Children, Families, Health, and Human Services Interim Committee

PO BOX 201706
Helena, MT 59620-1706
(406) 444-3064
FAX (406) 444-3036

59th Montana Legislature

MINUTES

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed. Committee tapes are on file in the offices of the Legislative Services Division. **Exhibits for this meeting are available upon request. Legislative Council policy requires a charge of 15 cents a page for copies of the document.**

January 26, 2006

Capitol Building, Room 152
Helena, Montana

COMMITTEE MEMBERS PRESENT

SEN. TRUDI SCHMIDT, Chair
REP. BILL WARDEN, Vice Chair

SEN. JOHN ESP
SEN. JERRY O'NEIL
SEN. DAN WEINBERG

REP. EMELIE EATON
REP. EVE FRANKLIN
REP. DON ROBERTS

STAFF PRESENT

SUSAN FOX, Lead Staff
DAVID NISS, Staff Attorney
FONG HOM, Secretary

Visitors

Visitors' list **(ATTACHMENT 1)**

COMMITTEE ACTION

- August 22, 2005, and October 20-21, 2005 minutes were approved.
- December 8, 2005 Conference Call HIFA meeting minutes were approved.

CALL TO ORDER AND ROLL CALL

SEN. SCHMIDT called the meeting to order at 8:35 a.m. The Secretary visually took roll. **(ATTACHMENT 2)**.

APPROVAL OF MINUTES

The Committee approved and adopted the minutes of the August 22, 2005; October 20-21, 2005; and December 8, 2005 Conference Call.

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES - Joan Miles and John Chappius

JOAN MILES, Director of DPHHS, and JOHN CHAPPIUS, Deputy Director of DPHHS, gave an update on the Department of Public Health and Human Services. She said that DPHHS anticipates a general fund shortfall of $6.1M primarily due to the situation at the State Hospital.

Status Report on DPHHS' Budget

JOHN CHAPPIUS handed out a synopsis of DPHHS' budget situation **(EXHIBIT 1)**. He discussed several points of the budget:

- the $6M supplemental;
- the shortfalls of the various divisions and the situation with the institutions;
- the CHIP program;
- the changes in claims and payment;
- the Medicaid program;
- addictive and mental disorders;
- the Governor's Office approving 36 FTEs;
- accelerated community development; and
- the Mitigation Plan for their budget situation.

QUESTIONS ON BUDGET

SEN. WEINBERG said that the population at the State Hospital is at 192. He asked at what number would Mr. Chappius consider comfortable. MR. CHAPPIUS said that they were budgeted at a census that is around 170. In terms of philosphically, he said that he is not sure where it needs to be because there are people who need to be in the State Hospital setting. What he would like to see is community services that are less restrictive and appropriate so that the people who are not appropriate to the State Hospital do not get sent there. He said that he could not answer Sen. Weinberg's question as to where he would like to see the number because he didn't know clinically, but budgetarily, 170 is the number.

REP. ROBERTS: You stated that part of the economic loss is because you are more timely in your payments, so what would have been a deferred payment last year is an on-time payment this year, but now it's catching up so it'll be part of the system so you're not going to have that problem with those dollars going out next year. CHAPPIUS: you are characterizing that

correctly. Actually we pay about 96% or 97% of our claims within 30 days. However this has speeded that up. So this inventory, especially of institutional claims that are related mostly to hospitals, is what this inventory reduction was. And those are paper claims. So what really happened is, they bought a new optical scanner that translates to electronic very quickly. That inventory has gone from nearly 60,000 claims down to about 8,000 claims. That's every month. By October next year, we will be back on a one-to-one basis. REP. ROBERTS: the Legislature two years ago set up a plan whereby we would try to do more in the communities. Are the communities not picking up this as a preventive thing and just deferring that to the State because we are not paying the communities enough for this kind of thing? Would they rather have the State incur the costs? What do you see as the problem, why a lot of these people are sent up for three or four days when in reality they could probably be treated by a local person in Billings or Kalispell? CHAPPIUS: I don't want to characterize that as a problem with the communities because in a lot of communities, you do see enhanced services, you see additional PACT teams for instance. Our crisis response is under development. Our community health centers and other big providers like AWARE are providing additional services. But when we had the big overflow at Warm Springs, we needed to place about 20 people in an inpatient setting. We called Deaconess down in Billings. They wanted to help. They wanted to do everything they could because we needed an inpatient setting, but they were sitting at 40 patients when they are licensed at 32. They just had no capacity. We saw similar issues in terms of Kalispell, for instance, and we called Kalispell and they said, well we do have one or two beds, but frankly, we don't have the psychiatrist, psychologist, counselors who would provide the appropriate treatment, so we're nervous about saying we're going to reserve beds for the State Hospital. They said they had to work with their own community, they needed to stay in their own region and they were barely able to handle that demand. So, some places had room, some didn't.

REP. O'NEIL: I understand that there are some people in the State Hospital that have been basically recovered or healed who can't go home for a day or two when they are ready to go home because of various reasons. Someone was trying to put them in the less intense care situation. CHAPPIUS: We have developed a service and this is related to the mental health nursing care center in Lewistown. There are people that are sitting in the State Hospital, that we would like to be able to send to the community immediately, and they are waiting for appropriate placement. But the first thing we did, we invited our partners in the community and they come here in a clinical sense and look at people that can go to the community. The mental health centers look at those folks, they look at the records in the hospital, AWARE does, other that have that type of capacity and say, okay we can take them. Those folks went through the records and tried to find placements. Unfortunately, they did not find anybody appropriate to take out of the Hospital in terms of that core population. Now, there's always a group that's ready to leave. Residential settings are hard to find; they are pretty full. I think meth is having a big factor in the demand also. So we opened our old receiving hospital that's not licensed as a hospital, it's licensed as an acute care group home. They got a lot of the treatment from our

psychiatrists, our psychologists, our counselors at the State Hospital, but it readies them to go to the community so services from our providers can actually help them. We're trying to expedite that process. I think it has helped some because we've gone from 212 down to 192. It hasn't stopped the problem but that's what we ended up having to do because, as I mentioned Deaconess and other hospitals, they just can't take this overflow. It's just not there.

REP. FRANKLIN asked how many PACT teams and how many patients do we have compared to when the program started, are there numbers on that? MR. CHAPPIUS said that he did not know that number but that Joyce DeCunzo can answer that.

Status Report on Rx, Medicare Part D, the Katrina Waiver and the HIFA Waiver

MS. MILES said that Medicare Part D is a new prescription drug program. She said that all of the concerns of what the transition would be like are coming true. It has been very difficult and very complicated for many people. She has asked Jeff Buska to talk about the dual-eligibles, they are eligible for Medicaid as well as Medicare. That's the area where we are involved with most. There are a lot of people who are experiencing problems. We have taken some steps to ensure that people who are Medicaid eligible, are being charged appropriately, or if they are being overcharged, we have taken some steps to ensure payment of those pharmaceuticals. We have stepped in and tried to help address that problem. The Federal Government is now talking about how to help reimburse states because we are one of 20 states that have taken this same step. This really is an institutional problem with how the dual-eligibles were enrolled and entered into the computer systems and that's why they are not coming back for the pharmacists. We have put a lot of things on hold in the Department. She said that she thinks they were very well prepared to deal with this for the things that they had in their control.

JEFF BUSKA gave an update of what is happening with the full benefit dual clients, which are the people in the State of Montana who have coverage under Medicaid Part A or have coverage under Medicare Part B, and are eligible for full Medicaid benefits that include the coverage of prescription drugs. They are classified as full benefit duals. We also have clients who are eligible for Medicare savings programs, that Medicaid wasn't paying for their prescription drugs before but those individuals are new to having a prescription drug benefit that are potentially running into the same issues and that they are having high co-payments and deductibles charged to them. With the implementation of the plan, Part D, the prescription drug plans did not have correct information to identify a number of clients as full benefit dual clients. That was information that was shared by the Centers for Medicare and Medicaid Services. We provided them with the data and then they were going to send it to the plans. When a number of clients went to fill their prescriptions, they were being faced with being told by the pharmacies that they would have a co-payment for three or four prescription drugs that ranged between $50 and $100, well above what they would normally be charged under the Medicaid program which our co-payment levels range from $1 to $5 with a maximum of $25 a month, depending upon how many prescriptions. But when they went into the pharmacies and were faced with being told

that they had $120, $150, some clients maybe $200, it was very problematic for them. Quite a few pharmacies, to their credit, did provide those prescription medications to the clients, recognizing that this was probably a glitch in the system and they let the prescriptions out the door knowing that they would be able to try to work with the plan and try to figure out what was going on. Unfortunately, at the same the time, what was happening is that there was not enough call lines, or customer service representatives, at the prescription drug plans for our clients, for doctors, or for the pharmacist to call, and so CMS was doing a lot of work trying to encourage the plan to beef up their customer service representatives. CMS' own help desk for pharmacies increased the staffing from 150 customer service representatives to 4500 in the first week of the implementation. They also did system enhancements to what is called an E1 transaction, which is an eligibility verification transaction that happens online at the pharmacy to a point of sale contractor that does eligibility verification.

There were problems with the response time and CMS made significant enhancements to try and improve that response rate for pharmacies. But the state was getting called directly with complaints about this. Regarding the clients and their high co-payments, CMS contacted the plans directly and getting back either to the pharmacy that we identified or back to us so that we could contact the client to go back to the pharmacy so they could rebill the prescriptions. We were successful in a lot of cases and were able to turn a lot of cases around within 24 hours to 48 hours to help people out. Unfortunately, this should not have happened in the first place. Recognizing that, CMS sent more data files to the plans with more instructions and guidance for providing 30-day transitional supplies and at about the same time, we were implementing a policy where the state would come in and be the guarantor for the pharmacy, that we would pay the high co-insurance deductibles if the plans were still charging those to our full benefit duals. We were able to verify that that person was Medicaid eligible and eligible for Medicare. We knew which plan they were in. If the pharmacy was still having difficulty getting that paid, then they could dispense the medications to the client, charge them the appropriate co-pay and then bill us the difference and we would pay that claim. What we were going to do and still are doing is whenever we get a request like that, then we work directly with CMS with the plans to try and get these issues fixed. And also working with CMS to say not only can we do this on a case-by-case basis, we can't sustain this, is that they need to make some changes to the system to get this type of stuff fixed. All the states are dealing with this. When we find out what we've been able to fix, a lot of pharmacies will then reverse their claim with the Part D carrier, rebill, charge the appropriate co-pay and then we will reverse our claims so it's like the transaction never happened.

Our pharmacy manager has told me that quite a few pharmacies like the plan, some of them are not happy about it because they have to send in their claim on paper. We understand how difficult it is administratively but that is the only way that we can price and pay the claim at the appropriate dollar amount without overpaying through an electronic process. To my knowledge, a lot of pharmacies are glad knowing that we are there, but no pharmacy has taken us up on

this offer yet to pay for their prescription drugs. Also, CMS has done a lot of work to get the data fixed with the plans and so they are now charging the right co-pays, so it may not be nearly the issue it was in the first week of the implementation. Some other issues that we have been dealing with the implementation of Part D is a lot of clients were not given their member cards fast enough. When they went to the pharmacy, the pharmacy did not know which plan they were in or what their unique member number was. The State received some inquiries and we were able to look those up based on old data that CMS gave us to identify which plan the beneficiary was in. But more importantly, a lot of plans were requiring that they bill with the unique member number. Another issue is the transition supplies, which the plans were supposed to pay for transition supplies for full benefit duals. It was left up to the plan discretion and it's been problematic and so CMS came out with guidance to identify that they must provide a 30-day supply. While that's admirable, it's probably not long enough especially in light of the fact that not only the pharmacies, but the physicians need to call the plan to provide the clinical information and that may take some time, especially if there is still waiting time on the phones. They might need some longer periods and so CMS is trying to work with the plans on reasonable transition supplies and addressing those clinical situations where doctors and pharmacists are calling to provide to get authorization for prescription medications.

We are getting calls and questions about user limits and prior authorizations on prescription drugs which is different than on the Medicaid program. It is allowed under MMA for the plans to implement unit limits and prior authorizations on a prescription drug and it is a change for a lot of clients and physicians and that's why we think there needs there needs to be a little bit more time in the implementation and transition supplies, especially if the physician is having to navigate this new system. For all these issues, we also have another policy where if we run into a situation where the client is in danger, we just pay the claim under the Medicaid program. If we are working these cases and we find out it's a situation where the client needs it, we will pay it.

There are some new requirements for pharmacies in billing Part B drugs, under the Medicare Outpatient Benefit. The prescription drugs that are dispensed usually at a physician's office are take home supply drugs, or various types of drugs like immunosuppressant drugs for heart transplants. But it depends on whether you had your transplant in a Medicare approved transplant center. If you had a transplant there, the drugs are supposed to be billed under Medicare Part B, not Part D. If you had a transplant at a center that is not a Medicare approved transplant center, then the plans are supposed to pay for it under Medicare Part D.

We have people working on cases like this. We have calls that come in directly to the OPA offices and they are doing their best to provide information and help clients with their questions. A number of questions and complaints come in directly to our SHIP program. The SHIP volunteers are also working a number of cases to provide information to clients about selecting plans, etc.

MR. CHAPPIUS said that it comes back to the question that was brought up at a HIFA work group meeting, he wanted to mention that their ability, the flexibility they have to be able to move money around, for instance, to be the guarantor for these folks who are no longer receiving Medicaid benefit, which means we are paying these drugs on 100% general fund. Had the subcommittee and later the full Legislature not allowed the flexibility within the appropriations to move money, we would not have had this ability to be able to respond. He emphasized how important that was, for their ability to respond, otherwise they would have been prohibited from doing that.

QUESTIONS

SEN. SCHMIDT asked if that was something new with this past Legislative Session? MR. CHAPPIUS said it has been an off and on thing. There had been a number of sessions where they have been restricted and you could use a Medicaid appropriation in relation to general fund strictly on Medicaid or on CHIP or whatever. And some appropriations were restricted this time, but our general base appropriations were not. We were given that ability to move that money around which does allow us to do that. In the last couple of session we had that flexibility. In 2001, we didn't, but 2003 we were given that flexibility again.

REP. EATON asked what would they recommend be the best way for people to deal with problems they see, to go back to their pharmacies, to call someone in the Department, how would you recommend people deal with these? MR. BUSKA said that if they have questions about the Part D plans and concerns, they need to file their concerns directly with 1-800-MEDICARE. They are staffed to respond to the beneficiary's question and assist them with whatever problem they are having with their plan enrollment. CMS is also asking a lot of the pharmacies to work directly with the plans and with sending in their transactions for plan verification and getting plan numbers. They have a help line and they are asking pharmacies to do a lot of that as well. If they need help selecting plans, they are referred to their SHIP programs and for advice from their state health assistance programs.

TAPE 1B

REP. EATON asked if it is their impression that this actually ended up serving more people or just throwing everyone up in the air and creating turmoil. MR. BUSKA said that he thinks that it is serving more people. CMS has sent out a report identifying in Montana that over 53,000 Montanans now have coverage under their prescription drug plan. About 14,000 are full benefit dual clients.

SEN. WEINBERG said that he thinks they are doing their very best to help people try to get prescriptons, but he also thinks that the Federal Government set up the train wreck. Without a doubt, there are people who used to get their prescriptions and they can't now or don't know how or something is getting in their way. Are we seeing any relationship to that in hospital

admissions or doctor's office admissions, or deaths, are we seeing anything statistically that would be related to people having trouble getting what they need? MR. BUSKA said that he can't answer that because he didn't have any statistical or anecdotal evidence. MR. CHAPPIUS said that they have not seen a surge in the State Hospital.

MS. MILES said that it was too early to have any statistical information and she is hopeful that they don't get that information. She said that one of her concerns is that for every case they know about that actually reach their offices and they are trying to help with, there certainly could be more cases out there that we don't know about and that is one of their concerns.

MR. CHAPPIUS said that when they testified in October or November, they said they were not going to have a grace period in Mental Health Services Plan (MHSP). They reconsidered that because they were unable to guarantee that all of the MHSP because of some of the data match problems. We do have a grace period going on through the end of March under the state program. Most of those folks are signed up, we know that because the mental health centers have told us that they have been working with these folks. That's a population that would have been at risk for the State Hospital and the fact that we haven't seen this surge there, indicates that they are getting their prescriptions.

REP. ROBERTS asked if they were experiencing certain problems on the reservations with people signing up or problems with Native Americans off the reservation signing on. MR. BUSKA said that he was not aware of any specific issues about Native Americans applying for the plans. All of their full benefit duals who are Native Americans were automatically enrolled in prescription drug plans and the pharmacies were able to bill their prescription medications. He knows that a lot of effort was done to try to get the other potential clients to apply for the low income subsidy and to get individuals to go out and select plans. REP. ROBERTS asked if Mr. Buska has compiled a formulary of commonly used medications that can be distributed to practitioners that are accepted for Medicaid. MR. BUSKA said that the Medicaid program has an open formulary meaning that if a drug manufacturer has a rebate agreement signed with CMS, the State Medicaid program must provide coverage for most covered drugs under the FDA that had manufacture rebate agreements.

MS. MILES said that they would like to acknowledge the work of her staff and also wanted to acknowledge the work done by the communities, the pharmacists in particular, the Senior Centers, AARP, all the SHIP offices. She said that she would encourage everyone to find out what is going on in your community, especially the pharmacists, and to let the Department know because they are trying to get as accurate information as possible to the Congressional Delegation, particularly to Senator Baucus who is looking at whether there are some changes that need to be made to the Medicaid Part D. MS. MILES said that you can email her at jmiles@mt.gov and she will get that information to the right people.

HIFA Waiver Status

JEFF BUSKA gave a brief update on the HIFA Waiver. He said that the comment period is closed and they received comments and the Committee had a conference call regarding the HIFA Waiver. There was also a work group conference call with the Legislative Finance Committee. Responding to the comments of the HIFA Waiver has been put on hold and no substantive changes have been made to the concepts yet. SUSAN FOX said that the Finance Committee's work group did not take any action or make any recommendations or comments. The Finance Committee is hoping to do that soon and when they have put something together, they will be mailing that to the Department. Ms. Fox said that she will forward the report from the Finance Committee when she receives it.

Katrina Waiver Proposal

JEFF BUSKA discussed the 1115 Research and Demonstration Waiver for healthcare services for Hurricane Katrina evacuees. Mr. Buska said that it is a Medicaid waiver that the Department is working on in conjunction with the Centers for Medicare and Medicaid Services, to try to help those evacuees who may have come to Montana as they sought refuge. The State of Montana has been working closely with CMS and CMS came out with the waiver template for all states to use **(EXHIBIT 2)**. Essentially the waiver template provides an expedited eligibility for evacuees to get Medicaid eligibility and to be able to access healthcare services. The waiver will also provide to the State of Montana 100% FFP for those healthcare costs that we incurred on behalf of those individuals. This is a short term waiver that goes through June 2006 and eligibility for these individuals will last five months. In compliance with SB 110, the Department did a public comment period, they put a draft of the waiver out for public comment, had a meeting for comments. No one showed up for the public comment other than a handful of Department staff. Information was prepared and sent to the Committee and he visited with Ms. Fox about the possibility of sending it to CMS because of a submission date of January 31, 2006. They submitted the waiver to CMS on January 23, 2006. They had not yet heard from CMS.

SEN. SCHMIDT asked Mr. Buska how many people were displaced and are in Montana. MR. BUSKA said that there are 75 individuals from the Katrina disaster who are eligible and 17 individuals from Hurricane Rita. Mr. Buska said that only the Katrina evacuees qualify for the waiver but that CMS is trying to include the Hurricane Rita evacuees as well.

CHIP Outreach and Feasibility Study

JOAN MILES gave an update of CHIP Outreach and Feasibility and on the Big Sky Rx Program, which is the state funded program that eligible seniors can access to help them pay for prescription drug plans that they are now accessing through Medicare Part D. Ms. Miles said that they are working aggressively to fill the slots in the CHIP program. The Legislature directed

the Department to look at alternatives for administering the CHIP program so that it is done in the most efficient manner and with the most dollars going to healthcare for children.

MARY DALTON, Health Resource Division, gave an update of the Big Sky Rx program **(EXHIBIT 3)**. Ms. Dalton said that this is the program that the Legislature funded to help the population that was below 200% of the Federal Poverty Level (FPL), who are Montana residents, and need help paying their premiums. They have received 2187 applicants and have doubled the number of people that they will enroll. They will be paying premiums for 362 people. There were 326 applicants who were qualified but still needed the Medicare drug plan or extra help information.

MS. DALTON gave an update on the CHIP enrollment for FY06. She said that the CHIP enrollment is made up of both people who will re-enroll, new applications, and people who will age out or go out for other reasons. In July they had 10,900. In mid-February they will begin a media campaign by doing radio commercials, TV commercials, and print advertisement in rural and weekly newspapers. They designed a web-based interactive application that allows people to enter it on their computer, print it and send it in. They will do follow up work with Back to School Campaign to get a media boost. Another thing that they plan on looking at is the effectiveness of working with both community based and tribal organizations.

Ms. Dalton said that on the 7th of February, they are going to do a summit to look at the different options of how they might continue with CHIP. They are a fully insured plan right now, they just signed a contract effective in October 2005. Options they are looking at are whether or not they want to become a self-administered program or to be a self-administered program that could use a 3rd party administrator to pay the claims and do the work. The meeting on February 7 is to explore those options.

QUESTIONS FROM THE COMMITTEE

REP. ROBERTS asked Ms. Dalton if she is finding that as they are reaching out to these children that the other costs incurred would actually be ameliorated by having care up front rather than catching them on the treatment side, that the prevention is working or is it too early to tell. MS. DALTON said she thinks it is too early to tell. The other problem is that they are not in their system and while she fully believes that and everything that she has ever read tells her that that is true in prevention, she did not have their costs before because they were being borne by the parents privately.

REP. WARDEN asked Ms. Dalton what is her advertising budget and how does she fund that for soliciting clients? MS. DALTON said that she didn't know what her budget will be but she is trying to do it as economically as possible. The filming is being done by her PR people and a private firm. They will pay each TV and radio station and newspapers to run the advertisement. She said her target is around $50,000. The money does come out of the CHIP Grant but that is limited to a 10% cap on administration.

SEN. SCHMIDT asked Ms. Dalton if information is being sent to PTAs and after school childcare programs. MS. DALTON said that the Back to School Outreach packets goes to schools, school boards, PTAs, MEAs. SEN. SCHMIDT asked if human resources in stores such as Target, Wal-Mart included. MS. DALTON said that they were. They were also sent to private insurance brokers.

SEN. WEINBERG asked Ms. Miles if the federal government is going to cut millions of dollars out of Medicaid. MS. MILES said that they did cut some but the jury is still out about what is going to happen in the future because of the costs associated with Katrina. JOHN CHAPPIUS said that it cut $11B over five years in the Medicaid program. Some of those cuts will be innocuous to our population.

SEN. WEINBERG asked Sen. Schmidt if there was anything that we can do as a Committee to respond. SEN. SCHMIDT said that we as a Committee can write a letter. SEN. WEINBERG asked if there is any support on Committee to make our desires known. REP. FRANKLIN said that it is an important statement to be made, that as a Committee, we recognize the risks and are concerned and she would support such an effort. SEN. SCHMIDT said that if there were no objections, she would work with Ms. Fox and Mr. Niss and others and get letter out.

REP. ROBERTS asked if part of the problem with Montana State Hospital is an increase in population but that the budget is staying in the same place. JOHN CHAPPIUS said that when this budget was put in for six years ago at a level for 135 clients. That lasted four years. Last time it came up to 170, which was still below where our experience was. The thinking was to force the Department to push with more community services and to keep the number down. We need to look at the State Hospital, look at our community treatment, look at some work between the chemical dependency system and the mental health system, and also cooperate more with our fellow departments, such as Corrections.

TAPE 2A

PUBLIC COMMENT ON DPHHS' REPORT

MIKE FOSTER, St. Vincent's Heathcare, Billings, said based on the report given by Mary Dalton regarding the CHIP enrollment program, wanted to pass along to you that in Billings the providers have a tradition of getting together and having a project related to a national event called Cover the Uninsured Week, which is May 1-7, 2006. In years past we have done different forums. We did an employee fund raiser for CHIP before and raised over $3,000 that we contributed to CHIP. This year we are focused on the enrollment aspect and so we are reaching out to various entities, including DPHHS and the school district and PTA and a wide range of people who can help us and organizations that can help us in our effort in the first week of May to enroll children in CHIP. We look forward to that project.

ADMINISTRATIVE RULE REVIEW ISSUES - David Niss

LICENSURE OF DAY CARE FACILITIES

DAVID NISS discussed an excerpt from the Administrative Rules and the amendments to Administrative Rules on licensure of daycare facilities proposed by the Department **(EXHIBIT 4)**. He said that he compares the proposed rules to the existing statutes, both the substantive statutes dealing with the program being implemented by the rules and also compares the rulemaking proposal to the Montana Administrative Procedure Act. He said that in reading these rules that there was one particular requirement that he had a concern about. He said that state agencies in Montana cannot just adopt whatever rules they feel like adopting. There has to be express statutory authority to adopt rules. In other states, agencies have those authorities expressed in statutes and necessarily implied, so agencies can adopt rules under implied legislative authority. In Montana, because of the requirements of MAPA, state agencies must have express statutory authority to adopt rules. They must have that authority and then they have to correctly implement the statutes and the rules have to be reasonably necessary.

It is that third requirement, rules have to be reasonably necessary, that he found issues in the proposed daycare rules. The statute says in 2-4-305 that a description of what a rule does, does not justify its existence. If an agency says that this rule does these three things, that is not a statement as to why the rule is necessary. It is just a summary. He said that there were six or seven rules contained in the Statement of Rationale in the excerpt, (Rule XXII Day Care Facilities: Protection of Children from Person Charged with Crime Involving Children, Violence or Drugs; Rule XXIV Day Care Facilities: Requiring Physical, Psychological, Psychiatric, or Chemical Dependency Evaluation; ARM 37.95.108 Day Care Facilities, Registration and Licensing Procedures; ARM 37.95.121, Safety Requirements, Section (3); ARM 37.95.132 Transportation; and ARM 37-95.140 Immunization) in which all of those rationales for those rules were really descriptions of what the rules do and were not a statement as to why the rule in the Department's judgment was reasonably necessary. He said that he called the Department about it and exchanged emails with the attorney who was advising the day care program about the rationales, that they were deficient in his mind and therefore subject to a successful legal challenge as to the lawfulness of the rule. The Department published a supplemental notice which is mostly additions to the rationale that were deficient. Under the Administrative Procedure Act publishing a supplemental notice is a good way to handle that issue. The Department therefore has given the public a full and complete statement as to why all of the rules contained in that original 60 or 70 page proposal why those rules are necessary in the judgment of the Department.

REP. WARDEN asked Mr. Niss if he was satisfied with what he perceived to be a problem legally and that that is no longer an issue in his mind. MR. NISS said yes.

SEN. O'NEIL said that he appreciated Mr. Niss watching out for our interest with these rules.

PUBLIC COMMENT ON DAY CARE FACILITIES RULES

ANDREE DELIGDISCH, Great Falls, read her testimony on the proposed rule changes on licensing of after school day care **(EXHIBIT 5)**. She requested that these rules be reviewed again.

ROY KEMP, Interim Administrator, Quality Insurance Division, Bureau Chief, said that he talked with Mr. Niss and assured him that when the rules have these kinds of impact, the Department will remain flexible when they receive comments. They have had the hearing and have received a number of comments as it relates to after school care in particular. He said that after-school care is the new piece that they are trying to place into the regulations. Ms. Deligdisch spoke to having no problems with A through E and that is because they are already existing rules and they apply to the full service day care centers. He said the issues surrounding after-school care are valid and the Department will be responsive to these comments and will revisit the requirements.

QUESTIONS FROM THE COMMITTEE

SEN. O'NEIL asked Mr. Kemp to comment on the Department requiring a day care provider to have a Bachelor's Degree. MR. KEMP said that he believes that the statute gives the Department the authority to establish that requirement. He said that he also agrees that there should be a recognition of the "hearts and hands portion" of experience. The rules that are put together over the last two years began to muddy the waters as to what is existing, what is not existing, and what is now onerous that they won't be able to meet. He said that he thinks there are two issues; one that the experience must be recognized, and that credentialing may be in excess of what is reasonable or available in many of Montana's communities. The rules are put together with input from many groups who are advocates and feel that if they have these different qualifications or additional qualifications, that that will provide a better environment, etc. He said that he believes that licensing regulations are the minimum requirements and that quality is based on public demand and how an operation is operated.

SEN. O'NEIL asked Mr. Niss what would be needed to do with the statutes to regain their prerogative to establish what kind of schooling credentials a person needs in order to be a day care operator. MR. NISS said that there were a couple of things. He said that if there is sufficient authority in the statutes for the Department to adopt those requirements as Administrative Rules, then a long term fix would be to amend those statutes to say "except for credentialing and staff ratios" and that would withdraw from the Department the legal authority to adopt rules for those purposes. A short term legislative fix depends partly upon the authority given this committee in the Montana Administrative Procedure Act, and partly upon the status of what the rulemaking proposal is and what the department's intention is with regard to the proposal.

SEN. SCHMIDT asked Mr. Kemp when the Department will be sending out their responses to

those who were concerned about this issue and when will the revised rules be adopted. MR. KEMP said that he believes that the Administrative Rules process allows the department up to six months to respond to all comments received and publish those responses, or the process starts over again. He said that the Department does not anticipate requiring that length of time, that the Department has received 26 comments, the majority of them were about ratio for after school care and some of the other after school programs. He said that generally speaking, the concern of the public is focused around the after-school program. It would be the intention of the Department to mitigate that concern because their intention was a benevolent one and that the language that they were talking about is for primary care givers, someone who has direct care for a child. They were trying to expand their abilities to bring their experience in and not limit it, that two years of experience in any program that was already in existence qualifies them. The new language would be Head Start, Early Head Start, or other recognized pre-school programs. So they were also trying to say, if you had been in Head Start, you qualify. It was not to say that you absolutely had to be in Head Start or some other recognized program. He said that he does understand the ratio issue and the Department will revisit the ratio issue.

SEN. O'NEIL asked Mr. Kemp if the Committee will be receiving a copy of proposed amendments prior to adoption those rules? MR. KEMP said that the Department will be happy to provide the Committee with their written comments at the March meeting and will delay the implementation of that rule for that purpose. SEN. O'NEIL asked that if the Committee was not happy with the amendments, would the Committee have any power to persuade the Department to change those rules. MR. KEMP said that this Committee has a tremendous amount of power to influence how he does his job.

SEN. WEINBERG said that he is aware that there is literature and research dealing with child development. He said that he has not heard the word "research" and that one would hope that the rules are based upon research and are not arbitrary. That is an issue and would Mr. Kemp speak to that. MR. KEMP said that there is a tremendous amount of research and resources out there and that research projects can require a tremendous amount of resources to be able to provide for the early childhood development aspects of day care rather than the babysitting aspect. He said that while research is one thing, national standards of practice are a measure by which we can measure ourselves. There was a very lengthy and comprehensive study that was done on all of their day care rules and our day care programs, a complete analysis of every area in the state was provided. They use that document when they were formulating what they felt was a reasonable and prudent approach, that they do not adopt all of what they consider national standards of practice because they don't apply in Montana. However, they are a guideline that can tell them what the main areas or categories that we should be paying attention to. SEN. WEINBERG said that in the area of ratio of care givers to children, where are the suggested rules with respect to those ratios. Are they at the national ratios or below or above? MR. KEMP said that they are specifically talking about the after school programs. They are not asking to increase ratios of care givers to children because he thinks they are already

prudent. Mr. Kemp said that he would be happy to provide that report to anyone.

DAVID NISS said that among the range of options that are available to all interim rule review committees is a provision in 2-4-305, MCA, that provides for the committee's ability to delay the adoption of Administrative Rules that have not already been adopted. A majority of the committee members inform the presiding officer that they believe that the proposed rules are beyond the authority of statute and that it does not require any particular legal analysis, and that they object to the rule. Mr. Niss recommended that the Department consider the comments that were made at the hearing, the comments that have been sent to the Department, and the comments that have made at this meeting and redraw the proposed rules and send them to Mr. Niss who will provide them to the Committee. The Committee members can review them and decide whether the level of staff ratios that the Department would like to adopt is sufficient for their purposes and decide whether the credentialing changes that the Department would like to adopt is sufficient for their purposes and if there are no objections by a majority of the committee members under subsection 2-4-305, MCA, then go ahead and adopt the rule.

TAPE 2B

REP. ROBERTS said that last session we had an issue that was dealing with social workers and the Department of Public Health and Human Services came before us and said that if we did this, I believe it was from the abused child situation, they would not be able to afford or provide services in areas like Circle. He thinks it is admirable that we want to increase the standards for a lot of this, but are we pricing the service out by adding these things. We have to put reality in check with what is being suggested. He was not sure if you would find enough people with those qualifications to handle all of the needs out there and we have to bear that in mind.

REP. WARDEN said that he is troubled that this is a solution looking for a problem in some of these instances. He asked if there was a crying need out there that precipitated these rules that people are having a problem with. MR. KEMP said that there are money in grants and other types of programs that will provide funds and their basic tenet is that you are a licensed program. He said that he believes that is one of the reasons that they are looking at an after school program under the core requirements of a day care center. They are actually quite different in the children they take care of and how they take care of those children. Yes, the Department does feel that there is a reasonable need to establish some parameters. He said that he would agree with comments made previously that you can establish the bar so high that you make it impossible. He agrees with Rep. Roberts' statements and he is sensitive to those issues and will be when they address the comments.

REP. WARDEN asked Ms. Deligdisch what the salary range is for people who are considered to be primary care givers and what salary can you offer to someone with a Bachelor's Degree

and what their response might be to the salary that you are able to pay. MS. DELIGDISCH said that they pay $7.00 hour for beginning workers. Ms. Deligdisch said that the problem is, and why it is so important that they make the rules separate before and after school programs and regular day care, is that regular day cares can offer a regular job. They can offer a person 6 to 7 hours a day, they stay there, they go home at 5 or 6 o'clock. We can't because we operate an hour and half to hour and 45 minutes in the morning and then we operate in the afternoon and pay for 3 to 3 1/2 hours. And so, which person with a Bachelor's Degree or a CDA is going to be willing to work two different shifts during the day. We have a hard time keeping our employees as it is and in finding them. One thing that is said in this 70-page document is that you only would have to apply those rules to new people who come in. That's all good and well, but it doesn't work that way. It is very difficult for before and after school programs to keep staff regularly. Because if they can get an 8 hour job somewhere else, they will take it. That is one of the real differences with a regular day care and so, we would hope that that is recognized when the Department revises these rules.

IMMUNIZATION REQUIREMENTS AND DAY CARE FACILITIES

DAWN HAGENDORN discussed her letter **(EXHIBIT 6)** asking for a review of the DHHS Day Care Vaccination Exemption Policies and her handouts supporting her stand on vaccine requirements **(EXHIBIT 7)**.

SEN. SCHMIDT said that the Committee will not be taking any action but that she would like the Department respond to Ms. Hagendorn's concerns. She said that if the Committee would like to have this on a future agenda, they can but as for now, this is just for information .

JOYCE BERGETT, Section Supervisor for the Immunization Section of DPHHS, said that there are two separate laws for the requirement of immunization in children. The school laws cover children who are over three years of age and are in pre-school, K-12, or post-secondary. There is some confusion between the pre-school children and the day care facility. But the pre-school are children who are over 3, they are in a curriculum and for limited hours. Those children are covered in their school immunization rules. The school law does allow medical and religious exemption. Children who are seen in regular day care facilities, (this is not the after school day care), where there are infants and children who have yet to be of an age that can be fully immunized. By allowing religious exemption for those facilities, we are allowing the people who do not choose to be immunized to choose for the families that want their children immunized. They cannot be immunized until they reach a certain age. The justification for immunization requirements in day care is based on the basic tenet of American citizenship. The privilege of democracy, including individual freedoms must be enjoyed in ways that do not interfere with or create risks for others. Immunization provides protection, not only for the immunized person but also for the people with whom the immunized person comes into contact. Severity of diseases that are vaccine preventable is greatly reduced even if some of the children develop the disease

is greatly reduced if they have some immunization on board. Ultimately the requirements result in high levels of immunization coverage, reduction in disease and a healthy day care community. We certainly support the continued recognition of only medical exemptions in day care. A reference had been made to Colorado, and we do know that Boulder, Colorado, is infamous for choosing to not immunize their children and there are Academy of American Pediatrics who have research papers on what has occurred in Boulder, Colorado.

DAVID NISS said there are in Dawn Hagendorn's letter two kinds of allegations: the allegation that there is a discrepancy between the Department's rules which do allow religious exemption for HIB; and the allegation concerning the form which does not allow for the exemption that is allowed by the rule. He said that he has not seen the form and can't speak to whether that discrepancy exists between the rule and the form. The Department would have to response to that. The two legal allegations that were made on the bottom of the first page, in his opinion, the above law clearly implies that religious exemptions are allowed for all children and all vaccinations. He can speak to that because it is a legal allegation and he has looked at the statutes and he can also respond to the legal allegation in the middle of the second to the last paragraph of the letter which says it is also the right of all Americans according to our Constitution to choose not to vaccinate if doing so goes against our conscience and our religious convictions. That is a legal conclusion which he can speak to, but he cannot address the factual situation concerning the form.

On the legal allegations, the one in the third paragraph on the first page is incorrect. The specific exemption allowing a parent to raise religious objections to the HIB vaccination is very clear in the statute. The exemption applies only to the HIB, to the flu type II vaccination and there is no place in the statutes where a religious exemption is allowed for any other type of vaccination. His advice to the Committee is that is how the statute reads and that legal conclusion at the beginning of the third paragraph is incorrect.

Secondly, as to the legal allegation concerning the Constitution, it is not stated whether the writer believes that that conclusion is taken from the Montana Constitution or the U.S. Constitution. He addressed the Montana Constitution first. He did an electronic search of cases decided by the Montana Supreme Court. There are not vaccination cases in Montana jurisprudence, we just don't know what the Montana Supreme Court would say about the religious beliefs of a family overcoming a police power requirement that children of a particular age be vaccinated whether it is prior to school or for day care purposes. We just don't know because the Montana Supreme Court has not addressed that issue and also because the Montana Supreme Court has held that the State Constitution can grant protections to citizens that are broader than the U.S. Constitution. As to the second point, whether the objection that is voiced in the middle of that second to last paragraph could be based on the U.S. Constitution, he knows both from his work in this area and research on this issue concerning the protections of the U.S. Constitution to parents who make religious objections to mandatory vaccination requirements, whether they be for school or day care. Both State Supreme Courts across the country and the Federal Courts in all circuits and even at the level of the U.S. Supreme Court

have upheld the ability of states to make a police power requirements for mandatory vaccination and have upheld the power of the legislature to do that since about the 1920s.

OUTPATIENT CRISIS RESPONSE FACILITIES LICENSE RULES

SEN. WEINBERG said that he has some concerns to the crisis response facility proposed by Billings that the Committee should review. He said that he has a concern about clinical practice. The proposal by Billings stated that they will keep people for a maximum of 23 hours and 59 minutes. The clinical question he has is that if somebody comes to the facility with a co-occurring illness, with intoxication or under the influence of drugs, and also has a mental health issue. He asked how would they accurately assess someone in that condition. He said that he thinks that it is unrealistic to think that someone can come in drunk and can be accurately assessed in 24 hours, which leads him to entertain the idea that the 24-hour should be extended to 72 hours.

In talking with some people, his understanding is that after 24 hours, if someone was thought to need further care, then they could be sent over to the emergency room. He is wondering that if someone who is intoxicated and has a co-occurring mental illness, once they dry up, if they dry up within 24 hours, will they willingly go to the ER. Is that realistic? Or are they going to want to head home or elsewhere? Whereas, if they knew that they had a few days to spend in the clinic, perhaps they would take that opportunity to consider entering treatment and getting the care they need.

When he thinks of that scenario, the population that most occurs to him are those who might be suicidal. If you can imagine someone who is suicidal or severely depressed and drunk, are they going to want to be escorted or sent over to the ER after drying out? He submitted that they might not and wanted to find some clinical basis for this plan.

One additional question he had for the 24-hour versus 72-hour period, was, but at what point in one's intoxication can the necessity for a medical detox be accurately diagnosed?

In summary, he is looking for some clinical basis in this plan and not just legal or administrative basis, looking for some clinical justification to keep these crisis people for 24 hours and feels that a 72-hour period might be better.

He has talked with Mr. Niss on what is necessary to change from 24 to 72 hours from the legal and legislators' perspective. His understanding is that it can be done, but there are several issues need to be discussed.

And lastly, the possibility of a cost shift was discussed. If they do it right, if the crisis system is set up appropriately and well, we can only expect that we are going to get more people coming through the door and getting services they need and deserve, let's tackle that up front and talk about a possible cost shift. The only economic part of this from their earlier meeting was that the hospitals are going to save money because these people won't go to their ERs up front. Let's look at the next consequences. The hospitals might be saving a couple of million dollars, but is the state going to pay more? The answer might be yes, and if it is yes, let's discuss if that's okay. Maybe it's going to cost us a lot more because we are doing the right

thing.

DPHHS' RESPONSE TO SEN. WEINBERG

ROY KEMP, Licensing Bureau Chief, said that the rules were developed with the collaboration with another division in the agency, the AMDD. The 24-hour assessment is an out-patient basis. In order to address why 23 hours and 59 minutes was chosen, beyond a 24-hour period of time, in the mental health rules there is already an in-patient crisis stabilization license, which upon admission can keep a patient for as long as necessary. One would only envision the emergency room seeing these patients again, if during the course of the 23 hour 59 minutes that they escalated to the point that they needed immediate intervention. Otherwise, the purpose of this particular model is to be able to try to assess whether or not an individual could be well served by out-patient services, or whether they need a referral to an acute setting or whether they could be referred to an in-patient crisis stabilization setting.

LOU THOMPSON, Chief of Mental Health Services Bureau, said that she is a collaborator with Roy Kemp to the rules. She said that she would like to address Sen. Weinberg's initial concern about the ability to do an assessment in 23 hours 59 minutes. She hopes that in responding to the rule comment that she can clarify in the rules more than they have in the original proposal of the rules, that the assessment that is identified for this type of facility is an assessment of the crisis situation and a determination of the appropriate disposition of an individual who is presented in crisis--is that disposition a transfer to an in-patient community crisis stabilization facility or to a hospital facility or to a facility that does medical detox? It is a determination of what is the best location to address the individual's crisis needs as they have presented to this facility. It is not to do a comprehensive psychological or psychiatric evaluation but merely to triage to the appropriate professional setting. She said that another piece that is often overlooked when dealing with individuals, particularly with adults who have a serious mental illness and/or a co-occurring substance use disorder, is that unless there is involvement by the court system, these individuals actually do have the ability to exercise a choice. And if after sobering up, they decide that's all they want and they are going to go home, there is no ability on the part of the mental health or the substance abuse systems to force them to do otherwise. It is unfortunate, we certainly do to the best of our ability to work with individuals with an addictive and mental disorder to work within the system, but the bottom line is that they are adults and they have the ability to exercise choice in their lives.

SEN. SCHMIDT said that one of the other concerns is the possibility of cost shifting to the state and that the state was going to pay a lot more. Do you have a comment on that? MS. THOMPSON said that as the rule is proposed and as the mental health system currently exists today, AMDD will reimburse for Medicaid services or services that currently exists in our Medicaid state plan that are provided to individuals who are currently eligible for Medicaid. We have not been asked by the Billings facility or had any conversation with any other organizations who are contemplating a crisis response facility for any other reimbursement. We have not

contemplated any reimbursement mechanism for an individual seen at this type of facility that is outside of what we would currently reimburse if that same individual were to present at a mental health center.

SEN. WEINBERG asked Ms. Thompson at what point can one diagnose for the necessity for a medical detox?

TAPE 3A

MS. THOMPSON said that she is not able to respond to that in a clinical term. She said that her expectation is that the staffing of a crisis response facility will have individuals on staff 24 hours a day that can render a determination of the appropriateness of that. It is her understanding that it is related to the substances on board and the duration of the use of the substances and it would be her expectation that the staff at these facilities would err on the side of caution and if there were any potential for the detoxification needing to be a medical detox and opposed to a social, that they would default to an appropriate facility.

SEN. WEINBERG said that it was never part of his thinking to compel or force people to stay for 72 hours but in the same vein, he would not want to force the clinic to throw them out after 23 hours 59 minutes. He said that he thinks what he is looking for is some flexibility that might allow for service based upon clinical necessity rather than treating everything by strict limits. MS. THOMPSON said that she understands and appreciated that and she is sure that the individuals who will be working in this facility would appreciate that kind of flexibility as well and it is certainly something that they will be looking to see if that is something that can be done within current rule and statute.

SEN. ESP said that the other rules used to say they could keep them for so long and then the new rules said that you had to average so long, and maybe that is something that you can consider this, the average length of stay had to be less than 23 hours or something. If you wanted some appropriate flexibility.

RESPONSE BY REPRESENTATIVES OF THE BILLINGS CLINIC

JOAN DALY, Director of Psychiatric Services, Billings Clinic, and Board Member, gave an update of the crisis center and provided handouts to the Committee **(EXHIBIT 8)** pertaining to assessments developed for the Community Crisis Center (CCC). She gave a copy of the Pact Tool, which is the tool they use in their emergency department currently that they assess these same population with. Also the mental health centers evaluation tool that they use when they are approaching these patients. What we will find if we evaluate all three tools is that the Crisis Center's evaluation tool is a more comprehensive tool.

She said that the less than 24-hour stay was arrived not so much as a cost shift from the hospitals. The ERs will always see this population and initially they will see them and often be

referring to the Crisis Center from the emergency rooms after they have been medically cleared until they can develop a sense of how these patients will flow. We are hoping that people will respond to the Crisis Center in terms of "I am in crisis, I'm not in an emergency situation and I need help and I need guidance" and then we can start setting up appropriate treatment plan and an appropriate crisis plan. If they are in need of that type of a medical intervention that would require an emergency room or in-patient facility, that would immediately be run through the medical protocols. Those medical protocols have been developed by medical professionals, including our emergency department physicians and also the first responders have contributed a great deal to the conversation of what they would assess in terms if they had to pick up a patient that was inebriated on the street. If they could not determine if they were medically sound, they would be taken immediately to an emergency room, they would not be brought to the Crisis Center. Some of the issues are not the expense in the emergency departments. What happens is the expense piece that they look at that could be a cost savings per se, but it is in the number of admits that into the in-patient acute facility for less than 24-hour stays for these patients that are presenting in crisis that we do not have an appropriate facility for. They have been drinking, they may be saying they might be suicidal, they are not really sure, but we are admitting them, that is a cost to the state if they have Medicaid. And they are wanting to leave the next morning and we are a locked facility, and unless we find that they are an imminent risk and we are willing to do a commitment to the State Hospital, we are letting these people go. So, we are seeing a great deal of patients that are coming in and out in a less than 24-hour stay into the in-patient facility. We are hoping that that population particularly will be able to be alleviated by some of these patients that are really needing help and wanting help but don't have any other place to go and are not necessarily wanting in-patient, but often times, once they can visit with us, sober up, they can also go to the mission. Currently the mission will not accept patients that do have drugs or alcohol on board, but they will take them if they have been sobered up and deemed that they are safe. Many of these patients would want to go to that level of care and they continue to come back to the Crisis Center to have help. For us, it is an opportunity to start allowing them to get help before they are in an emergency situation. They are hoping with medical protocols, the first responders, and the dialogue and the connection that they have with their emergency departments, that they will be assessing the acuity and the need for further lengths of stay that would require a 72-hour facility. One of the things that they were invested in when they were assigned to this project by the Alliance in Billings was that there are many services already available in the Billings community which includes 72-hour placements, the Mental Health Center provides 72-hour crisis beds, Rimrock Foundation provides those beds and medical detox. We also at the Hospital do some medical detox if that is necessary. We did not want to duplicate services that were already available and already managed in a very efficient way.

She wanted to emphasis that when they are assessing in the emergency room, they are assessing whether they are imminently a danger to self or others. Many of these patients are not an imminent threat to self or others, but they are certainly questionable and something that they are worried about. We have to look at the levels of needs and hopefully with this facility,

we are providing a level of care and assess to care that is not currently available except through emergency department at this time.

SEN. WEINBERG asked if it was realistic that if someone is drunk that within 24 hours you could do an accurate suicide risk assessment with them. JOAN DALY said that they are currently doing those assessments in their emergency rooms, and so yes, she thinks that they can. One of the things that happens if that after a couple of hours, you will be able to have that kind of conversation. Our goal is not just to keep them there for 24 hours. It would be to have them interacting with us over that course of 24 hours with our staff which are our Registered Nurses, licensed clinicians, mental health techs, people that are trained to assess their medical acuity. Also to assess how lethal these patients are and then work with them where they are at in their process. Many of the facilities that do similar types of programs like this, their average length of stay is perhaps 5 hours when there is a disposition made. They are either referred to another program, an in-patient facility, detox, or they are no longer in need of that level of care and can safely leave with the safety contract. We are not expecting that that is going to be the average length of stay. We expect that the average length of stay will be much shorter, much like what it is in other settings when they come in to be evaluated, it takes a couple of hours to evaluate somebody and if they have some time to sit and sober up and gain some peace of mind, we are going to be able to continue to evaluate that as we go.

SEN. WEINBERG said he is still curious at what point the necessity for medical detox can be evaluated accurately. MS. DALY said that if you look at the medical protocols, when they come in and they are assessed, first of all, they will be given a breathalyzer so they will know how intoxicated they are. If they have some sense of their history and know their history and if they are serious about wanting detox, they need to be somewhere else. But if they are coming in and they are not certain, they are not terribly intoxicated and they are not suicidal but they would like assistance, then that is the population they are targeting. If they are presenting at that lethality, then they would be immediately referred to in-patient or to Rimrock or another appropriate level of medical detox.

DR. DONALD HARR, Psychiatrist, Billings, said that he has had numerous opportunities to observe and work with individuals in these kinds of situations. From experience, he can say that it certainly is a clinical judgment that is based on features: if there is any history of how long this individual has been on the intoxicating substance, what the individual's general physical condition symptoms are at the time that they are presenting, the general attitude and behavior reaction to the individual that is doing the assessment at the time. All of these components put together are necessary and those are used to make a determination if this individual is in need of immediate detoxification, or if after observing them for an hour, two hours, sometimes longer than that, one can detect the symptoms that indicate a serious withdrawal reaction that requires proper medical detoxification. Some of those circumstances can occur even a day or so later. It is possible that the individual does not demonstrate the

signs of immediate medical detoxification. It could come up hours later, it could come up a day later. It depends a lot on the history if one is able to get some idea not only of the current level of intoxicant in the system but how long the individual has been absorbing those materials. SEN. WEINBERG asked Dr. Harr if it would be helpful to this population to have the ability to hang on to them for two or three days to more accurately assess what is going on with them. DR. HARR said only if there is some indication of the extended duration, if there is any history of previous withdrawal reactions that the person had. He did not think that it was necessary on each and every one that comes along. That would have be a clinical determination based on those factors that he mentioned. SEN. WEINBERG asked Dr. Harr what can one expect from somebody who presents as being drunk but also has suicidality, depression; is there a delay between the time they sober up and that period where they might do something that is destructive to themselves? If that were the case, does Dr. Harr think it would be helpful to hang on to them for two or three days? DR. HARR said that the highest risk is during the period of intoxication as individuals are able to recover from the degree of intoxication, it is much easier then to be able to evaluate them as to the depth of the suicide probability. It is important to determine after the individual is able to converse sensibly and talk with the person doing the evaluation as to what their feelings were prior to becoming so intoxicated because there are some individuals who have had some suicidal thoughts previously but they did not actually have a suicidal plan or a definite intention. It was only under the influence of the intoxication that they lost the previous controls that they had which allowed them to feel much more suicidal and have a greater capability of carrying through. I think what was previously said, that if the individual was able to reach a level of sobriety, that there is possibility of someone that is skilled in doing a psychiatric evaluation can assess what the person's attitude was prior to intoxication and get at the depth at that time. I do not believe that it would be necessary to mandate or force a retention for two or three days just to determine that. I think it can be done at a basis earlier than that. Because if the person doing the evaluation suspects that there is more underlying force there, then they definitely should be put into a different situation than the crisis response center itself. They should be put into the hospital where they can be evaluated on a thorough basis.

TYLIE MERKEL, Director of Community Crisis Center, said that she wanted to make it clear to the committee that they have transfer agreements that they are entering into with both Deaconess Billings Clinic Hospital, St. Vincent Healthcare, the Mental Health Center and hopefully Rimrock Foundation, so that when they are doing their assessment, if they believe that this person would be better served by a more lengthy stay and medical detox or in-patient acute care, that we then can transfer the patient to those facilities. Our medical protocols were put together by Dr. Bentler, Dr. Currian, Dr. Moore, to help our staff evaluate. When we have someone come in and if it looks like they are going south and we can't serve them there, we will immediately contact American Medical Response and have them transferred to a medical facility. Our primary concern is safety of the client that we are serving in the most appropriate setting and we don't want to duplicate services that we already have in the community.

REP. FRANKLIN asked Mr. Kemp where the term "inappropriate" came from when talking about management of inappropriate client behaviors. She said that she asks this question because this gets to the core of why this population is so hard to deal with. There are people who are aggressive, who are combative, who are unpleasant and why is it called inappropriate because it is appropriate for where they are at. MR. KEMP said he thinks that is an excellent point. He believes that it is the vernacular of choice for someone who is not acting like society would expect them to act. He said that Rep. Franklin is also correct that it is not inappropriate if they are in the proper setting, it would be expected in some cases. REP. FRANKLIN said that the only reason she thinks it has a life of its own and she was glad to hear Ms. Murkel talk about working on referral and transfer agreements because the bottom line is that unless those issues are addressed, we will just have a different level of patient dumping. Patient dumping happens wherever people don't want to take care of people. It doesn't matter unless there are clear acknowledgments of what is real about people when they are impaired and that the ultimate thing is there needs to be someplace for them to go and those behaviors need to be identified. MR. KEMP said that once a person enters into the system and shows or presents in an emergency room and submitted to this level of care, he believes it is important, and that is why it is written into the rules, that there would be a transfer agreement. Unless this individual was going to leave against medical advice and everyone can leave against medical advice, they would be referred by transfer if the facility was unable to assist, to de-escalate, or to treat this individual properly, that transfer to an appropriate level of care where they would be reaching a proper level of intervention occurs. He does not want this to be a perceived "Billings" rule. This rule was written in general terms and can be applied in Missoula, Great Falls or in any location that would be willing to provide this service. REP. FRANKLIN: For this population of folks, the nexus of activity is the relationship between the legal system that can enforce, to limit somebody's freedom and the clinical nexus. For this population, that where it's at. So is there anything you think in the rules speaks to that, that provides some safety for patients and clinicians. Should there be something particular in the rules that says "that provides clinicians a good avenue for mental health commitments" because that is where those decisions are made in those first few hours and that is the issue both patients and families have in they can't get them into treatment. How do we address that in the rules? If it isn't addressed, we end up with the same population of people, that people feel frustrated about because they can't get into treatment and no one really knows what to do about it. MR. KEMP said that one assumes that if we're not leaving against medical advice but we are willingly submitting ourselves to the recommended treatment as you need an out-patient service, an in-patient service, in acute service, and that that individual would willingly do that. As far as the commitment laws are concerned, that he would have to defer as to whether somebody is a danger to themselves or others and must be committed under the commitment laws. I would defer that to David or to an attorney. REP. FRANKLIN said that she would readdress that. Do you think that the effort for crisis centers would be helped or guided by rules that relates specifically to the commitment law and how they function in out-patient? MS. MERKEL said that she is not an expert on commitment laws, but she can say that as a licensed clinician, any time she is working with

someone, whatever setting they are in, if they are in her private office, or leave her office and she thinks they are a danger to themselves or others, she is going to call the police and have the police pick them up. That is there for them to use if they are ever concerned about that. Now, commitment law, Joan Daly could speak to that. REP. FRANKLIN said that she believes that within the rules there needs to be something that addresses what is the role and responsibility of a crisis center in acknowledging people's need for mandatory treatment and making sure that happens if it is identified at that point.

JOAN DALY, Director of Psychiatric Services, Billings Clinic, said commitment laws do not delineate any timetable for things to happen. Currently, she can speak for her facility that they do 99% of the commitments coming out of Yellowstone County and courtesy commitments from surrounding counties. That has become a very lengthy and cumbersome process for the purpose of protecting the rights of the patients but also the lengths of stay that are occurring in a locked facility to help people get into treatment because they need to be committed and they need that level of care. She thinks that is a problem all into itself and needs to be addressed in conjunction with this piece because they could probably clinically assess many of these patients and make some determinations and assess how emergent they are before they are put into a locked facility. Having a crisis center, how this relates to that, is it gives them more freedom, more choices, more opportunities to assess what it is that they need. One of the things that is happening currently is that people are not getting into the services they need to because they don't have an appropriate door to walk into and to get the appropriate referrals and transfers. They end up very emergent and in critical acute situations and we have no choice but to end up in a commitment process. What this would connect with is the prevention of the decompensation that would lead to a lengthy in-patient stay.

SUSAN FOX said that as a rule issue, the public hearing was held on January 12 and she attended. This amount of time that we spend on this far exceeds what was heard in public hearing, so there was no consternation in public hearing. Although the attorneys are disagreeing at this point how official this is, on a non-legal basis, the Department said it would extend its comment period until we met and any comments that we would provide to the Department, they would include in their MAPA process and make sure that they address the comments in their adoption procedures. What she would like to suggest is that we save some of these issues because there is information that you will be hearing about AMDD and other towns, Missoula and Helena specifically that have concepts and ideas for crisis and as Roy pointed out, this isn't a Billings rule, this is a rule for the State. Perhaps when we hear the ideas or questions from the other areas, we can start framing this. If you have enough information from the people you need, the Committee could hold this discussion during the work session and decide as a committee if there are motions to be made or if there are comments as a Committee to make to the Department. They would then address in the adoption of the rules, just like we talked about in the daycare ones. We could close this issue for now, wait until we get more information this afternoon, and then we can proceed to make a formal comment to the

Department who then would formally respond in the adoption process.

SEN. SCHMIDT asked Susan to discuss the interim study assignments. She said that Rep. Bill Jones has gone to an NCSL meeting on Children's Mental Health Services and he raised an issue about teenage suicide prevention. He had heard about a grant that the State of Montana got. There is someone from the Department who will give a status report on that prevention grant because we didn't want to raise the issue and leave you hanging. It then ties into bigger suicide prevention issues that are on the list of things that the Committee still needs to address. Rep. Jones can be here at our work session.

JO ANN DOTSON, Bureau Chief, Family and Community Health Bureau, DPHHS, gave an update and handed out a document entitled "Youth Suicide Prevention in Montana" **(EXHIBIT 9)**. She said that suicide in the state is a major concern, not only among youths, it is among all populations and specifically youth and the elderly. This is not unique in our state. You will find that these populations are at risk. Suicide in Montana is the second leading cause of preventable death for youths and young adults. This is based on a rate and our rate of death is 12.93 per 100,000. We had between 2000 and 2004, 130 suicides in Montana among youths aged 10-24. This is a significant loss to our state. Montana has been in the high range of occurrences for a number of years. If you look at suicide death rates in the United States for the time period 2000-2002, you will find Montana, Idaho, Wyoming, Colorado, Arizona, a lot of the states, Alaska, all have very high instances of not only youth suicide, but suicide in general. In that time period, 2000-2002, while our youth suicide rate was 12.93, the overall suicide rate is 18.88 for 2000-2002. Alaska is higher than us. New Mexico is higher, but Nevada is higher than us, but we have some major concerns with suicide in our state. The causes of suicide, if one wants to get to suicide, and one of the reasons that you will find it come up in discussions regarding mental health is, all people who go through suicide, are they mentally ill? That's a definition that hasn't been determined. Are they all using substances? No. Are they all mentally ill? No, we don't know. A lot of times there isn't an identifier. We do have a lot of information and best practice that has been identified as far as the background of suicide, and one of the efforts at the federal government just recently was recognize that youth suicide is a tragedy that is happening in our whole nation.

There was an effort to set aside funding in the form of the Garret Lee Smith Memorial Act that set funding aside to fund youth suicide prevention activities in states. Our state competed and was one of 14 states that were funded this last year. Beginning in September-October, 2005, to address the issue of youth suicide. The goal of the project that we are calling **Montana's Youth Suicide Prevention Project** is to prevent both fatal and non-fatal suicide behaviors among youths and young adults aged 10-24 years of age. We say that because we do know that if we are just going to try to stop the suicides, we don't know, the kids that are using substances that are in violent situations, that are driving while under the influence, all of those are the ones that we have the potential to stop. We can't wait for kids to try suicide and then affect that. Montana Youth Suicide Prevention Intervention Project provides planning,

coordination, resources to communities so they can address risk and incidences of suicide attempt and completions. One of the characteristics of the Garret Lee Smith is that they did want the majority of funding, and I believe it was in the 70%, to get funding out to the communities to work in a contract basis to work on actual efforts instead of keeping it at the state level. Our goals and activities will be to put funding to at least 16 and up to 15 community projects and to an institution of higher learning which was an occurrence or a condition of the grant to be funded to address their needs and input evidence based programs about suicide prevention in youth. One of the other requirements is to organize a statewide task force to continue ongoing work in the statewide suicide prevention plan, which we are in the process of doing, to assure that that task force helps guide public awareness and education of youth suicide campaigns. So efforts are out there. The overall goal of preventing both fatal and non-fatal suicide behaviors among 10-24 year olds are outlined in a series of objectives that are on page 2 of the handout. We are going to improve access to and availability of prevention services at a community level, increase access to in community linkages with mental health, implement activities for ongoing public information, establish a process which promotes effective clinical and professional practices. Those are on page 2 of this handout. What you are seeing on page 3 and 4 is the summary of the timeline by objective telling you the activity that will be carried out as part of the Garret Lee Memorial Project. On page 5 is the description of the task force.

TAPE 3B

SEN. SCHMIDT asked Ms. Dotson if the grant was received last fall? MS. DOTSON said that it began in October 1, 2005. She said that they are going to do an RFP to get 6 to 15 communities funded for projects to begin in the summer of 2006. SEN. SCHMIDT asked if Ms. Dotson could clarify the other grant that was received but never funded. MS. DOTSON said the Emergency Medical Services provided some funding to some of the start-up sites. They have done some work with communities. The Emergency Medical Services for Children funding is through the Maternal Child Health Bureau at the federal level. That funding is decreasing and they are in continuing resolution with that right now and the funding is on hold.

DRUG BENEFIT MEDICAID ENHANCEMENT PROGRAM

REP. EATON said that she had a lot of constituent response regarding the prescription dilemma, angry people frustrated, people questioning, people crying because they were unable to get access to their prescription drugs as they had thought that they would be able to. In researching, she was reminded that in this last Legislative Session, several bills had been passed that was to free up some more prescription drug availability for certain people. In working through some of the individual problems that she had encountered, she was trying to trace through how we could get access to some programs in some of these areas of help, and in doing that, she has corresponded with David Niss and he pointed out to her that there is a problem in the rules and in reality in initiating some of the bills that they passed last time. Rep.

Eaton turned over the discussion to Mr. Niss.

DAVID NISS said that in same legislation that created the Part D Wrap Around Program, SB 324, there was also a second pharmaceutical reimbursement program that is distinct from the Medicaid Wrap Around Program in that bill, referred to as Medicaid Enhancement Pharmaceutical Reimbursement Program. It is called in the Legislation, the Prescription Drug Plus Discount Program, that was originally passed in 58th Legislative Session in 2003, and then was enhanced in last Legislative Session. By enhanced, he means that those persons eligible for the program were increased from those with a family income from 200% of the Federal Poverty Level, now to 250% of the Poverty Level. So we now have essentially three state programs for pharmaceutical reimbursement for the poor and the working poor, those being Straight Medicaid, the Medicare Wrap Around Program in SB 324, and the Medicaid Enhanced Program, also in SB 324. Because of the manner in which this arose with a particular constituent of Rep. Eaton, just to give you an example of how far the state has gone in providing this third pharmaceutical reimbursement program, which has not quite begun yet, a family of three can earn under the Federal Poverty Guidelines, is over $16,000, and so a family of three under the Medicaid Enhancement Program can earn 250% of that and still be eligible for the program. So it is well over $30,000 for a family of three and still be eligible for this third pharmaceutical reimbursement program. As to that, there were several changes made in the 59th Legislature to the Medicaid Enhancement Program that was begun in the 2003 Session. In the last Legislative Session, it was changed both as to the scope of the program and will now include families at 250% of the Federal Poverty Level, but it was also made a discretionary program with the Department. That could be one of the reasons why it hasn't appeared yet because the Department no longer has to offer the program, they may offer the program and what that depends upon is funding. There is a funding provision in the law and the amount that is to accumulate with the Department in order to pay for the program has just gone pass the $1M mark. For that reason, the Department told him that they would be implementing the program by adopting rules sometime in the not too distant future. The person whom he talked to said that they would probably use the full 250% of FPL that is contained in the statute.

JANI McCALL, Montana Children's Initiative Providers Association, said that she wanted to remind the Committee that the Department is in the process of rewriting the rules for foster care and therapeutic foster care. The deadline for written comment period is February 3. They are writing a detailed response to the proposed rules because they have found issues on what is happening. She said that she wanted to raise the attention of the Committee to this because on the second day of this committee meeting, the Committee will be talking about foster care, recruitment and retention. If the rules are passed as they are, recruiting families for foster care will become more difficult, and there will be families leaving the system. She said they have particular concern regarding ranching and farming families which provide ideal environments for many of these children. She said that they will have a detailed written response that will go to the State and that each legislator on the Committee will receive a copy. She requested that this

issue be put on the agenda for the March meeting.

SJR 41 MENTAL HEALTH CRISIS RESPONSE - Susan Fox

SUSAN FOX, LSD Research Analyst, said that SJR 41 is studying Mental Health Crisis Response. She said that Joyce DeCunzo will be giving us the first blush of the proposals that they are looking at and taking around to the different parts of the mental health community. She would like the Committee to listen to what they have to say, see where it fits with what we heard the problems are before, think about the Billings facility, think about the State Hospital, and jot down the areas that the Committee is interested in pursuing.

PRESENTATION BY JOYCE DECUNZO, Administrator of Addictive and Mental Disorders Division, Department of Public Health and Human Services

MS. DECUNZO distributed to the Committee three documents: 1) Adult Mental Health System Options **(EXHIBIT 10)**; 2) Cover Memo **(EXHIBIT 11)**; and 3) a draft RFP for Community Crisis Response Services **(EXHIBIT 12)**.

Ms. DeCunzo said that she will try to address several issues that were brought up this morning regarding uninsured individuals who present for services, the State Hospital census. For their purposes, what they continue to do is to try to determine what does this system need to look like. We have institutional services and we have community services. Those seem to be two different things. What is common between them is the individual who moves from one of those service system to the other. So while this Committee is dealing specifically with crisis, and we spend a lot of time dealing on what we need to do about developing crisis response, at the same time, we are also spending a lot of time on the census at the State Hospital and for us that means, how do people get there and what do we need to do to be able to bring them out from there. For purposes of today's discussion, while you are interested in the crisis response system, what we discovered is that we simply cannot talk about one issue without talking about the other and as we start to try to figure out what are the options, what are the things that we need to do, the real steps that we need to take to be able to manage or to implement both of those things, they are very much connected.

She discussed the draft RFP **(EXHIBIT 12)** for Community Crisis Response Services. She said that in the last legislature, they made a commitment in their legislative subcommittee that they would use some funds they had in their budget to develop crisis response. They have $750,000 that will be available, they will put out a Request for Proposals to ask people to respond with what kind of creative ideas they have that are specific to crisis response services. The RFP has not been written but the expectation is that they will release money to have the project start July 1. Ms. DeCunzo said that they are moving forward on that and want to have stakeholders in the State to help make determinations about which projects would be worth funding.

Ms. DeCunzo said that they have spent time working with and talking with the Department of Corrections. The commonality between their institutional services and their community services regarding mental health and chemical dependency is that the same

individual moves through those systems. They have yet another commonality with the Department of Corrections, and that is, many of those individuals move through all these systems together. She said that that is a fairly new and serious effort and it moving along very well, but that she cannot talk in detail except that they are working hard to identify people that are common to all of their systems; i.e., corrections, mental health and chemical dependency and trying to find ways to efficiently provide services to that individual both from a cost standpoint and from a service standpoint.

Ms. DeCunzo discussed the Options paper **(EXHIBIT 10)**. She said that they focus a great deal on the issues regarding the Montana State Hospital where they have needed to develop some long term solutions to the growth at the hospital. The question asked is, what are they going to do regarding the State Hospital census. Are they going to build more beds, are they going to change treatment modalities, are they going to develop a different set of community services that will allow them to be able to assure that people move through that system as seamlessly and as quickly as their illness allows them to?

On the Community Mental Health Services side, they cannot separate the issues at the State Hospital from the issues they have regarding the services in the community for people with both chemical addictions and mental illness.

Ms. DeCunzo said that each of the options listed have the ability to impact their system in some way. She gave an analogy of a room with windows covered with blinds. If what you want is to get some light in the room, you can raise one of the blinds and that will improve the light in the room. If you raise two of the blinds, it will have more of an impact on where you are trying to get. If you raise all of the blinds, then you potentially will get to the full impact of what it is that you hope. Raising all of the blinds may be too expensive, but what they want to do is to develop it in a way that they can build, that it is not just what is going to happen in the coming year or two years, but rather, where are we trying to get over a period of several years knowing full well that it takes time to do that, but every step they take, it is closer to what their goals are. The cover memo **(EXHIBIT 11)** explains some ideas of how they can put together certain options and feel like they would have an impact that would be substantial as opposed to doing individual things.

Ms. DeCunzo talked about the uninsured people who present in crisis. They are not eligible for public health benefits; i.e., Medicaid, SSI, and they do not have the money to pay for their care. That creates a huge bottleneck for people trying to get services. When people don't have the money to pay for their services, they continue in their illness until they are so ill that they have to be in the highest level of care that is available which is the State Hospital or one of the community hospital's psychiatric units.

TAPE 4A

JOYCE DECUNZO said another concern is when people leave the State Hospital and they have nothing. When their census got intolerable in the State Hospital and they didn't have appropriate staffing to be able to care for those individuals, they started trying new and different

things, one of which was to add staff and open a new wing in the State Hospital. They started looking at what is happening to these people who go out and are cycling back in. They realized that people left the Hospital and had no place to go. Some people said they are contributing to homelessness because they knew that these people did not have a place to live, so they leave the State Hospital, and go to a shelter.

Ms. DeCunzo said that one of the things that they are started was identifying on a case by case basis providing for those leaving the Hospital. They are negotiating with hospitals in the State to serve some individuals longer instead of sending them to the State Hospital. That was expensive but at least it assured people of good services.

Ms. DeCunzo said that these are good ideas and they are going around talking to people about them, asking them what they think are the most important issues to discuss.

QUESTIONS FROM THE COMMITTEE

SEN. O'NEIL asked Ms. DeCunzo how much potential is there for expanding the peer support services in prison and State Hospitals and the communities in order to provide more services at a lesser costs. MS. DECUNZO said that she couldn't answer that for Corrections because she isn't close enough to that service delivery system and how that works. But on the State Hospital side, she can say that it has been a long standing desire to have peer support services in the hospital and those would be going toward having an individual who is doing well in their recovery. One way to provide peer support would be having FTE and for each FTE, they could hire two individuals, who have mental illness, as peer support specialists. She says that because of the cyclic nature of the illness one of the things that people get concerned about hiring individuals with mental illness is what is going to happen when they are ill and there is no one then doing the job for whatever period of time they need to get well. One way to handle that is to have job sharing. As an example, individuals who would be able to start with a person in the State Hospital who has an integrated services delivery plan for the community setting and then they could meet that person, help them navigate the system, help them find a place to live, do those kinds of things. There is a lot of potential there. Have great opportunities there, and that it is one of the reasons they have it on the Options page.

SEN. ESP said that in the past, utilization at the Hospital has been significant by several counties in the west. If you were considering adding beds, he would add them in the west because it would save the county money transporting to and from, could convince them to kick that into the facility and that might help being able to keep the hospital licensed capacity and then add beds someplace else.

Ms. DeCunzo said that she neglected to mention that in that transitional setting, they have a real need to develop some residential services that would be something longer than a 2 or 3 night stay. They do have, as an example, on the chemical dependency side, recovery homes for women with children and the average length of stay is 18 months. They believe that there are some opportunities there if they had some transitional living for individuals where they would continue to get services and the support they need while they get a job. The question

about adding more beds, whether it is on the Warm Springs campus or someplace else is more difficult. They want so much to be able to serve individuals in their own communities and in their own homes. From an advocacy standpoint, there is not nearly the consensus regarding the building of beds as there is regarding building of community services. What her hope is, if they were able to develop the community systems in more levels so that people get the service at the level they need, instead of having to go from a basic out-patient level all the way to a hospital level. They are hoping to fill in some of those spaces that will help with those issues.

SEN. ESP said that it might be easier to recruit and retain staff in that setting, in Missoula vs. Warm Springs, and he said that it at least deserved some thought.

REP. WARDEN asked how many beds are at Warm Springs and how many beds can there be at Warm Springs. MS. DECUNZO said that there are 209 licensed beds, and there is a unit that with work could be opened and so there is potential for another 20 beds. She said that there is a difference between the licensed capacity and the treatment capacity. The licensed capacity tells them that they can have more individuals at the State Hospital, so they could put two people to a room. From a treatment standpoint, the staff at the State Hospital has found that that is not effective. If a person is in the crisis that puts him in the State Hospital, they have difficulties with treatment when you start doubling people up. Technically speaking, they could serve more individuals in licensed beds, but from a treatment standpoint, it is a firm belief of the staff that it is not effective because they are in a bed and it takes longer to help them with their illness. The other issue is the staffing. They were staffed for 170 and they have received 36 plus modified positions to help deal with the current census, but they are still understaffed in terms of their desired modalities.

REP. WARDEN asked if Ms. DeCunzo has tried to get the 72-hour presumptive eligibility put back in and what would the fiscal note on that be. MS. DECUNZO said that was not part of her EPP request last time and she does not have the data on the costs of that because during the managed care years when that was being provided they did not have data from the managed care company. She said that on the providers who did this before managed care, all they have is old data. They will find the methodology to project what that would be.

REP. WARDEN said that if the Committee is going to consider that as they go forward, it would be important for him and others to have some sense of what the dollar figure is and if she could do whatever she can to help the Committee address that issue.

SEN. WEINBERG asked if somebody gets picked up by police under the influence of methamphetamines, do they have a legal problem or a mental health problem? MS. DECUNZO said that they may have both, they may have only one. Not every individual who has a substance use disorder has a mental illness and not every person who has a mental illness has a substance use disorder. The fact of the matter is, a huge chunk of them do have both and so

she does see a rising number of individuals present to Montana Chemical Dependency Center with methamphetamine addiction and she is seeing rising numbers of individuals with meth addiction presenting to the State Hospital.

SEN. WEINBERG said that members of the Committee received a newspaper article that reported that the State Prison was $8M over budget because they had a thousand more people there than they wanted and a lot of the cause was due to meth use. He asked if she was seeing a similar problem in the state mental hospital that meth was causing numbers to go up. MS. DECUNZO said that they are seeing some of that, although what they are seeing on the addiction side is a much higher presentation of the use of opiates and prescribed drugs, even higher than meth.

REP. EATON asked Ms. DeCunzo about the requirements in their draft RFP and the $750,000 that would be available to communities, what does the community need to look like, and what community collaboration is required. MS. DECUNZO said that the draft RFP is not intended to go to one size community or another. Their hope is that the money can be used to spur people to think creatively about how they might develop a crisis response system in their community.

SEN. ESP asked if the proposals have been seen by the advisors from the Governor's Office and did she have any part in developing these options. MS. DECUNZO said that they have been working closely with both the Governor's Budget Office and the Policy Advisor.

SEN. O'NEIL asked if the State will no longer support the proposed services when developed and does it have the funding sources there. MS. DECUNZO said that she didn't know how to quite answer his question. She said that this Administration is putting a lot of emphasis on sustainability and for all of them, that has been an important issue. If you are going to put money into testing something, having some kind of pilot project to see if that is going to work, if it does work, you want some forethought on how would you then make that work. So, while someone might get money from this RFP to get started, to do planning or some implementation of a pilot project, we wouldn't want them to figure out at the end of the project, what do we do now? We want them to be thinking ahead of time about how would we get revenue for this program, what would it need to look like, how much would it need to be, and who are the community partners that could participate? This is an issue but what we will want to see from proposers is some real thought about how if this turns out to be a good thing, how would we expect to keep it going, where would the money come from? We don't believe that we can come to the Legislature with every idea and say, we want you to fund it.

SEN. SCHMIDT asked if the Committee will be able to see what the proposals will be and the fiscal impact at the March meeting. MS. DECUNZO said that it should be very close. They will have been heavily involved in their departmental EPP requests. She said that she would expect by then that they will be firmer in terms of what it is that they believe that they can ask for and by

then they will have from the Governor what the guidelines are regarding the budget. SEN. SCHMIDT asked if they would be prioritized and how do they see that. MR. CHAPPIUS said that at that end of March they will still be in the prioritization process. Everything that they are looking at and the things they are working on are open. They will have those ready, but whether they will be prioritized by that point, or accepted into the process, depends on the dynamic aspects of that process, how much money do they have, what can fit into that amount will have an impact on what they will include in the budget and what they won't.

CRISIS RESPONSE EFFORTS AROUND THE STATE

Maureen O'Malley, Licensed Clinical Social Worker, City County Health Department, Missoula, said that after the Health Department received funding, it proceeded to set project goals. They were concerned about providing education regarding suicide risks and prevention for all citizens in Missoula County, building awareness of the problem by providing special events addressing suicide prevention and reduction, reducing the stigma of seeking mental health services, and studying the mental health crisis response and service delivery systems in her county, and recommending and facilitating improvements. The Health Department sent out a survey to the 200 plus licensed mental health professionals in their community asking how many Medicaid clients they saw, how much pro bono work they were currently doing, what perceptions they had of how the system was working and what improvements they thought needed to be made, and what part did they wish to play in that.

Ms. O'Malley discussed her position paper on the Mental Health Crisis Intervention Project for Missoula County **(EXHIBIT 13)**.

TAPE 4B

SEN. WEINBERG said that we've talked about what's going on in Billings and the new crisis center. He would like to make a suggestion. He wanted to look at a change of rules or laws if it is needed that would not require holding people for 72 hours but it would make it possible for people to stay on for more than 23 hours and 59 minutes, make that a treatment option that may or may not come into play. He is not after imposing anything on them, but he thought it might be worthwhile to make that a treatment option, and he would be happy to work on helping make the rules or laws fit that option.

JOAN DALY said that expanding the stay to a 72-hour stay in a specific facility is a zoning issue and a Medicaid/Medicare in-patient facility vs. an out-patient facility, You are talking about a whole different level of care which is more complicated and expensive and is not just related to legal or administrative rule changes, it is also Medicare and Medicaid and other insurers and how they pay for services. So, imposing that to move to opening for a 72-hour stay would change the entire model at this point.

REP. FRANKLIN said that maybe one of the Committee's staffer could do some background

work on this. SUSAN FOX said that she believes that there was an exception in the past, but she believes that they also got rid of it because it was so much trouble for the Department. The 24-hour issue is an in-patient/out-patient issue for multiple things and ambulatory surgical center was one, residential psychiatric care is another one, so it's a consistent model that when you get over 24 hours, you tend to be considered in-patient. So, it's not only in this one instance and apparently there's other federal regulations.

REP. EATON asked Ms. Daly if she at this particular time views the problem that this Committee is having as a problem where some view this proposal in Billings as an institution that will provide care and services, and some are understanding that you only want to set up an institution that does assessment and referral? MS. DALY said that she believes there is some confusion in what they are trying to do. There are services in her community that do provide treatment, including the Billings Clinic, Rimrock, the Mental Health Center. There are crisis beds available that can be used up to 72 hours. What they are trying to do is get a better handle on the population that is moving consistently through all of their health care systems and not getting better, consistently decompensating to the point they are in emergency situations and are needing in-patient care and then potential commitments to the State Hospital. She said they are trying to create a database and tracking and crisis plans for all these people so when they are accessing all of these points of care, they can keep referring them back to the Crisis Center and start helping them stop falling through the cracks. She said they are trying to have a central intake and an assessment and referral process that does have clinical people present to do those assessments and to continually assess over a period of hours so that they can know exactly what it is that they need and refer them appropriately.

REP. EATON said that that was the crux of the question regarding the 24 hours versus the 72 hours, is that you are not looking to provide services necessarily, you are looking to have a database for people so that you can know where they've been and where they would best be sent to at this particular time. MS. DALY said that hopefully deal with their crisis in the moment.

SEN. WEINBERG said that he is reluctant to make a motion. He does not want to force this on them but he really thinks that more flexibility has clinical merit. But if they are dug in and if they don't want any part of it, he didn't know that there is any reason to do it. He is open to guidance from his fellow Committee members, but he is a little bit discouraged.

SEN. ESP said that since Sen. Weinberg asked for guidance, the discussion today convinced him that the model Billings is pursuing is the correct model for them. It may not be for every place, but for Billings, with the services available in place and the desire not to duplicate those services, he thinks it makes perfect sense for the situation that they are in and he would support them doing that and he would support a motion from this Committee to encourage the Department to work with them to get it done.

SUSAN FOX said that she might make a suggestion that if the Committee does not want to make a formal comment, they could specifically ask the Billings people to keep us informed as to the progress once they actually get the facility open and ask them to come and give us a progress report because maybe they will learn something in that next six months that brings your issues to the forefront. She said she could incorporate that into the study plan, ask them to come and give us regular updates on what they are learning through the process so that by the time we are done in September, if we do see a need for a change in law, or a change in their rulemaking authority, we certainly can pursue that at that time, or do that in addition to your making comments at this time.

REP. ROBERTS said that in Billings it has been difficult for group homes to be re-certified in certain areas, to change the zoning where these units are to something that would better accommodate a longer stay there, to be re-classified as a hospital would be disastrous and it's a good facility, they would like the endorsement of the state to some extent with what they are doing. He has talked to them personally and they said that they will provide information as to what they learned and what they hoped to progress with, and he is in favor of recommending that the Committee endorse what this project is and have a period of time after which we reassess how this is progressing and make appropriate adjustments. He said that he thinks the program in Billings is worth the effort and he would like to propose that this Committee endorse such a policy.

REP. ROBERTS moved to endorse the Community Crisis Center (CCC) proposal and ask for review after a period of time when assessment is appropriate. SEN. O'NEIL seconded the motion. MOTION CARRIED UNANIMOUSLY.

INSTITUTE FOR MEDICINE AND HUMANITIES - Ron Perrin, Chair

MR. PERRIN gave a brief background on the Institute for Medicine and Humanities (IMH) and passed out brochures of IMH **(EXHIBIT 14)**. IMH is the joint effort of the University of Montana and St. Patrick's Hospital. The Board of Directors is comprised of members from the healthcare professionals, faculty, administrators from the University and members of the community. He said that the mission of IMH is to bring to bear upon healthcare issues, the perspective of the humanities. A subcommittee was formed to gather information on the delivery of healthcare services in Missoula. The subcommittee learned that there is a level of frustration, stress, and depression across the board with the people who are responsible for providing mental health services, there is a problem of lack of resources and lack of communication between the various players in the mental health service environment, and that there is a degree of animosity between crucial players on the mental health system community. They have identified three things that the Board could do to address the issues they found. They are: 1) serve as an honest broker among the various players and bring the products together; 2) convene a task force of people in the mental health delivery system to present a series of white paper to the Legislature and to the Governor in terms of how they see the problem; and 3) raise the level of

public awareness of what the natural of the issue and what the nature of the problem is. By the March meeting of the Committee, IMH will have made recommendations that will be either accepted or rejected, or have concluded that that problem is too vast for them to deal with.

REP. ROBERTS said that he is concerned about the number of psychiatrists that aren't taking call, is this a tort reform problem, is it the liability that they assume when they take care of something like this that has far reaching concerns. MS. O'MALLEY said that the liability concerns enter into it and the demands of taking call after hours is a deterrent because their catchment area has grown in recent years. MR. PERRIN said that for every person they see in the night call context, it costs them almost entire day out of their private work to deal with all the repercussions of it, the paperwork and so on.

SEN. WEINBERG asked Ms. O'Malley if she could tell how many suicides were in the Missoula area in 2005. MS. O'MALLEY said that in 2005, they had 23 in Missoula County, population of approximately 100,000. SEN. WEINBERG asked if anyone tracked those suicides with respect to how many people touched the healthcare system and how many were completely outside of the system. MS. O'MALLEY said that she had met with the Chief Coroner and they have not completed the study, but possible 40% had contact with the system that they are aware of.

SEN. O'NEIL asked Rep. Jones if he has any comments on this. REP. JONES, HD 9, Bigfork, Dentist, said that this is a fundamental question of licensure and the Legislature has complete authority over this. This is a question of whether a license to practice medicine is a privilege or right to practice in Montana.

SEN. O'NEIL asked if Sen. Jones believed that if the license of psychiatrists in Montana are not able to adequately address this problem that the field of those we allow to solve this problem be expanded. SEN. JONES said no.

ROCKY MOUNTAIN DEVELOPMENT COUNCIL - Curt Chisholm

MR. CHISHOLM gave a brief background of the Rocky Mountain Development Council. The Council is a CAP agency or human resource development agency that covers the state. They are District 12 and are called the Rocky Mountain Development Council and serve a 3-county area: Lewis and Clark, Jefferson and Broadwater Counties. The Rocky Mountain Development Council is doing community development work, facilitating collaborations to get things going in communities that result in the development of programs or the saving of programs that are necessary to serve disadvantaged and low income people.

Mr. Chisholm gave a brief history about what is going on in this area. The Central Service Area Authority was organized two years ago as a result of legislation passed four years ago. They initiated respective local advisory councils to organized within the 15 counties that are covered by the CSAA to begin the process of identifying and planning to deal with local needs relative to those who suffer from mental illnesses. The Helena Local Advisory Council,

after their meeting on October 27, 2005, had after an almost two-year period of struggling with what they think is important for the community of Helena, identified a need for some type of crisis intervention facility and program for its citizens as their number one priority. However, given the nature of such a committee and the size of the committee, between 40 to 60 people that would show up at any one time (representative of local government agencies in this area, county commissioners, representatives of the city government, mental health centers, NAMI, mental health association, private practitioners, St. Peter's Hospital, consumers, interested citizens), they have struggled with this issue for almost two years and got to a point where they knew what they wanted but they couldn't get it developed into a real program to the point where you could actually open its doors. They were frustrated about not being able to move forward. They could report their intention and their findings to the CSAA and ultimately to the state as this is one of their chief priorities, but they were not able to go further to implement their proposal.

Its chairman asked the Director of Rocky Mountain Development Council if they would be willing to take this proposal under its wing and see if they could do something about it to make this a reality. He agreed. On December of this year, the Lewis and Clark County Commissioners unanimously, by resolution, appointed Rocky Mountain Development Council as its agent to carry forth with the recommendations of its local advisory council to develop and then possibly implement a proposal in Helena to deal with crisis intervention. Mr. Gene Leuwer hired a consultant, John Wilkinson, to develop a proposal on behalf of the Lewis and Clark County Commissioners, its county attorney, and its sheriff to draw up a proposal and meet with the Addictive and Mental Diseases Division. They met in January and found out that AMDD had planned to come out with an RFP, which this Committee has been briefed on. He had hoped to get the official RFP in February and expect to make some awards out of the $750,000 that is left out of AMDD's $900,000 appropriation. They knew that money was there and we were going to help them spend it by asking them for a little over $100,000 to give us the developmental costs to flesh out this proposal. We were a little disappointed that it's February of 2006, but that is okay, we will wait for the RFP, we will fine tune our proposal to meet the requirements of AMDD's four requirements for submittal of the proposal and expect to have the endorsement of both the local advisory council and the CSAA before we submit the proposal.

The proposal is basically to allow Rocky Mountain, along with some CSBG money spent on both clinical consultations and Mr. Wilkinson's salary, to go through the process of dealing with community collaboration arrangements that need to be lock solid in this community in terms of being able to open the doors for such a program, to deal with licensure requirements, put together a business plan to do the appropriate cash flow analysis to help facilitate a systemic approach to dealing with serious mentally ill people that need crisis intervention facilities so there is a place for them to go after they leave this crisis intervention program, to deal with issues such as detoxification and to ensure that we deal with these people on a co-occurring disease basis, that no one is turned down because they are either mentally ill or perceived to be simply under the influence of a chemical substance or an alcohol substance.

We would hope that there is no slippage in the timelines announced by AMDD relative to

getting this RFP out so that we can at least submit a proposal for the appropriate endorsements and then go forward with the development of this proposal. One of the things that we are concerned about, and I want to mention to this Committee that there are things that we are already aware of, that the State needs to be aware of and ponder them seriously. We are serious about opening such a proposal and we are serious about making sure that we cover the 3-county area, even though right now, the committee that's involved and the agency that's involved, started out by representing only Lewis and Clark County, but we know that we want to represent the interest of Jefferson County and Broadwater as well.

There are a number of shortfalls or problem areas that we are going to run into: One, the cost of either acquiring property or a building or the remodeling of a facility to accommodate this program, (whether it is within the local hospital, or without the local hospital is yet to be determined). But there is going to be some acquisition costs that are going to probably be significant. Secondly, I'm sure there is going to be a deficit operational situation for that program, probably ad infinitim. You have been told a number of different times, as we have been told, that between 50% and 80% of those people that will be coming into this facility don't have a dime in their pocket, no insurance, they are probably not eligible for Medicaid, Medicare, or the mental health services plan money. We don't expect to make a lot of money on this type of program, but we want to make sure that it is economically viable and we will take it upon ourselves in the development of this proposal, to see if at the local level, we can offset these deficits as best we can.

But I think the state needs to be aware of the fact that if they are serious about allowing these kinds of programs at the various community levels, it is going to have to do something about acquisition of facility costs amortized over the life of the program and the operational deficit is expected in terms of rethinking of Medicaid/Medicare rules and regulations, mental health services plan money, serious consideration about the 72-hour presumptive eligibility, and even the 30-day presumptive eligibility for a person clinically diagnosed as suicidal. All of these things are going to become important ingredients to facilitating these kinds of developing interests in local community services for people in crisis. We also intend as best we can, according to the committee, trying to facilitate service to young adults, those under 18. We can't ignore the fact in a bifurcated system here at the state, that young adults and adults may not be able to be served in the same facility, but we are going to try our best to make sure that no one is left out in terms of the families and the potential clients that are in crisis.

The other thing that I would like to remind the committee of and why it is so important to allow some of this money for developmental purposes is that until you get proposals from the community such as Helena and Billings. The state is not going to have the data that it is going to need to know what the costs are out there until these communities are encouraged to go through the process that we are going through. What's in it for Rocky? Rocky is doing this simply as a turnkey operation to facilitate the development. By the time we get to the point where we can actually open the doors in such a program, hopefully there will be someone there to operate it. It's either going to be the local hospital, the Mental Health Center, or some other private non-profit corporate entity will step forward. In the absence of that, Rocky Mountain

Development Council would agree to operate the program, but we would rather do this as a turnkey operation. We are very interested in your money for developmental purposes, very interested in getting something opened in Helena because in the absence of this program we have virtually nothing in this area to serve the needs of people in crisis. The local hospital closed its in-patient facility in the year 2000, so right now, the way our Sheriff's and Police Departments are operating, as first responders to people in crisis, they can either take them to Warm Springs where many of those "taking to Warm Springs" are inappropriately admitted, according to the people at Warm Springs, or we have to take them to Great Falls, or they wind up in the local detention center. All of this is viewed by the Local Advisory Council as not only terribly inappropriate, it is an embarrassment to the community, and morally unacceptable. So we have to do something about developing programs here at the local level and especially in this community.

I would like to say something since everybody was talking about suicide a moment ago. On the average, 180 people in this state take their lives. If you believe what the National Alliance on Mental Illness tells you, they tell you that between 90 to 92% of those people take their lives because they are suffering the effects of a serious mental illness, if that's the case, that means 175 people in this state on average die by taking their own lives, struggling with these kinds of debilitating and very serious illnesses. AMDD just published a report that said 60% of these people take their lives. Well, if you believe AMDD as opposed to NAMI, that's still 108 of our citizens take their lives because of the effects of a serious mental illness. We think, Rocky thinks, NAMI thinks, and a number of mental health advocates think that that's a real public health issue that should be elevated to the level of a public health issue. Because if there was some virus out there or a bacteriological agent that was taking those kinds of lives in this state every year and there were no facilities or programs at the local level to deal with these people when they are at the throes of desperation because of their crisis, there would be an outraged cry the likes of which you had never heard before. So I think that's why Rocky is doing this, on behalf of that Local Advisory Council, and that's why we think it's important for you at the state level, legislatively and for AMDD, to consider some of the possible deficits to making these programs economically viable and feasible on behalf of these people that are suffering from these serious illnesses.

Mr. Chisholm distributed to the Committee a summary of the Mental Health Crisis Services meeting at the request of the Local Advisory Council which outlined their findings and the struggle they had to get to that point **(EXHIBIT 15)**.

TAPE 5A

PUBLIC COMMENT

MIGNON WATERMAN, Chair, Mental Health Oversight Council for State of Montana, said that she would like to highlight several things for the Committee's consideration as it looks at recommendations they will be making on crisis services. She said that the Mental Health Oversight Council last May, prioritized the needs that they saw in the state, again listening to

people from the communities, from the SAAs. They identified three areas that they believe need immediate attention and can have the most profound effect on the mental health system: 1) crisis services in the community, responding to people in the community, and providing them services is the best place to do it as opposed to building beds; 2) interaction with the criminal justice system dealing with people with mental illness; and 3) employing certified peer support specialists.

DR. GARY MIHELISH, Vice Chairman of Central and Western Service Area Authority, said that the Central, Western and Eastern Service Area Authorities support the Addictive and Mental Disorders Division in this process and appreciated the fact that they came to the Service Area Authorities and to local advisory committees to get input from people who live with mental illness, their families, providers, and other stakeholders and advocates. The SAAs would like to collaborate to help the Committee to find the direction in which to go. The Western Service Area Authority prioritized all the services that were listed to the Committee by Joyce DeCunzo and the Eastern Service Area Authority met and is willing to go along with what the Western had decided on their prioritization of services. They are concerned about the costs and what things costs will determine what services are implemented in the mental health system. The Central Service Area Authority will meet to prioritize the services listed. He said that they are working together and that they will make this work. He presented their changes to the AMDD's list of options for Crisis Management Initiatives **(EXHIBIT 21)**.

MIKE MCLAUGHLIN, Executive Director of Golden Triangle Community Mental Health, said that he wanted to point out that the Center is supportive of the project that the Helena Local Advisory Council is proposing. He said he is here today to speak as a member of the Local Advisory Council in response to Sen. O'Neil's questions about peer support and to underline what Ms. Waterman said about peer support. He said that at the last Mental Illness Conference there was a presentation by a psychologist who works with META Services in Arizona. This is a mental health organization that employees 300 individuals and over 100 of those people are consumers of mental illness or have mental health issues. We were struck by the fact that they have a crisis peer support model that is called the Living Room and it is a very supportive model. One of the things that they have learned since that time is that they have a managed care waiver so the funding issues of that model may not relate to Montana in that we are not under a managed care waiver. However, the Department did bring from consultants from Georgia and South Carolina to Montana through the Mental Health Oversight Advisory Council and a number of people from Great Falls attended that training, and we learned that they also added crisis peer support as part of that service. So, states that have been in development of this peer support have included crisis in that model. We began researching and found some excellent resources on the mental consumer self-help clearinghouse website and others that have been compelling along with the presentations we've heard to move us to the direction to wanted to very aggressively look at ways to develop consumer peer crisis programs. We are very intrigued by the idea that peers can provide support for one another in crisis and I would

echo what Mignon had said in that regard that consumers in recovery can be an excellent resource for things like compliance with medication. They have begun to identify issues, certainly the Mental Health Association in Montana has been sponsoring what is called WRAP Training or Wellness Recovery Action Planning. This is an issue that LAC in Great Falls in looking into. One of the main issues for development in Montana would be that issue of sustainability and looking at states such as Georgia and South Carolina that have developed mechanisms for funding peer support under Medicaid. I would say that the major issue that we run into is fear on the part of consumers about working and I would say that most of the states that have been successful in developing consumer peer support have also found ways to assure that people who are consumers don't lose their medical benefits.

COLLEEN MURPHY, Executive Director of Montana Chapter, National Association of Social Workers, Licensed Clinical Social Worker, said that the commitment that the social work profession has to these issues is deep. She said that she was confused on the community mental health services side is recruitment and retention of professional staff and was bewildered if the community mental health section also included independent providers or if it was only community mental health centers and other agencies. She said that there is more independent mental professionals in the state than there are people who work for the community mental health centers. One of the things that she is concerned about is the increased MHSP, poverty level and the fact that she doesn't see allowed private providers to treat this population. If you are talking about crisis response throughout the state, the mental health person who is most available to anybody in the community is a private practitioner in their community with a private practice and they are not allowed to see the population of people who are showing up at our doors most. You can increase that poverty level.

She said she has been confused for a long time how many private providers are actually engaged in providing public mental health services. You would want those statistics and she would encourage the Committee to request that from the Department.

She also said that the state should consider loan forgiveness programs for people getting their degrees if they commit to working in the mental health systems.

CHILDREN'S MENTAL HEALTH SERVICES - Mary Dalton and Pete Surdock

MARY DALTON talked about letter to Senator Cooney and a sample news release to the editor that was suggested by Sen. Laible **(EXHIBIT 16)** and passed out information on the Big Sky Rx Program **(EXHIBIT 18)**. Ms. Dalton gave an overview of the Children's Mental Health System **(EXHIBIT 16)**. The information she passed out talked about what serious emotional disturbance means. For a child, it is different than a chronic mental illness. They are talking about people under the age of 18 and they age out into the adult system, their mental illness is expected to last 6 months or more, and they require services from two or more youth services agencies. She said that the crisis response in Montana for youth is one of three hospitals; i.e., Shodair, Billings Deaconess, or St. Patrick's. These are the ones that will take children under the age of 18, or you go to a residential treatment facility; i.e., KBH in Butte, Shodair, YBGR in Billings.

There is not a state institution, so there is a different population and service mixed in. Ms. Dalton talked about the graph that shows what they have paid in claims for children and adolescents. They have served over 9,000 children for the last four years and spent somewhere between $50-$59M for their mental illness costs.

PETE SURDOCK, Bureau Chief for Children's Mental Health Bureau, talked about the Children's Mental Health Service Plan, System of Care program, and the Kids Management Authority **(EXHIBIT 17)**. Mr. Surdock talked about the map that is the last page of Exhibit 18. Children's Mental Health has five administrative regions that are outlined on the map by a narrow blue line. Incorporated into the map is the designated areas of the Service Area Authorities. This will enable you to see not only the SAAs but how the Children's Mental Health Administrative Regions tie in with what the adult system is doing.

Mr. Surdock said that in terms of crisis services, they are beginning to hear about the need for children who are around the age of 17, going on 18, being able to transition to the adult system. When that point of transfer comes in, that does create a crisis. He explained what a crisis is for a family. Sometimes it is about the child being kicked out of school. Sometimes it is about the fact that their child is attacking them and beating them up. Sometimes it is about them attacking a sibling in the family. Sometimes it is about the fact that they need help and there is just no place to go to get the help and a way to pay for it.

REP. ROBERTS asked if families feel guilty because they feel that they should be able to handle the situation, they can't and so they are looking for answers from other people. MR. SURDOCK said that is a correct statement, but that he would not say that is true of all families, but one of the things that is not unlike cancer several years ago, is that when you have a mental illness, you are seen as being unable to doing anything, that you are helpless and there is a stigma attached to having a mental illness for a child, and that stigma not only is used for the child, it goes to the family. We also have family members who will tell us that they are helpless and when they are helpless, they feel guilty because they know and they are committed to their child and they can't accept the fact that they can't help their child.

REP. ROBERTS said that in the last session they passed a bill that allowed for some of the children in crisis to maintain insurance until they are 19 or 20. Has that been helpful? MR. SURDOCK said that that might have been the HIFA Waiver and that is being worked on. He did not think that the waiver is in place, they are still working on that, it hasn't been approved by the federal government.

SEN. WEINBERG asked David Niss what the state's legal obligation to provide crisis services. MR. NISS said that very generally first, that there is no decision by the Montana Supreme Court that he is aware of. Secondly, he would say that the general law on the issue of the responsibilities of government is that there is none outside of statute, but if one is provided, it has to be done so competently.

SEN. SCHMIDT asked Mr. Surdock a question on map he provided in his presentation. She said there are three adult Service Area Authority and five regions for the Children's Mental Health Bureau. There are 5 people that are program officers, one headed up by MSW and the rest don't have a social work degree. MR. SURDOCK said that they have various degrees. They have bachelor's level degrees. The MSW is listed there only because it is a professional credential that they typically do that in mental health and when people have those kinds of credentials. SEN. SCHMIDT asked if Missoula includes Lincoln, Flathead, Sanders, Missoula, Ravalli; the Helena region includes all of those outlined in blue, is that right. MR. SURDOCK said yes, that would be Lewis and Clark, all the way down to Park County. SEN. SCHMIDT asked if Mr. Surdock had any idea of the number of children they are dealing with in these regions. MR. SURDOCK said that by region, he can't tell offhand, but he can say that approximately 240,000 children between the ages of 6 and 18, roughly 60% are contained in about 13 counties in the state and most of those counties are in the west with the exception of Yellowstone. SEN. SCHMIDT asked if they also serve the Indian Reservations. MR. SURDOCK said that that was correct.

REP. WARDEN said that he thanked them as presenters and for being brief and succinct. He said that they have identified MET-NET Conferences that they are going to have, they have identified these problems, it is your intention to return to this Committee with some potential solutions. MS. DALTON said that it is their intent to report back to the Committee in March what they hear from those MET-NETs. They have in targeted case management a regional system unlike other Medicaid systems where it is actually contracted out and that has been identified by some people as a problem. They started out looking at targeted case management, they wanted to use the opportunity to get some crisis response back.

TAPE 5B

JANI McCALL, Montana's Children Initiative Provider Association, the State System of Care Committee, said that in the 2001 Legislature, costs for children went through the roof. They had approximately 153 children who were being treated in out of state residential facilities. Most of the children's average costs were $6,000 per day. In concert with MCI, Department of Public Health and Human Services, the Mental Health Ombusman, Mignon Waterman, and Susan Fox, we were beginning to build legislation that today is showing a fairly strong system that is being created in the State of Montana. Ms. McCall wanted to share with the Committee that once that first piece of legislation was put into place in 2001, MCI then went to the Board of Crime Control and Youth Justice Council, received a series of continuation grants that allowed them to set up some pilots to put together a local planning process that Mr. Surdock has referred to. That was the beginning of the local planning process. In 2003, the Legislature strengthened the language. They changed the language to match up with the federal Children System of Care development and that allowed them to have a real strength going in when they applied for the SAMSA grant. The Children's Mental Health Bureau has done a good job in

making this a priority and putting these services around the state. She said that in Billings, they are working with the Community Crisis Center to look at protocol for kids who present in the Crisis Center, although it is mainly geared to adults at this point. They will establish protocol for those children who are already in the system and need to be re-referred, they will also be setting up protocol for those children who are presenting for the first time, possibly with their families or not, and getting them for the first time into the system.

PUBLIC COMMENT

MELANIE MARTIN-DENT, said that she is a parent of two children with mental health issues. She said that she has served on the Mental Health Oversight Advisory Council as a parent/representative, has been a parent/representative of the Policy Academy, served on the System of Care Committee, involved in the Missoula KMA Committee, and has a parent support group that is called H.O.P.E.abc, Helping Other Parents of Emotional and Behaviorally Challenged Children. She talked about the document Community Crisis Response Survey Results **(EXHIBIT 19)**, which she distributed to the Committee.

BONNIE ADEE, Mental Ombusman, said that she wanted to specifically tie those five field staff positions that the Legislature approved last session to what was described by the Children's Mental Health Bureau as the growth of the KMA. She said that from her perspective that is a critical factor in being able to see as many locations as was seen on that list. It is the KMA model that was heard described, but the one thing that she didn't hear was that it is providing the vehicle for our cultural change. From her perspective, there is still huge coverage issues for children.

JANI MCCALL, MCI, said that there were a couple of things that she didn't mention that she thinks are of value. When she mentioned in 2001 that they had 150 children out of state, once these initial pilots began to work, the utilization review contractors were doing a good job, provider accountability was there. From 2002 to almost mid-2005, they dropped the numbers down from 150 to between 20 and 30 children going out of state each month. A significant change. She said that she thinks that according to First Health, they are at 45. They have gone up and the reason for that is that they have had some issues with one of their in-state residential treatment facilities, around quality issues, they weren't able to accept children, they are now in compliance and they are taking children again. You can see first hand that this kind of a process does work. The other thing she wanted to mention about the Kids Management Authority model is that kids' services are complex and require services from many agencies. One of the key things that makes this work is that all of the public agency people are at the table and the decision making authority in funding authority person is the one who is there. These people from juvenile justice, from child protective services, from mental health, from the schools and so forth, can really set design plans and actually make the decisions that are going to work for kids.

QUESTIONS

SEN. SCHMIDT asked Mr. Surdock if he could elaborate on the Children's Mental Health EPP ideas or that language. MR. SURDOCK said that there are several things they are considering and what they are doing as part of the public hearing process is to continue to look at that. He said that he mentioned two of those concepts where he talked about the therapeutic triage facility and the in-home services. They are also looking at increasing funding for room and board. Access is an issue for parents whose children are not under the custody of the Department and if they need to use the group home service, they have to pay the room and board. They are looking at possible funding in that area if the Department decides to move that forward. They are looking at funding to help support the System of Care continuation in six years at the community level. Under the federal grant, the match requirement is 25% for the first three years, 50% for the fourth year, and 66 2/3% the fifth and sixth year. In working with communities, their target is to reach 40% in-kind or hard match for the money that they are providing. They are expressing serious concerns about being able to go up to the 50% and the 67% and so they are asking legislative commitment to continue those so that what they are gaining in system development and services in filling in the gaps which all relate to the crisis services as well. It is something that we will be able to sustain beyond that.

MARY DALTON said that they are still in the 'gleam' part of the EPP and so these are our Bureau proposals which will get rolled into our Division proposals, but the Department hasn't made any decisions about what will ultimately be included in their package.

PRESENTATION ON NCSL PRECONFERENCE "PROMOTING CHILDREN'S MENTAL HEALTH" - Bill Jones

REP. BILL JONES talked about the NCSL Preconference "Promoting Children's Mental Health" that was held in December 7, 2005, and which he attended **(EXHIBIT 20)**.

SUSAN FOX said that she would like the Committee to pick three issues that they want to concentrate their efforts on. She said the Committee is at the tipping point of the interim and there are three more committee meetings after this and they need to focus on a direction that the Committee will be taking.

SEN. SCHMIDT asked that the Committee make their lists so that at tomorrow's meeting they can begin to focus on areas for more information, possible legislation, more information from the Department and their EPP process for the March meeting.

ADJOURN

SEN. SCHMIDT adjourned the meeting at 5:15 p.m. Cl2196 6066fhxa