Children, Families, Health, and Human Services Interim Committee

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59th Montana Legislature

MINUTES

December 8, 2005
CONFERENCE CALL

Capitol Building, Room 137
Helena, Montana

COMMITTEE MEMBERS PRESENT BY PHONE

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

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

REP. EMELIE EATON
REP. DON ROBERTS

COMMITTEE MEMBERS EXCUSED

REP. EVE FRANKLIN

OTHER LEGISLATORS PRESENT BY PHONE

SEN. CAROL WILLIAMS
REP. RAY HAWK

STAFF PRESENT

SUSAN FOX, Lead Staff
FONG HOM, Secretary

CALL TO ORDER AND ROLL CALL

Meeting started at 3:02 p.m. with Susan Fox setting the conference call up.

Present at this meeting are: (see blue sign up sheet)

SEN. TRUDI SCHMIDT welcomes everyone.

WAIVER PROPOSAL PRESENTATION - Jeff Buska and John Chappuis, DPHHS

JOHN CHAPPUIS, DPHHS gave an overview of the waiver proposal.

I want to take a moment to thank you all for putting this together, and especially Susan, we certainly appreciate all that you've done. I want to give a very quick overview and a little bit of history on this waiver effort and also tell you where we are in the process. I'll begin with just saying that this waiver came out of the public health care redesign efforts that went on in 2003 and 2004. It was an idea that came up from a number of people as to how to really refinance the mental health services plan. A lot of things we looked at that related to sustainability and keeping services here, but making the resources go further. Remember we were in a different time fiscally then. So, money was extremely tight, Mental Health Services Program (MHSP) was actually in some danger of not being funded at that time. I just want to remind people that this waiver allows us to refinance the MHSP funds. It refinances some of the MCHA, which is the Montana Comprehensive Health Association. What that really does here is the refinancing puts it into Medicaid, it allows us to garner the approximately 70% match that the federal government will allow here, and allow us to provide the same services, and then enhance services in terms of physical health for that population.

There are approximately 2200 people who are actually on the MHSP plan. This is a state-funded plan that provides mental health services for those adults who are above Medicaid but under 150% of the poverty level. We will provide assistance, either premium assistance or other assistance with physical health needs for that population through this refinancing. But even with that, there is an ability to provide some assistance to other groups, including seriously emotionally disturbed children between 18 and 21, those children currently lose Medicaid coverage once they reach 18. This will allow us physical health coverage and some mental health coverage for up to 300 people in that group, and it helps them to transition into adulthood and not just have a cliff effect or a cutoff of services at that point in their lives when many of them are still vulnerable and in need. It also allows coverage for a CHIP look-alike program for about 1600 kids. What that really is, it's the same as the CHIP benefit, but it is funded under Title IXX, which is the Medicaid funding. The next group that we're talking about covering with this waiver are the parents of Medicaid children who currently are not covered. Right now adults are covered at about 30% of the poverty level. This will allow us to cover up to 600 of these parents who have children who are on the Medicaid program and have no coverage right now.

It also allows a refinancing of the Montana Comprehensive Health Association funding, that's with the Insurance Commissioner's Office. That program has had some problems with this funding and continuing the level of support that has been operated in the past. Also, it will allow some ability to utilize the waiver for funding some of the efforts in terms of premium assistance, which are authorized under HB 667. Certainly the amount of money that would be authorized to be spent under this waiver for premium assistance is to be determined by the committee authorized under that bill. Those are the groups that are affected here.

One thing I want to note right up front is that in terms of the base Medicaid population,

nobody loses services, nobody loses any type of funding, no changes in co-pay, nothing here will affect the base population in Medicaid. These are add-on populations.

I want to talk a little bit of where we are in the process. We've just completed the comment period. And you may recall that SB 110 allows a 60-day comment period and the federal government requires one for the tribes. So they were commensurate; it just finished. We did receive 20 letters and there were many questions in those letters. We're working on pulling the comments together and seeing what is appropriate for change, if necessary, in the waiver concept paper. Many of the comments, some were very positive, some were ambivalent in that they had positive and negative, some just had concerns. We are really taking those seriously. We're looking at them and seeing what we can do that can improve this waiver. Jeff is going to talk more about that, but a lot of the concerns in my mind, I must tell you, dealt with the overall health of the adult mental health system in terms of funding, in terms of what we do. Some of these concerns would be whether we do a waiver or not, quite honestly. I don't think there's too many people who would disagree with me out here that the adult mental health system, this waiver really is probably one step in the process of overall improvement. That's where we want to go.

Our target date for pulling all the comments together is about January 15. We were going to do this quicker, but frankly, we want to take these seriously and make sure that we take those into account and make this the best product we can. So, it'll be sometime in January. If it takes longer than January 15, it'll take a little longer, but we're going to do that before we pull together a document that would be basically our final document and recommendation to the Governor's Office for a formal submission.

That's where we are and with that, I would turn it over to Jeff who can talk in more detail about what we're doing.

JEFF BUSKA, DPHHS, gave presentation on the outline that was on the METNET Video Conference held October 26, 2005 **(EXHIBIT 1)** and refers to the Concept Paper **(EXHIBIT 2).**

I will start on page 3 of the outline with the bullet titled "Medicaid and Waivers 101". One of the things that I think is important to do is give you a baseline understanding of the state plan Medicaid services and how waivers relate to the existing Medicaid program.

Under the state plan Medicaid services under federal law, if a state chooses to participate in Medicaid, then every resident of the state who meets the Medicaid state's eligibility requirements is entitled to have payment made on his or her behalf for covered services. In the Medicaid program, a lot of the covered services typically include things like in-patient and out-patient hospital services, physician services, pharmacy, DME. There's a wide variety, a wide menu of services that are covered under the Medicaid program. We're able to control and limit the amount, scope and duration of those services with unit limits and prior authorization. But as generally a broad-based coverage of services for our low-income beneficiaries.

The state plan is the fundamental basis of our Medicaid program that provides a safety net for these individuals. It is our contract with the federal government, with CMS, regarding the eligibility under the Medicaid program regarding the coverage of services and how we're going

to pay for services. And a lot of it is under the statute of Title IXX of the Social Security Act for the coverage of the Medicaid program. So, when we're talking about waivers in certain spots in the Social Security Act, the federal government allows us to waive requirements of the Medicaid program. In typical areas that you see that are identified for Medicaid waivers, on the next slide used by the federal government to enable the state to experiment with new ways in providing those state plan services. In waiving provisions of the Social Security Act you'll often hear of 1115 Research and Demonstration Waivers 1915B, Freedom of Choice Waivers, and 1915C, Home and Community Based Waivers. It's basically to change the concept of these entitled benefits and only applies to these waiver clients.

An 1115 Waiver allows the states to develop an innovative plan to address the health care needs of the uninsured by waiving certain requirements of the Social Security Act, such as comparability of services, statewideness, freedom of choice, absent services and costs sharing. A HIFA waiver is just another vehicle that's used by CMS that is simply another form of these 1115 Waivers to provide greater flexibility for states in operating the Medicaid programs, has a goal of increasing the number of low income people with health care benefits, and also for restraining the growth in Medicaid.

The HIFA Waiver concept gives states the ability to serve new and low-income eligibility groups using Medicaid funding, to provide a different set of Medicaid services to these individuals or a different menu of services than what's entitled under the state plan services, and also allows the state's ability to limit the enrollment of and total spending on those services for these new eligibility groups.

Under certain conditions, HIFA Waivers, typically for the 1115 Research and Demonstration Waivers, allow the states the ability to convert state-funded health care programs using Medicaid funding as long as savings that are generated from that refinancing effort are then reinvested in expanded health care coverage for low-income people who are uninsured. It also requires a maintenance of effort as one of the requirements for the federal government. Montana is currently operating with an existing 1115 Waiver. That waiver is a waiver that we had approved February 1, 2004, which is our basic Medicaid waiver for able-bodied adults. It is basically an extension of our previous FAIM Waiver that we had implemented since 1996, where clients received a reduced benefit package of Medicaid services. A reduced benefit package generally excludes routine eye exams, eye glasses, dental and denture services, personal care services, audiology hearing aids, and durable medical equipment. Some of these services are still covered under the Medicaid program through an essential-for-employment provision in that waiver, and also as emergency type services, like with dental and denture services.

What we propose to do in this waiver is to amend this existing 1115 Waiver and incorporate a lot of the HIFA concepts and refinancing of state funded program and providing health care to over 5000 uninsured Montanans. We want to leverage the costs savings that we've been experiencing under the existing 1115 Waiver to meet the federal budget neutrality requirement.

On page 40 of the Concept Paper, there's a graph that depicts the savings that is

generated under the existing waiver that we have, and for under the proposed waiver, how much of that savings that we proposed to use for the refinancing services under this proposed waiver.

As John mentioned, some of the key features of this proposed waiver is to secure Medicaid funding for portions of the Mental Health Services Plan. As John has mentioned, it is currently a state funded program and if we use Medicaid funding, we'll free up roughly about 70% of the state general fund that's being currently spent on MHSP that we can refinance in providing the services for the uninsured. We're going to reinvest it for the uninsured people for a primary care benefit for low income individuals.

The proposed groups that we had planned to use with the refinancing funding under MHSP include providing primary care benefit in existing mental health services for those individuals in a mental health services plan. Refinancing will provide uninsured working parents with children on Medicaid or CHIP a physical health care benefit, and will provide services for uninsured seriously and emotionally disturbed youth, ages 18-20.

The Mental Health Services Plan proposal provides coverage for up to 1500 uninsured MHSP clients. Based on our estimates, the program currently provides services for approximately 2200 clients that are utilizing services on an average basis each month. The MHSP number of eligibles is much higher than that, but a lot of the individuals that are currently utilizing the services on an average monthly basis amounts to about 2200 clients. Of that approximately 1/3 we believe do not qualify for the waiver because they have other health care coverage under Medicare or a private insurance plan. Again, refinancing these services, it's for individuals who are uninsured. We believe that CMS will consider these individuals to have health care coverage, so therefore we have to continue their existing services with state funded dollars.

We propose to provide the following health care benefits for the MHSP clients, to continue their existing mental health services that they currently receive and enhance the MHSP services with the new short-term in-patient hospital acute care services. The proposal identifies approximately $200,000 per year for that benefit. Also, to provide physical health care benefit. The physical health care benefit is to provide a choice of three options for the client. The first is to provide employer premium assistance if they have health care insurance available to them through their employer, of about $166/month. If the client cannot obtain those services through their employer and they are able to obtain the health insurance through the private health insurance market, again, the state will provide $166 in premium assistance for the purchase of that benefit. And third, the proposal identifies in the absence of the client being able to select those two options, that they will have Medicaid individual health care benefits similar to a medical savings account of $166/month that if it is not used may be carried forward into future months, as long as the client is still eligible for the program.

The next group on the refinancing of the services for the uninsured is to target the uninsured working parents with children on Medicaid or CHIP. We propose to provide coverage up to about 600 uninsured working parents and again to provide them with the same physical health care benefit that will be available for the MHSP clients, which again is employer premium

assistance, premium assistance under individual private health insurance plans, and a Medicaid individual health care benefit.

The other group for the refinancing of MHSP is to provide coverage for uninsured children. We propose coverage for up to 1600 uninsured children. The target group are those children who lose or apply for or lose Medicaid eligibility because they no longer meet the income and resource requirements for Medicaid. These children may be eligible for CHIP, but remember that as we were putting this proposal together, there was a waiting list for the children's health insurance program. Currently they do not have one, but they cannot access CHIP so therefore, if there was a waiting list, we would use the waiver services to provide that health care benefit for them while they are waiting for a slot to open up under CHIP. The benefit package we would provide them would be exactly the CHIP health care benefit in terms of paying the premiums on behalf of that individual and to try to create a seamless transition for them from Medicaid to coverage under the waiver program to when a CHIP slot is open up and try to put them into the children's health insurance program.

It also provides coverage for up to 300 uninsured SED youth, those individuals who are seriously emotionally disturbed, ages 18-20. We want to provide them with the physical health care benefit that is identical to the one provided under the children's health insurance program. That would include the mental health services that are also provided under CHIP. We would also provide a wrap around benefit which would be a set of therapeutic and support services to assist the individual in making a successful transition into adulthood. These would include training instructions for the individual to develop intangible life skills defined as problem solving, decision making, impulse control, and critical thinking.

The next area in terms of the waiver involves the refinancing of the program for the Montana Comprehensive Health Association, specifically related to the premium subsidy pilot program. It is currently under the current year and the proposal is budgeted at $570,000 per year. We believe that it would provide coverage for up to about 260 individuals. Again, there's a population that we believe, approximately 10%, would not qualify for the waiver because they have health care coverage under Medicare. So those services would continue to be provided under these general fund or state's special revenue as they are now, but for the rest of the individuals, we would include them under the waiver and fund their services, their premium assistance with Medicaid dollars.

We proposed to adopt their existing MHSP eligibility criteria, the benefit package, and procedures that are utilized by the MCHA program, and refinance their services with Medicaid. Again, under HIFA waivers, you have to reinvest that into providing health care coverage for the uninsured. What we see is the MCHA program has a waiting list of individuals trying to get into that, so we'll be trying to either target those individuals to buy them into health care coverage or try to take those individuals for their premium assistance. In the last year some hard decisions were made that they had to reduce that premium assistance from 55% to 45%, and what was found is that the enrollment is dropping in that program as a number of people cannot afford those premiums anymore. So, we are having more and more people going uninsured. We hope to be able with this refinancing to stabilize the program to try to insure the contingent

financial viability of MCHA.

The next proposed waiver group is related to what was passed under HB 667 and the small business insurance purchasing pool. Under that bill, it had a provision for the state to seek the option of pursuing the waiver to fund some of these services through the small business purchasing pool with Medicaid dollars. So, we've amended the waiver that we had during the Legislature in January to incorporate the concepts out of HB 667. For those individuals or small business employers that join this purchasing pool, created through the Insurance Commissioner's Office, that receive assistance we would be able to participate in paying a portion of the monthly insurance premiums and assistance payments. This would be premium assistance payments for the employee and premium incentive payments for the employer.

We plan to coordinate these services with the State Auditor's Office. For those individuals who would qualify to be eligible under Medicaid, we would fund a portion of their services with Medicaid dollars and receive the general fund dollars from the Insurance Commissioner's Office as the matched dollars. For all those individuals who would otherwise not fall into a Medicaid track, would continue to be funded under the General Fund/State's Special Revenue that was appropriated under HB 667.

The proposed effective date that we had when we put this waiver out was July 1, 2006. That effective date would probably need to be adjusted depending on when we could get the waiver proposal submitted to CMS and obtain their approval. Some waivers have been approved within 30 days, some are taking a couple of years to get approved. It is hard to tell what will happen in the negotiations with CMS. We estimate the economic impact will be an additional $15M drawn down in federal Medicaid funding for Montana, and providing coverage for over 5000 uninsured Montanans. No additional costs to the state general fund, just what was already appropriated under MHSP, MCHA and what came through as new funding under HB 667. As John has mentioned, what the waiver will not do is reduce the quality, quantity of Medicaid benefits or services currently available under the existing Medicaid eligibility groups for Montana. I know John has repeatedly said this that in our negotiations with CMS, if there's going to be a requirement of changing eligibility or increased co-payments for the existing Medicaid population, the state will not proceed with this waiver. We will not impose any additional expenditure limits or growth gaps on the payment of services to the existing Medicaid populations, our Medicaid eligibility groups that exist right now. We will negotiate in good faith with the federal government to make sure that this waiver proposal is advantageous to the State of Montana in covering the uninsured.

With that, I will open it up to comments.

SEN. SCHMIDT thanked Jeff and John.

QUESTIONS OR COMMENTS FROM THE COMMITTEE

REP. EATON had a concern regarding the group of parents whose children are covered by

Medicaid but they themselves are not covered, page 29, group three, that they specifically said working parents as referenced on page 8 of Jeff's handout. These people do not necessarily always work, or where they work they don't want to participate in the state plan; would these types of people be picked up under the waiver? MR. BUSKA said for this eligibility group who are being identified as those individuals who are working parents, we can provide those three options for them. For those individuals who have incomes that are over the eligibility requirements for Medicaid, roughly at about 38% of the federal poverty level for a family of three, we are proposing to increase that eligibility requirement to 200% of the federal poverty level. If they have children who are funded under Medicaid or CHIP, they would be eligible for one of these 600 slots and we would not have an acid test for eligibility under the waiver. Under the alternative, those individuals could qualify for premium assistance and receive funding through HB 667. Through that eligibility process with the Insurance Commissioner's Office, we identified that particular working parent who would qualify under a Medicaid track; we could use Medicaid funding for their premiums, or they would be able to get assistance through HB 667. We have that protection on both avenues if they qualify under that program as well. The third thing I should add is that if during the application process, we identified an individual who would qualify under existing state plan services and have health insurance provided through their employer, we have the option under existing state plan services to pay those premiums in full on behalf of the client, thus, saving money under HB 667. We wouldn't have to utilize the slot under the Medicaid waiver.

REP. EATON asked Mr. Buska if she could give his name and the Department number out for people who have individual situations that are difficult to mediate. Who would be a contact person that they could find out in their own individual situation? MR. BUSKA said they could get the information to him and he would work with his eligibility staff to try to identify if this person would be able to qualify under the waiver services.

SEN. ESP asked if Mr. Buska if he has loose priority or firm priority amongst the different programs and how is he going to work that? JEFF BUSKA said that they have already had discussions about individuals eligible under the Children's Health Insurance Program. If there are no waiting lists, they will have to do something with that eligibility group. JOHN CHAPPIUS said that they do have an ability to move money around. We have to look at the need and look at the priorities and principles that were passed by the Legislature this year to look at moving the money around. He said that his number one priority is making sure that they do the best job they can for the MHSP population because they are the most in need. SEN. ESP asked if their target of 300 FTEs is based on historical numbers of those in transition; what did you base the 300 slots on? JOHN CHAPPIUS said they did a study of the emotionally and disturbed population and found out that about 500 of the approximately 8000 that are designated as SCD under the Medicaid program used about half of the resources in terms of the overall spending. The 300 came about as a figure based on that. They did not have enough information to take on the 18-, 19-, and 20-year old population to be able to say that they based the 300 on that.

There is a group of very heavy users, very much in need which they made an estimate based on that in the existing Medicaid population.

SEN. ESP, in reference to the physical health benefit for the MHSP population, are they looking at limiting the number of slots to 1500 for their other mental health services? JEFF BUSKA said that they are proposing to have a slotted basis in terms of individuals at 2200. It's based on the identification of the amount of general fund that they have to be able to provide services for that population. That's identified as those individuals who are utilizing the services and to continue with their existing mental health services, their existing pharmacy services, and then being able to provide them with the physical health care benefit. For the individual with the physical health care benefit, their estimate is to serve about 1500 individuals. But it doesn't say that they couldn't reserve some of the general fund to continue other state funded services for the MHSP population. It will have to be a capped mechanism to ensure that we are staying in within our budget neutrality cap, which is identified as the savings that we are realizing under our existing basic Medicaid services. This is a population that would not otherwise qualify under Medicaid. There's no way we can take this population and make them Medicaid eligible, so we have to have the savings under the existing Medicaid services to provide these services under the waiver. We can fund what we can and provide those services with Medicaid dollars and some of it would have to be funded with general fund.

REP. ROBERTS said that Jeff Buska stated that the mental health services plan provides services for approximately 2200 clients, and one third do not qualify for the waiver because they have health care coverage under Medicare or private health insurance, which would be about 735 people. Why would they be considered part of the state mental health services plan if they are covered with private health insurance or Medicare? What does the state have to do with these groups or what influence do we have with them? JEFF BUSKA said that the reason they are eligible under the mental health services plan is for access to prescription drugs and the prescription drug benefit, and counseling and targeted case management services provided under the mental health services plan. The rest of their health care benefits are covered under Medicare.

REP. ROBERTS asked if whatever their private insurance will cover, and then go to the state for that which is not covered for the mental health? JEFF BUSKA said that for mental health services, that would be correct.

REP. WARDEN asked how long is this $15M forecast going to be used for, is it a biennium or one year deal? JEFF BUSKA said that he believed it was estimated that $15M is the figure that they came up for the first year of the waiver. REP. WARDEN asked what would he forecast in terms of long-term sustainability of what he is doing with the money for this one year? JEFF BUSKA said that on page 37 of the Concept Paper, it identifies the dollar figures over the life of the waiver. In the first year, it would identify federal Title IXX Medicaid dollars at about $15.9M.

In the second year, the waiver would be roughly at $15M. The third year, the waiver would go down to about $14.4M, and then it would go to about $14.2M, then roughly in the fifth year, the waiver down to about $14M. That's all based on the existing general fund appropriation in just applying that over the life of the waiver.

TAPE 1B

SEN. WEINBERG asked how sure are they that the $15M is going to be there with the federal cuts being proposed? Have we received any indication from the federal government that this is really going to happen? JOHN CHAPPIUS said that in terms of the services we are offering, those are not services that are proposed to be cut. The reductions that are in the federal budget cutting process right now are primarily in pharmacy and some co-pay latitude that won't affect Montana. There is some language that deals with targeted case management, but we think we have fixed the language so it won't affect our programs very much. In terms of HIFA waiver, it is a five-year waiver and anything can happen in that timeframe.

SEN. WEINBERG asked how they were dealing with the letters they have received regarding the waiver; are they getting back to the people and having conversations, or are they writing answers to their concerns. JOHN CHAPPIUS said that they are first compiling them and looking at how they will address them. They will have that published; didn't know if they would send letters answering their concerns directly. JEFF BUSKA said that they are compiling all the comments and putting them into a "Comments and Response" document and will have that available for review on the internet website and be able to assess the need for any changes in the proposed waiver before we submit it to CMS. JOHN CHAPPIUS also said that some of the concerns of MHSP are things that we need to address to make sure that they don't harm that population. That will take some time and that is the reason we extended the date until mid-January. SEN. WEINBERG said the reason he asked the question is that perhaps it would be beneficial to some of these folks to have a conversation with them rather than just getting an answer because they might have a view of the situation that is unique and important to understand. JOHN CHAPPIUS said that they will keep that in mind and if the situation looks like something that would be beneficial, they will do that.

SEN. SCHMIDT said that she is looking at the information from Gene Haire, Board of Visitors, and that this proposal is predicated upon a massive underestimation of the number of people at SDMI in Montana. Please comment on that and are you concerned about that? JEFF BUSKA said that he would like Lou Thompson, who administers the MHSP program, to comment on that. LOU THOMPSON said that unbeknownst to Gene Haire when he submitted these comments, the Addictive and Mental Disorders Division had entered into a contract with WICHE to do a prevalence study of individuals with serious mental illness, looking at poverty levels of 100, 150, and 200%. They expect to have the findings from that study at the end of January or the middle of February. JOHN CHAPPIUS commented that he would note on the prevalence of

the SDMI or lack thereof, however the study comes out, the problems would exist regardless of whether we do this waiver. The current funding is not enough to deal with that issue.

SEN. WILLIAMS said that she did not get the documents that Jeff used in his presentation and would like that be made available at the meeting next week. JEFF BUSKA said that information will be available and is also on their website. SEN. WILLIAMS asked if there were advocacy groups that were part of the public comment, either positive or negative, or were they mostly individual comments? JEFF BUSKA said that he received letters from: The Service Area Authorities of Montana, NAMI-Montana, Western Montana Mental Health Center, HOPE Support Group, the Mental Health Oversight Advisory Council, the Montana Advocacy Program, the Montana Children's Initiative Provider Association, Gene Haire from the Board of Visitors, Bonnie Adee from the Mental Health Omnibusman Office, the Montana Mental Health Association, the Montana Primary Care Association, the American Cancer Society, the Southwest Regional Director of the Montana Mental Health Center, the Montana Council of Community Mental Health Centers, a personal care provider, a registered nurse who works at St. Pete's, a client, the Hospital Association, and AARP, and one other hospital.

SEN. WILLIAMS asked if he was able to incorporate any of the concerns raised into the actual waiver? JEFF BUSKA said that what they are doing is going through and assimilating all the comments that they have received and working on considerations for whatever changes they need to make to the waiver, and putting together responses to those comments. JOHN CHAPPIUS said that is why they extended the date to January so that they would have time to do a very reasoned and exhaustive approach as to what in their opinion should or should not be entered into the concept.

REP. HAWK would like transcript of Jeff's testimony so he could look it over.

SEN. ESP asked John if the appropriations from the state general fund over the life of the waiver could be raised above the amount we use to qualify for the waiver? JOHN CHAPPIUS said that there are limitations in terms of the budget neutrality and the caps that they are talking about are caps on the new population and not on the Medicaid program.

SEN. ESP asked that if putting more money into the line item to handle the need of MHSP population, would affect the rest of the people in the waiver? Can we help them without hurting the waiver? JOHN CHAPPIUS said that program would not affect this waiver, or vice versus. Regarding Sen. Esp's comment about the MHSP population, changing that would definitely have an effect on the budget neutrality issues that he talked about overall. Some of the populations don't have much effect because there are things the state could choose to do under the state plan, called optional populations. But for our waiver population, they can't be covered at all without this waiver. The MHSP population is definitely subject to that budget neutrality, but there is some room there.

JEFF BUSKA said that for the community health center, the waiver services would not impact their prospective payment system and how their rates are calculated under the waiver, but it would provide an ability for those facilities to obtain reimbursement for the services they are providing right now, which is uncompensated care. For instance, if an individual was able to obtain a premium assistance through their employer and it might be a Blue Cross Blue Shield product, that facility would then be able to bill Blue Cross Blue Shield and receive payment for those services. In the alternative, if the client selected the plan that had provided $166 per month, then that particular facility would be able to obtain some reimbursement for services that are going as uncompensated care.

SEN. ESP said that the one thing he would ask that they look at writing into the proposal is how they are going to apply the priorities to the various programs. They could look at their underlying document and the legislation, and then envision how they would do it and put it in writing in the waiver. Sen. Esp thought that it is important for everybody to understand up front.

SEN. SCHMIDT said that the Committee needs to think about is whether they are supportive of this, if a letter from the Committee would be beneficial, or if the Committee feels that they know enough to support this. Sen. Schmidt said that she wonders if Sen. Baucus' staff is supportive of this.

SUSAN FOX said that she will be working with Lois Steinbeck to help figure out participation with the Finance Subcommittee and will try to get public notice as soon as they can so everyone will know when that meeting might happen.

SEN. SCHMIDT adjourned at 4:03 p.m.

SEN. ESP said to John Chappius that he wanted to explore two subgroups of MHSP population: one, who is eligible for the waiver and who is not; and two, if you use the increased appropriation to do pharmacy benefit for the groups who weren't eligible for the waiver without affecting the waiver population. JOHN CHAPPIUS said that the question is if those folks who are not eligible and under Medicare, would they get the Medicare Part B benefits. The answer depends that if the need were there it might be appropriate, but it is something that he would have to study more.

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