MINUTES

MONTANA HOUSE OF REPRESENTATIVES
57th LEGISLATURE - REGULAR SESSION
JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH & HUMAN SERVICES

Call to Order: By **CHAIRMAN DAVE LEWIS**, on January 17, 2001 at 8:30 A.M., in Room 152 Capitol.

ROLL CALL

Members Present:
Rep. Dave Lewis, Chairman (R)
Sen. John Cobb, Vice Chairman (R)
Rep. Edith Clark (R)
Rep. Joey Jayne (D)
Sen. Bob Keenan (R)
Sen. Mignon Waterman (D)

Members Excused: None.

Members Absent: None.

Staff Present: Robert V. Andersen, OBPP
Lois Steinbeck, Legislative Branch
Sydney Taber, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing(s) & Date(s) Posted: Continuation of the Addictive and Mental Health Disorders Presentation, 1/17/2001
Executive Action: None.

{Tape : 1; Side : A; Approx. Time Counter : 0.1-10.9}
Lois Steinbeck, Legislative Fiscal Division, requested that the Department provide her with the underlying assumptions used to estimate the supplemental, in order for her to complete her analysis of the supplemental. **CHAIRMAN LEWIS** wants the information from the budget office on the implications for FY02 and FY03 regarding the $1 million in the alcohol tax state special revenue (SSR) funds.

{Tape : 1; Side : A; Approx. Time Counter : 11-15.9}

Dan Anderson, Administrator of Addictive and Mental Disorders Division, presented an e-mail from Michelle Thibodeau with information regarding Medicaid coverage for people with chemical dependency and other addictions which the Committee had requested **EXHIBIT(jhh13a01)** . In terms of determining disability, a person with an addiction would have to have other related medical problems in order to receive Medicaid.

{Tape : 1; Side : A; Approx. Time Counter : 16-24}
Mr. Anderson discussed decision package DP 117, the proposal for refinancing to expand Medicaid to include chemical dependency services **EXHIBIT(jhh13a02).** The Division plans to use earmarked alcohol taxes which are already part of the chemical dependency budget as match for the Medicaid benefit and to replace the funding with federal substance abuse prevention and treatment block grant funding.

The refinancing will cause a trade off in which there will be a decrease in the amount of money that would be available for non-Medicaid populations. This decrease would be mitigated by a block grant increase. The trade off will mean less in funding for the non-Medicaid population, while assuring the availability of a complete menu of Medicaid funded chemical dependency services for people with disabilities and mental illness.

Over the biennium, the Division would get to the point where it would have a Medicaid benefit for chemical dependency services of about $5 million total funds. The plan will phase in benefits over a period of two years. The Division is intending to use the state approved chemical dependency programs as the providers of the service. Some state approved programs that do not get county funds would still be eligible for the funding. All state approved programs would be approved as service providers in this program and would provide coverage throughout the state.

{Tape : 1; Side : A; Approx. Time Counter : 24-28.5}
In response to a question from **REP. JAYNE, Mr. Anderson** said that there are no general funds being used to fund Montana Chemical Dependency Center (MCDC). There is about $150,000 in state general fund which would be included as part of the match and which funds youth inpatient services. It is also possible that counties could consent to transferring SSR funds distributed to them for chemical dependency back to the state for Medicaid match.

{Tape : 1; Side : A; Approx. Time Counter : 28.6-43}
CHAIRMAN LEWIS made the suggestion that the Committee could designate $150,000 per year out of the earmarked alcohol tax for the match for the youth services and the general fund could be

taken out. There would still be a big increase in the program. **Roland Mena, Chemical Dependency Bureau,** suggested that there may be a maintenance of effort issue.

Ms. Steinbeck said that if the general fund cannot count toward maintenance of effort then neither can the state special revenue allocated to Medicaid. If it is simply which state fund you take it out of, then there is no maintenance of effort issue, since it is all used as Medicaid match. **Mr. Anderson** suggested that if the general fund were taken out and replaced with the earmarked tax, there would be a net decrease in all state funds. **CHAIRMAN LEWIS** said that in the base year, there was no earmarked tax. Then there would be $1.2 million of earmarked tax in 2003 which would certainly be maintenance of effort. Why couldn't $150,000 be taken out and say that a portion of the earmarked account be used to match the youth services? **Mr. Anderson** said that the earmarked tax being spent at MCDC is being counted as maintenance of effort.

In discussion with **SEN. COBB** regarding determination of those who would not receive services as a result of reductions, **Mr. Anderson** stated that it would be the non-Medicaid population with incomes under 200% of poverty, but that these funds are already being used to serve the Medicaid population. He further explained that the mental health and chemical dependency programs work differently in community services for the non-Medicaid population. The chemical dependency program has set contracts with providers, the providers document that someone is eligible for service, and serve who they can with the money. The providers may receive less funding in provider rates, but they also receive the majority of Medicaid funds.

{Tape : 1; Side : A; Approx. Time Counter : 43.1-48.4}
Ms. Steinbeck went over the growth in the Medicaid funded portion by eligible person and the average cost per eligible person. Over the three years of implementation the average cost per person increases, partly due to the way the Department will structure Medicaid rates. **Ms. Steinbeck** asked the Department to provide her with the cost of the 599 persons served in the base year in order to determine the number of individuals that might lose services. Those individuals would have been Medicaid eligible, but were served with 100% state funds. When the state match for Medicaid exceeds the total cost of serving the 599 persons in that base year, funding available for other low-income people is reduced.

{Tape : 1; Side : B; Approx. Time Counter : 0.2-4.9}

SEN. WATERMAN asked **Mr. Anderson** if he had discussed the possibility of intergovernmental transfers with counties, and why they would not do such a thing. He responded that the Department and Missoula County had considered the intergovernmental transfer several years ago, but did not know if it could be done with only one county. Since that time, **Mr. Anderson** has pursued the idea with other counties, but the Department considered that there was enough money in the budget to handle this without adding general funds or county money.

Ms. Steinbeck explained that an intergovernmental transfer program can be used to provide the match or to raise provider rates. **SEN. WATERMAN** remarked that the need for chemical dependency treatment had not been met, and she would like to create a large pool of funding to increase provider rates and expand services. **SEN. WATERMAN** suggested that an intergovernmental transfer for the county money could be tied to a treatment program to treat fourth DUI offenders. The down side of expansion would be that expansion of the pool of funding could create problems with finding providers for the services.

{Tape : 1; Side : B; Approx. Time Counter : 5.0-8.1}
CHAIRMAN LEWIS summarized the discussion to this point. At the present time the counties receive $1.5 million per year from the alcohol tax, and the Committee is discussing having the counties give some of that funding, on a contractual basis, back to the Department. The Department would match it out with Medicaid to bill the program at the expense of the federal government, but would still have to deal with Medicaid eligible clients. If the counties returned $600,000, and the Department matched that with Medicaid, that would buy $2 million worth of services. **SEN. WATERMAN** would like to target a specific population with greater needs.

{Tape : 1; Side : B; Approx. Time Counter : 8.2-10.5}
SEN. COBB and **SEN. WATERMAN** expressed concerns about the disparity between the state rate for providers and the private sector since alcohol and drug dependency drive many of the problems in the state.

{Tape : 1; Side : B; Approx. Time Counter : 10.4-12.9}
In further discussion regarding intergovernmental transfers, **Mr. Anderson** commented that counties do not necessarily wish to use the funding the way the state would, and reiterated that the Department has enough money to fund the Medicaid population. **SEN. WATERMAN** suggested that it could be presented as an option rather than mandate to counties.

{Tape : 1; Side : B; Approx. Time Counter : 13.0-22.2}

Mr. Anderson began discussion of Montana State Hospital (MSH). **Mr. Anderson** introduced **Ed Amberg, Administrator of Montana State Hospital.** The project to consolidate the campus, build a new hospital and remodel other buildings encountered significant delays, and ended a year later than proposed. The delay in completion of the construction caused budgetary problems and was a major inconvenience and intrusion in life to those living on the campus. Another major problem has been the instability of population levels and the difficulty in estimating population levels. This caused the closing of a wing and elimination of staff. Census increases later in the year required the reopening of the wing and rehiring of staff.

The hospital has now received Health Care Financing Administration (HCFA) certification and is eligible for Medicaid and Medicare reimbursement.

Recruiting and retaining physicians, psychiatrists, and registered nurses has historically been and remains a significant problem for the state hospital. There is considerable turnover, and there has been an extended period when there was no medical director. MSH finally hired a medical director this last year, but he has already left for a better job.

{Tape : 1; Side : B; Approx. Time Counter : 22.3}
In response to **SEN. WATERMAN, Mr. Anderson** stated that the Division does do exit interviews with some staff, but he did not know if one was done with the medical director. **SEN. WATERMAN** suggested that it was essential to do exit interviews with all employees if the Division wished to retain employees. **Mr. Amberg** said that he had been focusing on hiring psychiatrists rather than the medical director.

In the following discussion, **SEN. WATERMAN** commented that the condition of the campus and the buildings is deplorable and asked how the building lawsuit is going. **Mr. Anderson** said that he has nothing new to report on the unresolved building lawsuit. **Mr. Amberg** explained that the new building is complete, but that there are still some problems that need working out. The forensic unit will be moved into the last unit in the next week.

{Tape : 1; Side : B; Approx. Time Counter : 30-39.5}
Mr. Anderson continued his presentation with information on state hospital commitment numbers. **CHAIRMAN LEWIS** remarked that the figures show that one-third of admissions are from Butte-Silver Bow, and he was curious whether the system was being taken advantage of. **Mr. Anderson** said that the convenience factor does play a factor in the preponderance of admissions from nearby communities. The Department has been working to develop

alternative services in local communities. **SEN. COBB** requested some options on what alternative services could be done at the local level, and how the Department could get it done. **CHAIRMAN LEWIS** suggested that the Department could increase the charges to local governments as a deterrent.

{Tape : 1; Side : B; Approx. Time Counter : 39.5-45}
SEN. WATERMAN went over some of the admission figures and suggested that there are two different kinds of services that communities need. The services provided to divert people from involuntary commitments are different than the crisis services needed in emergency detentions. The medical necessity should be considered and whether the individual needs the level of care provided at the state hospital.

{Tape : 1; Side : B; Approx. Time Counter : 45 - 47}
Ms. Steinbeck discussed the LFD issues regarding admissions exceeding licensed capacity. The issues are: preventing admissions from exceeding licensed capacity, and the repercussions should admissions exceed capacity. Would there be sanctions or a loss of funding?

Taped over already taped discussion on Tape 2, Side A. Transcribed from notes only.

Mr. Anderson said that data on use of the hospital during FY00 indicated that the average length of stay at Montana State Hospital was 169 days - of the 482 discharges, 62 stayed less than 8 days. The overall population two years ago was 170 patients and had been predicted to stabilize at 135. One year ago the high was 140's-150's, and then in May the population had risen to 153. During the summer, there was an even greater increase in the daily population census. This increase was not just in admissions, but also in the number of people that stayed. As of this day, the hospital is 5 people from capacity.

In order to keep people at risk of going into the state hospital in communities, the Department has promoted community services programs and adult foster homes.

Mr. Anderson stated that the Department agrees with the gatekeeping approach, but that if there were not a single point of responsibility then different standards or interpretation of standards could cause problems and a lack of accountability. In further discussion of possible methods of gatekeeping, **Mr. Amberg** suggested that the state hospital make the determination of hospitalization which would allow for a single methodology. Responding to a question from **SEN. COBB** regarding a time-line for

implementation of a gatekeeping system, **Mr. Amberg** said that it should be pretty easy to implement.

In further discussion on the state hospital, **Mr. Anderson** stated that there are currently 50-55 forensic patients for the 32 forensic beds, and that it was always expected that some forensic patients would be in the general population. When asked if the prison sent the forensic patients over without consent, **Mr. Anderson** answered that these admissions are court ordered to start in the mental health facility, and that eventually they may be transferred to the prison. Corrections does not pay the hospital for those patients. The original projection was that there would be 35 forensic patients and that there would be no prison inmates.

Mr. Anderson gave a detailed description of the four different types of forensic patients: guilty but mentally ill (GBMI), court ordered evaluation (COE), not guilty but mentally ill (NGBMI), and unfit to proceed (UTP). Evaluations are paid for by the counties that send the forensic patients to the state hospital. Patients classified as UTP are considered unfit to stand trial and must stay at the hospital until such time as they are fit and able to stand trial. Should that not happen, then the patient becomes a civil patient and general fund pays the costs. **Mr. Amberg** gave the average length of stay for COE patients as 25 days and for UTP patients 180 days.

{Tape : 2; Side : B; Approx. Time Counter : 0.1-15.6}
Mr. Anderson continued with the explanations of the categories. Those who are NGMI could not have the state of mind necessary to commit the crime and are sent to the state hospital until mental illness has subsided; they must prove to a judge that they are no longer a danger. Those who are GBMI are convicted of the crime, but in sentencing the judge may say that due to mental illness the person may not have appreciated the criminality of his act, and send the person, in custody of the Department, for placement in a mental health or correctional facility.

There is a 5-year conditional release for individuals adjudged NGBMI. Some are not in need of inpatient psychiatric treatment, and they are released to the transitional care unit for forensic patients (TCUX) to receive transitional treatment before return to the community.

{Tape : 2; Side : B; Approx. Time Counter : 15.7-29}
Mr. Amberg stated that between 25% and 30% of the hospital population is comprised forensic patients. Some are very dangerous, some very stable. There was general discussion over a particular patient that had been in the hospital for 28 years.

The process of discharging forensic patients is elaborate. The court must be convinced that the patient is no longer a danger to himself or others, which bottlenecks the return of forensic patients into the community.

Mr. Anderson added that not all forensic patients are the same kind of people. The range of service needs, types of crimes, and dangerousness of the forensic patients is almost as wide as non-forensic patients. Some of the patients may be borderline developmentally disabled (DD) and would be victimized in the correctional facility.

{Tape : 2; Side : B; Approx. Time Counter : 29.1-4}
There was discussion over the Xanthopoulos building. The Department believes that it does not need the Xanthopoulos. To expand the hospital to another ward, whether it was the Xanthopoulos or the new building, would cost roughly $2 million per year.

SEN. WATERMAN expressed concerns about the crowding of people being moved from Xanthopoulos to the Spratt building and why they needed to do this. **Mr. Anderson** said that the Spratt building, until now, was the only federally licensed and certified building. The license was based on having four people to a room. The Department is intent on consolidating patients to reduce costs. In further response to **SEN. WATERMAN**, **Mr. Anderson** said that the plan was that the new building and the Spratt building would be the state hospital, and that the Xanthopoulos building is now a corrections facility.

Back to taped over side.
{Tape : 2; Side : A; Approx. Time Counter : 0.1-5.4}
Mr. Amberg went over the measures that had been taken to remodel the Spratt building. There are now 50 patients in Spratt, well within its licensed capacity. In the next week, the higher security forensic patients will be moved into the forensic unit of the new hospital. At that point, only one ward in the Xanthopoulos building will still have patients, and those will be moved out by February 14. Most of these individuals will go to the Spratt building. Discharges should create more spaces in other areas of the facility.

Mr. Amberg responded to an issue raised by **SEN. WATERMAN**, that there is not adequate staffing to handle individuals as they are placed and that there is a safety issue. He stated there are management challenges associated with this move, but it is not more unsafe than previously. The population at the state hospital is always challenging.

{Tape : 2; Side : A; Approx. Time Counter : 5.6-}
Mr. Anderson continued with discussion of the state hospital. The projected budgeted population for the biennium is 165, but **Mr. Amberg** indicated that the hospital may be 20 over that as of today. If the budgeted population is exceeded, three cost issues come into play. One issue is variable costs such as food and medicine. The second issue would be the addition of clinical staff. The third issue would be support costs such as housekeeping and food services. If the census does not stay at 165 population, but goes as high as 213 and the Department has to open another unit, the additional cost would be $3.6 million per year.

In response to a question regarding Medicaid services given worst-case scenarios, **Mr. Anderson** said that Medicaid certification is fine for the new facilities. If the Xanthopoulos is now a correctional facility and the Department needs to use the receiving hospital, it could not be licensed as a state hospital. It could, however, be licensed as a mental health center facility, but the state would not get Medicaid reimbursement for that.

Given a choice of the Xanthopoulos building and the receiving hospital, the Department would prefer to use the Xanthopoulos building. The Xanthopoulos building could be certified. The Department is still under the assumption that the Xanthopoulos building is going to be used by Corrections.

Mr. Anderson went over the present law adjustments. There are increased costs in the holiday, overtime, and differential pay. There are increased pharmacy contract costs. Part of the supplemental present law adjustment is 27 FTE, the additional staff needed to adequately handle the patient load. Those staff are already on board in modified positions.

{Tape : 2; Side : A; Approx. Time Counter : 15}
The Nursing Care Center in Lewistown is a specialized nursing home for mentally ill individuals. There are three levels of care - an open unit, the controlled access units, and a locked unit. Over the years, patients introduced to this facility have been more disabled with mental illness. A little over half of the admissions are transfers from the state hospital. The Nursing Care Center has also been hit with recruitment problems. It has trouble filling RN, LPN, and NA positions, and has had to contract with agencies that supply nurse aides in order to meet staffing.

{Tape : 2; Side : A; Approx. Time Counter : 20.7 - 29.7}

Ron Bellis, Superintendent of the Nursing Care Center, reviewed reasons for the staffing problems. There is competition with other nursing homes in the area, but basically the problem is that the wages are too low. In comparison to other facilities in the area, entry level is low. The local hospital and nursing homes are paying additional dollars for experience, but the Nursing Care Center is unable to do that. At the Nursing Center RN's are offered $15.50 per hour, LPN's $10.00 per hour, and NA's $8 per hour; the ads for Great Falls offer RN's $20 per hour and LPN's at $15 per hour.

Mr. Anderson went back to his overview of the Nursing Center. The present law issues are: holiday, overtime, and differential pay; authority to spend federal Medicaid revenue on pharmaceuticals; and pharmacy cost inflation.

{Tape : 2; Side : A; Approx. Time Counter : 29.8-25.3}
Going on to the Mental Health Services Bureau, **Mr. Anderson** explained that the Mental Health Services Bureau is responsible for mental health services outside the state institutions. Services are provided both to Medicaid recipients and people in the Mental Health Services Plan (MHSP). The MHSP takes adults who are under 150% of poverty and meet the Department's definition of severe and disabling mental illness. It also takes children and adolescents with incomes under 150% who meet the definition of serious emotional disturbance. A person has to have had a diagnosis of significant mental illness, a level of disability due to the diagnosis, and the disability for some duration in order to qualify.

Medicaid recipients and those in the categories are eligible for this program. The Department picked up the program from the managed care company in 1999, and it has spent the past few years in developing and defining providers, rates, and the eligibility process.

{Tape : 2; Side : A; Approx. Time Counter : 0.3 - 4}
There is a therapeutic foster care service which wraps mental health support services around the child and foster parents. The Bureau redefined this therapeutic foster care program to also deal with the child in the natural home. The Bureau has developed school-based mental health service to provide a variety of services in schools, and it has also worked with the Technical Assistance Coalition (TAC) to develop a long-range plan for improving the mental health services.

{Tape : 2; Side : A; Approx. Time Counter : 4-11.7}
SEN. KEENAN asked **Mr. Anderson** whether First Health and its five regional care coordinators had made progress in the children's

mental health system. **Mr. Anderson** responded that he did believe that it is helping, but since the regional care coordinators had only been in service since November, there is not a lot of data to back this up, yet. The new utilization review is taking a critical look at the recommendations for high-end services, and is weeding out individuals that do not meet the definition of serious mental illness.

SEN. WATERMAN asked if the Department has been getting reports from First Health on issues identified, services needed, or services that they assisted people getting in to. The Department is receiving regular reports and meeting with First Health on a regular basis. **SEN. WATERMAN** suggested that the Department should ask First Health to focus on appropriate services for high-end individuals which would be just as appropriate but less expensive.

Randy Poulsen, Mental Health Services Bureau, explained that not all care coordinators were on board when the program began in November. It is a little early to see the effects. The Department has requested that First Health do retrospective reviews where there are particular instances where there may be reason to question the medical necessity or appropriateness of a service. This will be done by requesting records from the provider and doing a desk review.

{Tape : 2; Side : A; Approx. Time Counter : 11.8}
CHAIRMAN LEWIS summarized that 5 or 6 years ago, the financial burden of these services required the Department to look into a managed care contract. The money "saved" in the managed care contract was used to increase eligibility and expand services. The program never did reduce services or eligibility.

Mr. Poulsen responded that the contract is not managed care, but is a utilization management to ensure that people are being served at the appropriate level. People are aware that there are services, and more people are coming forward for those services. There is an increase in the number of Medicaid people being served, as well. The Medicaid pharmacy program had an increase of 1,000 recipients of psychotropic medications in 1999-2000.

{Tape : 2; Side : A; Approx. Time Counter : 19.7}
Mr. Anderson continued his presentation on the Mental Health Services Bureau. Two other programs that the Mental Health Services bureau administers are PATH and PASSARR. PATH is a federal program to provide outreach to mentally ill homeless people, this money is contracted out to community mental health services. The PASARR Program is a nursing home screening

program to ensure that those with serious mental illness are not admitted to a nursing home.

{Tape : 2; Side : A; Approx. Time Counter : 29.9-40.2}
Mr. Anderson went over upward the cost trends in the Mental Health Services Bureau. The Bureau is serving more people in Medicaid and MHSP than have ever been served in the Montana public mental health system before. In terms of the 2002-2003 budget, the Department would like to calculate for MHSP what it would cost per person and then determine how many people the program could serve.

{Tape : 2; Side : A; Approx. Time Counter : 40.2-48.6}
Ms. Steinbeck went over the LFD Issues. The HJR 35 Committee asked the subcommittee to ensure that CHIP financial eligibility for children was the same as the eligibility for the non-CHIP eligible persons. Another option the Committee could consider would be more federal TANF funds out of FAIM Phase II. Eligibility for some of the children can be maintained by using existing TANF state maintenance of effort for children and backfilling dollar for dollar with TANF funds. The Committee could also establish a separate state program. The HJR 35 Committee wanted to review updated estimates to expand MHS financial eligibility and cost sharing options initiated under the study. Another thing that the Department of Health and Human Services was expected to develop for review of this Committee was a calculation of the average cost of providing mental health services by system component and age of recipient. **Ms. Steinbeck** has not received that information, yet.

{Tape : 3; Side : B; Approx. Time Counter : 2.5-7.5}
Ms. Steinbeck went over other issues that the HJR 35 Committee requested the Department and Committee to address, such as the average cost of a high end user for both children and adults; evaluation of the appropriation request for the state, particularly the estimate of the average daily population.

The HJR 35 Committee had also identified the issue of the ability of local governments for the cost of transporting people who appeared to have a mental illness and were Medicaid eligible to a medical service. **Ms. Steinbeck** attempted to contact HCFA and work this out, but was unable to do so. Finally, the HJR 35 Committee had asked DPHHS to develop a case management model that would direct people to more appropriate services.

{Tape : 3; Side : B; Approx. Time Counter : 7.6}
Ms. Steinbeck went over the issue of state licensure and its effect on Medicare and Medicaid revenue when patients are transferred to outside hospitals for medical treatment. The

state hospital can bill Medicare/Medicaid for patients that receive those services. The estimate was presented to the Committee, but there is an LFD issue regarding the amount of revenue that will be produced. Nursing care centers and state hospital base budgets have a level of Medicaid revenue. Nursing care centers should be able to sustain that given the patient mix and no changes in licensure.

The change in licensure at the state hospital the amount of Medicaid revenue generated is more difficult to anticipate. Medicaid revenue that the state hospital used to receive was due to the care of nursing home certification of one of its wards, and persons who were nursing home eligible over the age of 65 and under the age of 21. Medicaid eligibility was closed for all other persons when they entered the state hospital, but with hospital licensure, the Department can bill for those persons. Questions that the Committee might ask the Department are:

can Medicaid be reinstated for these individuals,
how soon could this be done; and,
what level of Medicaid revenue would be generated?

Further, last session the Department requested statute changes, which were adopted. These changes required Medicaid revenue be deposited in the federal special revenue account and allowed the Legislature to budget that revenue for support of state institutions. After all revenues the hospital collects are put into a debt service account and debt service is satisfied, the Legislature can appropriate Medicaid revenue in excess of that debt service to support state institutions. The Committee could also amend statute to choose to do this with Medicare. The Committee could consider linking the generation of Medicare and Medicaid revenue to directly supporting the state institution budget. This would take the revenue out of the general fund and may provide an incentive for facility staff to understand that when they bill Medicaid and Medicare they get the benefit.

CHAIRMAN LEWIS commented that an unintended consequence of such a proposal could be a reluctance to release patients.

{Tape : 3; Side : B; Approx. Time Counter : 8.5-16.3}
SEN. WATERMAN asked for clarification on where collections from insurance companies, private pay, and counties for people at the state hospital go. **Ms. Steinbeck** stated that the money first goes into the debt service and that revenues in excess of the debt service are deposited to general fund.

There was discussion regarding the bar that is at the entrance to the state hospital grounds and problems with patients getting liquor there and going back to the facility with it. The bar is

on property that is leased from the state. **Mr. Amberg** did write to the proprietor regarding his lease and the agreement that he had entered into with the state. If it happens again, **Mr. Amberg** does intend to report the proprietor so that his license will be taken away.

ADJOURNMENT

Adjournment: 12:00 P.M.

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REP. DAVE LEWIS, Chairman

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SYDNEY TABER, Secretary

DL/ST

EXHIBIT(jhh13aad)