MINUTES

MONTANA HOUSE OF REPRESENTATIVES
58th LEGISLATURE - REGULAR SESSION

JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH & HUMAN SERVICES

Call to Order: By **CHAIRMAN EDITH CLARK**, on January 10, 2003 at 8 A.M., in Room 472 Capitol.

ROLL CALL

Members Present:
Rep. Edith Clark, Chairman (R)
Sen. John Cobb, Vice Chairman (R)
Rep. Dick Haines (R)
Rep. Joey Jayne (D)
Sen. Emily Stonington (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

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed. The time stamp refers to material below it.

Committee Business Summary:
Hearing(s) & Date(s) Posted: AMDD Overview

Executive Action: Motion to Return $44 Million to DPHHS Budget

Motion to Allow Proxy Voting in Accordance with Rules

EXECUTIVE ACTION

{Tape: 1; Side: A; Approx. Time Counter: 0.8 - 8.8}
CHAIRMAN CLARK called a brief executive session.

Motion: SEN. STONINGTON moved TO NOT ALLOW ABSENTEE OR PROXY VOTING IN THIS SUBCOMMITTEE.

SEN. COBB provided members with a copy of his substitute motion.

EXHIBIT(jhh05a01)

Substitute Motion/Vote: SEN. COBB made a substitute motion that THE DPHHS BASE BUDGET BE INCREASED BY $24,585,665 GENERAL FUND IN FY04 AND BY $24,798,263 IN FY05. Substitute motion carried 3-2 with REP. CLARK and REP. HAINES voting no. No proxy was voted for SEN. KEENAN.

CHAIRMAN CLARK and **REP. HAINES** objected to the way the vote was done. **SEN. COBB** said that it was clear that it could be done this way, and the budget is now back to where it was on Monday morning. **CHAIRMAN CLARK** said that they do not have the money. **SEN. COBB** said that it did not matter, the motion has been made; if they have to make cuts, it will take a majority. He will make cuts and others will make cuts; if they want to do it the correct way, they will do it that way. **REP. HAINES** expressed resentment over the motion and **SEN. COBB** overruling the chair. He said that the substitute motion was totally unrelated to the original motion, and he objected on both counts. **SEN. COBB** replied that he can make a substitute motion, and one of the purposes for doing this was the process. They have done the motion, there was no motion to adjourn or recess. He suggested that they could get a ruling on this, but as of now, they have done this. **CHAIRMAN CLARK** that she would get a ruling from the Rules Committee and repeated that she did not agree with his unanticipated move.

Motion: SEN. COBB moved that PROXY VOTES BE ALLOWED IN ACCORDANCE WITH THE RULES.

Discussion:

CHAIRMAN CLARK said that she is allowed to vote **SEN. KEENAN's** proxy. **SEN. COBB** said that until a motion is made, no proxies are allowed. This has all been done in accordance with the rules. In further discussion over the rules on voting by proxy and who can call a vote, **SEN. STONINGTON** requested that **CHAIRMAN CLARK** call Greg Petesch, Director of Legal Services, Legal Council, in for a legal ruling. **SEN. COBB** withdrew his motion to allow proxy votes until a ruling had been made.

HEARING ON OVERVIEW OF MENTAL HEALTH PORTION OF AMDD

{Tape: 1; Side: A; Approx. Time Counter: 11.5 - 24.6}
Dan Anderson, Administrator of Addictive and Mental Disorders Division (AMDD), provided the Subcommittee with several handouts (Exhibits 2 and 3). Referring to Exhibit 2, **Mr. Anderson** began his overview of the Mental Health Program component of AMDD with a review of the organization and its purpose, introduced bureau chiefs, and touched on the principles established by the Mental Health Oversight and Advisory Council.

EXHIBIT(jhh05a02)
EXHIBIT(jhh05a03)

Medicaid and NonMedicaid Mental Health

{Tape: 1; Side: A; Approx. Time Counter: 25.1 - 35.6}
Mr. Anderson reviewed some history of expenditures on institutional care and community service programs for mental health. He then went over program requests separated out into nonMedicaid, Medicaid, and State Facilities, and expressed the belief that the reduction in need for nonfederal money is due to better use of federal money to meet program needs. He highlighted some points of the Mental Health Program, reviewing the numbers served and money spent. **Mr. Anderson** then addressed the issue of the Mental Health Medicaid Program and gave examples of the substantial cost increases within the program. AMDD has spent significant time on efforts to control costs rather than on development of new programs.

{Tape: 1; Side: A; Approx. Time Counter: 35.6 - 49}
{Tape: 1; Side: B; Approx. Time Counter: 1 - 14.5}
In referencing the cost-cutting measures, **Mr. Anderson** stated that the major issue is maintaining a good level of service while at the same time avoiding cost shift to other services. There are always cost shifts, but the challenge is to minimize the damage. The Mental Health Program (MHP)has been working with the 25 mental health care provider organizations to minimize cost shifting. Since Medicaid is an entitlement, services cannot be denied, but there are efficiencies that can be utilized to reduce costs. AMDD has developed refinancing plans which will use county and school district money to fund mental health services.

Mr. Anderson then reviewed the growth in the adult Medicaid program. There has been an increase in the disability of people in the program so costs have grown as well. Addressing the issue of high cost children, **Mr. Anderson** went over the expenditures and the ways by which reductions may be made in this area, emphasizing that it needs to be a cross-agency effort. He highlighted the services that go to disturbed children who are most in need of out-of-home placement.

Mr. Anderson then gave a brief overview of the evolution of the nonMedicaid Mental Health Services Plan (MHSP), its purpose, and funding. After the creation of the Department of Public Health and Human Services in 1990's, there was also creation of the Mental Health Access Plan managed care program. He reviewed the creation of the managed care program for those with serious mental illness or emotional disturbance and its purpose. It was similar to an entitlement, and the managed care company was told that it must provide service for a set amount of money. A pharmacy benefit was added so that a nonMedicaid client could get pharmaceuticals paid for by the program. The managed care program ended in 1999, and AMDD attempted to continue the nonMedicaid program, but it has experienced significant cost increases and insufficient funds to continue it. It is a longstanding program serving a very needy group. The people in this program have a family income below 150 percent of the federal poverty level.

{Tape: 1; Side: B; Approx. Time Counter: 14.5 - 27.2}
Mr. Anderson emphasized that the changes that they will be making to this program are painful, not only to the recipients of those services, but also to those who have developed and worked with the program over the years. He reviewed the changes that they have made in the program which have been part of the budget-cutting process (page 26 of Exhibit 2): 1)elimination of MHSP coverage for children covered by CHIP; 2)development of service contracts with five mental health centers; and 3)limitation to $250 per month pharmacy benefits. The funding for the program includes the federal Mental Health Block Grant, which is about $1.2 million. With most federal programs, states must have a maintenance of effort(MOE)in order to continue to receive block grant funding. With some of the reductions in spending that they have had and are anticipating, they are in danger of losing the block grant for fiscal year (FY) 2004.

Mr. Anderson touched on Projects for Assistance in Transition from Homelessness (PATH), the homeless mentally ill block grant, which is $100,000 state funding and $300,000 federal money. AMDD contracts with four community mental health centers (CMHC) to do outreach to the homeless mentally ill. Preadmission Screening and Annual Resident Review (PASARR) is the screening process for nursing homes. An individual must meet the level of care requirement for a nursing home and need active treatment for mental illness for this program.

{Tape: 1; Side: B; Approx. Time Counter: 25.5 - 33.6}
The budget issues involved in this program are a substantial reduction to MHSP, a restructure proposal, and requests for federal authority for federal block grants. **SEN. STONINGTON** asked **Mr. Anderson** for the total dollar amount in MHSP, and he replied that in FY02, they spent $11.6 million. **Ms. Steinbeck**

added that the program is supposed to receive $3.2 million general fund in the current executive proposal for an $8 million per year general fund reduction. This single change accounts for almost half of the general fund reductions in the Executive Budget.

Mr. Anderson then reviewed graphs (Exhibit 2) which show the month-to-month expenditures and numbers of recipients over the past three years in the youth program. The graphs reflect the reductions in services for children under MHSP over the past three years. In fiscal year(FY)2000 they served as many as 800 children per month, and in FY02 only 200 per month. There has already been a great reduction in the services for youth. For adults, there was dramatic growth in FY00, and for the past two years, they have maintained relatively constant growth. **Ms. Steinbeck** commented that what the State spends in MHSP children's services is funded and included in the Temporary Assistance for Needy Families (TANF) MOE. Should the Subcommittee wish to discontinue all of this spending, it would need to continue it somewhere else because it double counts as TANF MOE for about $672,000 per year.

{Tape: 1; Side: B; Approx. Time Counter: 33.6 - 37.7}
Mr. Anderson said that they have taken the CHIP children out of the MHSP program. They are proposing to expend about $670,000 per year over the coming biennium to serve nonMedicaid and nonCHIP children who have a serious emotional disturbance and are 150 percent below the poverty level. They are expecting that they will be able to serve about 150 children.

Mr. Anderson next reviewed the dramatic changes in the pharmacy figures. Over the last three years, the number of people using the MHSP pharmacy program each year has gone from 3,300 in 2000 to 2,900 in 2002. The reduction in the MHSP pharmacy program has resulted in an increased cost of $1 million per year to the State. There have been similar cost increases in Medicaid programs and in the institutions.

{Tape: 1; Side: B; Approx. Time Counter: 37.7 - 44.3}
Montana State Hospital

Mr. Anderson continued with an overview of the Montana State Hospital (MSH). The average census last year was 176 patients with close to 500 admissions and a staff of 261.8 full-time equivalents (FTE). It is the second largest program in dollar amount in AMDD. The program has been the most consistently funded program that he is associated with, but the amount that they spend to run the state hospital is about the same that they spent ten years ago. The MSH issues are utilization and control of admissions and discharges. The facility is now federally certified, which resulted in the generation of several million

dollars in Medicare revenue for the general fund over the biennium.

EXHIBIT(jhh05a04)

{Tape: 1; Side: B; Approx. Time Counter: 44.3 - 50.5}
{Tape: 2; Side: A; Approx. Time Counter: 0.5 - 4.6}
Mr. Anderson stated that MSH has developed a program which tracks patients based on their needs and gears services to the type of patient and desired outcome. Another program offers a comprehensive approach to treatment of patients who bounce back and forth between the institution and community. They have formed a team including MSH staff, community providers, and chemical dependency counselors to ensure that patients receive consistent treatment whether they are in the institution or in the community.

Mr. Anderson reviewed the budget request for MSH and said that institutional programs require base adjustments for the overtime, holiday pay, differential pay needs, and inflationary increases for pharmacy due to the 24-hour 7-day-a- week nature of such facilities. He then went over the proposal to restructure inpatient mental health care such that the population will be reduced through creation of behavioral health inpatient facilities(BHIF), which would bring more federal participation in paying for care. They have looked at several states where there are such facilities and believe that such facilities will help AMDD reduce institutional lengths of stay and allow people to receive services closer to home. They have contracts with the Department of Corrections (DOC) to operate the WATch program at the state hospital, and they fund four FTE and some utilities, so they will need budget authority for this. Finally, there is a decision package reduction of three FTE at MSH.

{Tape: 2; Side: A; Approx. Time Counter: 4.6 - 7.8}
Referring to the graph on page 16 of Exhibit 2, **Mr. Anderson** said that it shows that MSH has cost about $20 million per year for the past ten years. The cost of service per person has been reducing over the years, but the number of episodes of care has been growing while the budget has not. The average daily population has not increased or decreased much over the years, but the number of admissions has grown rather rapidly. More people are being served every year, but the length of stay has been reduced. MSH tries to move people through the hospital and back into the community. Many more episodes of care are being provided with the same resource. **SEN. STONINGTON** asked if the annualized cost per person was about $110,000 per year, and **Mr. Anderson** said that it was about right.

{Tape: 2; Side: A; Approx. Time Counter: 7.8 - 15.6}
Mr. Anderson then reviewed the trends in admissions and capacity,

and said that the Subcommittee must address the population issue and find a solution to it. It will need to consider whether that solution is to increase the state hospital budget, bring older buildings up to code, cap admissions, create BHIFs, or something else. He reviewed the information on admissions: voluntary, involuntary court-ordered, and forensic. Voluntary and civil involuntary admissions have generally declined over the past five or six years, and the forensic involuntary admissions have grown and will continue to grow. He touched on the length-of-stay data and admissions by counties, and invited the Subcommittee to visit the facility.

Montana Mental Health Nursing Care Center

{Tape: 2; Side: A; Approx. Time Counter: 15.6 - 20.9}
Mr. Anderson went over the nursing home admissions and average census and explained that it is a psychiatric nursing home program. It was originally created as an overflow for MSH to remove older patients, and many of the admissions still come from the state hospital. In order to be admitted to the nursing care center, an individual must require nursing home care and not be able to be served in another nursing home. The nursing home has had a declining census, but among those patients served there has been an increase in the level of acuity. **Mr. Anderson** stressed that a state institution should be serving the most difficult patients. There has also been a decline in the average age of the patient, which is an issue of concern to them. The declining census did allow them to close a wing and to reduce force at the center. The wing will be used for other DPHHS staff in Lewistown. The nursing care center is federally certified and receives Medicaid reimbursement for those who are eligible. Retention and recruitment of staff is particularly difficult at the facility since there are two other nursing homes in Lewistown, and they are all competing for the same nurses, LPNs and aides.

Mr. Anderson then touched on the base budget adjustments and the proposal to restructure the services. There are a number of patients who are under 65 years of age, and even though all of these individuals would ordinarily be Medicaid-eligible because they are in an institution for mental disease, Medicaid will not pay their cost. The other issue involved is the appropriateness of placing individuals under 65 in a nursing home. They are proposing the creation of specialized intensive services for those who are under 65, which will allow them to reduce the nursing home maximum census to 75, close another wing, and reduce staff further. They will also receive the benefit of the federal participation for the care of those individuals in community programs.

{Tape: 2; Side: A; Approx. Time Counter: 20.9 - 28.6}
REP. JAYNE asked how the Department anticipates creating the structured community settings, and **Mr. Anderson** replied that several providers have assessed the patients, and while they do not have any specific proposals yet, there are some who believe that they can serve these clients. It would probably be a group home combined with some sort of specialized day program for the clients. It would be a level of group home that is currently unavailable in the system. Many of these individuals were transferred from the state hospital and almost all have been in other community mental health programs at one time or another. There is good evidence that these are individuals who do not need to be in the state hospital, but do need a more intensive program than is currently available.

{Tape: 2; Side: A; Approx. Time Counter: 28.6 - 30.6}
CHAIRMAN CLARK asked how many of the individuals would be dually diagnosed with disabilities and mental illness. **Ron Balas, Superintendent of the Nursing Care Center**, replied that it would be approximately 20 percent.

Mental Health Services

{Tape: 2; Side: A; Approx. Time Counter: 30.6 - 49.5}
Mr. Anderson continued with the Mental Health Services Bureaus and said that they have been moving to a regionalized mental health system to take over management of the mental health system. He said that there is a trust building issue involved since they want providers to help with management, but later tell them that they are going to need to cut their rates or eliminate services. They have developed contracts with five mental health centers and given them responsibility for services in their area, which has eliminated numbers of individual providers. **Mr. Anderson** said that in case management for children they have given five providers an exclusive area within which to provide services. This has allowed them to control costs through elimination of competition between providers, and it has also allowed a measure of quality control.

Mr. Anderson then touched on the Service Area Agency (SAA) issue and said that providers have a lot at stake in the system and consumers have even more at stake so involving them makes sense. He also briefly touched on the emergency planning that the bureau has been doing. He briefed them on the Olmstead issue and the bureau plan with respect to moving individuals from institutions to the community.

In his overview of case management of children, **Mr. Anderson** reviewed the statistics showing a decrease in the numbers of children going to out-of-state treatment. He attributed this to a statewide initiative to prevent out-of-state placement or to

bring a child back from out-of-state placement. They have care coordinators throughout the state who have helped to manage children's cases, and the in-state residential treatment facilities have done more to broaden their scope to include treatment of the more difficult cases. This is one bright spot in AMDD.

{Tape: 2; Side: B; Approx. Time Counter: 0.5 - 9.2}
Mr. Anderson said AMDD has looked to a group of state agencies to plan and better use individual resources in a collaborative effort. Through the assistance of the Montana Children's Initiative Organization, they have developed some pilot projects in communities. AMDD has also done intensive program monitoring, which has led to some funds recovery. AMDD staff has been looking at utilization of certain services and providers and has identified areas where the billing is questionable and has made substantial fund recovery. The budget proposal includes contract changes for the utilization review contract with First Health, and a reduction of one FTE from this bureau. He addressed cost cutting measures in this bureau on page 26 of Exhibit 2. He added that there are four vacancies in the Mental Health Services Bureau that are being held vacant. Holding these positions vacant means that they are increasing the workload for staff and reducing accomplishment. He concluded the mental health overview and said that he would answer any questions.

EXHIBIT(jhh05a05)
EXHIBIT(jhh05a06)

{Tape: 2; Side: B; Approx. Time Counter: 9.2 - 13.9}
Referring to pages 28 and 29 of Exhibit 2, **REP. JAYNE** asked how the cost-cutting measures in mental health services for children and adults have impacted tribal services. **Mr. Anderson** replied that the measures have impacted tribal children and adults much the same as the rest of the population who use these programs. In some cases, services are more difficult to obtain or no longer exist. A big issue involved with these measures is provider accessibility. Many of the providers almost exclusively serve the public sector, so when the Medicaid program cuts its rates by five percent, it is a direct five percent cut to their revenue. Other providers may serve only ten percent of Medicaid patients which would have a smaller impact. They worry that some of the providers will be unable to survive the cuts.

REP. JAYNE next asked if there had been a loss of Indian service providers due to the cuts. **Mr. Anderson** replied that he does not know this, but he has heard within the last few days that In Care Network would be discontinuing some of its services. He does not know the details about that, yet.

{Tape: 2; Side: B; Approx. Time Counter: 13.9 - 19.3}
Gail Gray, Director of the Department of Public Health and Human Services (DPHHS), said that she would like to be on the record that of all the programs in the Department, the mental health portion of Addictive and Mental Disorders Division is in most need of additional revenue. It has the biggest fiscal impact, and is the one about which they have the most concern.

A break was called during which legal staff provided counsel on the proxy issue.

{Tape: 2; Side: B; Approx. Time Counter: 19.3 - 21.5}
Motion/Vote: SEN. COBB moved that PROXY VOTES BE AUTHORIZED ON STANDARD FORMS WHICH WILL BE SUBMITTED TO THE SUBCOMMITTEE SECRETARY AFTER THE VOTE. Motion carried 5-0. No proxy was voted for SEN. KEENAN.

EXHIBIT(jhh05a07)

{Tape: 2; Side: B; Approx. Time Counter: 21.5 - 22.1}
Motion/Vote: SEN. COBB moved THAT THE SUBCOMMITTEE WOULD USE THE SMALLER PROXY SLIPS FOR VOTES. Motion carried 5-0. No proxy was voted for SEN. KEENAN.

CHAIRMAN CLARK closed the executive session.

LFD Issue Associated with the State Hospital Proposals

{Tape: 2; Side: B; Approx. Time Counter: 22.1 - 30}
Lois Steinbeck, Legislative Fiscal Division (LFD), stated that there are significant policy and budget decision issues involved with this division, which is why it is first before the Subcommittee. The most significant policy decision is the proposal to cap the state hospital population. The cap would be related to the budgeted capacity of the state hospital, such that if there were more than 135 individuals admitted, counties of commitment would be charged on a per day basis above the cap. LC 1083 accompanies this division's budget proposal and is crucial to the executive budget proposal.

Ms. Steinbeck said that the Subcommittee would need to determine what would happen to the executive proposal if the state hospital population were capped and DPHHS built two BHIFs. **Mr. Anderson** said that the original proposal was to build three BHIFs, but projections now indicate that two would be sufficient to meet needs. **Ms. Steinbeck** then said that at this point the Executive Budget as reflected in the LFD analysis may not tie in with the executive proposal regarding BHIFs.

{Tape: 2; Side: B; Approx. Time Counter: 30 - 36.}
SEN. STONINGTON asked **Mr. Anderson** if they would raise the state hospital cap if there were two BHIFs instead of three. Referring to Exhibit 3, **Mr. Anderson** replied that at the end of the biennium the two BHIFs would bring them down to the 135 beds. Some of the money in the budget identified as going to the BHIF facility would go to the state hospital while it has a population above 135. **SEN. STONINGTON** expressed her concern that, while the average population per day is 180, the proposal caps at 135, placing a significant burden back on the counties. **Mr. Anderson** responded that they are anticipating that the local BHIF beds would turn over more quickly. The same number of people could be served with a shorter inpatient stay because individuals would receive ongoing daily treatment from community providers who would also be more immediately available for discharge.

{Tape: 2; Side: B; Approx. Time Counter: 36 - 49.8}
Ms. Steinbeck referred to B-166 of the LFD Budget Analysis. She explained the layout of the analysis, and said that a proposal that is presented in tandem with the cap to the state hospital will reduce the MHSP. The plan will go from about 3,000 slots to about 500 slots. **Mr. Anderson** corrected that to 800 slots. **Ms. Steinbeck** continued that the biggest change is the elimination of the pharmacy program for MHSP. **Mr. Anderson** said that they are proposing to contract with mental health centers for a set dollar amount per slot, and the mental health centers would provide pharmaceuticals for those individuals, but it would cease to exist as a separate benefit. **Ms. Steinbeck** pointed out that when the State decided to pay for pharmacy, it thought that it could fund 350 slots. She asked how community mental health centers could fund 800 slots and pharmacy under the same amount of funding at which the state can fund only 350 slots and pharmacy.

Ms. Steinbeck said that access to prescription drugs is key to maintaining people in community settings. If CMHCs have difficulty in accessing prescriptions within available funding, the executive proposal may not work. The Department received word from its federal counterpart in November that it would have to maintain a state MOE, in order to produce a Medicaid waiver to allow some people to be Medicaid-eligible who were MHSP-eligible. This would negate any savings that could be realized by this plan. Later, the Department was told that if another population were rolled into the expansion, for instance, pregnant women, then there would be no MOE. Under the original Department proposal to expand Medicaid to the MHSP recipients losing eligibility, this proposal was coupled with a slight expansion in access to physical health services. If it is possible to do that, the Subcommittee may wish to ask the Department whether Medicaid eligibility under a waiver could be expanded for some of the MHSP adults to provide them access to community services in mental health, prescription drugs, and a limited physical health

benefit to save general fund dollars. The Subcommittee could also consider abrogating some of the impact of the elimination of the Montana Initiative for the Abatement of Mortality in Infants (MIAMI) program with this such a proposal since some of the low-income pregnant women may be able to access an expansion group in Medicaid.

{Tape: 3; Side: A; Approx. Time Counter: 0.3 - 7.4}
Referring to the major issue that she would have with the development of BHIFs, **Ms. Steinbeck** said that she is unsure of the feasibility of the executive proposal. Each of the BHIFs was originally planned to be a stand-alone facility licensed as an inpatient hospital, and staffing would require 1.4 psychiatrists. She questioned the ability to accomplish such staffing in a 15-bed facility. In states where BHIFs have been successful, there has been a state commitment to: 1)provide start-up grants to providers, 2)design the facility specifically for the services, and 3)develop a community service network. This proposal has been put forward at a time when major reductions to community services and benefits are being proposed. She added that as the Subcommittee analyst she has major questions about the feasability of the proposal. She also pointed out that within this proposal BHIFs are supposed to take the first 30 days of commitment, do evaluations, and emergency detentions. The total average daily population (ADP) at the state hospital was 176. For several days during 2003, the state hospital had an on-campus population above its licensed capacity of 189. The executive proposal including 135 beds at MSH plus two BHIFs would be a 165 ADP, which is at times 30 below the capacity that was experienced during the last year.

{Tape: 3; Side: A; Approx. Time Counter: 7.4 - 17}
Ms. Steinbeck noted that the general fund cost of the proposal for BHIFs may be understated in that the MSH is now a licensed hospital and is able to accept Medicare reimbursement for its services. Medicare reimbursement went from $50,000 to $3 million because of the licensing, and that money is first used to pay off state hospital bonds and then goes into the general fund. The first 30 days of Medicare reimbursement for each of these admissions would now go to BHIFs, reducing the Medicare reimbursement that comes into the State. If the proposal is accepted, there will be a revenue impact associated with it. The Subcommittee should not design services solely based on of the revenue impact, but it is one of the budget effects of the proposal which must be taken into account. She added that she will be working with the Department to narrow and define the Medicare revenue impact.

Ms. Steinbeck went over the proposed reductions of 45 FTE and Medicaid provider rates, the expansion of the mental health intergovernmental transfer (IGT), and the shifting of $2 million

in-state special revenue (SRR) alcohol tax as Medicaid match.

Referring to page B-167, **Ms. Steinbeck** said that they have already covered the significant policy issues associated with downsizing MSH and BHIFs. The next issue is a shift in general fund to support more institutional services as opposed to community services. State fund expenditures for treatment services and the total fund treatment services expended by the division have grown, but $26 million in general fund will be spent serving 205 individuals in state institutions. This is significant because general fund is the primary vehicle for leveraging federal funds in the community. LFD has no disagreement that the State is spending more in this division on direct community services, but the policy issue is that more than half of the general fund supports 205 adults in institutions. Another major policy issue raised by LFD is that there is a disproportionate share of the funding reductions that have occurred within children's services in this biennium.

Reviewing the average daily cost(ADC) and the average daily population(ADP)for each of the state institutions, **Ms. Steinbeck** said that the average daily population was 176 at an average annual cost of $95,000 per person within AMDD institutions in FY02. In the executive budget, this amount grows to $148,000. **Ms. Steinbeck** questioned the kinds of efficiencies that would be employed in the base budget year or foregone in the current executive proposal that would cause a 50 percent increase in the ADC of a person served at the state hospital. In conclusion of her discussion of policy issues, she suggested that there may still be efficiencies available in the coming biennium so that some of the money could be used to address other Subcommittee priorities or the BHIF proposal.

{Tape: 3; Side: A; Approx. Time Counter: 17 - 21.5}
SEN. STONINGTON requested clarification on the cost per person per day for 2000, and **Ms. Steinbeck** said that it was $294 or $300 per day because the population was higher and more funds were expended. **Ed Amberg, Director of the Montana State Hospital,** said that it has been very stable and the total expenditures in the year 2000 were $18,400,000. Significantly, the average daily census was decreased during that year. **SEN. STONINGTON** requested further clarification of what appeared to be a spike in costs. **Mr. Amberg** said that the budget has been very steady for the last ten years and they are projecting this year's costs to be about $19.8 or $19.9 million. He has not done a budget analysis of why those increases have occurred.

Responding to questions from **SEN. COBB, Mr. Amberg** said that if there were another BHIF and they could close another wing, the costs would still be the same. They would like to reduce or modify a 60-bed unit. Due to differences in the population, some

people may not be qualified for placement in BHIFs.

{Tape: 3; Side: A; Approx. Time Counter: 21.5 - 24.6}
Referring to the graph on page B-170 of the budget analysis, **Ms. Steinbeck** reviewed the executive proposal general fund expenditures in MHSP, Medicaid, and state institutions in FY02 and noted that over half of the general fund in the budget, a little over $26 million, will be allocated to state institution costs, and $24 to $25 million will be allocated to community services. The more general fund that can be put into the community, particularly if they can match Medicaid or CHIP, the more services can be funded in the community. This is an important consideration in the BHIF proposal. She pointed out that on B-171, there is a potential general fund revenue increase under the executive proposal for the Nursing Care Center, which has to do with the average daily rate, and that more of the population in the center is Medicare-eligible. While there are adverse general fund potential impacts at MSH, the executive proposal would potentially add general fund increases that are not considered in the revenue projections.

{Tape: 3; Side: A; Approx. Time Counter: 28 - 38.7}
In a review of the Olmstead decision, **Ms. Steinbeck** assessed the impact it would have in moving people to the community. The Subcommittee will hear more about Olmstead in the Disability Services Division (DS). Both divisions have populations that move between state institutions and community services, and they have some of the same funding and commitment issues. There is a current court case, brought on equal protection grounds, for which Mr. Anderson will provide testimony next week. The basis for the lawsuit is that the state has a commitment process for seriously mentally ill adults, regardless of ability to pay and provides hospital services to them, but it has no such process, facility, or funding stream for children. **Mr. Anderson** noted that there is a process in place since the commitment law does not say it applies only to adults, but the State has no facility for children.

Ms. Steinbeck concluded her presentation with a review of SB 55, the key proposal in addressing the state hospital populations by limiting commitment to MSH. She said that some individuals found not guilty by reason of mental illness can end up at the state hospital for life. Yet, if found guilty of the crime for which they were charged, they would only be in a prison for 20 or 30 years. The bill limits length of commitment to the state hospital to no more than a sentence would be had a person been found guilty. If the person is a danger to self or others, commitment proceedings would have to be brought under the involuntary commitment statute. The bill could impact the number of forensic commitments at the state hospital which could potentially free up beds for civil involuntary commitments.

{Tape: 3; Side: A; Approx. Time Counter: 38.7 - 48.9}
Bob Mullen, Operations Bureau Chief, reviewed his analysis of the Montana State Hospital costs if returned to the 2002 base. If they ran it exactly as they had in 2002, it would cost $2.1 million more in general fund in FY04 and $2.4 million in FY05. The average daily cost per patient is $327 in FY04 and $331 in FY05. This was calculated by dividing the requested total cost for FY04 and FY05 by 175 patients. He pointed out that institutions are expensive. **Ms. Steinbeck** pointed that the FY02 actual expenditures is $18.7 million and they served 176 patients per day. The Executive Budget for FY04 is $19,638,674 - not much different from the $20 million on the chart, and it serves 135 people a day. She acknowledged that she is not an institutional expert, but she would like to know the efficiencies employed in FY02 that could be rolled forward to FY04.

{Tape: 3; Side: B; Approx. Time Counter: 0.4 - 4.7}
Mr. Mullen said the reductions in staff and BHIF proposal would save about $1 million per year.

Mr. Anderson referred to Exhibit 3 and observed that they probably all agree that they should serve as many people as they can in the community and leverage as much money as possible for those who qualify for federal benefits. The question would then be whether the BHIFs will be successful in reducing the number of people in the institutions and providing the appropriate level of service for them, and whether they will meet the goal of leveraging more federal money. Another question would be how much it should cost to serve 135 people at MSH. He agreed that it sounds like a lot of money a day, but that amount does include hospital-level care, physician services, pharmacy, lab, x-ray, emergency treatment, and all outside medical costs.

{Tape: 3; Side: B; Approx. Time Counter: 4.7 - 10.7}
REP. JAYNE commented that with the budget cuts as they are, there will be more people off their medications. While they could create one or two BHIFs, there may be an increase in people being committed. She asked how the Department is minimizing that effect.

Referring to page 4 of Exhibit 3, **Mr. Anderson** reviewed Option A and their assumptions of average daily costs and the average daily population. There will be populations that exceed licensed capacity. This all assumes that there is no change with the reduction of MHSP and that other programs will not impact admissions at the state hospital. Referring to Option C, **Mr. Anderson** said that they already anticipate that they will be over capacity. Whether or not the Subcommittee believes that the BHIF is the appropriate way to go, the population issue must be dealt with.

{Tape: 3; Side: B; Approx. Time Counter: 10.7 - 17.5}
SEN. STONINGTON sympathized with the problems, but questioned whether hospitals in two communities in the State would be ready to facilitate this vision given the expense of financing a lock-down facility. **Mr. Anderson** said that there are models in other states, and that some of those facilities are remodeled. BHIFs could be expansions of existing inpatient facilities or existing hospital units. They are not anticipating any being online until October 1, 2003. The Department has discussed this with some providers who have expressed concern that the State will pay enough to operate such facilities. There appears to be a need for such facilities given the high cost of the state facility and the population problems, but they would want to have rule-making authority to limit the number of BHIFs so that there is not a proliferation. **SEN. STONINGTON** then asked about the discussion that they have had on the statewide distribution of the BHIFs. **Mr. Anderson** said that the original proposal was to have one in each of the three services areas; but with the elimination of one from their proposal, they would want to have one generally east and one generally west.

{Tape: 3; Side: B; Approx. Time Counter: 17.5 - 22.9}
SEN. COBB asked if they would have considered BHIFs if there had been an ideal funding situation and more community services, and **Mr. Anderson** replied that they would consider this even without the financial crisis. It is a needed level of care. They fund crisis facilities for adults and pay a lot more than for a group home. The people that they are discussing may be aggressive and intoxicated and may come to the attention of the system at inconvenient times, so every system needs these kinds of facilities to deal with this level of care. For many people, it is a day or two before they need to be discharged.

SEN. COBB then asked how the budget would be impacted if they did not get the BHIFs up and running at the target date. **Mr. Anderson** said that if that happens, people would end up in MSH so they would have to have the ability to expend the appropriation.

{Tape: 3; Side: B; Approx. Time Counter: 22.9 - 30.3}
Referring to the private prison in Shelby, **SEN. STONINGTON** said that they are now wanting to take out-of-state prisoners because they are not filling up with in-state prisoners. She asked if they would envision guaranteeing a certain number of bed days, and **Mr. Anderson** said that he would want to have a cost-based formula. He added that they may prefer a contract, which would ensure that so many beds are available for DPHHS patients, but there may well be some private-pay patients. It is not wise to create a separate system, but such a facility would be the first line of defense and would be required to take involuntary commitments and the emergency detentions.

SEN. STONINGTON then asked what the impact would be if they were to authorize development of the BHIFs, but not authorize limitations on MSH enrollment. **Mr. Anderson** said that he would be concerned because if population went up, they would have a limited ability to address that situation. Through their proposal to charge counties, they will be enlisting the counties in the effort to control the increase in the MSH population. The old approach to reducing the state hospital population was creation of new community programs without controls on the state hospital population. In the last session, they had a gatekeeping bill which did not pass because there were no options. This is an effort to create an option, but also to involve counties in payment for hospitalization at MSH if they are over the cap.

{Tape: 3; Side: B; Approx. Time Counter: 30.3 - 32.9}
CHAIRMAN CLARK asked Mr. Amberg at what point in the population explosion they would lose certification and whether they could lose it on that factor alone. **Mr. Amberg** responded that they are at risk now. His understanding is that it could be based on a number of factors; if they are slightly over population, but still providing required services, he does not think that they will have a problem.

Director Gray said that the big concern with quality assurance is long-term overpopulation. If they are slightly over for a few days and can provide the services, then it is understandable; however, if it were to go on for three weeks, it would be another matter. **CHAIRMAN CLARK** pointed out that the sustained population increase has gone on for three weeks. **Mr. Amberg** said that they have been over the overall capacity only a few days in the last year. **Director Gray** added that they have been over the funded amount in the biennium, and **CHAIRMAN CLARK** said that this was her misunderstanding.

{Tape: 3; Side: B; Approx. Time Counter: 34.9 - 38.9}
REP. HAINES asked if there was a potential for conflict with other types of group homes across the state if they constructed the BHIFs, given the economic situation and the money that would be needed to put them together. **Mr. Anderson** said that he did not believe that this would be the case since it would be a different concept and a different clientele. **REP. HAINES** interrupted that he understood that the clientele would be different, but he was wondering about siphoning money from the system into development of the physical plant and the operations. **Mr. Anderson** said that he does not believe that this would be the case, and it is conceivable that group home facilities could even be increased.

{Tape: 3; Side: B; Approx. Time Counter: 38.9 - 42.7}
Ms. Steinbeck commented that she had understood the facilities to

be budgeted at $380 a day, and if they are cost-based, the Subcommittee must ensure that the costs included in the Executive Budget are adequate to fund the facilities. If there was an increase needed for group homes, it would come at a time when there is an $11 million reduction slated for community services. She questioned how they could fund fewer community services in order to fund potentially more of the higher-end community services that may be needed. **Ms. Steinbeck** added that it is not a comment on the worth of the BHIF service, but more a comment on how this would work in the executive budget proposal.

{Tape: 3; Side: B; Approx. Time Counter: 42.7 - 46.3}
Mr. Anderson said that they have assumed a per day cost in the BHIFs of $500, and it is comparable with what other states have paid for this level of service.

Director Gray said that Ms. Steinbeck is correct about the spiral, but she said that they are already spiraling to more and more days and use, which is why they are looking at this alternative.

{Tape: 4; Side: A; Approx. Time Counter: 0.1 - 2.1}
Responding to staffing questions with regard to BHIFs from **SEN. COBB**, **Mr. Anderson** said that there are three vacant positions. **SEN. COBB** observed that there could be another four percent vacancy savings and expressed his concern that they will not have the staff for this when there may be cuts to complicate matters.

{Tape: 4; Side: A; Approx. Time Counter: 2.1 - 5.1}
Director Gray commented that the bureau has done an extraordinary job under very difficult circumstances. It is extremely difficult to deal with vacancy savings when there are institutions which must be staffed 24 hours a day, 7 days a week. All of the divisions with institutions have a much lower percentage of their centralized staff filled than any other divisions. She said that she is amazed at what people can do under incredible pressure and has confidence that they will continue to do this.

{Tape: 4; Side: A; Approx. Time Counter: 5.1 - 6.5}
REP. JAYNE asked for elucidation on the vacant positions, and **Mr. Anderson** replied that one is a law-enforcement training liaison and the other two are for the regional planning process. One of those positions needs to be an adult mental health expert and the other position needs to be a data analyst.

{Tape: 4; Side: A; Approx. Time Counter: 6.5 - 14.7}
Mr. Anderson referred to the summary of options on page 6 of Exhibit 3. **SEN. COBB** asked **Ms. Steinbeck** what the savings in the Executive Budget are, and she referred him to the total mental health budget on B-179 of the budget analysis. She stated that

the Governor's budget is $1.6 million general fund each year below the base budget spending, which is largely driven by the reduction in MHSP. BHIFs are funded through savings at the state hospital and MHSP, and some of the savings in MHSP are diverted to fund Medicaid caseload growth. It is very difficult to pull the pieces apart without creating a problem elsewhere.

Ms. Steinbeck continued that she had not had an opportunity to review this information, yet. She added that she had not seen the data on the projected impact on state hospital populations due to the reductions in MHSP before the presentation today. Her analysis at this point indicates that the impact exists whether there are BHIFs or not. She said it appears that this is the amount of general fund that the Executive Budget is underfunded in its current proposal because it does not take into account the shift in the loss of the MHSP to needing inpatient psychiatric care. Either it will require additional changes or one could assume that it is the cost shift to counties.

{Tape: 4; Side: A; Approx. Time Counter: 14.7 - 16.1}
Mr. Anderson said that his options, based on the assumptions they made, show that even with increased numbers of people showing up for inpatient care and two BHIFs, they believe the Executive Budget is adequate to care for those accommodated in the state hospital. **Ms. Steinbeck** responded that she was pointing out that the Executive Budget, as submitted, did not include the impact to inpatient hospitalization due to elimination of MHSP. If it did, she did not have access to that information.

Mr. Anderson referred to page 21 of Exhibit 3 and reviewed decision package (DP) 344. He said that they are proposing to buy slots from the four CMHCs and will pay $5,000 per year per slot under the new more stringent eligibility requirement. They would pay a lower amount for slots when the individual is Medicare-eligible since they would have some of their mental health and medical costs paid for, but pharmacy and rehabilitation would not be paid for. He next reviewed the new eligibility criteria on pages 21 and 22 of Exhibit 3. **Mr. Anderson** said that if there assumptions on cost are correct, they will have enough money to fund 822 slots at $5,000.

{Tape: 4; Side: A; Approx. Time Counter: 16.1 - 26.3}
Mr. Anderson said that the children's program will remain much as it has been. This discussion is only about the nonCHIP children who are seriously emotionally disturbed and below 150 percent of poverty - about 135 children. He reviewed the services that would be added to the menu: family-based service, case management, and school and community treatment. This group has been causing less stress to the system than previously anticipated. There is about $60,000 left per year, and they would like to retain this as flexible funds for use. They spend

some of the money now on special needs for children, but he would like to tie the funding to the multi-agency children's initiative.

{Tape: 4; Side: A; Approx. Time Counter: 26.3 - 28.3}
Referring to DP 140 and DP 141 on page 25 of Exhibit 3, **Mr. Anderson** said that these DPs deal with federal spending authority for anticipated increases. They are also seeking $4,000 in general fund money to bring them up to the full match required for the PATH grant.

{Tape: 4; Side: A; Approx. Time Counter: 28.3 - 33.3}
Referring to DP 147 on page 27 of Exhibit 3, **Mr. Anderson** said that it includes the base adjustments at the nursing care center, and the restructuring plan for the nursing care center.

Referring to DP 143 on page 30 of Exhibit 3, **Mr. Anderson** said that this is the Medicaid caseload increase. They are asking for a 9 percent increase in FY04 and an 11 percent increase in FY05 in the Mental Health Program. They are requesting a much larger increase due to the projected 21 percent increase in growth in the chemical dependency portion of this.

{Tape: 4; Side: A; Approx. Time Counter: 33.3 - 40}
Referring to DPs 135 and 351 on page 33 of Exhibit 3, **Mr. Anderso** reviewed the proposal to expand the mental health IGT to cover increased caseload and the refinance of the Medicaid caseload. Responding to a question from **CHAIRMAN CLARK** whether the counties are on board with this, **Mr. Anderson** said his impression is that they are.

SEN. STONINGTON said that the money is currently budgeted by the counties and leveraged by CMHCs and asked if it would require statutory change, to which **Mr. Anderson** said that he hopes not since they are doing this already through administrative rule. **SEN. STONINGTON** asked if there is a written agreement with counties to do this, and **Mr. Anderson** said that there would be a written agreement between the division and the counties. This is different from the nursing home IGT in that the money from the counties is paid to the MHCH, not back to the counties.

LFD Issue with DP 351

{Tape: 4; Side: A; Approx. Time Counter: 40 - 45.2}
In explanation of the LFD issue with DP 351, **Ms. Steinbeck** said that one way that DPHHS attempted to ensure continuation of services in rural areas was to use an IGT in which counties gave part of the $1.2 million to DPHHS in matched federal funds and increased rates for "frontier" services. In 2001, the Subcommittee approved this proposal as one-time payments. She

added that she is confused about the $657,000 in the amendment in the executive proposal which does not appear to be an IGT, but a funding shift which supports ongoing Medicaid caseload. This would mean that the county funds would support ongoing present law Medicaid caseload costs and counties and CMHCs would not necessarily receive an increase in the use of the funds. If this is not the executive proposal, she said that she needs to be corrected because in DP 351, it simply replaces general fund Medicaid match.

{Tape: 4; Side: A; Approx. Time Counter: 45.2 - 48.1}
Deferring to Mr. Mullen, **Mr. Anderson** said that the attempt is to leverage part of the money and give it back to the CMHC. **Mr. Mullen** referenced page 34 of Exhibit 3 and explained that the counties give them $1.2 million and they take $542,400, turn it into $2 million, and give that $2 million to the counties for a net gain to them of $800,000. The Department then takes the $657,000 difference that it saved and puts it into the Medicaid program to offset general fund. This saves $657,000 in general fund.

{Tape: 4; Side: B; Approx. Time Counter: 1.5 - 3.9}
Ms. Steinbeck thanked Mr. Mullen for the clarification and said that the LFD issue would now be a little different. She continued that if DP 351 could be constructed as an IGT similar to the nursing home IGT, and counties were asked to pay, they could match the entire $657,000 to generate additional Medicaid funds or return $1.2 million to the counties and give the State $657,000. She said that she could work with the Department on this, and if it were structured like a nursing home IGT, there is the potential to give the counties as much as they give the state. **Mr. Anderson** responded that under the Medicaid program, they can not give the counties money for services because the counties are not the providers.

Ms. Steinbeck then said that her original LFD issue is still an issue in that if the counties did not agree with this in the future, the general fund would be short that much money each year for Medicaid match. If the counties are not on board now, the Medicaid budget is $1.2 million short over the biennium.

{Tape: 4; Side: B; Approx. Time Counter: 3.9 - 7.3}
Mr. Anderson referred the Subcommittee to page 35 of Exhibit 3, and went over DP 339, which requests federal authority for MHSP so that they can use school funding as the match. About six months ago, they had to discontinue a school-based service, and they could now reinstate it using school spending as the match. On page 36, he reviewed the request for a 1.87 percent provider rate cut in the Medicaid program in DP 353. He referenced DP 352 on page 37 and said that it shows the impact of the change in the federal matching rate on the budget.

Ms. Steinbeck recommended that if the Subcommittee adopts Medicaid caseload increases that the total increase be funded at the correct matching rate. She added that this is the only division in which they will see the general fund breakout of the change due to the change in federal matching rates. She asked that she be allowed to roll this DP into the Medicaid caseload change DP.

{Tape: 4; Side: B; Approx. Time Counter: 7.3 - 12.4}
Mr. Anderson continued with his review of mental health decision packages in Exhibit 3. On page 38, DP 354 takes care of Medicaid eligibility changes, and on page 39, DP 141 is the utilization review contract reduction request. First Health is no longer doing the eligibility and prior authorizations of services for the nonMedicaid program, so the general fund cost for the contract is also reduced. They anticipate caseload increases in Medicaid, so there is a built-in increase. There is also an inflationary increase of five percent, and they have asked for additional funding for retrospective reviews of services that are not already authorized. The net effect of these changes is a reduction in general funds.

Mr. Anderson concluded his presentation of decision packages with DPs 131 and 154 on page 41 of Exhibit 3. He said that they are requesting federal authority and continuation of one FTE for this federal grant to improve data gathering and analysis of the capacity in the mental health program. DP 154 involves a request for budget authority for four FTEs for a contract between MSH and DOC in which MSH supplies maintenance services, boiler operations, and utilities to the DOC WATch program located on the Warm Springs campus.

Other information was provided by Mr. Anderson.

EXHIBIT(jhh05a08)

ADJOURNMENT

Adjournment: 12 P.M.

_____
REP. EDITH CLARK, Chairman

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SYDNEY TABER, Secretary

EC/ST

EXHIBIT(jhh05aad)