**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 18, 2001 at 8:00 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. Mignon Waterman (D)

**Members Excused:** Sen. Bob Keenan (R)

**Members Absent:** None.

**Staff Present:** Robert V. Andersen, OBPP
Pat Gervais, Legislative Branch
Lois Steinbeck, Legislative Branch
Sydney Taber, Committee Secretary
Connie Welsh, OBPP

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

**Committee Business Summary:**

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| Hearing(s) & Date(s) Posted: | Technical Assistance Collaborative Report - Mental Health Recommendations; HJR 35 Requests |
| Executive Action: | None. |

***{Tape : 1; Side : A; Approx. Time Counter : 3.5 - 13.8}***
**Lois Steinbeck, Legislative Fiscal Division (LFD),** reviewed information on the Department's mental health program: a calculation of the number of members per month that they anticipate in the 2002-2003 budget and the average estimated cost per member per month. She would also like the information for the supplemental request. The information that she already has starts with the FY00 expenditures and makes incremental changes. She and the Department will work with the changes so that when

the Committee looks at the mental health budget, it will be able to tell how many individuals are expected to receive services. **Dan Anderson, Administrator of Addictive and Mental Disorders Division** (AMDD), responded that the Division had provided a draft projection of what it expects membership to be in 2002 and 2003 and will also provide additional background information.

**Ms. Steinbeck** said that she does not have any information that states the number of eligible individuals and the average eligible costs. There are questions concerning this since the $1 million savings in FY01 from eliminating children's services could be half of what is listed or greater than listed. She would like to see the assumptions made about the children's costs since she is unsure of the methodology used to project costs. There is additional data that Bob Mullen has broken out as she needs it that he will get to her. If she does not have the information by Friday, she will not be ready to support the Committee during its executive action on Mental Health.

**Mr. Anderson** said that he and his staff are preparing the information for **Ms. Steinbeck.** There was further discussion on this issue.

***{Tape : 1; Side : A; Approx. Time Counter : 13.8 - 17.8}***
**Randy Poulsen, Mental Health Services Bureau Chief,** explained that SB 534 in the last session required that the Department contract with a consultant to help design a managed care program. The Technical Assistance Collaborative (TAC) was chosen to conduct an independent review of the state's mental health system, recommend outcome and performance indicators for the future, and recommend system changes and improvements. He went over the credentials of TAC and the selection process used.

***{Tape : 1; Side : A; Approx. Time Counter : 17.8 - 28.1}***
**Steven Day, Executive Director of TAC,** distributed a presentation on the summary of findings **EXHIBIT(jhh14a01).** He went over the state's managed care system, which he said was a good plan, but was poorly implemented. There were good ideas about how the system should work, how the quality of the system should be measured, and how outcomes should be defined. The failure of the system does not mean that these ideas were not right. The state understood that it did not have the capacity to manage such a system so it hired Magellan to do this, and when that contract ended, the capacity to manage was gone.

***{Tape : 1; Side : A; Approx. Time Counter : 28.1 - 39.4}***
**REP. JAYNE** asked for an example of the excellent elements that were poorly implemented. **Mr. Day** replied that Magellan began losing money immediately and tried to cut rates to providers to

make up the shortfall. This caused providers to cut back services to people. When the managed care plan ended, many new people, who had been prevented from receiving services under managed care, entered the system.

**SEN. WATERMAN** added that Magellan had assured the Department that it could develop community-based services that the state did not have to move people from high end services. Magellan did not do the day to day things such as bill paying and data production that it was assumed a national corporation would know how to do.

**Mr. Day** said that one reason that Magellan did not pay bills is that it did not have the money. It had a bad computer system and a bad bill paying system, but it just did not have the money. After the end of that managed care contract, the mental health system was still losing money because there was so much demand from those truly needing services. Some of the alternative community services that would have prevented the higher cost services were never developed. TAC recommends that the state now try to develop some of those services.

In further elaboration, **Mr. Anderson** said the biggest obvious disaster was an inability of the managed care company to pay providers in a timely fashion. This led to providers not being willing to be part of the system and refusing to offer services. **Ms. Steinbeck** stated that officials from Office of Public Instruction (OPI) testified that they would need another $325,000 to $375,000 to backfill services provided by the managed care corporation in the 1999 session. While there may have been some areas that benefitted from the managed care system, that was not the total experience.

***{Tape : 1; Side : A; Approx. Time Counter : 39.4 - 45.6}***
**Mr. Day** reviewed the process TAC had used to arrive at its conclusions. In reviewing Medicaid and Mental Health Service Plan (MHSP) data from July of 1999 to July of 2000, there was slow growth in Medicaid and almost no growth in enrollment in the MHSP. At the end of managed care, the number of Medicaid enrollees that accessed services grew by 30%. The proportion of people on MHSP that accessed services grew by over 22%.

***{Tape : 1; Side : B; Approx. Time Counter : 0.3 - 7.1}***
**Mr. Day** went over Montana State Hospital's (MSH) planned capacity, census, and admissions. The hospital has long lengths of stay, indicating a lack of accountability. One TAC recommendation focuses on creating the responsibility, so that when individuals go into the hospital someone is responsible for a discharge plan, and the patient is released as soon as possible. The average length of stay at MSH is 60 days. If that

were reduced to the typical average in other states of 30 days, there would be no census problems in the state hospital.

**SEN. COBB** asked for examples of how other states handle this. **Mr. Day** explained that in most states, there is someone in the community responsible for keeping people out of the hospital. If a person does go into the hospital, that responsible party must get that individual out as soon as possible. Montana does have some of the services, but it does not have someone with the assigned responsibility. Another factor is that in most states the local entity responsible for getting the person out of the hospital has some financial incentives in the decision. If too many bed days are used, it has to pay for the hospital bed days or financial penalties are applied. For example, in Ohio, the county mental health boards all are allowed to use a certain number of days of state hospital beds. If they use more than those days, they must pay for them. If they use less than the days, they keep the money and reinvest that money in community-based services.

**SEN. COBB** asked how those states deal with commitments. **Mr. Day** replied that all states have commitment standards and for the most part people who go to the state hospital are civilly committed as in Montana. As soon as someone is clinically ready to leave the hospital, the state has the commitment order vacated. Often 10 or 20 days into the commitment, the states will have that involuntary commitment changed into a voluntary commitment so that when someone is ready to leave they do not have to go back to court to change the civil commitment. This can be done in Montana as well.

**Mr. Anderson** said that the state hospital has the authority to discharge an involuntary patient whenever he is clinically ready.

***{Tape : 1; Side : B; Approx. Time Counter : 7.1 - 46}***
**SEN. COBB** asked if other states have a mechanism, which uses the private sector before the public. **Mr. Day** answered that most states do use the private sector services before admission into the state facility. Montana has this as well, the problem here is that many of the private facilities are considering closing the capacity for mental health inpatient treatment. Most people who are admitted into local general hospital psychiatric units stay for four to seven days and go back into the community, so there is continuity of care, housing, support, and case management services. This is a more effective model of treatment than sending someone several hundred miles away to a fairly isolated facility removed from family and support.

**REP. JAYNE** commented that her experience in Missoula has been that a person either voluntarily or involuntarily will go to the ward there, and if the doctors do not want to deal with that individual they send him to Warm Springs. **Mr. Day** said that there is nothing to prevent a private psychiatrist or doctor in a general hospital to send someone to the state hospital since there is no clinical or financial responsibility to keep people in the community.

**Mr. Day** reviewed the areas that are important for the state to measure the way the system is working. Access to service; the appropriateness of care; administration ; cost for value; and consumer outcomes are the things that should be measured. This information is critical to the decision making process involved in mental health spending.

**Mr. Day** proceeded with the TAC findings. There is a lack of: consistent service philosophy, which would hold the system together; services; a single point of accountability; and consumer involvement in the system. Since the end of managed care, the Department and providers have worked quickly to correct the problems that were in the system. From the point of view of consumers and providers, the changes have been positive. Cooperation and communication between the Division, service providers, families, and consumers has been much improved. The next step in this would be to put some boundaries on the system, manage it properly, and develop new services.

The report makes the point that the state needs new resources in the system and a redirection of resources. **SEN. COBB** asked how resources could be redirected. **Mr. Day** responded that if the state brought some of those high end children home and provided services locally for them, then the money saved from that could be used to develop more community-based alternatives for children. Also, if the length of stay at the state hospital were reduced then instead of spending more money to provide more staff at the state hospital that money could be used to create vocational resources for adults in the community. These are reinvestment strategies. There are places in the system where the state uses way too much of its scarce resources to provide a small number of very high end services. It would be beneficial to reduce the number of resources going to very high end services and spread the resources out more evenly around the state into mid- and low-range services designed to prevent people from being hospitalized or sent out of families. This would encourage the recovery process and family stabilization.

**SEN. COBB** asked if other states have the same ratio of children in services or have they done a better job of keeping that ratio

down, and how can we get that ratio down. **Mr. Day** replied that there is an 80-20 rule in the public health system, which is the rule that in general 80% of resources serve 20% of the people. Montana exceeds that with the children's services: less than 10% of the children using services use over 60% of available children's resources. Most states have identified the high end children and try to wrap services around those individuals to keep them in the family and school and to do what is necessary to prevent them from going into the hospital or residential placement. Those programs have been very successful.

**SEN. COBB** asked what the goal should be. **Mr. Day** suggested that the state should try to have less than 15% of the total resources in the service system going for in-patient hospital care and other alternatives for in-patient hospital care. Right now, the state is spending close to 75% of the total resources of the system on either hospital or out-of-home facility-based services. This should be flipped so that only 15% or 20% of resources go to those services and the rest go to community-based services. **SEN. COBB** asked how long it would take to do this if the management structure were there. **Mr. Day** responded that with the right clinical structures and financial incentives in place, it takes about three to five years. However, some quick action could be done in one or two years that would have big payoff. **SEN. WATERMAN** interjected with an example from the state of Kansas which used a system of care involving wrap around services at the community level which reduced the use of bed days by 400% in a fairly short period of time.

**Mr. Day** gave an example from the Positive Assertive Community Treatment (PACT) model of services, which is a wrap around service model for adults. The demonstration has been operating for only about a year, and in that time, the amount of money spent at Montana State Hospital per month has gone from $200,000 for the group receiving these services down to $0. That is the sort of thing that can be done quickly, when services are wrapped around people.

**SEN. COBB** asked for an example of a state with good clinical and incentive structure for providers. **Mr. Day** stated that the best that he has seen for kids is Wrap Around Milwaukee, which is a program that has been operational for six or seven years and serves about 1,200 children. It has been extremely successful in reducing hospitalization for children and keeping them in the home. Ohio has been doing this for a long time on the adult side for adults with mental illness and chemical dependency issues. The state of Ohio puts the risk at the county level, and counties receive financial rewards if they keep hospital utilization low, and pay if it goes up. Michigan also has county authorities,

which are responsible for mental health and developmental disabilities and are at full risk for all services: Medicaid, non-Medicaid, mental health, and developmental disabilities. The counties must pay whatever it costs if people are in state hospitals or other kinds of residential placements, and they receive an absolute 100% reward if they use those resources more effectively.

**SEN. COBB** asked how far the state hospital should be reduced. **Mr. Day** replied if everything were running as it should in Montana, given the population size, the hospital should run around 120 to 140 beds. This would depend on maintaining the capacity in general hospitals to do psychiatric care locally. Without the general hospital capacity, the state will need to create capacity or increase the state hospital capacity.

***{Tape : 2; Side : A; Approx. Time Counter : 0.4}***
**Mr. Day** continued that hospitals in the private sector like a good payer mix, which is Medicare and private insurance. Medicare and private insurance have all gone to managed care approaches or other service limitations, so these are no longer such a good source of payment as they once were. The services in general hospitals are so valuable, that if it takes a little more money to pay those hospitals to keep doing the care, it is worth it. It is much more cost effective to pay a general hospital to provide services for four to seven days to get people back in the community, than it does to send someone to the state hospital for 30 to 60 days.

**SEN. COBB** asked if AMDD had enough people in the management and infrastructure to do the work they need to do. **Mr. Day** said that TAC believes that AMDD does need more resources. It needs staffing to expend effort on state and regional planning, quality assurance and improvement activities, and data management and analysis. **SEN. COBB** asked if TAC had given a staffing recommendation. **Mr. Day** said that they had indicated specific types of positions and a sequencing over a three-year period. **SEN. COBB** asked if there isn't the infrastructure how can they do any of this other than piecemeal? **Mr. Day** said the Division has been doing crisis management for some time and is stretched very thin, but that it does have the capacity to start working with regional planning. It could look at state standards for a regional structures and what kind of criteria should be used in their establishment. **Mr. Day** said that moving to the regional structure will give AMDD the tools it needs to deal with the daily operation of Warm Springs and to organize high end services around high end children.

**SEN. WATERMAN** said that the utilization management contract with First Health is a start. There are five case managers that they have hired around the state who will work to develop services to bring individuals, who are presently in residential or out-of-state services, back to the community. **SEN. WATERMAN** suggests that if the Department sets up a structure to pull together the people from the different agencies to focus on these individuals, that over the period of a couple of years, with the assistance of providers, a regional team will slowly develop. It would take several years to get there, but it is necessary to get on top of the high end costs and develop a regional system. **SEN. COBB** and **SEN. WATERMAN** want to know how many staff the Department would need to implement the proposed staffing additions in the report. **SEN. COBB's** concern is that without staff none of the rest will get done.

***{Tape : 2; Side : A; Approx. Time Counter : 16.7 - 27.1}***
**SEN. COBB** asked if **Mr. Day** had any specific recommendations on the provider rates. **Mr. Day** said that they did not look at the overall rate structure of each service type specifically, but did have recommendations for increasing some of the rates and decreasing rates. For example, the fee for service system does not allow for incentives since there are no risk or performance payments. Where the rate is set is an incentive for providers, however, and right now, the state pays providers a fairly good rate for partial hospitalization for children, a frequently used service. If there were alternatives, in terms of wrap around services, then those services would not be necessary and there would be a big savings to the state. Most states provide minimal or no partial hospitalization, since it is not cost effective.

Conversely, there are a number of community support services under the Medicaid rehabilitation option, for which the state pays such low rates, that most providers will not provide them. Those are the services geared to helping adults maintain independent lives in the community, which are linked with affordable housing and vocational services. This is a way of linking and pooling resources for people as well as for providing supports in the community. TAC suggests increasing this rate so that there is an incentive for providers.

**SEN. COBB** asked **Ms. Steinbeck** and the Department to get the information on what rates are too low and too high for the Committee. **SEN. WATERMAN** stated that some of those rates are set by rule within the Department, and she thinks that the Department does need flexibility. She suggested that **SEN. COBB** create language that says that they will provide rates that encourage service for the low-end community-based service. **SEN. WATERMAN**

does not want the Committee to get into setting rates in statute.

**Ms. Steinbeck** suggested that the Committee could condition rate increases to be expended in a certain way, allowing the Department the flexibility to not provide the same rate of increase to all providers. It could also approve provider rate increases or attach a rate increase as a condition of the regular appropriation.

***{Tape : 2; Side : A; Approx. Time Counter : 27.1 - 47 }***
**Mr. Day** continued with his presentation discussing regional structures as a means of managing service access and care coordination for people on a regional basis. He suggested that the regional structures be made up of providers, consumers, families, and other resources in the regions. The local regional group may decide that it would like to contract with some other entity to do some or all of the work, but there should be a local group that has the responsibility and authority to take charge of the regional service and to make recommendations on how that service system is managed within state guidelines.

There are good reasons to move to a regional structure. Statewide systems have problems because they do not consider local variations, needs, and control issues, nor do they involve providers in a partnership way. In Montana, the statewide managed care contracts started out in partnership with providers, but this ended when the managed care provider found it didn't have the money. A statewide system becomes a bureaucratic system, which has the incentive to say no to services.

TAC believes that the regional system provides the opportunity to get providers to buy-in to responsibility for the system as a group. It is a way to: get good consumer, family, and other stakeholder in-put at the local level; create structures that are based on local people's needs and choices; and encourages people to buy-in to a single system of care. The regional structures will have the authority to keep and get people out of the hospital and to wrap services around people.

Regional structures have the potential to become the mechanism to manage the total system and take financial responsibility for systems. They are an alternative to a statewide managed care contract. Because the current system is fee for service, there are no boundaries in the mental health budget. The state needs to establish boundaries for the mental health budget. Decision makers want there to be predictability in the system, and currently with fee for service, there is no predictability. Since providers are given 365 days under Medicaid in which to get their bills in, the state may not know for a year how much it has

expended. Other states encourage providers to get their bills in sooner with bonuses and contract requirements.

***{Tape : 2; Side : B; Approx. Time Counter : 2.5 - 12.9}***
TAC envisioned planning advisory councils which would develop regional structures by putting together a plan under state guidelines. The structure would have to meet certain criteria in terms of membership, governance, consumer and family participation, and capacity to assure a defined core of services. Once that plan is accepted by the state the regional entity can be formed. Development of the regional structures could happen one region at a time, although the standards should be in place and applied uniformly statewide. It will probably take three years for the regional structures to be up and running to the point where they are capable of managing a system of care. In the long term, the regional structures could share risk. This would mean going for another Medicaid waiver that would allow the right flexibility in the regional structures.

He went into further detail regarding the function of the regional structures. TAC considers this the best plan for Montana given its needs, resources and way of doing business.

***{Tape : 2; Side : B; Approx. Time Counter : 12.9 - 14.6}***
**SEN. WATERMAN** commented that the Mental Health Oversight Advisory Council (MHOAC) voted to move toward a regional system in its last meeting and to work with the Department in three areas to implement recommendations in the TAC report. It will work to move toward a regional structure by defining core services that should be available throughout the state, establishing performance measures and outcome requirements.

***{Tape : 2; Side : B; Approx. Time Counter : 14.6 - 38.}***
**SEN. COBB** asked if there was anything that the Council did not like about the report and **SEN. WATERMAN** said that she is unaware of any disagreements with the report.

**SEN. COBB** said that there is another division that takes care of children and foster care and sometimes they need mental health and substance abuse money, but AMDD has the money. He asked **Mr. Day** if the regional plan would wipe out the divisions or did they look at the divisions to see if they work together. **Mr. Day** replied that TAC did recommend that AMDD work at the state level to do many of the things talked about at the regional level, including working with youth services, juvenile justice, state level educational and vocational services and housing services to provide leadership for coordination and pooling of resources.

**SEN. COBB** said that coordination is fine, but it's a matter of responsibility. If you go to the regional plan, who is responsible for the children, would it be Child and Family Services or would that division be left out and transferring money to mental health all the time? **Mr. Day** responded that there is nothing in the nature of the regional structure that would change the nature of how people access resources for children receiving services in multiple departments; it is intended to strengthen that and provide a better mechanism.

The regional structures will require some infrastructure, but there is already a lot of infrastructure out there. There are many smaller provider agencies who can begin to share in the cost of making their infrastructure more efficient. In discussion of infrastructure, there should be certain key elements, but the state does not need to invest in a lot of new resources.

**Mr. Day** summarized the steps that need to be taken within this next year in order to begin implementation of the regional system: development of regional planning advisory councils; setting standards and criteria for regional structures; definition of core services; and improvement of the state information system infrastructure. He reviewed the steps that should be taken after the initial implementation in about two years: increased consumer and family role; definition of levels of care and eligibility; addition of youth and adult services beginning with core services; continued improvement of state and local infrastructure; expansion of utilization management; and implementation of resource management plans. Steps that should be taken in probably three years are: full implementation of the quality management and quality improvement process; movement toward incentive-based financing; system-wide needs assessment; additional resources for additional services; and comprehensive data systems.

**SEN. WATERMAN** asked if having a system that gives overall performance incentives to all providers is a better plan for Montana regional centers. **Mr. Day** said that with a regional system there need to be incentives and rewards for cooperation and some incentives for uniform performance across the system. It is good to have friendly competition between the regions in mental health, but it is also a good idea to reward everyone for doing a good job, since the systems are interdependent.

***{Tape : 2; Side : B; Approx. Time Counter : 38.3 - 51.4}***
**Mr. Day** continued his presentation. The assumption is that each regional structure will be a single point of accountability. Some things will be done uniformly for all consumers, but much of what they need to do will be specific and targeted for other

populations in the regional structure. The services will tailored to the needs and choices of individuals within the population, but under the umbrella of the regional structure. The MHOAC is a positive force that is focused on advice and advocacy and has worked well as an independent advisor to AMDD and is a model of how advocacy groups can work in transforming the system to a regional system.

**CHAIRMAN LEWIS** asked where the line of responsibility should be drawn in regard to MHOAC since if there is no accountability without specific authority.

***{Tape : 3; Side : A; Approx. Time Counter : 0.4 - 50}***
**Mr. Day** said that it is important for the MHOAC to remain an independent entity so that it can challenge and critique, but it does not mean that it must be without a place in the administrative structure of government. Most states have advisory councils since it is a federal requirement that there be oversight of mental health, and in most states the council is part of the mental health division.

**SEN. WATERMAN** commented on the advisory council, its make up, and where it is placed regarding responsibility. She suggested that when the regional system is implemented there may be regional advisory councils, but that there will need to be strong ties between the state and those councils. **Mr. Day** remarked that the recommendations around the Oversight Advisory Council and the Division is that ultimately they need to have the same priorities and work toward the same goals.

**CHAIRMAN LEWIS** reiterated his concerns over accountability and ensuring that the governor, director and division administrator are completely accountable for results.

**Mr. Day** reviewed the TAC recommendations for the necessary conditions to implement the changes in the system, stabilization of the current system, and needed legislative action.

***{Tape : 3; Side : B; Approx. Time Counter : 0.4 - 13.3}***
A willingness to act is the key to the everything in this system change. The worst thing that the state can do is leave the system as it is now. The process of change needs to continue in a forward move with providers being part of the solution. There needs to be enthusiasm for the change which arises through concentrating the focus on family and community involvement in the system. It takes political will at all levels to change the system.

***{Tape : 3; Side : B; Approx. Time Counter : 13.3 - 19}***

**CHAIRMAN LEWIS** asked how risk sharing and rewards are built into this system. **Mr. Day** responded that he is a proponent of risk sharing. Once the regional structures are running to a point where they are capable of accepting some risk, it is a good thing to do, since it is a powerful motivator. Some states use both risk and incentive payments, but TAC recommends sharing risk rather than expecting a provider to hold full risk since full risk requires that providers reinsure themselves. It is much less costly for a provider to reinsure when it accepts a shared risk, and the state could provide some of the reinsurance. Second, if regional systems do well and are efficient, they get money to use in their service systems. Sharing risk allows the state to also receive some of that money for reinvestment.

**CHAIRMAN LEWIS** asked if there were samples of risk sharing contracts. **Mr. Day** responded that he will send the Committee a copy of such a contract.

***{Tape : 3; Side : B; Approx. Time Counter : 19 - 35.2}***
**Ms. Steinbeck** commented that even if the Department proceeds expeditiously, it will be three years before there will be one regional entity up and running. Given the current cost overruns and the potential for more because of the nature of the system, she asked **Mr. Day** for some recommendations on cost controls that do not divert a lot of staff resources and that would move toward a regional plan. **Mr. Day** suggested access be tied to clinical and acuity criteria; high user children and the Montana State Hospital strategies can be identified; core services can be defined; and school services rates can be unbundled.

There are things that can be done to make service delivery more logical and clinically appropriate and also ensure control costs. In a fee for service environment, maximum of obligation contracts can be used and allow providers to provide a certain number of units and bill for them at a fixed amount. In Medicaid this cannot be done without a waiver. In the short term, the Department may need to look at some of the controls on some of the routine outpatient treatments, too. In terms of the longer term plan, if there are plans that work well now, when the regional structures are in place there is no reason that some of these cannot be incorporated into the regional system.

**Ms. Steinbeck** mentioned that at some point there will need to be capitation under the fee for service. The Legislature may wish to direct the Department to maximize any type of intergovernmental transfer program that could be undertaken now, because it may not be possible to leverage it in to a shared risk or capitation rate under the regional system. **Mr. Day** commented that at this time the state is in a good place to do these

calculations for the waiver. The growth rate for mental health is trended forward for several years, which is the federal upper payment level.

***{Tape : 3; Side : B; Approx. Time Counter : 35.2 - 47}***
There was discussion with **Susan Fox, Legislative Services Research Analyst,** over legislation she is drafting for this system. She questioned use of some language and asked for input and collaboration in drafting a bill that does not hamper the eventual development of the regional system.

***{Tape : 4; Side : A; Approx. Time Counter : 0.3 - 20.2}***
**Mr. Anderson** referred to information distributed to Committee members **EXHIBIT(jhh14a02)** and went over the method used to determine cost per recipient of the various services offered in Mental Health Services in relation to HJR 35. He reviewed an interagency collaborative effort that the Division is making to determine the proportions of high cost children and moderate cost children that are involved in services from other agencies. He reviewed the use of federal funds to help local communities provide transportation to medical facilities when individuals are in psychiatric crisis. HCFA recommends that this be considered an administrative cost for which there would be a 50% federal match. One of the issues would be that presumably the local community would pay the state match, and there would be an intergovernmental transfer to cover the state portion. **Mr. Anderson** reviewed the final HJR 35 item, a case management model involving the level of training, method of intervention, case management providers, scope, payment, financial risk, service authorization responsibility, and consumer choice.

***{Tape : 4; Side : A; Approx. Time Counter : 20.2 - 22.4}***
**Ms. Steinbeck** commented on the case management model. The Committee was looking for a recommendation on a method of providing services differently than is currently done. There was a belief that case management would gear people to the correct services, which would prevent further cost overruns, and there were also concerns that intensive case management needs should be looked to serve the higher cost clients.

***{Tape : 4; Side : A; Approx. Time Counter : 23.5 - 46.1}***
**Ms. Steinbeck** went over the issue of Medicaid reimbursements at MSH and outside of MSH and whether they should be left in general fund as revenue or whether they should be budgeted for support of the institutions. She reviewed the estimate of the average daily population for which the Committee must budget and suggested that there may be an additional $43,000 in state alcohol tax that this Committee could use.

**Ms. Steinbeck** summarized issues that she will evaluate and update for the Committee regarding present law adjustments, funding shifts, maintenance of effort, the level of pharmacy inflation, and staffing levels.

**Ms. Steinbeck** reviewed the Auditor's finding of the accounting practice of abating expenditures. The Division must add the cost of the expenses that were covered by the drug rebates from participating pharmacies into the budget and put the money in the general fund or a state special revenue account, and the Executive chose to put it in a state special revenue account. **Ms. Steinbeck** went over the statutes governing special revenue accounts and notes that LFD does not believe that this should be used as state special revenue.

***{Tape : 4; Side : B; Approx. Time Counter : 0.2 - 8.7}***
**Ms. Steinbeck** referred the Committee to a summary on Medicaid waivers and discussion of available grants in the budget analysis. She also mentioned that the estimate of total expenditures in FY00 state funding for persons who would have been Medicaid eligible was $430,000. The Medicaid match that is budgeted in FY03 is $1.5 million and the Division would reach "crowd out" some time in FY02.

**Mr. Anderson** commented that he had handed out a chart showing the total funding for community chemical dependency treatment based on refinancing and using Medicaid, and then showing what it would be without Medicaid. The Department would be able to serve significantly more people by refinancing with Medicaid.

**Ms. Steinbeck** explained that the staff issue regarding refinance is that the system impacts are neutral to people who are not Medicaid eligible if the amount of state funds diverted from the system does not exceed what would have been paid to refinance services for the dually Medicaid eligible people. The client service mix changes with the chemical dependency refinance, and while it does put more money into the system, the average cost per client goes from $1,300 to $7,000 over three years. She does not think that this means that people are receiving more services, but that the services people receive are more intensive.

**REP. JAYNE** asked for a Department reaction to the TAC report.

A letter regarding the Montana State Hospital campus was submitted **EXHIBIT(jhh14a03).**

**ADJOURNMENT**

Adjournment: 12:00 P.M.

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REP. DAVE LEWIS, Chairman

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SYDNEY TABER, Secretary

DL/ST

**EXHIBIT(jhh14aad)**