

**DEPARTMENT OF HUMAN SERVICES
(Office of Information Services, Office of Operations,
Mental Health and Alcohol and Drug Abuse Services)**

FY 2010-11 JOINT BUDGET COMMITTEE HEARING AGENDA

**Wednesday, December 16, 2009
1:30 pm – 5:00 pm**

1:30-1:45 INTRODUCTIONS AND OPENING COMMENTS

LIST OF DEPARTMENT PRESENTERS

Karen L. Beye – CDHS Executive Director

Joscelyn Gay – Deputy Executive Director, Office of Behavioral Health and Housing

Reginald Jefferson – Deputy Executive Director, Office of Operations and Financial Services

Will Kugel – CDHS Budget Director

William Browning – Governor’s Office of Information Technology Services – Acting Director of CBMS

1:45-3:20 FORT LOGAN CLOSURE – MENTAL HEALTH INSTITUTE DIVISION

1. Please describe the process of determining whether an individual receives mental health services in the community or in one of the state's mental health institutes. Are there individuals receiving treatment at the institutes that could be provided similar services in the community instead?

Response:

All 17 Community Mental Health Centers (CMHCs) have an individualized assessment process that evaluates each person’s mental health treatment needs and determines the level of care to be provided in the community and /or the State’s Mental Health Institutes (MHIs).

In addition to the Institutes, other inpatient hospitals provide inpatient psychiatric services for adolescents and adults, including the elderly. The Institutes are considered the ‘safety net’ for inpatient mental health services and as such provide care to individuals with very complex needs for whom there are not services in the community. For example, the Mental Health Institutes are increasingly caring for individuals with severe co-occurring issues such as a developmental disability, traumatic brain injury, or sex offense behavior in addition to a mental illness. Services for these types of individuals are difficult to find in the community.

2. Please explain the interaction between community mental health centers (CMHCs) and the state mental health institutes. Do community health centers cooperate when placing individuals in the institutes or do they act in silos, not communicating well with the institutes?

Response:

Yes, the CMHCs cooperate, both with the Institutes and with each other. For example, each CMHC is allocated a specific number of adult civil beds at the Institutes. The CMHCs often “borrow” beds from each other to facilitate the admission and treatment of patients.

The Institutes and CMHCs work closely together to facilitate the admission, treatment, and discharge of patients at the Institutes. Prior to admission at the Institute, the CMHC’s crisis team will assess a patient who needs inpatient hospitalization. The assessment for inpatient hospitalization is typically completed in a community hospital emergency room or in another residential setting where the patient is being held. The CMHC then makes a referral to the Institute’s admissions department and the patient is admitted. The CMHCs continue to work with Institute staff throughout the patient’s treatment planning process, including the development of a discharge plan for the patient’s return to the community once inpatient treatment is complete.

3. Why did the Department recommend closing the children's, adolescent, and geriatric treatment divisions at Fort Logan, but not the adult treatment division?

Response:

The Department recommended closing the children’s, adolescent and geriatric treatment units because these populations tend to have Medicaid or Medicare benefits to pay for their care in the community. Adult civil patients are often uninsured, so these patients have more difficulty finding appropriate care in the community. Also, the children’s and adolescent units have maintained an occupancy rate under 65% over the past three years, whereas the adult civil units maintained over 90% occupancy over the same time period.

4. Please describe the anticipated length of stay for the individuals currently receiving mental health services in the treatment divisions slated for closure on January 1, 2010.

Response:

The Table below details the average length of stay for patients on each of these units as of December 3, 2009.

Unit	Census	Average Length of Stay (Days)
Children's Unit	2	14
Adolescent Unit	2	3
Geriatrics Unit	14	896 (or 2.5 years)

5. Has the Department surveyed mental health service providers to determine if they are willing to develop additional facilities? For example, is Cedar Springs interested in opening a facility in the Denver metro region?

Response:

No. The Department has not conducted a survey of providers concerning the development of additional facilities, but a few providers have contacted the Department to explore the expansion of their services. The Department is working closely with the Community Mental Health Centers, the Behavioral Healthcare Organizations (BHOs), and the Department of Health Care Policy and Financing (DHCPF) to facilitate the development of existing and new models of service delivery to meet the treatment needs of the populations served by the units that are closing.

The Children's Hospital contacted the Department as soon as the closures were announced to discuss expansion of their inpatient capacity. Cedar Springs is interested in examining the feasibility of opening a facility in the Denver metro region. The Department will discuss options with Cedar Springs, including the possibility of locating a Cedar Springs program on the Fort Logan campus.

6. Please describe the community placement options available to individuals currently receiving mental health services in the adolescent treatment division at Fort Logan.

Response:

The table below lists the current inpatient psychiatric hospital bed capacities in the Denver metropolitan and Colorado Springs areas for adolescents. In addition, the Department operates a 20-bed adolescent unit at CMHIP.

Facility	Bed Capacity
Denver Health	10
Children's Hospital	18
Centennial Peaks	18
Highlands Behavioral	32
TOTAL	78

7. Please describe Denver General's plans for expanding its inpatient adolescent mental health treatment services.

Response:

Denver Health currently has 10 inpatient beds for adolescents ages 8-18 years. This unit is undergoing renovation to develop more private rooms and expand to 11 beds by April 2010. Denver Health is also collocating adolescent inpatient services with its adolescent outpatient and substance abuse services in a new 16-bed unit to be completed in the fall of 2011.

8. What will happen to adolescents that receive treatment at Ft. Logan as a service provider of last resort? Are they going to have another place to go?

Response:

Fort Logan has treated adolescents with significant behavioral disorders and other co-occurring conditions, including autism and developmental disabilities. These youth will be able to receive services from one of the providers listed in the table above. Two of these providers, Children's Hospital and Denver Health, will be increasing bed capacity over the next several months. These youth can also be treated at the Colorado Mental Health Institute at Pueblo (CMHIP), which continues to operate an adolescent unit. The Department recently increased capacity of this unit from 16 to 20 beds. The occupancy rate of the unit was 53 percent in November 2009.

9. Please describe the statewide Psychiatric Residential Treatment Facility (PRTF) capacity in terms of services provided, number of beds, and occupancy rate of beds (if available).

Response:

There are four Psychiatric Residential Treatment Facilities (PRTFs) located in Colorado: two in the Metro Denver area, one in Colorado Springs, and one in La Junta. PRTFs provide an intensive level of residential psychiatric care which includes, but is not limited to; individual, group and family therapy, psychiatric evaluation and treatment, psycho-social assessment, functional assessment, individualized treatment planning, independent living skills, social skills training, pre-vocational and vocational training, educational services, activities programming, nutritional assessments, special dietary planning, and discharge planning. The total current bed capacity of PRTFs in Colorado is 173. As of December 11, 2009, 45% of PRTF beds (78 of 173) were occupied. Of the 78 occupied placements, 8 are from Colorado, and the balance is from out-of-state.

10. Where will the children currently served in the children's treatment division at Fort Logan be placed after the division is closed? What is the likelihood they will end up in county jail? Will Children's Hospital accept them?

Response:

The children currently served at Ft. Logan will complete their course of treatment and be discharged from the unit. Therefore, no children will be placed in an alternative inpatient psychiatric setting upon discharge. No children will end up in county jail as a result of the closure. Children's Hospital accepts children between 5 and 17 years of age, so Children's will accept patients similar to those served at Ft Logan.

11. What is the status of Children's Hospital expanding from 17 to 22 beds?

Response:

Children's Hospital currently has 18 beds and will expand its children's inpatient psychiatric capacity by four beds by March of 2010 for a total of 22 beds.

12. Please describe the principal psychiatric diagnosis of individuals in the geriatrics treatment division at Fort Logan. Is there capacity in the community to provide comparable services to patients with this diagnosis? For example, where would a geriatric individual with a principal psychiatric diagnosis obtain services in Grand Junction?

Response:

The principal psychiatric diagnoses of the individuals treated by the Fort Logan geriatrics unit range from bipolar disorder, psychotic illnesses including

schizophrenia, and major depression. Although these patients may develop a dementia type illness or Alzheimer's disease, the hospital does not accept individuals from the community with only a primary diagnosis of dementia or Alzheimer's for treatment, as dementia and Alzheimer's are not treatable psychiatric disorders.

There is some capacity to meet the inpatient treatment needs for patients with these diagnoses through adult inpatient psychiatric care in hospitals, through the geriatrics units at the Colorado Mental Health Institute at Pueblo and through the Trinidad State Nursing Home. The Department is working to strengthen this capacity in acute care hospitals, in addition to working with nursing homes and community mental health providers to strengthen the community capacity to provide long-term residential care options for geriatrics patients with behavioral health needs, once those any acute needs have been stabilized.

A geriatric individual in Grand Junction with a principal psychiatric diagnosis of schizophrenia could obtain services through their designated Behavioral Health Organization, Community Mental Health Center, Medicare network provider, and/or the West Slope Mental Health Stabilization Center.

13. At what age do individuals qualify to be placed in the geriatric treatment divisions at Fort Logan and Pueblo? Is there a process in place for transferring individuals from an adult treatment division to a geriatric treatment division once they reach the age requirement of the geriatric division?

Response:

Individuals who are age 60 years or older can be admitted to an institute geriatric unit. On occasion, a patient below age 60 may be transferred from an institute adult treatment unit to a geriatric unit due to nursing care needs that are best provided by the geriatric units.

Yes. An institute physician will write an order to transfer the patient when he or she reaches the age of 60 or if the patient's medical or nursing needs requires a transfer at an earlier age.

14. Is there a statewide demand for treatment service at levels comparable to the geriatric treatment division at Fort Logan that will drive capacity building at other facilities around the state?

Response:

Yes, there is statewide demand for inpatient services for geriatrics patients. However, there is some capacity to meet that demand through adult inpatient psychiatric care in hospitals, through the geriatrics units at the Colorado Mental Health Institute at Pueblo and through the Trinidad State Nursing Home. The Department is working to strengthen this capacity in acute care hospitals, in addition to working with nursing

homes and community mental health providers to strengthen the community capacity to provide long-term residential care options for geriatrics patients with behavioral health needs once any acute psychiatric needs have been stabilized.

15. Please provide the Committee with an update on the potential of Jefferson Center for Mental Health developing capacity to provide services to geriatric patients currently receiving services at Fort Logan.

Response:

The Department contacted Dr. Harriet Hall, CEO for Jefferson Center for Mental Health (JCMH), to confirm the status of their capacity development. JCMH is interested in developing a residential program that is not licensed as a hospital or nursing home. The program would be secure and have a length of stay that accommodates the longer-term needs of the geriatric population as well as their mental health treatment needs. A facility license does not currently exist for such a program. The current licenses issued by the Department of Public Health and Environment are for nursing homes, hospitals, or other facilities that are for short-term duration (Acute Treatment Unit), or are not secure (Assisted Living Residences). While the Department and JCHM recognize the need to develop additional geriatric beds, this capacity requires appropriate licensure and should be considered a longer-term solution.

16. Please describe the Department's confidence that the mental health service providers in the community have the capacity to provide treatment to individuals currently receiving services in the children's, adolescent, and geriatric treatment divisions at Fort Logan.

Response:

The Department is confident that the mental health service providers in the community will maintain and increase the capacity of services available to meet the treatment needs of individuals currently receiving services in the children's, adolescent, and geriatric treatment divisions at Fort Logan. As discussed above, both Children's Hospital and Denver Health plan to expand capacity to serve children and adolescents. The Department has also increased its inpatient adolescent capacity from 16 beds to 20 beds at CMHIP. In addition to inpatient hospitalization, the Department and community mental health providers are examining options to increase the utilization of Psychiatric Residential Treatment Facility (PRTF) services for adolescents that need a residential placement with more intensive treatment services than provided by a Therapeutic Residential Child Care Facility (TRCCF).

With regard to elderly patients previously served at Fort Logan, the Department is working with the Community Mental Health Centers; Behavioral Healthcare Organizations; the Department of Health Care Policy and Financing, and the Colorado Healthcare Association to identify strategies to develop more support for

nursing homes who take mental health clients to provide better services while people are residing in a nursing home and to transition people from nursing homes back into the community. In addition, the Colorado Mental Health Institute at Pueblo continues to operate two 20-bed inpatient units for elderly patients and Institute staff will be meeting with center and BHO staff early next year to discuss how to best utilize these beds.

17. Please provide a status update on the potential of migrating all civil beds from Pueblo to Fort Logan. Has the Department conducted an analysis of the costs? Has the Department conducted an analysis of the service delivery?

Response:

The Department has not conducted an analysis of the costs and service delivery implications of moving all of the civil beds from Pueblo to Fort Logan.

18. Does the reduction of 96.8 FTE as a result of the treatment division closures at Fort Logan represent actual layoffs? If not, how many FTE are actually being laid off.

Response:

No. The Department completed a layoff plan, which dictated the process, and positions impacted by the layoff pursuant to state personnel rules. The reduction of 96.8 FTE impacted over 160 employees and resulted in 17 staff receiving formal layoff notices. The Department is still working with the 17 staff who received layoff notices to determine if they are qualified for other open positions in the Department and has found positions for eight people thus far. Since the layoff process is not yet complete, the Department does not have a final number of people who were laid off as a result of the FTE reduction for Ft. Logan.

3:20-3:35 FORT LOGAN CLOSURE – OFFICE OF OPERATIONS

19. Please describe the process used by the Department to determine the level of fixed cost services provided by the Office of Operations needed to support the two state mental health institutes.

Response:

The Department uses a federally approved Public Assistance Cost Allocation Plan (PACAP) to determine the percentage of fixed and indirect costs charged to all benefiting programs. Simplistically stated, the PACAP groups homogenous types of activities into “cost pools”, and then distributes the cost of those activities to the benefiting program using a rational basis for allocation. For example: the cost of operating the Payroll Unit is charged back to each benefiting program based their

percentage of total FTE; the cost of the Vouchering Unit is allocated based on the percentage of total payment vouchers processed; and, Procurement is allocated based on the percentage of total purchasing transactions.

Is it possible that there are additional fixed costs in the Accounting, Procurement, or Contract Management divisions that could be reduced as a result of the treatment division closures at Fort Logan?

Response:

Independent of Fort Logan closures the Office of Operations has conducted an in-depth assessment of its staffing and has eliminated all non-essential positions. The August 24, 2009 budget reduction eliminated 6.0 FTE and \$379,318 from the current appropriation, including Procurement staffs and support staff. Accounting staff have been reduced as a directly related to the bed closures. Contract Management staff consists of 3.0 FTE for the entire Department and cannot be reduced without a significant reduction in the size of the Department. Similarly, most of the fixed cost positions cannot be eliminated without a corresponding elimination of major program areas. For example, all Departments, regardless of size, have a Controller. The Department has 15 payroll clerks. Even if the total FTE were reduced by 50%, there would still be a need for a payroll supervisor.

It is also important to note the majority of costs covered by the revenue transfer are for direct program costs and not fixed or indirect cost. The federal cost report for FY 2008-09 shows that only 7.1% of the total support provided by the Office of Operations is for fixed and indirect cost.

Office of Operations MHI Support		
Direct Charges	\$11,458,973	72.0%
Fixed & Indirect	\$1,131,937	7.1%
Utilities	\$3,333,635	20.9%
Total	\$15,924,545	100.0%

Finally, the proposed reduction of 96.8 FTE related to Fort Logan closure represents a 1.7% reduction in total FTE. The Office of Operations combined reductions and vacancy savings requirements exceed that amount.

What is the feasibility of redistributing the fixed costs of the Office of Operations amongst divisions and offices Department-wide rather than relying on a General Fund refinance by Fort Logan?

Response:

The Department’s PACAP is structured to prevent the intentional redistribution of fixed costs. The PACAP is designed to ensure all benefiting programs pay their fair proportional share of fixed costs. However, to some extent the PACAP does redistribute the fixed costs to other programs, both General Fund and non-General Fund. For example, for any of the cost pools that are allocated based on FTE, Fort Logan’s proportional share will be reduced by 96.8 FTE and all other benefiting programs will have a very slight increase in their proportional share.

This funds transfer is not a refinance in the typical sense. The Department is not requesting new General Fund to cover costs, but rather is transferring existing General Fund that is already part of the institute’s funding requirement. The Long Bill has historically transferred cash patient fees to the Office of Operations, but that distinction is arbitrary since the institutes are funded through a combination of General Fund, cash funds, and reappropriated funds. This transfer partially corrects the revenue transfer to the Office of Operations to make it more representative of the overall funding for the mental health institutes.

	Total	General Fund	Cash Fund	Reappropriated
Current MHI Funding	\$ 98,067,775	\$ 81,083,491	\$ 8,496,231	\$ 8,488,053
		82.7%	8.7%	8.7%

	Total	General Fund	Cash Fund	Reappropriated
MHI Revenue Transfer	\$ 4,475,449	\$ 0	\$ 1,559,830	\$ 2,915,619
		0.0%	34.9%	65.1%

3:35-3:50 COMMUNITY MENTAL HEALTH SERVICES

20. Please provide a historical review of the contracted rate per individual for mental health services and substance abuse services from FY 2000-01 through the current fiscal year.

Response:

Attachment 1: Mental Health and Substance Abuse Rates provides a historical review of the contracted rate per individual for mental health services and substance abuse services from FY 2000-01 through FY 2009-10.

21. Are medically indigent individuals served in the community tracked by number of contacts or by each unique individual?

Response:

The Department's Division of Behavioral Health data system tracks individuals and their corresponding number of service contacts. The table on page 22 included in the Joint Budget Committee FY 2010-11 Staff Budget Briefing dated December 9, 2009 represents an unduplicated count of individuals served or projected to be served in each year.

22. Please describe the outcomes of the Veteran Mental Health pilot program.

Response:

Senate Bill 07-146 created the Mental Health Services Pilot Program for Families of Recently Discharged Veterans (sunsets on June 30, 2010). This three-year pilot program provides assessment, case management, family therapy, individual therapy, medication management, community outreach and education, and other mental health services to family members of discharged veterans of Operation Enduring Freedom and Operation Iraqi Freedom living in the Colorado Springs area.

Service utilization has been lower than the 92 family members per year that were projected for the program. The Department believes that the outcome of lower than anticipated utilization is based on the pilot being geographically limited to the Colorado Springs area and also, that it is specifically limited to family members of discharged veterans.

Veterans Mental Health Funding Utilization by Fiscal Year

Description / Fiscal Year	Actual FY 2007-08	Actual FY 2008-09	Projected FY 2009-10
(8)(B)(1) Veterans Mental Health Appropriation	\$285,529	\$285,529	\$285,529
Expenditure	\$178,519	\$52,488	\$32,000*
Reversion (Appropriation - Expenditure)	\$107,010	\$233,041	\$253,529
Family Members Served	31	62	26**

*FY 2009-10 expenditure is based upon a straight-line projection of year-to-date expenditures as of September 30, 2009.

**FY 2009-10 Family Members Served represents year-to-date through September 30, 2009.

3:50-4:20 SUBSTANCE ABUSE TREATMENT SERVICES

23. Please provide a comparison of funding levels for substance abuse treatment programs from FY 2002-03 to FY 2009-10. What level of funding would be required to restore funding to previous levels? Over what timeframe would the restoration occur, assuming state revenue generation normalcy several years from now?

Response:

Attachment 2: Substance Abuse Funding Restoration provides a comparison of funding levels for substance abuse treatment programs from FY 2002-03 to FY 2009-10. The attachment indicates that as of FY 2009-10 funding for both prevention and treatment services has been fully restored.

24. In light of the proposed two percent reductions in community provider rates, is there administrative relief the Department could offer providers of substance abuse services? For example, currently every substance abuse provider location must be separately licensed. Is it possible to license each provider organization rather than every location?

Response:

While it is possible to license each provider organization rather than every location, it is not prudent to do so. Granting a single license to a provider that is operating in as many as 30 different locations would compromise the oversight necessary to ensure public safety and welfare. Furthermore, an adverse licensing action resulting from non-performance at one site would jeopardize all of the organization's other sites. While licensing each site individually creates administrative work for the Department, it does not significantly increase the administrative work for each provider since an organization submits a single application that includes all sites.

25. Please provide state-by-state information on the prevalence of substance abuse and the level of funding that other states are dedicating to substance abuse treatment. Does the Department have a long-term plan to address the unmet substance abuse treatment needs in Colorado?

Response:

State-by-state information on the prevalence of substance abuse is included in Attachment 3: State by State Comparison, which includes an excerpt from "Substate Estimates from the 2004-2006 National Surveys on Drug Use and Health" (pages C-74 through C-85). In addition, according to averaged findings from the 2006-2007 NSDUH, among all 50 states for the 12 or older age group Colorado ranked:

- **3rd for first-time marijuana use (12th in 2006);**
- **3rd for persons needing but not getting treatment for illicit drug use (7th in 2006);**
- **4th for cocaine use in past year (7th in 2006);**
- **4th for illicit drug use in past month (7th in 2006);**
- **6th for illicit drug dependence in past year (6th in 2006);**
- **6th for marijuana use in past month (10th in 2006);**
- **8th for marijuana use in past year (10th in 2006);**
- **8th for illicit drug use other than marijuana in past month (10th in 2006);**
- **9th for alcohol use in the past month (8th in 2006);**
- **10th for alcohol dependence in the past year (9th in 2006); and**
- **19th for non-medical use of pain relievers in past year (15th in 2006).**

Also, Attachment 4 is an excerpt from a report titled "Shoveling Up II-The Impact of Substance Abuse on Federal, State and Local Budgets," which contains information on the funding that other states are dedicating to substance abuse prevention, treatment and research. This 2009 report is the latest publication that provides this level of state-by-state information.

The Department has a three to five year strategic plan that includes specific strategies to address the unmet substance abuse treatment needs in Colorado. The Department utilizes a three-pronged approach to address this need: 1) to make the most efficient use of existing resources; 2) to pursue discretionary grants to supplement base funding; and 3) to request additional funds through the annual budget process for unmet needs.

26. Does the Department have information about total state expenditures for substance abuse treatment? If not, what action could the General Assembly take to assist in gathering such information and to help coordinate treatment resources statewide?

Response:

Yes. The 2009 “Shoveling Up II” report, referenced in the response to question #25, is the most current information about total state expenditures for substance abuse treatment.

For more detailed reporting on substance abuse treatment expenditure information specific to the Division of Behavioral Health, the Department has provided its October 31, 2009, report to the General Assembly: “The Costs and Effectiveness of Substance Use Disorder Programs in the State of Colorado” (pages 27-30) to Joint Budget Committee staff.

27. Are existing substance abuse treatment services provided through the Judicial Department, the Department of Human Services, the Department of Corrections, and the Department of Public Safety adequate to meet the need for services? Are available treatment services effective?

Response:

No. The 2009 Population in Need Study identified 49,051 adults in Colorado living at or below 300% of the federal poverty level who were in need of, but not receiving, substance abuse treatment services. Additionally, the Commission on Criminal and Juvenile Justice identified the need for behavioral health services (both substance abuse treatment and mental health treatment) for re-entry of offenders into the community and for reducing recidivism.

Yes, available treatment services are effective. Perhaps the most critical measure of substance abuse treatment success is the change in frequency of drug use from admission to discharge. In FY 2008-09, there was a decline from 48% to 19% (admission to discharge) in the proportion of all treatment clients reporting any substance use in the previous 30 days. For more detailed reporting on treatment effectiveness, the Department has provided JBC staff with its report, “The Costs and Effectiveness of Substance Use Disorder Programs in the State of Colorado.”

4:20-4:30 INFORMATION TECHNOLOGY SERVICES

28. Has the Department addressed the issue of erroneously generated client correspondences from CBMS. If not, what steps is the Department taking to remedy the issue?

Response:

Under OIT leadership, the CBMS team has been working to identify, address and improve client correspondence issues. The first phase of this strategy was focused on reducing unnecessary correspondence to reduce the financial costs to the State. Working with both CDHS and HCPF, the CBMS team identified areas where correspondence could be eliminated or streamlined. The second phase is focused on improving client correspondence so clients can better understand notices and benefit information.

Additionally, the CBMS team worked with HCPF program area in April/May 2009 to perform a complete analysis and revision of the Medical programs rules cites and text to assure that correct information was sent to clients.

Many issues with correspondence are a result of the data entry processes within CBMS. Working with both agencies, the CBMS team has defined the first generation of requirements to improve the new CBMS interface, which should reduce data entry errors while improving application submission processing timelines. This strategic initiative, called Intelligent Data Entry, will revolutionize the user experience within CBMS and, consequently, reduce errors with system-generated correspondence.

Finally, the CBMS team has implemented the first stage of the self-service portal, the Program Eligibility and Application Kit (PEAK). PEAK allows existing clients to check their benefits on-line and provide information in a user-friendly, clear format. This will, in the longer term, strategically reduce the demand on traditional paper-based client correspondence and will empower clients to receive vital information through this portal.

29. Does the Department consider the impact of benefit program changes on CBMS client correspondence costs when submitting information for fiscal notes?

Response:

Yes. Always included, as part of any program change, the financial impact including potential client correspondence costs.

30. Please describe the role CHATS plays in administering the Division of Child Care's programs.

Response:

CHATS is a data system that supports Division of Child Care (DCC) and the 64 counties in managing over \$96 million annually in subsidized Child Care through the Colorado Child Care Assistance Program (CCCAP). The system serves over 48,000 children within 23,000 low income and disadvantaged families who receive services from 10,000 licensed and legally exempt Child Care providers. CHATS currently supports many DCC business functions, including: client administration, provider administration, payments, recovery, program technical assistance, program monitoring, and reporting.

4:30-5:00 MISCELLANEOUS

31. Once a mentally ill inmate is in custody of a county jail, does the level of mental health treatment vary from individual to individual? For example, are there different levels of supervision reserved for individuals with different levels of mental illness?

Response:

Yes. There are 61 county jails and processes differ from county to county as does the level of mental health treatment and supervision provided. Most jails screen for the offender's safety (danger to self or others); however most do not assess for the level of mental health treatment needed.

Many jails do not have funding for mental health treatment, are not equipped to provide such treatment, and therefore rely on community providers for treatment and assessment. Therefore, while the individual is in jail, they are managed through varying levels of supervision. In some parts of the state, community mental health centers are working with the jails to provide treatment (including medications) to offenders with serious mental illness with positive results.

32. Do individuals receiving Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) continue to do so after admittance as an inpatient in a state mental health institute? Are there other federal benefits that inpatients are excluded from receiving?

Response:

Patients receiving Supplemental Security Income (SSI) are ineligible for SSI when admitted to the Institutes since they are residing in a public institution; however, the following exceptions apply:

- 1) Patients over the age of 65 are eligible for a \$30/month Supplemental Security Income (SSI) cash benefit to be used only for the patient's personal needs.
- 2) A physician certifies that the patient is expected to be hospitalized at the MHI for 90 full consecutive days or less and the recipient demonstrates the SSI benefit is needed to pay expenses for a home or living arrangement to which he/she may return.

Under both exceptions, these funds may not be used to reimburse the cost of a patient's care at the Institutes.

Civil patients receiving Social Security Administration (SSA) and SSDI benefits continue to receive those benefits while hospitalized. SSA and SSDI monthly cash benefits are suspended when a recipient is admitted to the Institutes if the patient has a legal status of Not Guilty by Reason of Insanity or Incompetent to Proceed.

Under Section 27-12-104, C.,R.S., all insurance and other benefits payable for the care, support, maintenance, and treatment of a patient are considered available for the payment of care at the Institutes. So, the Institutes bill all available insurers (including Medicare, Medicaid) and patients with resources are required to contribute towards the cost of their care. Thus, patients who continue to receive SSA and SSDI benefits while at the Institutes are charged according to their ability to pay. Currently, the ability to pay calculation allows \$70 per month for a patient's personal needs. The balance of the SSA or SSDI benefit is assessed by the Institutes and is revenue to the State to reimburse for the cost of Institute care.

The only federal restriction on benefits for inpatients at the Mental Health Institutes is for Medicaid for individuals between the ages of 22 and 64 years of age. Although the individual is Medicaid eligible, the institute cannot bill Medicaid for the services it provides to this age group because of the IMD exclusion.

33. What factor(s) is responsible for the increase in the number of court ordered competency evaluations at the Institute for Forensic Psychiatry (IFP)?

Response:

No statutory or procedural change occurred within the state court system over the last several fiscal years to increase the number of court ordered competency evaluations. Therefore, reasons for the increase in the number of court ordered evaluations are entirely speculative. Ideas presented include funding reductions in the community mental health system during the State's last economic downturn in FY 2002-03 and FY 2003-04, as well as an increased awareness by the State's public defenders about the option of requesting a competency evaluation for defendants.

34. Please describe the patient evaluations conducted by the two mental health institutes and the Institute for Forensic Psychiatry (IFP).

Response:

As “27-10 designated facilities” the two Institutes conduct evaluation of civil patients who appear to be an imminent danger to self or others or gravely disabled. A 27-10 evaluation may be either initiated by an appropriate professional (as defined in statute) or by a court. Patients receiving these evaluations may be detained for up to 72 hours. Depending on the results of the evaluation, the person will either be released, referred for care on a voluntary basis, or certified for short-term treatment.

The IFP conducts court-ordered evaluations of patients with pending criminal charges to determine if the patient is competent to stand trial and to assist with his or her defense. If the court finds the individual incompetent to proceed, he or she is admitted to CMHIP for restoration to competency or the individual is determined to be permanently incompetent to proceed. In addition, the IFP conducts sanity evaluations to determine if an individual was sane at the time of the alleged crime. The Institute for Forensic Psychiatry also performs mental condition examinations that are very similar to sanity evaluations but are used to mitigate sentences for individuals charged with a crime, or to determine if a mental condition (e.g. head injury) impaired functioning at the time of the crime in a manner analogous to mental illness.