MINUTES

MONTANA HOUSE OF REPRESENTATIVES
58th LEGISLATURE - REGULAR SESSION

JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

Call to Order: By **CHAIRMAN EDITH CLARK**, on February 13, 2003 at 8:13 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. Bob Keenan (R)
Sen. Emily Stonington (D)

Members Excused: None.

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 & Date Posted: AMDD
Refinance
Executive Action: None.

HEARING ON REORGANIZATION OF AMDD BUDGET REQUEST

{Tape: 1; Side: A; Approx. Time Counter: 0.3 - 20.4}
Dan Anderson, Administrator of Addictive and Mental Disorders Division(AMDD), distributed a proposal for reorganization of the AMDD budget request and bill draft request. He thanked the community mental health centers(CMHC)for their assistance with this proposal, saying that it had been a good, cooperative process and adding that Paul Myer would present a brief overview of this from the CMHC viewpoint. They are not asking for any net increase in general fund, but are rearranging the executive request.

EXHIBIT(jhh32a01)

Referring to Exhibit 1, **Mr. Anderson** said that the first point is a proposal to take $1 million from the general fund which was previously budgeted for the non-Medicaid Mental Health Services Plan(MHSP) and leverage it with federal Medicaid funds to give the four CMHCs an "access" payment. It would be a block grant payment to assure access for Medicaid recipients throughout the State. These four CMHCs serve every county and have a great deal of experience in providing community mental health services. An important issue is assuring access in rural areas. While the access payment will assure Medicaid recipients access to mental health services, it also gives the providers the means to provide care for other low-income indigent people.

Mr. Anderson said that his second point is funding for the adult MHSP program; they would contract with the four CMHCs to serve this population. The eligibility criteria would remain the same, but these would also set priority criteria to assure that those with the highest priority receive treatment. He reviewed the types of individuals who would be highest priority. The CMHCs would continue to report on the services that they provide so that the division would have complete data, and they would provide annual service plans to the division.

Mr. Anderson continued that the next major change would be a recommendation that the Montana State Hospital(MSH) be funded and staffed to serve an average population of 175. Their earlier proposal to implement three behavioral health inpatient facilities(BHIF)was an attempt to bring the MSH population down to 135 individuals. There was some concern about the ambitiousness of that proposal, so there will be more people in the state hospital than originally projected. Within this proposal, CMHCs would be responsible for screening all admissions to MSH, and they would develop a financial incentive for them to serve people in the community. If the population of MSH were

brought down to the point where they were saving money at MSH, those funds would become available to the CMHC. If, however, the population goes up past the point that it can be funded, CMHC contracts would be reduced in order to meet the additional costs at MSH. Referring to the bill draft, he explained that it puts CMHCs in the process on involuntary commitments. This would allow the CMHCs to always have the opportunity to put together a treatment plan before an individual is admitted to MSH. The division has a great concern that the population at MSH will continue to rise, and at some time, they would need to remodel an existing building and staff an entire additional unit, which would mean even greater cost. They believe that using CMHCs as gatekeepers and providing a financial incentive to them is a good way to attempt to keep that population down.

Mr. Anderson went on to explain the fourth point which authorizes establishment of one BHIF in order to test the feasibility of the concept. Billings Deaconess Hospital is very interested in working with the division on this. They believe that the use of BHIFs would allow them to handle admissions that would otherwise go to MSH. Senate Bill(SB)348 is tied to the BHIF concept which would give them the authority to establish BHIFs, write rules, and allow them to limit growth of BHIFs. SB 347 is also indirectly related to this proposal and would give them the authority to establish service area authorities and repeals laws defining CMHCs. The Department will suggest amendments for restoration of the language on CMHCs with whom they wish to partner for provision of adult mental health services.

In summary, it is a cooperative proposal with CMHCs to stabilize the adult community services and population at MSH, to limit the state's exposure to rising costs, to provide completed data on all individuals involuntarily committed, and to commit to a positive cooperative partnership among CMHCs, DPHHS, and MSH.

{Tape: 1; Side: A; Approx. Time Counter: 20.4 - 26.1}
Paul Meyer, Executive Director of Western Montana Mental Health Center and representing the four regional mental health centers, thanked the Department for allowing them to be involved in the proposal. This proposal offers flexibility with accountability and makes overdue structural changes in the community mental system. It allows for better management of MSH, glue for the commitment process ensuring the language in law about the least restrictive alternatives, requires presentation of treatment plans for those remaining in the community, and annual presentation of service plans. He said that CMHCs do not recommend repeal of SB 347 since it is an important part of maintaining CMHCs in statute. The block grant concept would allow them the flexibility to serve individuals who are not

Medicaid-eligible. He cautioned that they did take the constraint of working within the Governor's budget seriously, and the proposal before them rearranges the dollars to fully fund those 4,800 MHSP clients that the State has historically served, and they believe that there is provision for them to be funded within this realignment. However, there is no pharmacy benefit for those individuals within this proposal. They estimate that it would take $4.5 million per year to fund pharmacy for those individuals given a reasonable monthly cap of $600 to $650. The MCHCs do not believe that they can get by without the pharmacy benefit since it is increasingly important in management of major mental illnesses. This proposal is not a complete fix on all the mental health service problems, but within the adult arena it is a good, comprehensive solution. They are in support of the attached committee bill, and would like their support for a pharmacy benefit. The fiscal note to fully fund a pharmacy benefit for MHSP clients is $4 million to $4.5 million per year.

{Tape: 1; Side: A; Approx. Time Counter: 26.1 - 29}
Director Gray said that this is not a cure-all. Mental health is still underfunded, but this is a reasonable plan to focus on the greatest needs of adult mental health. This committee bill is a great first step.

{Tape: 1; Side: A; Approx. Time Counter: 29 - 40.7}
SEN. STONINGTON commented that she has been struck by the unbelievable volatility of the AMDD system, so she appreciates that stabilization should be the first goal, but there also needs to be a long-term vision. She asked Mr. Meyer how or whether this plan would fit in with the Service Area Authority(SAA) concept. **Mr. Meyer** responded that the proposal is consistent with the SAA concept in that it regionalizes the adult care system. The other component of stability that the proposal adds is that it works with the four agencies that have been providing services for more than 30 years; increases the connectedness between district courts, MSH, and CMHCs; and provides a safety net for low-income people who may not meet federal criteria. He said that he believes that it provides a great deal of stability and does look to the future. The SAA service model is a devolution of authority from the state level to the regional level.

Responding to a series of questions from **SEN. STONINGTON, Mr. Meyer** said that he does see this as a step in the direction of SAAs. It builds the concept that there is a responsible entity providing care on an outpatient basis and that MCHCs are not just another service provider offering alternatives, but that they also have legal responsibilities to provide care to people. This does not mean that CMHCs would do everything, but they would be a

hub for ensuring that services would be provided and would contract some of those services out to AWARE and other private providers of outpatient services. It provides for accountability. The proposal has incentives for overutilization of MSH and underutilization, which is a nice structural piece. CMHCs will be given targets on a civil involuntary basis at MSH. If a center uses an excess of days, it will be charged for those. If a center is successful in drawing down their use of civil involuntary days, it would receive financial payments from MSH.

{Tape: 1; Side: A; Approx. Time Counter: 40.7 - 45.4}
Responding to questions from **SEN. COBB, Mr. Meyer** said that they are in the position paper and would be handled budgetarily in contracts with the centers. The access payments would be adjusted upwards or downwards based on over or under utilization of MSH. They will also need some pharmacy benefit in the proposal for it to work. The CMHC statute which talks about service plans and recognizes CMHCs as an entity on which the courts can rely should be left in place.

{Tape: 1; Side: A; Approx. Time Counter: 45.4 - 49.8}
{Tape: 1; Side: B; Approx. Time Counter: 0.3 - 1.8}
Lois Steinbeck, Legislative Fiscal Division(LFD), commented on the funding. In the base budget year, about 3,000 adults were served in MHSP, and the Executive Budget is based on the premise of 500 slots for MHSP with a capped pharmacy benefit. Another concern she expressed is that there are a number of people committed to MSH who are not financially eligible for MSHP, are not Medicare or Medicaid-eligible, and have no private insurance. She said that it is her understanding that the CMHCs would also be responsible for providing services to a group of people in the community for whom they are not responsible for providing services now. Some of this is uncompensated care, but maybe not all of it. She questioned whether this is workable since they are already shifting financial risk to CMHCs. Ideally, they would have extra resources to fund these individuals, but with no pharmacy benefit in the community before this proposal, she questioned how this would work financially. **Mr. Meyer** said that it is exactly right that they have provided uncompensated care for individuals at 150 percent of the poverty level who have completed their stay at MSH. This budget approach with block grants for uncompensated care gives them the flexibility to do this.

{Tape: 1; Side: B; Approx. Time Counter: 1.8 - 3.9}
SEN. STONINGTON said that if the Department creates a BHIF when the budget is so tight, they could create another wreck for themselves. She asked how much money in the budget has been set aside for the BHIF and suggested that it should be put off for

another time while they work on stabilization. **Mr. Meyer** said that initially they were lukewarm to the idea of BHIFs because they would focus on inpatient care while they are cutting outpatient systems. They now believe that it is worth investing in one on an experimental basis to see if the concept will work for the State. In states where BHIFs operate, it is a successful service model. Once a patient between 18 and 65 enters a state hospital, all federal funding ceases for that patient; however, with the same treatment in a BHIF, they could capture 75 percent of the treatment costs and have shorter lengths of stay. This would be a smart investment for the State, but the transition will not happen easily.

{Tape: 1; Side: B; Approx. Time Counter: 3.9 - 9.1}
SEN. STONINGTON said that the concept is good, but she is worried about stability within the system. She expressed concern that they are moving too rapidly with one concept or another and does not want to need to constantly recreate. In response, **Mr. Anderson** said that it is an ambitious plan, but ultimately, part of the solution to stability must be expanded capacity for inpatient care outside of MSH. There has been a contraction of inpatient capacity in local communities. He believes that this is part of the formula for stability. A small unit in Billings could accommodate over 100 admissions per year that would otherwise go to MSH. The stability of the population at MSH is the biggest priority to controlling costs over the long haul. One option that they did consider was remodeling one of the existing abandoned buildings and opening a new ward at MSH, but if they did this, there would be no impetus to move people into the community. At least 50 percent of those patients who would go into BHIFs would receive a combination of Medicare and Medicaid. Although Medicare does reimburse care at MSH, for most patients, Medicaid does not. They have allocated about $1 million between general fund and state special revenue(SSR), which was reduced from $3.3 million in the original budget.

{Tape: 1; Side: B; Approx. Time Counter: 9.1 - 13.2}
Responding to several questions from **REP. HAINES**, **Mr. Anderson** said that BHIFs are eligible for Medicaid and Medicare reimbursement, which brings in other ways of paying for the services. The original proposal was three 15-bed facilities, but the more they reviewed data and experience elsewhere, they became convinced that they would not need so many beds. They would like to try a BHIF this coming biennium to see what the experience in Montana will be. The experience in other states is a dramatic reduction in population at the state hospital, partially because of these facilities. They would suggest putting one in Billings because it is far away from MSH. They would put out a request for proposal(RFP)for this.

{Tape: 1; Side: B; Approx. Time Counter: 13.2 - 14.8}
Gail Gray, Director of the Department of Public Health and Human Services(DPHHS), expressed the Department's enthusiasm for this proposal. They are concerned about stability, but if they do nothing to control the increase at the state hospital, there is no stability anyway. It is important for long-term stability within the adult system that they serve more individuals in community settings. She stated that she truly believes that this is the way to go.

{Tape: 1; Side: B; Approx. Time Counter: 14.8 - 20.7}
REP. JAYNE asked Mr. Anderson how many other community providers there are in the state other than the CMHCs. **Mr. Anderson** replied that this proposal is for nonMedicaid programs. Within the Medicaid portion of the adult system, there are hundreds of providers. In the adult nonMedicaid portion there are a small number of other providers. As part of recent program changes made to control the budget, they have narrowed the number of providers to these four for adult nonMedicaid.

Ms. Steinbeck asked how it could be only for nonMedicaid service if it is supposed to work to control all admissions to the state hospital because some of those people would be Medicaid-eligible. **Mr. Anderson** explained that these systems are entwined. Most of this proposal has to do with the nonMedicaid adult population, the state hospital, and the BHIF proposal. Some of these individuals are Medicaid recipients, so their community services are funded by the Medicaid part of the budget. It is still appropriate that the designee at the local level determine if there is a way for those individuals to be served within the community.

{Tape: 1; Side: B; Approx. Time Counter: 20.7 - 40.9}
Following up, **REP. JAYNE** said that this proposal is for all individuals regardless of funding, but it raises a red flag for her. She said that somewhere in the bill it states that a CMHC can agree not to accept someone, so she wants to know what would happen to such an individual. **Mr. Anderson** said that he believes it says a private provider is not required to serve someone without compensation, and the language is intended to require CMHCs to take the responsibility of serving individuals. In another follow-up question, **REP. JAYNE** said that this would kick in after the initial commitment hearing and requires an individual to go to one of the four CMHCs. **Mr. Anderson** confirmed that it would require the mental health center to evaluate the respondent or consult with those who have been serving the respondent to determine if the CMHC can provide the necessary services. In another follow-up, **REP. JAYNE** asked what the bill says will happen if the respondent does not want someone

at one of the centers to serve him, and **Mr. Anderson** replied that the respondent can choose to not cooperate with an evaluation, and he would guess that the judge would take that into account. The proposal is drafted to say "can a community mental health center provide treatment plan and the services this person needs," and part of this would be the cooperation of the individual needing treatment. Probably, if the person meets MSH admission criteria and refuses to cooperate with any outpatient treatment, the judge would decide to commit that individual to MSH.

In one last follow-up, **REP. JAYNE** referred to the bill draft(Exhibit 1) and provided a hypothetical situation, after which she asked if her understanding was correct. **Mr. Anderson** replied that if a doctor is not an employee of the CMHC, the CMHC would have to be noticed and evaluate the person directly or through that doctor. **REP. JAYNE** stated that it appears to be a duplicative service and questioned its purpose and how it would save money. **Mr. Anderson** said that before they decide to take an individual involuntarily into MSH and commit state resources to pay for the care at MSH, it is appropriate and worthwhile to bring in an agency with many years of mental health experience to see what alternative treatment it could provide. In a follow-up observation, **REP. JAYNE** said that she is concerned about this because she likes objectivity, and this gives business to the four mental health centers while it takes business from private providers. **Mr. Anderson** responded that the public mental health system does not have sufficient funds to be all things to all people or for an unlimited number of providers providing every variety of mental health service. This proposal is a step in the process to focus the funding on regional entities to take on responsibility for services and funding as part of the system.

{Tape: 1; Side: B; Approx. Time Counter: 40 - 45.}
REP. HAINES asked why the Department would not go with a statewide RFP for the BHIF rather than focusing on Billings. He suggested that it makes more sense to see where the market puts it. **Mr. Anderson** said that he is not ruling out a statewide RFP, but one reason for SB 348 is that it would allow them to do an assessment of where the service is most needed and target it at that place. They have looked at Billings because there is a provider who is interested in doing this, but it does not mean that this is where it will be. **REP. HAINES** questioned whether it is a realistic expectation that they will have a BHIF up and running within two years, and **Mr. Anderson** said that it would require provider interest, but he believes that it is a realistic to have something up and running within two years.

{Tape: 1; Side: B; Approx. Time Counter: 45 - 48.9}

Ms. Steinbeck said that unless the Department is going to eliminate Medicaid provider participation in the program, she does not know how the funding supports the concept. She understands how the state general fund can support the concept, but she does not understand how the Medicaid funding supports the concept if the CMHC is not the provider. If an individual is Medicaid-eligible and receiving services from an entity other than a CMHC, the individual would be committed to the state hospital. This would cause the CMHC to go over its bed-day cap, and it would be economically sanctioned for the admission of that individual.

{Tape: 2; Side: A; Approx. Time Counter: 0.2 - 3}
Mr. Anderson reviewed a hypothetical situation in which a Medicaid-eligible individual is seeing a private practitioner and at some point, it is decided that this individual should go to MSH. As part of that process, the CMHC would be called in to evaluate the individual and might be able provide treatment for the individual. The CMHC is also a Medicaid provider, so there would be Medicaid funding to pay for the services that are provided, but the court would ultimately decide what to do with the individual.

Ms. Steinbeck commented that she does not understand how the commitment process could be construed to violate freedom of choice among Medicaid providers. If the community provider is not a CMHC and is willing to accept the patient, she does not understand how this jives with the Medicaid policy of freedom of choice.

{Tape: 2; Side: A; Approx. Time Counter: 3 - 6.1}
Mr. Meyer explained the process whereby an individual is brought before the court and it is determined either that there is a reasonable alternative for treatment in the community or the need for commitment to MSH. He does not believe that this proposal would interfere with the therapeutic relationship between an existing client and a Medicaid provider. It is essential that someone be available when law enforcement requires an immediate evaluation.

{Tape: 2; Side: A; Approx. Time Counter: 6.1 - 11.1}
SEN. KEENAN said that the bill appears to be an effort to strengthen or designate the gatekeeping process to the state hospital. He asked who can send people to the state hospital, and why they want to strengthen the commitment statute. **Mr. Anderson** said that the statute does say that the CMHC must provide screening for people going to the state hospital. It is a service that the four CMHCs must be available to provide. The law does not currently require every judge in every involuntary

commitment to use the CMHCs. Any licensed physician, psychiatric nurse practitioner, and certified professional in the state can testify in a commitment hearing, whether they work for a CMHC or not. This bill says that they can do this, but if they are not working for a CMHC, AMDD wants the CMHC to be involved as well.

{Tape: 2; Side: A; Approx. Time Counter: 11.1 - 14.2}
Referring to the bill proposal, **SEN. KEENAN** said that recently emergency rules came up dealing with access payments and requested comment from Mr. Anderson. **Mr. Anderson** said that they used emergency rule to use county funds from the CMHCs to make access payments. This is taking general funds appropriated by the legislature and using them for the access payment. **Ms. Steinbeck** suggested that the Executive Budget request could be restructured to continue $675,000 in county funds currently in the budget as one of the DPs to offset general fund and transfer them to the access payment and put the general fund back for Medicaid match.

{Tape: 2; Side: A; Approx. Time Counter: 14.2 - 17.7}
SEN. KEENAN asked if there was an appropriation or disbursement of $500,000 with the emergency rule, and **Mr. Anderson** replied that they have not disbursed any access payments yet. The emergency rule changed the frontier rate and used county money to leverage more federal money. This was done as part of the budget mitigation to take more county money to help save general fund. In follow-up, **SEN. KEENAN** asked what the connection was to the crisis lines. **Mr. Anderson** confirmed that one of the purposes of the access payment was to provide a crisis services. Another refinancing strategy that they tried this year was to use some of the county funding that is transferred to AMDD for crisis telephone communication. All licensed mental health centers are required to provide 24-hour access to their clients. The contracts with the four CMHCs are for general crisis calls, not just their own clients.

Ms. Steinbeck said that there are also mental health centers that are required to have 24-hour telephone services as part of their licensing requirements, but are not reimbursed by the State for that, whereas community mental health centers are. **Mr. Anderson** responded that every licensed mental health center is required to have 24-hour access for its client. In addition, the four community mental health centers have a separate contract to provide toll-free crisis contact in every county.

{Tape: 2; Side: A; Approx. Time Counter: 17.7 - 27.7}
Referring to the bill request, **SEN. STONINGTON** questioned the clause which says "if they agree to accept the respondent" and asked how it would affect the incentives if CMHCs do not accept

respondents. **Mr. Anderson** said that if CMHCs routinely send people to MSH, they would be financially penalized by AMDD based on a numerical determination if the state hospital population is above a certain threshold. Conversely, if the hospital population goes down, the resources they save would be distributed back to the regions that are keeping people within the community.

{Tape: 2; Side: A; Approx. Time Counter: 27.7 - 39.6}
SEN. STONINGTON commented that this system has never been able to stay within costs, so in her mind this is a step in the right direction. **SEN. KEENAN** observed that this is true, and they have tried new, but ultimately unsuccessful methods to keep things under control over the years. **SEN. KEENAN** said that his first priority for Subcommittee funding is an MHSP pharmacy plan. Estimates on MHSP pharmacy were distributed.

EXHIBIT(jhh32a02)

SEN. COBB asked what they need to make this proposal work. **Director Gray** said that they will need more staff at MSH than was originally approved. If they do not get more staff for adult mental health, there will be a train wreck to begin at the start. They will also need pharmacy.

Ms. Steinbeck explained the FTE requests and said that it requests 8.00 FTE above the FY02 level. The decision package originally reduced the FTE at MSH by 23.00, but those will now stay and they will add 8.00 more FTE for a total of 31.00. There was a discussion on vacancy savings and the problems it causes for institutions. **Director Gray** reiterated that in order to make the proposal work they will need some of the positions.

{Tape: 2; Side: A; Approx. Time Counter: 39.6 - 48.9}
SEN. KEENAN asked Ed Amberg, Superintendent of the Montana State Hospital, how many people are being discharged from the facility now. **Mr. Amberg** said that situation has improved greatly since several years ago and reviewed the number of discharges and the types of problems involved in the ability to discharge. **SEN. KEENAN** next asked about the group homes and the cost effectiveness of such facilities. **Mr. Amberg** said that there are two group homes on the Warm Springs campus. They have considered remodeling some of the old buildings to create more group homes to prepare individuals for movement into the community. Responding to questions from **SEN. STONINGTON** with regard to the relatively high turnover in commitments, **Mr. Amberg** said that some of those individuals are emergency detentions, and typically those individuals do not stay for long periods of time. Emergency detentions are not running the costs.

{Tape: 2; Side: B; Approx. Time Counter: 0.6 - 6}
Mr. Anderson explained the purpose of the access payment to **REP. JAYNE** again and confirmed that only the four CMHCs would receive that payment. They have targeted the original funds for these four providers of nonMedicaid adult services. The Governor's request is $8 million below the current level, so this is a way to help those providers maintain services. **REP. JAYNE** asked how a mental health center becomes a community mental health center. **Mr. Anderson** said that there is a section of law which establishes the mental health centers. The county commissioners in each region have established these community mental health centers. Under the current system, any mental health center can not become a community mental health center. Part of the original purpose was to cover the entire state without duplication.

{Tape: 2; Side: B; Approx. Time Counter: 6 - 10.4}
SEN. KEENAN asked if BHIFs are designed to take pressure off of the emergency detentions, and **Mr. Anderson** said that they were not. The real purpose was to take the pressure off involuntary commitments. **SEN. KEENAN** then asked if there is a minimum stay requirement at Warm Springs. **Mr. Anderson** said that there is no minimum requirement. Referring to intergovernmental transfers(IGT) and the current proposal, **SEN. KEENAN** asked if county money comes to the State, is turned into Medicaid match, and somehow transformed into general fund money. **Mr. Anderson** said that when the money is paid to the provider it is a Medicaid payment, but it is not tied to a specific unit of service. Once the provider receives it, it helps the provider keep its doors open and make services available to Medicaid recipients and other low-income people. **Ms. Steinbeck** added that they can do what was described by **SEN. KEENAN**, but this is not what the access payment will do.

{Tape: 2; Side: B; Approx. Time Counter: 10.4 - 17.4}
REP. HAINES referred to the pharmacy part of the proposal in Exhibit 1 and asked how much of the funding for the adult nonMedicaid program is lost administratively. **Mr. Meyer** responded that the State is asking the four centers to manage the pharmacy benefit for nonMedicaid individuals. They have yet to set up the structure and have been discussing the options. The State knows that if it continues to manage the benefit as it has done, it will continue to see a 10 to 20 percent growth in costs per year. There is hope that growth will be held down by managing this through the centers with more specific pharmacy contracts and other options. The center does make use of prescription programs through pharmaceutical companies and other things to stretch this. They may also investigate using the pharmacy at MSH as the central pharmacy for this program. This

growth is due to the cost of medications; as drugs are more effective, they are more expensive. **REP. HAINES** said that he is trying to get a handle on how much the centers would expect administration of such a program to cost, and **Mr. Meyer** replied that they do not expect to make money on it. Referring to Exhibit 2, he said that within the Department's estimated pharmacy benefit, they believe there is adequate funding to administer this, but they have not estimated any percentage. At present, the Department is paying processing and packaging fees.

{Tape: 2; Side: B; Approx. Time Counter: 17.4 - 24.3}
Referring to the financial spreadsheet in Exhibit 1, **SEN. STONINGTON** said that they have budgeted $1.7 million annually for the BHIF concept and asked how it would be spent. **Mr. Anderson** said that it will pay for services for clients. **SEN. STONINGTON** said that a hospital would have to set it up, and asked if it would be a lock-down unit. **Mr. Anderson** said that they would insist that a BHIF have all of the security needed in a psychiatric inpatient facility. **SEN. STONINGTON** asked how flexible the BHIF money would be, and Mr. Anderson said that the money set aside for the BHIF would not be transferred. For Medicaid recipients it would go as fee-for-services, but they have also discussed the possibility of a block grant to assure that the provider has basic operating funds. **SEN. STONINGTON** asked if they intended to reserve a certain number of beds for State purposes. She said that it would save counties a lot of money if they did not have to take people to Warm Springs for detention. She can see them using these BHIF beds as a regional holding facility. **Mr. Anderson** said that they have not seen the need to specify bed occupancy since most of those emergency detentions are short-term.

{Tape: 2; Side: B; Approx. Time Counter: 24.3 - 31.1}
Responding to questions from **SEN. KEENAN**, **Mr. Anderson** said that this proposal would create some erosion in consumer choice providers since it would be for adult nonMedicaid people and sets up CMHCs as publicly funded service providers. They have discussed the BHIF proposal with Billings Deaconess. The closure of the psychiatric unit at St. Peter's Hospital had no initial impact on MSH; in fact, there was lower statewide utilization of MSH through the fall. Since Christmas, the population at MSH has risen dramatically. **Ms. Steinbeck** commented that it was her understanding that, regardless of the availability of psychiatric facilities, there are cyclical admissions patterns at MSH. **Mr. Amberg** said that there are always ebbs and flows with admissions. In January, they had 53 admissions which is very high. He does not know if there is any correlation to Christmas, but they have not seen a flood of admissions from Lewis and Clark County above normal expectations.

{Tape: 2; Side: B; Approx. Time Counter: 31.1 - 49.8}
SEN. KEENAN expressed concern about hospitals turning out psychiatric patients so that they can increase their profit margin.

Mike McLaughlin, Executive Director of Golden Triangle Community Health Center, said they manage the psychiatric unit for Benefis Hospital in Great Falls. There is a pattern of patients from Helena going to Benefis for treatment. The state hospital admission rate from the Helena area more closely approximates the admission rate from the other counties that Benefis serves. There is not a high admission rate from Benefis into MSH.

CHAIRMAN CLARK asked Bonnie Adee, Mental Health Ombudsman, for her take on this proposal. **Ms. Adee** said that given a choice between a shrunken or no benefit for nonMedicaid adults and this proposal, she supports the direction of the proposal. Without some level of coverage, there would be a tremendous vacuum. She did express concerns over the issue of choice, the grievance mitigation process in the contract, BHIFs, and concerns for protection of rights. She stressed that pharmacy must be covered, and expressed concerns for those who are not the most acute cases.

SEN. KEENAN asked **Mr. Meyer** about his commitment level to the concept of SAAs. **Mr. Meyer** responded that they need regional services and that local decision-making is critical to its success. He said that he is comfortable with the proposed plan.

{Tape: 3; Side: A; Approx. Time Counter: 0.3 - 6.4}
SEN. KEENAN said that his concern with SAAs is that they will end up with another layer of bureaucracy. He said that he is not condemning the SAAs, but they are at a crossroads, and they need a back-up plan. He suggested three regional administrators in the field to do this, stating that it might be more cost effective than a board. Referring to the budget, he said that it bothers him that in a $116.5 million budget, the direct county contribution is only $1 million per year. He would like a greater partnership with counties and perhaps that could be done through CMHCs. He asked Mr. McLaughlin if he is committed to making the SAA process work.

Mr. McLaughlin said that he is committed to making the SAA process work. There are two key components to this: 1) providing a regional entity for consumer and family member involvement, and 2) managing resources at the local level.

{Tape: 3; Side: A; Approx. Time Counter: 6.4 - 10.8}

Responding to questions from **SEN. STONINGTON**, **Mr. McLaughlin** said that the Central SAA has chosen to focus on stakeholder involvement and is beginning a process of strategic planning for management of services and resources. They have identified specific areas, such as consumer and family education, peer support, and empowerment on which to provide training and education. SAAs require consumer support in order to work. They received a planning grant, which has been expended. They are assured that there is additional funding to support the ongoing planning process. He said that he expects to be able to provide a product within less than two years. The SAA would manage funds that the Department manages currently, but which could be managed through the SAA.

{Tape: 3; Side: A; Approx. Time Counter: 10.8 - 20.6}
SEN. KEENAN said that he is concerned that the SAA would involve expense when they are trying to find funding from pharmacy. The model that he is considering would be a regional administrator working with CMHCs. He read the statute affecting the provision of mental health and said that he would like to see them do what is written in statute. He asked Frank Lane, representing the eastern regional SAA, to address the SAA concept. **Mr. Lane** reviewed the process that the eastern region had gone through, and said that their model is ready to go, but they decided to wait so that they would have an idea about the direction in mental health that this legislature would take. They have been committed all along to developing this in as efficient matter as possible. Because they incorporated an already existing mental health provider into an SAA and are the only ones who do involuntary commitments in their area, this proposal would change nothing for them.

{Tape: 3; Side: A; Approx. Time Counter: 20.6 - 25.6}
REP. HAINES asked **Mr. Lane** what function the SAA would serve that AMDD does not already, and **Mr. Lane** replied that there is none. He said that the concept behind SAAs is that decisions would be made locally.

{Tape: 3; Side: A; Approx. Time Counter: 25.6 - 35.4}
REP. HAINES commented that he is hearing no reason for the SAA, and asked for AWARE comments. **Jeff Olson**, **AWARE**, said that they had a mixed reaction to the proposal for SAAs. He questioned how it would operate, whether there would be choice, and whether competition would be allowed. He questioned the vision and the leadership, but said that he owes **Mr. Anderson** an apology because there is vision and leadership, it is just that he disagrees with that vision. The vision focuses on cost, not service, and there is a theme of putting all the funding in one place. He said that legislative policy should focus on the consumer, but what this

proposal does is define capacity by limiting choice. He said that access payments and creative financing are great, but rather than use the access payment for CMHCs, they should use it for pharmacy. **Mr. Olson** continued if the Medicaid access payment is being paid as a Medicaid payment, there are problems with having a provider panel, and there are problems in large sections of the state where CMHCs are not serving children. He questioned why they would use that funding exclusively for adult services to the exclusion of children. He commended Mr. Anderson and the Department for including the BHIF proposal within the budget proposal and said that the BHIF proposal is the most progressive piece of it.

{Tape: 3; Side: A; Approx. Time Counter: 35.4 - 48.5}
Ms. Steinbeck commented that about 75 percent of the Medicaid payments in the division are for children's services. If the access payment were allocated proportionally among Medicaid service payments, 75 percent would go for access to children's services. There are more Medicaid-eligible adult clients than there are children.

SEN. COBB reviewed the history of mental health plans and said that this looks like the old system although there are a few changes. **Ms. Adee** said that for the most part this is accurate, but she would make the distinction is the children's mental health portion. As far as the adult services, she agreed that the proposed model does look a lot more like what there was prior to managed care. **SEN. COBB** said that if they do go back to this system, what can they do to control the system.

{Tape: 3; Side: B; Approx. Time Counter: 0.3 - 1.3}
SEN. COBB said that if they put some checks and balances on this perhaps they will not have the problems they did before.

{Tape: 3; Side: B; Approx. Time Counter: 1.3 - 10}
SEN. KEENAN asked **Mr. Anderson** about his vision for and commitment to SAAs. He said that he included the SAAs in SB 347 so that there would be discussion of this issue. **Mr. Anderson** said that the Department is committed to the concept and envisions SAAs as a regional management system for children and adults, but the process will need to be coordinated with the entire Medicaid redesign process. There seems to be agreement on the idea of local management of services, decision making, and determining priorities. There is a question about the vehicle by which this could be done. The problem with having a regional authority from the state is that families, consumers, and advocates want to be more directly involved in the policy-making process. He said that there is money in the base budget for consumer and family education, and this is a function that he

would like to turn over to the SAAs. He would like to turn over some of these functions little-by-little to SAAs. He said that the proposal for the non-Medicaid adult system tests the SAA idea. It places responsibility for management of mental health services and the flow to and from the state hospital on local community mental health centers. This will be a basis on which they can conclude that the SAA concept of local control will or will not work.

{Tape: 3; Side: B; Approx. Time Counter: 10 - 13.1}
SEN. KEENAN commented that they will never have enough money for mental health and asked what was wrong with prioritization by diagnosis in the adult system. He expressed concern that they are trying to do too much with the system, and those with acute needs are not receiving services to the detriment to the safety of the community and themselves. **Mr. Anderson** said that he agreed and the original proposal narrowed the eligibility for the non-Medicaid. He said that in the contracts they will have with the CMHCs they will identify priority populations, which will be determined by diagnosis, history of repeated hospitalizations, co-occurring chemical dependency, and criminal history.

{Tape: 3; Side: B; Approx. Time Counter: 13.1 - 17.5}
Responding to questions from **REP. HAINES** regarding SAAs, **Mr. Anderson** said that value of SAAs lies in their connection to the local community. He said that providers, consumers, families, and other advocates would have a direct role in helping create the local policies. **REP. HAINES** expressed concerns that the Department would not have control and that there would be a lack of accountability. Mr. Anderson replied that DPHHS would maintain control since it would appropriate the funding for the SAAs.

{Tape: 3; Side: B; Approx. Time Counter: 17.5 - 45}
{Tape: 4; Side: A; Approx. Time Counter: 0.3 - 3.5}
Ms. Steinbeck observed that the agency and the providers say that the proposal is underfunded. They also say that pharmacy is underfunded. She said that she did not know what the appropriate level of funding would be. There was discussion of funding for the proposal and pharmacy. There was also discussion of the level of risk which would be shifted to the CMHCs and whether they have the right to refuse services. The Subcommittee expressed frustration over adult mental health services and requested a more cohesive plan including a vision of what could be accomplished in two years. **Mr. Anderson** said that he will bring them a revised plan and emphasized his continued commitment to the SAA concept. He said that the division will continue to work with local providers on a process and time lines. The Subcommittee discussed what could be accomplished with SAAs,

CMHCs, BHIF and what level and streams of funding they would require.

{Tape: 4; Side: A; Approx. Time Counter: 3.5 - 5.5}
Ms. Steinbeck reviewed the plan for the remainder of the hearing.

HEARING ON REFINANCING

{Tape: 4; Side: A; Approx. Time Counter: 5.5 - 14}
Chuck Hunter, Administrator of the Refinance Unit, distributed a handout and explained the difficulties inherent in predicting savings. He said that one issue is the need for maximum flexibility in order to do the things that must to collect as much federal revenue as they can. The second issue involved is authority. If they are going to achieve savings and maximize federal revenue in a variety of places, it will be difficult to predict where the savings will show up and in what amounts. They will need more federal authority if they are successful in pulling down more federal revenue. There will be contract costs which will need to be paid. The final issue is the recovery of administrative costs. He then directed them to the proposed refinancing language in HB 2 in the handout (Exhibit 3).

EXHIBIT(jhh32a03)

Mr. Hunter went over the proposed language which authorizes the refinance unit five FTE and recovery of costs from the savings generated by refinance. The Department is considering a rate of perhaps one percent on savings recovered department-wide. The second paragraph discusses the application of the savings generated: 1)to pay for the cost of the refinance unit; 2)maintenance of existing services; 3)reinstatement of services that have been cut in the 2003 biennium. Additional savings would revert to the general fund. There would be no program expansion.

{Tape: 4; Side: A; Approx. Time Counter: 14 - 21}
Ms. Steinbeck said that these would be good concepts, but are inappropriate for HB 2. The second paragraph is an implied amendment to substantive law. The correct vehicle for this would be a subcommittee bill. She suggested that the Subcommittee could consider funding for 5.00 FTE as a one-time-only separate line item.

{Tape: 4; Side: A; Approx. Time Counter: 21 - 30.2}
Mr. Hunter discussed the Maximus Consulting Firm summary of initiatives and potential revenue. The amounts are total funds and in most cases represent an increase in federal dollars that may be available by pursuing these initiatives. Maximus believes

that $14 to $19 million might be realized. One-third of those are related to issues which would take more general fund to achieve. He also discounted some of the initiatives based on feedback from administrators. **Mr. Hunter** said that he believes that they could realistically save about $10 million in new federal money over the biennium. It would be new federal money as a result of pulling down more federal dollars with existing revenues. Of this amount, they need to generate $6 million for Child and Family Services(CFS). A discussion on potential additional amounts that could be generated, how they could be used, and needed statutory changes with respect to the funds followed.

{Tape: 4; Side: A; Approx. Time Counter: 40.2 - 49.5}
Mr. Hunter said that the Intermediate Care Facility for the Mentally Retarded(ICF/MR) tax bill is still in the drafting process. He discussed the issue involved in the upper payment limit(UPL)for the two facilities and cautioned about putting too high a tax on this. The Department feels that they are safe with the 5.5% level proposed in the tax, but if they wanted an extra measure of safety they could drop it to 5%. **Mr. Hunter** said that closure of Eastmont would increase revenue and expenditure of Montana Developmental Center(MDC) which would affect the numbers. If clients at MDC are certified at a different level, it would impact the numbers as well. There was discussion of the Centers for Medicare and Medicaid Services(CMS)review of MDC, the redefining of individuals needing active treatment, and when they could expect a report.

{Tape: 4; Side: B; Approx. Time Counter: 0.1 - 6}
Jeff Sturm, DD, reviewed the issue of allegations of abuse and neglect in the ICF/MR and said that it requires immediate suspension which can cause staffing problems. There will be a compliance check on this, after which they will have more information. There was further discussion of Medicaid payment for individuals with behavioral issues, associated problems with the redefinition, and possible actions that Disability Services Division(DSD) could take to mitigate the problems.

Mr. Hunter said that the Department would work with staff on the refinance issues.

Ms. Gervais reviewed the update of the comparison of eligibility for DPHHS programs.

EXHIBIT(jhh32a04)

ADJOURNMENT

Adjournment: 12:00 P.M.

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REP. EDITH CLARK, Chairman

_____
SYDNEY TABER, Secretary

EC/ST

EXHIBIT(jhh32aad)