The table below summarizes data provided to the Committee by DPHHS at its September 2021 meeting.

Dementia Diagnosis	2019		2020		2021 (as of 9/13/21)	
	#	% of Total	#	%	#	%
Primary Diagnosis	11	1.5%	9	1.1%	6	1.1%
Secondary Diagnosis	9	1.3%	21	2.6%	4	0.7%
Total	**20**	**2.8%**	**30**	**3.7%**	**10**	**1.8%**

Total Patients = 718 in 2019; 803 in 2020; 567 to date in 2021

The Committee also heard from a panel of speakers about potential alternatives to involuntary commitment. However, because of time constraints, members were not planning to take additional action on the HJR 39 study. That changed in early 2022, however, as members first heard concerns from Montana State Hospital workers about patient care and staff turnover and the Centers for Medicare and Medicaid Services later issued a notice of Immediate Jeopardy for the hospital.

At a March meeting devoted to hearing about the Immediate Jeopardy notice, Committee members agreed to consider two bill drafts that would:

- eventually prevent the commitment of people with dementia to the Montana State Hospital, using as a model the transition process outlined in 2015 legislation that led to closure of the institution serving developmentally disabled individuals who had been involuntarily committed to the state's care; and

- require the Montana State Hospital to provide Disability Rights Montana with records related to reports of abuse and neglect at the hospital. Disability Rights Montana is the state's designated protection and advocacy organization for people with mental illness and is authorized under federal law to review reports of abuse and neglect if the reports are provided to them.

Based on public comment received in May, the Committee requested additional changes to the involuntary commitment bill and subsequently approved those changes in June.

Committee Legislation

In an effort to reduce the number of involuntary commitments involving people with Alzheimer's disease, other dementias, or traumatic brain injury (TBI), the Committee approved LC 158. That bill would:

- on July 1, 2025, end involuntary commitment of people with a primary diagnosis of Alzheimer's disease, dementia, or TBI when they meet only the commitment criteria related to an inability to provide for their basic needs of food, clothing, shelter, health, or safety. People who pose a risk of injury to themselves or others could still be committed.
- require DPHHS to immediately begin transitioning Montana State Hospital patients into community-based services if they have a diagnosis of Alzheimer's disease, other dementias, or TBI;
- allow the agency to use money appropriated for the Montana State Hospital to create the services needed in the community; and
- create a legislatively staffed committee to monitor the progress of the transition and make recommendations for any action needed.

The Committee also approved LC 159, which would require DPHHS to share reports of abuse and neglect at the State Hospital with the statewide protection and advocacy program for the mentally ill.

APPENDIX A:
CHILDREN, FAMILIES, HEALTH, AND HUMAN SERVICES INTERIM COMMITTEE MEMBERS

Before the close of each legislative session, the House and Senate leadership appoint lawmakers to interim committees. Members of the Children, Families, Health, and Human Services Interim Committee serve one 20-month term. Members who are re-elected to the Legislature, subject to overall term limits and if appointed, may serve again on an interim committee. This information is included in order to comply with 2-15-155, MCA.

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