June 2022

Children, Families, Health, and Human Services Interim Committee
Sue O'Connell, Legislative Research Analyst

DRAFT 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

LEGISLATIVE SERVICES DIVISION

P.O. Box 201706
Helena, MT 59620-1706
Phone: (406) 444-3064
Fax: (406) 444-3971
WEBSITE: HTTP://LEG.MT.GOV/CFHHS

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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 4th 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 Committee, which had to balance how much time it could spend on each study, 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 only to hear 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 State Hospital employees who were concerned about staffing matters and patient care. Shortly after that, the federal government issued a notice of Immediate Jeopardy for the hospital based on patient safety concerns. The hospital subsequently lost its federal Medicare and Medicaid funding after the Centers for Medicare and Medicaid Services determined the hospital had failed 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 State Hospital for people suffering from Alzheimer's disease, other dementias, and 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:

[Insert information on decisions made at the June and August meetings]

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 four 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

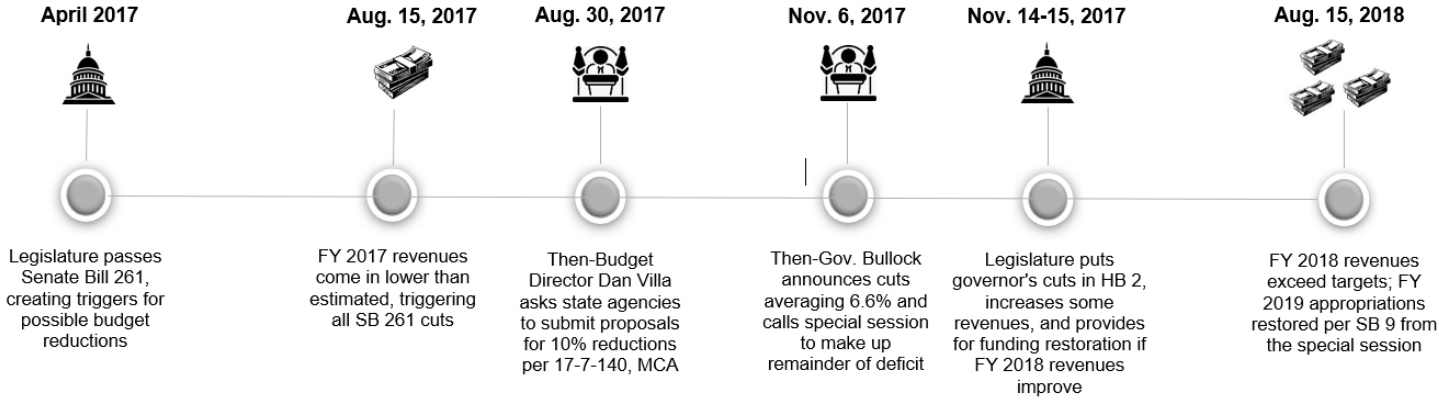
Members learned early on in the interim about the effects of budget cuts that were triggered when state revenues for fiscal year 2018 fell short of projections. Mental health providers were hit with a triple whammy by cuts that the 2017 Legislature pre-approved to go into effect if revenues didn't come in as expected. Providers were affected by a general 0.5% cut to the DPHHS budget, an additional 1% across-the-board cut for all Medicaid providers, and specific cuts of $965,000 to the budget for both adult and children's 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% for the targeted case management rate.

The Legislature also met in special session in November 2017, taking up revenue proposals from the governor and incorporating 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.

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. Care is provided in an equally wide range of settings, from secure psychiatric facilities to group homes and drop-in centers.

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 type. The Legislature has taken steps in the past to try to alleviate direct-care workforce pressures, including passing bills to increase wages and 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, ranging from the COVID-19 pandemic to 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 workers may be able to earn more money at jobs that are less physically demanding and emotionally draining.

Speakers also discussed efforts underway to assess and address behavioral health 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
- incentive programs for physicians and for other health care professionals

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:

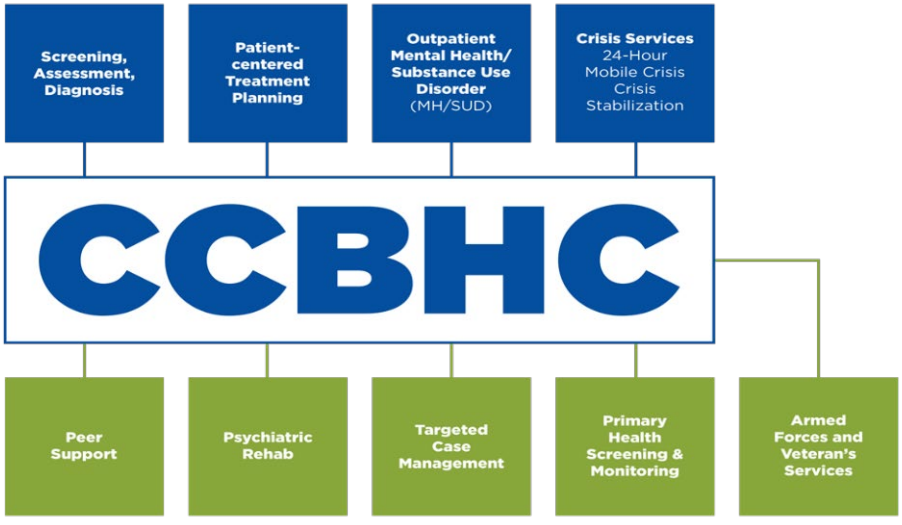
- a new method of delivering mental health services that advocates say would improve crisis response, better coordinate physical and mental health care, and reimburse providers for the actual costs of care; and
- a way to speed up licensing of behavioral health providers who have already been licensed 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, and many care coordination activities are not reimbursable.

Under federal law, CCBHCs also must 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.



[Insert information on decisions made at the June and August meetings]

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.

[Insert information on decisions made at the June and August meetings]

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 middle 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 Medicaid and Medicare Services notified DPHHS in 2016 year that it would no longer approve 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 funds 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.

Schools are now required 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 dawn the federal funds. DPHHS then reimburses the schools for the full cost of the services.

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, while 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

Committee members also learned about other activities designed to support student mental wellness. Those included:

- 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. 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 therapeutic group homes (TGHs) or to reduce the number of beds available in psychiatric residential treatment facilities (PRTFs). Providers also told the Committee that providing services to very young children or to children with high-level, specialized needs also is difficult. They noted that the services often involve just a small number of children but require high staffing levels and specialized physical space, making it cost prohibitive to offer the services.

Under legislation passed in 2009, DPHHS is required to report to the Committee on the number of children placed out of state for PRTF or 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.

The Committee focused attention on ways to increase the capacity of in-state providers to treat these high-needs children.

[Insert information on decisions made at the June and August meetings]

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 CMS 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 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 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.

[Insert information on action taken at the June and August meetings.]

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.

Senate Members

Senator Chris Friedel
3302 2nd Ave. N.
Billings, MT 59101
Ph: 406-272-2245
Email: chris@chrisfriedel.com

Senator Jen Gross
P.O. Box 30472
Billings, MT 59101-0472
Ph: 406-696-0649
Email: Jen.Gross@mtleg.gov

Senator Theresa Manzella
640 Gold Creek Loop
Hamilton, MT 59840
Ph: 406-546-9462
Email: theresa.manzella@mtleg.gov

Senator Mary McNally
P.O. Box 20584
Billings, MT 59104-0584
Ph: 406-671-1376
Email: Mary.McNally@mtleg.gov

House Members

Representative Ed Stafman, Presiding Officer
515 W. Cleveland St.
Bozeman, MT 59715
Ph: 406-640-3362
Email: Edstafman@gmail.com

Representative Dennis Lenz, Vice Presiding Officer
P.O. Box 20752
Billings, MT 59104-0752
Ph: 406-671-7052
Email: Dennis.Lenz@mtleg.gov

Representative Mary Caferro
P.O. Box 668
Helena, MT 59624-0668
Ph: 406-461-2384
Email: marycaferro@gmail.com

Representative Jennifer Carlson
110 Flying Eagle Way
Manhattan, MT 59741
Ph: 406-579-2929
Email: Jennifer.Carlson@mtleg.gov

Representative Jane Gillette
P.O. Box 1751
Bozeman, MT 59771
Ph: 406-868-1549
Email: Jane@DrJaneGillette.com

Representative Danny Tenenbaum
P.O. Box 8612
Missoula, MT 59807
Ph: 406-285-1460
Email: drtenenbaum@gmail.com

Children, Families, Health, and Human Services Interim Committee Staff
Alexis Sandru, Attorney | Sue O'Connell, Legislative Research Analyst |Fong Hom, Secretary