MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING
AND
JOINT SUBCOMMITTEE ON INSTITUTIONS AND CULTURAL EDUCATION

Call to Order: By **CHAIRMAN JOHN COBB**, on January 25, 1995, at 8:00 a.m.

ROLL CALL

Joint Subcommittee on Human Services and Aging Subcommittee Members Present:

Rep. John Cobb, Chairman (R)
Sen. Charles "Chuck" Swysgood, Vice Chairman (R)
Rep. Beverly Barnhart (D)
Sen. James H. "Jim" Burnett (R)
Rep. Betty Lou Kasten (R)
Sen. John "J.D." Lynch (D)

Members Excused: none

Members Absent: none

Joint Subcommittee on Institutions and Cultural Education Members Present:

Rep. Marjorie I. Fisher, Chairperson (R)
Rep. Red Menahan (D)
Rep. Steve Vick (R)
Sen. Larry Tveit, Vice Chairman (R)
Sen. Gary Aklestad (R)
Sen. Mignon Waterman (D)

Members Excused: none

Members Absent: none

Staff Present: Lois Steinbeck, Legislative Fiscal Analyst
Lisa Smith, Legislative Fiscal Analyst
Connie Huckins, Office of Budget & Program Planning
Mary LaFond, Office of Budget & Program Planning
Douglas Schmitz, Office of Budget & Program Planning
Ann Boden, Committee Secretary

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

Committee Business Summary:

Hearing: Mental Health Managed Care Program
Adult Mental Services proposals
Executive Action: None

{Tape: 1; Side: A; Approx. Counter: 000; Comments: This meeting was recorded on two 60-minute cassette tapes.}

HEARING ON
MENTAL HEALTH MANAGED CARE PROGRAM

Dr. Peter Blouke, Director, Department of Social and Rehabilitation Services (SRS), spoke about the merits of SB 223. A key component of the proposed Mental Health Managed Care Program is to be able to expand the eligibility for mental health services up to 200% of the federal poverty level. Legislative authorization is necessary to do this. In addition, SRS wants to incorporate the Montana State Hospital into the Managed Care Mental Health System. This bill will provide for a special revenue account and the spending authority for this.

Ms. Mary Dalton, SRS Primary Care Bureau Chief, explained that the bill is also necessary due to the fact that the company that will be managing this organization does not meet the requirements for being a HMO in the state at present. In conjunction with the Insurance Commissioner, SRS has chosen to seek an exemption for this company rather than drafting a new set of regulations.

Dr. Blouke then stressed that all the positive aspects of the Managing Resources Montana (MRM) Program would be incorporated into the Mental Health Managed Care Program. Personnel involved in the MRM Program have been and will continue to be involved in the Managed Care proposal process and the development and evaluation of the RFP (Request For Proposal). He stated that funding for the MRM Program needed to be provided for both years of the upcoming biennium.

SEN. MIGNON WATERMAN asked for more information regarding how the good aspects of the MRM Program would be incorporated into the Managed Care Program and how this would appear in the RFP. She wanted assurance especially that the child and parent-involved team approach to case management would specifically be included in the RFP. She suggested that the advisory boards which are components of the MRM Program be used as models when designing the new system. She wanted to be assured there would be adequate funding for youth services and that it wouldn't get "lost" in the Managed Care Program. **Mr. Blouke** said SRS is not in a position yet to say exactly what the language would be in the RFP. However, he agreed conceptually with **SEN. WATERMAN'S** statements. One of the main reasons they are going this route is to expand services to children and provide for a seamless system between children and adults and he assured **SEN. WATERMAN** it could be incorporated into the RFP so that all the funding wouldn't be drained off to adults.

Mr. Hank Hudson, Director of the Department of Family Services (DFS), then spoke. He emphasized that there is a feeling among the departments involved in formulating the Managed Care Program

that things are getting done in a collaborative way much the same as occurred when the MRM Program was initiated.

Mr. Rick Day, Director of the Department of Corrections and Human Services (DCHS), said his department has been directly involved in the process of putting together the managed care proposal and they are in support of the Program being instituted.

Ms. Lois Steinbeck, Legislative Fiscal Analyst (LFA), then reviewed the LFA issues with the Managed Care Program, as outlined on pp. B-33-35 of the LFA 1997 Biennium Budget Analysis book. Regarding the LFA issue suggesting that the Legislature may wish to consider costs and savings of the proposal once the executive develops its cost/benefit analysis, she reported that the department is awaiting some information from a consultant regarding the cost of the proposal and it has been requested that the Legislature receive a "blueprint" of the budgeted amounts from SRS, DFS and the Department of Corrections and Human Services (DCHS) so that there will be a baseline to judge costs from. This will help address some of the issues brought up in terms of what will happen to MRM.

Ms. Nancy Ellery, Administrator of the Medicaid Services Division, SRS, addressed the LFA issues. She urged the subcommittee to recognize that the savings expected and the funding coming in is coming from different departments. The money that will go into the "managed care pot" is funding which is already in the respective departments' budgets. Regarding revising expected savings due to the delay in implementation in FY96, she reemphasized that the delay is related to the length of time that HCFA is taking to approve waivers. About 22 other states are looking at implementing or have implemented waivers at present. The expected date of implementation of Montana's program is July 1996. Because of that, SRS feels it is important to take out $2.1 million in savings from the budget. SRS's contractor has given them some estimates regarding savings and they still feel the $2.1 is a realistic amount to expect, although it will not materialize in 1996.

In terms of the executive identifying what type of funds should be appropriated to the Montana State Hospital, **Ms. Ellery** said figures were forthcoming which will show what portion of the State Hospital money should be included in the budget, as well as the Center for the Aged.

Regarding the possibility that the federal government will not approve the proposal as it stands, SRS has attempted to deal with all of the issues HCFA has raised.

Ms. Ellery addressed the issue raised about the leverage the department has if managed care costs exceed the appropriation. She emphasized that the approach in the mental health component would be different than in the physical health portion. On the mental health side, every person would be covered under this

system. They have contracts which provide for amendment of the contract in the case of under-appropriation. She did not expect this to happen because the orientation of the program is to reduce the rate of growth and to project costs accurately. She pointed out that the other things that usually make expenditures exceed appropriations will be controlled through the Managed Care Organization (MCO), and they expect there will be savings and the situation that might occur in the fee for service programs would not occur in this case.

Ms. Ellery explained to **CHAIRMAN MARJORIE FISHER** that for the people between 100-200% of the federal poverty level, there will be a "co-pay" requirement on all services. The beginning level of the co-pay will depend on what the actuary comes up with; these calculations have not been completed.

In response to **SEN. J. D. LYNCH, Mr. Dan Anderson,** Administrator of the DCHS Mental Health Division, said the Montana State Hospital under Managed Care would continue to be state-owned and staffed with state employees. The MCO will purchase services from the State Hospital in the same way it would from other hospitals and providers.

SEN. LYNCH wanted to know how the State Hospital came up with its daily rates, etc. **Mr. Anderson** said it would be his preference that DCFS determine the rates. Part of **SB 223** would allow the department to establish an "all-inclusive" rate. They believe that over approximately four years the population of the State Hospital will go down to somewhere around 135 patients, but this will depend on what happens with Managed Care. The MCO will undoubtedly be involved with the patients at the hospital regarding when they will be ready for discharge and the services that will be needed after that, but the laws regarding commitment will not change. A conflict resolution process will be needed for those instances where DCHS might disagree with the MCO about a discharge decision. State Hospital staff are concerned about whether there will be appropriate community-based services available, and if they are there should not be many conflicts.

SEN. LYNCH wanted to know if there would be any additional staff layoffs at the State Hospital. **Mr. Anderson** said they anticipate there will be fewer employees at the hospital in four years. They hope to accomplish this through attrition and transfers.

REP. RED MENAHAN said it was his feeling that in order for the companies involved in Managed Care to make a profit they would have to cut back on services or costs. **Mr. Anderson** said any system set-up has to look out for incentives to not do the right thing. It will be important to very carefully write both the RFP and the contract with the MCO to ensure adequate oversight on the part of the state. Also it needs to be required that the MCO itself have oversight over the services they are buying and whether they are effective. He pointed out that if a person who

is discharged from the State Hospital is ignored, the MCO runs the risk of incurring more costs if the person relapses.

CHAIRMAN COBB pointed out that the MCO would not be required to purchase services from the State Hospital, and if they didn't, the hospital would have to downsize due to a shortage in revenue. **Mr. Anderson** said they anticipate a phase-in for the State Hospital into the Managed Care System. Under this scenario there will be an increasing number of beds the MCO purchases. DCHS does not want to jump into a completely new system and risk the loss of the safety net for the system. He acknowledged that over time the State Hospital might be used less than it is being used at present.

SEN. LYNCH said his problem with the proposal was the only patients that will be at the State Hospital will be patients sent by the MCO. Other hospitals will have patients from more than just this source. **Mr. Anderson** pointed out that the forensic patients would be outside the managed care system. He added that the process of getting into the State Hospital would remain the same. The financing of the services is what is really going to be changed. Money currently going from DFS, SRS and DCHS will be going into one system. The funding for the forensic patients will be appropriated in the same way as it has been in the past.

REP. MENAHAN wanted to know if turning over the Managed Care Program to a private company would result in staff reductions within state government. **Mr. Anderson** said that in terms of their functioning in the Mental Health Division, they will need all their current staff until the program is up and running. After that point, staff reductions might be possible. He stressed the importance of keeping in mind that the MCO is being asked to do something quite different from what the state's staff is currently doing. He anticipated that they would continue to have the responsibility for oversight of these programs, particularly in the community settings.

SEN. LYNCH wanted to know what the potential MCO's anticipate their profit margin would be. **Ms. Dalton** said when the contract is bidded out it will be at a flat rate which the companies will have to provide all services and administration under. SRS will be asking for what would have been in the budgets of DCHS, SRS and DFS, minus $2.1 million in general fund from FY97. She pointed out that this money will be paying for not only people who have been served previously but also those people up to 200% of poverty. The contract with the MCO will last for two to three years; the waiver will be for five years.

CHAIRMAN COBB wanted to know how the projected general fund savings figure of $2.1 million was arrived at, and why this couldn't be said about Managed Care. **Mr. Blouke** explained that an organization was going to be contracted with to manage the system. An alternative would be to hire the FTE to do the same thing, but the contract will be with a corporation with

experience in this area and has the financial backing to develop and work with the funds, and the state is contracting so the CMO will have the risk and not the state. There is only one person at SRS who is working on this. The MCO will have all the resources available that a large corporation has and thus will be in a better position to try and make a profit.

REP. MENAHAN concluded that the MCO will be making money off the state's poor management. **Mr. Blouke** said this was correct, and pointed out that this was the case whenever an agency contracts for expertise outside its scope. He also pointed out that the MCO would have the flexibility to utilize its employees in ways the state wouldn't be able to. **REP. MENAHAN** felt that if management was going to be handled by an outside corporation then there should be corresponding staff reductions within state government, specifically in Helena. **Mr. Blouke** said what they want to do is not expand the staff in Helena but to expand the staff and the treatment in the field. **REP. MENAHAN** submitted that was impossible under this system: the way the MCO makes money is by cutting services to the people in the field.

In response to **CHAIRMAN FISHER, Ms. Dalton** said very early in the process an RFI (Request for Information) was sent out to different kinds of companies which asked for input on whether SRS should separate out physical from mental health and what kinds of qualifications the companies had for doing the job. Several large companies are interested in the mental health portion of managed care. They do not have a sole source but will be putting out an RFP. Some states have particular license categories and rules for these kind of companies because they offer a limited service. The Insurance Commissioner felt at this time that it would be better to just grant an exception to the HMO law than to try and develop a full set of insurance laws to cover them. They have talked to eight or ten companies that are interested in doing the job.

In response to **REP. BEVERLY BARNHART, Ms. Dalton** said one of the components of a federal 1115 Waiver is that the state has to do a quality assurance program as well as the managed care company. The state also has to have under a demonstration waiver an independent evaluation to assure that the care is at least as good under the new system as it was under the old system. If it is not as good, the federal government will not continue the waiver. SRS intends to use advocates in its advisory group to make sure that care does not deteriorate under the new proposal. She said that everyone under 200% of the federal poverty level will be served, about 40% of the population of the state. In this system, instead of having a piece of the population that won't be served, comparisons will be made against other states which do not have managed care systems.

REP. BETTY LOU KASTEN asked for information about how income was determined when arriving at the 200% figure. **Ms. Dalton** said she

believed it would be based on gross income, and the intent is to keep the determination procedure simple.

In response to **CHAIRMAN COBB, Ms. Ellery** said SRS has some preliminary information from their consultant on rates and based on those assumptions they are still comfortable with what they have in their budget for savings. The one thing absolutely critical to a managed care system is to integrate the financing and delivery of the system. SRS feels problems would arise if only adults were included in the system because there would be a different accountability system for kids than adults. With a family it is important to have the same system for all members of the family.

In response to **CHAIRMAN COBB, Ms. Ellery** said the whole point of having a managed care system is that the state will have more control over costs. Based on the experience in other states, the rates set will result in improved access, expand services at the lower end of the continuum and contain costs.

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Ms. Ellery said they estimate that under managed care there will be 10% less growth than what would have occurred otherwise.

SEN. LYNCH wanted to know if the Legislature would be able to meet with the companies that are interested in the MCO job. He asked who would ultimately make the decision of which company to chose. **Ms. Ellery** said some of the companies would be delighted to talk to the Legislature. A committee from the advisory council will be selected to evaluate the RFP's. They will make a recommendation to the Governor and the directors of SRS, DFS and DCHS, who will have the final decision. **Mr. Blouke** said ultimately the Governor would be involved in the final decision.

SEN. WATERMAN spoke in support of having one managed care contract that would cover all the members of a family in need of services. If in the future the cost of mental health is escalating the MCO could present the state with options for meeting the increased costs. She said this would be better than what has been done in the past. Either way the Legislature will be facing cuts but she preferred making more informed decisions based on the expertise of the MCO. **Ms. Dalton** said they hope they will get the best handle they can on management through the Managed Care Program.

In response to **SEN. LYNCH, Ms. Smith** said it is her understanding that the Legislature could authorize a contract for up to two years; anything beyond that would be contingent on continued legislative approval.

CHAIRMAN COBB asked if it had been decided specifically how MRM would work with Managed Care. **Mr. Anderson** said it has been decided that under the Managed Care system the MRM system would

disappear as its own managed care system. The specifics regarding the interactions between the regional teams and the MCO have not been worked out.

REP. BARNHART asked if it would be feasible to write into the contract with the MCO limits on the amount of profit they could make. **Ms. Dalton** replied that some states have done this. The person that has done the system design in Montana has recommended initially for the state not to do this, however. The reasoning is that with a cap what you have is the state's financial people disagreeing with the company on how much profit occurred. The recommendation instead was for a quality assurance program.

Testimony:

Ms. Kathy McGowan, representing the task force from Helena, then spoke. She explained that the reason a majority of the persons on the force were from Helena was due to attempts on the part of the represented groups to save on transportation costs and travel considerations.

Ms. McGowan stressed that either the Managed Care proposal or something like it has to happen or there will not be mental health services in the state as they have come to be expected. Most of the mental health centers have come around from their original opposition to the proposal because they know something has to be done. Regarding the 200% of poverty issue, right now all of those people are already being served anyway, but it is happening with general fund dollars. She cautioned the Legislature not to thumb its nose at federal dollars while they are still at least available.

Regarding the question about expertise, she expressed doubt that at present the state could do what would be required. The state has no management information system or the expertise to present the good outcome information the Legislature desires. Regarding setting a cap on profits, she said this was done in Massachusetts. She pointed out there were vast differences between that state's situation and Montana's, however, including many more mental health facilities. She said Montana could not anticipate the same level of profits as in Massachusetts. The companies the mental health centers have been talking to since they decided to support managed care do not expect any profit at all for the first several years, and maybe 3-5% thereafter. Consultants hired by the CMHC's suggested that they develop a formal relationship with a company they felt comfortable with; this has been done. **SEN. LYNCH** wanted to know what they would do if it was not the company the state chooses to go with. **Ms. McGowan** said there were lots of other eligible companies, but the company they have entered into the relationship with will probably be the one that they join with in making a proposal in response to the RFP. No matter what happens, the CMHC's will end up being providers just like anyone else.

Ms. McGowan reinforced that they had also come to the conclusion that it would be best to fold MRM into the new system. She said it has done an admirable job, but it truly is not an MCO. A big problem with this, however, is it would require having to run dual systems for children and adults. She added it did not make fiscal sense to have separate administration of two different programs. She stressed the need for careful consideration of the issue, with an eye to what the situation will be in a few years.

Mr. Patrick Pope, Director of the Meriwether Lewis Institute and a member of the Medicaid Managed Care Advisory Group, testified. He distributed a copy of his testimony as well as a position paper which had been submitted to Medicaid regarding the Managed Care RFP. **EXHIBITS 1 and 2** This is the first time they have had hope that there can finally be a mental health system in Montana that actually works. He disagreed that Managed Care companies will make money by cutting services: they will make money because they will be providing less restrictive services. The Managed Care company will be able to address such things as employment, which will lead to fewer clients needing services.

Although the Institute started out as an adult advocacy group, they have become more and more involved in children's issues. He stressed the importance of a smooth transition in services from youth to adult. He emphasized that the Legislature needs to keep politics out of its decisions and instead focus on the lives its decisions will affect.

Mr. Ron Green then testified, as a mental health consumer and a physically and mentally disabled veteran with post-traumatic stress disorder. Inadequate treatment related to budget cuts would be prevented under a managed care system.

Ms. Marty Onishuk, Vice President of the Montana Alliance of the Mentally Ill, spoke. Forty-four different states are looking at Managed Care as an alternative. The present fee-for-service system does not include all of the services their family members need. Managed Care would be a more flexible system and she expressed hope that some of the money being used for hospitalizations would be moved to the communities. They have a concern that children's needs might not continue to be addressed as they are under the MRM system. They are also concerned because the State Hospital, which has 512 FTE, is using up a great deal of the present general fund budget. They feel this does not make sense: the State Hospital is nearly twice as costly as it would be to provide community-based services. She stressed the use of a rehab model vs. a medical model, to get people back into society and functioning.

HEARING ON
ADULT MENTAL HEALTH SERVICES PROPOSALS

Informational Testimony:

Mr. Dan Anderson, Administrator of the DCHS Mental Health Division, spoke. The executive budget increases represent necessary expansions of services, regardless of the funding mechanism. He gave a brief overview of the public mental health system for adults in this state, which contains three main components: the State Hospital, the Center for the Aged and the Community Mental Health system. The hospital serves only adults, about 200 per day on average. Virtually all patients come to the hospital through court order. Patients in the acute unit have an average stay of about 40 days. Other units have longer stays; overall the average length of stay is 200-250 days.

The Montana Center for the Aged, located in Lewistown, has 140 patients. The Center serves persons older than age 55 with mental illness who do not require active in-patient treatment.

The Community Mental Health Program for adults in Montana has changed over the past 15 years. At one time money was granted to the CMHC's and they were expected to serve a wide range of people. Now, 92% of the funding directed at the CMHC's is directed specifically for adults. 92% of the adult money is for severely disabled mentally ill persons. In 1994 the Community Mental Health system served about 4,100 adults with severe mental illnesses. Services include intensive case management, day treatment, psychiatric services and crisis intervention. The CMHC's are private non-profit organizations.

Mr. Anderson referred the subcommittee members to pp. D-139 and D-140 of the LFA Budget book. Regarding the proposal for expansion of housing and crisis intervention services, the housing part of the proposal has been successfully tested in Butte. He stressed they were not proposing a rent subsidy program; the funding would be for the CMHC's to help get people into housing and to oversee their progress. In several communities now there are crisis intervention houses. They have six to eight beds which are used for up to a two-week period in times of crisis. Medical and support services are made available to the client. This set-up helps prevent hospitalization. Part of the reason this program was adopted was in response to legislation passed which ended the practice of holding mentally ill persons pending commitment hearings in jail.

Mr. Anderson then discussed the proposal for a sex offender treatment program. Sex offenders are currently held at Boulder, Warm Springs and the State Prison, but none of these institutions has a specialized program to meet their needs. It is proposed to use existing space and staff resources at the State Hospital to start such a program. He explained that the persons under this program would all be adults who had been convicted of a sexual

offense. The operating expenses being requested would run the program as well as provide for aftercare services.

Proponents' Testimony:

Ms. Donna Hale, representing the National Association of Social Workers and the Montana Mental Health Private Providers Coalition, then spoke. In response to concerns regarding the mental health managed care bill an advisory committee was formed. She emphasized, as a member of that committee, that many hours have been put into addressing the questions before the subcommittee. She said that for the first time in Montana, consumers, private providers, mental health centers and state agencies are all working together. She urged the Legislature's support of this.

Ms. Hale submitted the present system does not even come close to meeting all the needs of the consumers; a managed care system would provide a better chance for this to occur.

Mr. Keith Schaffer, representing CMG, one of the managed care companies interested in the RFP, then testified. His company is a behavioral health care company, not a HMO, and serves about 1,500,000 people in 34 states. This proposed change should result in both quality and cost-efficiency, but if it is done with only the goal of cutting the budget it will not be successful. One of the ways the state will know the system is working will be via a reduction in the number of persons entering residential care, fewer suicides and a reduced amount of persons re-entering in-patient care settings. The positive aspects of a successful managed care system will show up as increased employment of mentally ill persons and the maintenance of positive home environments for those in need. Although it is difficult to do, there are ways to build quality into the system as well as cost-efficiency.

The issue of why the state can't do this itself was addressed. In Missouri, as director of that state's Department of Mental Health, he was involved in trying to reform that system . There is a culture in managed care very different from the public mental health sector. The private sector can provide a lot of technical expertise, but he felt that after five years or so the state will be able to take back responsibility for even the technical aspects of the system. A big profit margin will not happen in the public sector managed care world for behavioral health. His company hopes to break even in the first few years and someday hopes to achieve a 5% profit margin.

Mr. Schaffer expressed admiration for the MRM Program and stressed the importance of retaining the philosophy behind that program. He felt this could be done within the context of managed care or outside the context of it, depending on how the RFP is written.

{Tape: 2; Side: a; Approx. Counter: 000; Comments: n/a.}

Regarding the State Hospital, he said the hospital will continue to have a market for forensic business. He did not, however, see a major role in acute care, which needs to be moved back into the community.

Mr. Bob Olson then spoke on behalf of the **Montana Hospital Association** in support of managed care, provided it treats facilities and their patients fairly. **EXHIBIT 3** They do not believe that the budget should be cut during the coming biennium in anticipation of savings from managed care. At this point in time the Hospital Association does not support the closure of the Montana State Hospital, although they do support the development of regional adult residential care. Regarding gaps in service, he reported that Shodair wrote of $1.3 million in uncompensated services since the system was crashed in 1993, and they believe these costs ought to be covered under managed care.

Ms. Barbara Mueske, Program Director of the Butte Community Support Services Program, spoke. Their 24-hour crisis response team service helps people be evaluated in hospital emergency rooms rather than in jails. In this process people can be placed appropriately in the least restrictive environment. The State Hospital is used when necessary but they look at all possible community options as well. She reported that the census at the State Hospital has gone from 225 to 180-195 due to these kinds of efforts. In 1994 their crisis response team responded to 442 calls.

Ms. Cheryl Jorgensen, Program Manager for Silver House, the crisis stabilization program in Butte, then reviewed that program. In 1994 they served 363 consumers. Due to the majority of their clients having a history of years in the State Hospital or with no treatment, there are many needs which have to be addressed. The average length of a stay at the crisis house ranges from three days to two weeks; they have a capacity to serve eight clients and people are turned away every day. She stressed the need for more crisis houses.

Ms. Denise Matheson then testified from her perspective as a former client of the Silver House. She read some letters congratulating her on her successful transition to the community setting and praising the work of the Silver House.

Mr. Jane McCall, Executive Director of the non-profit private corporation called Youth Dynamics, then testified. Her company provides therapeutic foster care to emotionally disturbed youth as well as family-based services. She rose in support of taking a progressive rather than a reactive approach to the issues, and stated that managed care was a good way of doing this. They are serving over half of the 163 therapeutic foster care placements in various programs around the state. She stressed the importance of developing a system which will address the needs of

the entire family. A private/public partnership in Montana is long overdue.

Mr. John Lind, Associate Director of the Mental Health Center in Missoula, spoke. He also spoke as vice chairman of the state's Mental Health Advisory Council. The public debacle of deinstitutionalization in Montana in the 1970's was a result of funding not following the patients into their communities. Historically in Montana nearly 80% of the general fund dollars for mental health has gone to institutional care. He acknowledged the importance of the role of the State Hospital but pointed out that there is an increasing amount of technology in the communities to support individuals closer to their homes. The most critical gaps in service in the communities have to do with housing and crisis services. The proven programs now in place exist in Helena, Kalispell and Butte. Increased funding is being requested so more communities can establish similar programs.

Mr. Patrick Pope, Executive Director of the Meriwether Lewis Institute, then rose in support of the Mental Health Division's budget request, specifically the expansion of housing services. The money being requested is nowhere near what is needed but is a start. He stressed the importance of crisis intervention services as well. Although they have some concerns about the proposed Sex Offender Program, they support it in concept.

Mr. Terry Schroeder, representing the Region Five Community Mental Health system's Crisis Intervention Services, then testified in support of DCHS's funding request. The crisis house concept, especially in urban areas, married with the mental health professional component provides the glue of consistency to crisis intervention. They see a lot of people who are not seriously mentally ill but are in situational crises; in the last three months Flathead County had 343 such encounters. Crisis intervention services provide both a cost-effective and compassionate way of dealing with people in crisis.

Ms. Candace Butler, Region Five Community Support Program Director, then spoke in support of the request for increased funding for housing. Lack of affordable, safe housing is frequently one of the factors leading to crises and contributes to longer hospital stays. Housing assistance is important for consumers who have been discharged from an institution but do not yet have an income. At present, most consumers have to exist on an average monthly income of $464.

On behalf of the Montana Mental Health Association, she highlighted some of the platform statements of their Public Policy Committee. They support the inclusion of institutional services presently offered by the Montana State Hospital in a pre-paid managed mental health plan. They also support a requirement that state-funded in-patient psychiatric services be provided in a facility that is accredited by the Joint Commission

on Accreditation of Health Care Organizations. They support comprehensive community mental health services which provide continuum of care, regardless of diagnosis. They also support a prepaid mental health managed plan which includes both Medicaid dollars as well as state funds, with all savings to be retained in that system.

Ms. Onishuk added to her testimony that housing is one of the most important things their family members need. They also think crisis intervention is very important. Regarding the Sex Offender Program, they are concerned about mixing a prison population with people with chronic and serious mental illnesses, such as **HB 93** proposes.

Mr. Bob Torres, representing the National Association for Social Workers, rose in support of the budget request. They estimate that over half of the mentally ill are untreated, and support initiatives in both the public and private sectors that provide services; they are in support of the Managed Care proposal. Overall, the existing range of services needs to be expanded, with an emphasis on early intervention that is less restrictive; they feel a comprehensive RFP would do that. They feel this will provide cost savings. A high priority for them is services to children. Regarding questions about the safeguards of quality, he emphasized that the reviewers and case managers need to be licensed, certified and experienced and they hope this will be spelled out in the RFP.

Mr. Jeff Stern, Clinical Director of Helena Community Support Services, which is part of Mental Health Center, Inc., then spoke. His organization provides a variety of services to seriously mentally ill adults. The crisis programs in Helena contain a continuum of services including a 24-hour on-call crisis response therapist, crisis phone lines and a residential treatment facility. The primary goal of Crisis Services, in additional to providing quality care, is to provide a diversion to in-patient care. Nationally, crisis stabilization programs have regularly documented 90% or more reductions in hospital admissions. Currently their cost for providing services is $159 per day, half the cost of the State Hospital and one fourth the cost of private authorizations. Not only have crisis services reduced hospital admissions, but they have limited hospital stays. Their services have not only benefitted Helena residents by averting more serious problems but likely have interrupted many suicide attempts.

Another problem faced by providers is the availability of housing for the mentally disabled. Affordable housing in Helena is difficult if not impossible to find. As of January 1995 the Helena Housing Authority reported there were 287 individuals on their waiting list and 582 on the waiting list for Section 8 housing. He pointed out that substandard housing is a factor in the problems with depression some of their consumers experience. Housing support needs to be viewed not just as a supplement to

services for the mentally ill but as a vital component of a community-based mental health system.

Questions:

REP. MENAHAN said the places that were picked by the providers for housing were in the high-cost areas. He asked why the providers are not considering establishing some of these programs in areas where people with lower incomes could have better housing than is available in other communities. **Mr. Stern** replied that there are programs in smaller communities, but he pointed out that the clients often locate in larger communities for reasons related to better employment and other opportunities. **REP. MENAHAN** submitted that programs were being expanded in communities where the cost of housing was the highest. **Mr. Stern** said they encourage the start of programs in smaller communities.

Ms. Andree Larose, a staff attorney with the Montana Advocacy Program, then spoke. She emphasized that Montana law says treatment should be provided in the least restrictive setting. The law says that the problem is, this is not always the reality and this needs to change. They support the department's request for funds for community services. Only if a continuum of appropriate community services is developed will this be implemented.

REP. MENAHAN asked for a definition of the term "least restrictive." **Ms. LaRose** said this generally this refers to an environment in which people can maintain social and family ties within a community where they have access to services that other people have. **REP. MENAHAN** said he couldn't see the rationale that an urban setting would be less restrictive than a rural one.

Mr. William McCausland rose in support of adequate funding for housing as well as the managed care proposal.

ADJOURNMENT

Adjournment: 11:26 a.m.

Note Read 6/95

REP. MARJORIE I. FISHER, Chairman

REP. JOHN COBB, Chairman

for DEBBIE ROSTOCKI, Recording Secretary

Note: These minutes were proofread by Lois Steinbeck, LFA.

MIF/JC/dr

INSTITUTIONS

Joint Appropriations Subcommittee

ROLL CALL DATE 1-25-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Marj Fisher, Chairman	X		
Rep. Red Menahan	X		
Rep. Steve Vick	X		
Sen. Larry Tveit, Vice Chairman	X		
Sen. Gary Aklestad	X		
Sen. Mignon Waterman	X		

Mary LaFord - OBPP
Lisa Smith - LFA

HUMAN SERVICES AND AGING

Joint Appropriations Subcommittee

ROLL CALL DATE 1-25-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. John Cobb, Chairman	X		
Rep. Beverly Barnhart	X		
Rep. Betty Lou Kasten	X		
Sen. Chuck Swysgood, Vice Chairman	X →		
Sen. J.D. Lynch	X		
Sen. Jim Burnett	X		

Doug, Connie, Lois

EXHIBIT 1
DATE 1-25-95
HB

Meriwether Lewis Institute

562 Fifth Avenue
Helena, Montana 59601
(406) 442-7416

January 25, 1995

Mr. Chair, Madame Chair, Members of the Sub-committees,
For the record, my name is Patrick Pope, I serve as Executive Director of the Meriwether Lewis Institute and am a member of the Medicaid Managed Care Advisory Group. I have mental illness that I manage through a combination of medications, peer support and therapy.

For those of you who not familiar with MLI, let me briefly explain who, and what, we are. The Meriwether Lewis Institute, more easily called MLI, is the only non-profit corporation in Montana that was created solely by and for people who have mental illness. MLI was founded in 1991 by a small group of people with mental illness, also known as mental health consumers, who felt that consumers in our state suffered from isolation and a frightening sense of aloneness, and that by establishing a statewide umbrella organization to bring consumers in contact with each other, we could probably help alleviate the terribly painful isolation that has killed so many of us.

We believe that every mental health consumer has the right to reach his or her full potential, whatever that may be. Toward that goal, we

continually advocate and educate, seeking the mental health services that will allow consumers to improve, gain some independence, and begin the healing process of acceptance. Much of our educational work involves explaining what mental illness is, and isn't, to all who are interested. In the past 3 years, MLI has helped establish 13 consumer groups throughout Montana, enabling mental health consumers to offer support and understanding to each other in our own communities in a safe atmosphere. The Board of Directors for the Meriwether Lewis Institute currently consists of 10 people with mental illness, and it is their responsibility to make all major decisions and shape the future of MLI. MLI represents a great many of the people who will be affected by managed care.

Although we have a great many concerns, we do have hope that, under managed care, the Montana mental health system can begin to operate as an efficient system that helps those of us with mental illness regain our dignity and take charge of our own lives. Our current mental health system is a care taking system. Once you are in the system, there is little likelihood that you will ever get out. Under managed care, services that make sense can be implemented, not just those that pay.

Medicaid has included mental health consumers in its planning around managed care, and we believe that they have a willingness to listen to, and incorporate our concerns in the development of a realistic managed care plan. I thank you for your time.

EXHIBIT 2
DATE 1-25-95
HB

Meriwether Lewis Institute

562 Fifth Avenue
Helena, Montana 59601
(406) 442-7416

To: Randy Poulsen

From: Pat Pope, Executive Director
Kathy Standard, President

Re: Managed Care RFP

Date: October 6, 1994

POSITION STATEMENT OF THE MERIWETHER LEWIS INSTITUTE

QUALITY ASSURANCE: MLI believes that in order to have the highest possible quality of care, that quality must be monitored by an entity outside the mental health system/Managed Care company. We strongly recommend that the Board of Visitors be the primary entity for developing a Quality Assurance Program, and that a QA team will include primary consumers, family members, and advocates. MLI also proposes:

1) All Site Review teams include Board of Visitors, consumers, and family members. Adequate funding for training, travel, lodging and food costs for Site Review participants will be provided.

2) Mental health professionals be required to have the same credentials whether employed in the community or at Montana State Hospital.

GRIEVANCE PROCEDURE: MLI believes that all consumers should be able to utilize the same Grievance Procedure, whether they are in the community or at Montana State Hospital.

M.H.P.A.C. STANDARDS COMMITTEE RECOMMENDATIONS: MLI supports all of the recommendations, and hopes they will be incorporated into the RFP.

CONSUMER-RUN ALTERNATIVES: MLI requests that the RFP requires at least 1% of the total Federal and State Managed Care budget to be designated for consumer-run alternatives. The consumer-run entity that governs projects is to be accountable only to the Managed Care company. Should a situation arise where a Managed Care company partners with the Community Mental Health Centers and is awarded the contract for Montana, steps need to be taken to assure that the CMHCs have no control over the funding or governance of consumer-run alternatives.

EXHIBIT EXH 3
DATE 1-25-95
HB

TESTIMONY OF THE MONTANA HOSPITAL ASSOCIATION REGARDING MENTAL HEALTH MANAGED CARE

The Montana Hospital Association, on behalf of its 57 member health care facilities, including five hospitals with distinct part psychiatric units, and two freestanding children's psychiatric hospitals, appreciates the opportunity to comment on the development of a statewide capitated mental health managed care program.

Hospitals are on record as supporters of managed care systems, provided these programs treat facilities and their patients fairly. MHA, along with several hospital representatives, has followed the progress of the Department's proposal to significantly alter the way mental health care is delivered in Montana. MHA believes the system proposed by the Department of SRS is ambitious, but moves in the right direction. There are still numerous details yet to be worked out, but hospitals are supportive of the Department's efforts.

The table below lists the seven Montana hospitals which provide mental health care to adults and children. **Managed care may mean some of these hospitals have more patients, some may close and some may restructure their resources to some other purpose.** The only thing we know for sure at this point, is that things will probably change dramatically.

HOSPITAL	LIC BEDS	ADULTS	CHILDREN
Deaconess Hospital-Billings	60	Yes	Yes
St. Peters-Helena	14	Yes	No
St. Patrick-Missoula	21	Yes	Yes
Deaconess MC-Great Falls	27	Yes	Yes, 6 beds
Kalispell Regional Hospital	14	Yes	Yes, 7 beds
Shodair Hospital-Helena	22	No	Yes
Rivendell Hospital-Butte	32	No	Yes
TOTALS	190		

In responding to that change, Montana hospitals ask that the decision makers consider that these facilities serve all patients in a community, not just those the state helps pay for. Changes made to the system in pursuit of saving dollars affects the services available to everyone.

THE MONTANA STATE HOSPITAL

MHA, and its member hospitals, believe it is appropriate for Montana State Hospital to continue providing key mental health services at this time. If this Legislature decides to continue services at MSH, **hospitals also support the Department of Corrections and Human Services efforts to achieve certification of the state facility. All other Montana hospitals providing psychiatric care are required to meet state and federal licensure and certification standards, and meet the requirements of JCAHO.**

Montana hospitals play an important role in providing stabilizing care for certain types of patients. Hospitals envision themselves continuing in this role under a managed care setting. Patients who are acutely ill, and are able to respond to short term, stabilization care are appropriate for community hospitals who offer psychiatric care.

Patients who are physically dangerous, who need long term stabilization care, forensic admissions and those who are in need of long term hospital or residential care are not considered appropriate for the existing psychiatric units. These patients should continue to be served at the Montana State Hospital.

There is some discussion about terminating services offered at Montana State Hospital, and shifting those services to the community. Hospitals believe some patients, given the financial support of managed care, may be retained in the community. **But hospitals cannot support closure of MSH at this time.**

It is not impossible to relocate services provided at MSH in community hospitals. Such a move would, however, require creation of a secure hospital environment for difficult patients needing specialized treatment currently unavailable in community based facilities. **Such a change would require considerable advance planning, investment in new or remodeled physical plant, and the creation of needed treatment programs.** Transfer of these services should not (and probably could not) be accomplished simultaneously to creation of managed care.

MHA believes the existence of the state hospital is important. The location, however, poses an access problem to Montanans living in Central and Eastern Montana. Typically, these patients receive inpatient treatment at Billings Deaconess Hospital. Transportation to and from Billings and destinations to the East and North is expensive. Transitioning patients released from the Montana State Hospital to community aftercare is more difficult because of the distance.

For this reason, hospitals suggest that the development of adult residential care be located regionally, and be available to transition MSH patients into community care.

Were the state to desire to privatize the services currently provided by the Montana State Hospital, MHA believes these services would need to be excluded from mental health managed care, and that a separate proposal be prepared to investigate such a proposal in detail.

GAPS IN SERVICE, HOSPITAL ISSUES

Shodair and Rivendell Hospitals currently provide a great deal of free care to children who are Medicaid eligible, but not served by MRM. These children are not high enough on the priority list for MRM to address their needs. But these children find their way into treatment, oftentimes being dropped off at the emergency room door by police officers. Still others are admitted by MRM, and are paid for by 100 percent general fund dollars. Hospitals also provide inpatient care to adults who are moved into the community setting, but whose hospital needs are not covered by state resources. General, acute care community hospitals provide stabilizing treatment in their emergency rooms and provide transportation services to psychiatric hospitals.

MHA believes that these services must be included in the managed care system. Hospitals are concerned that if these services are not included, more people will be shifted into these service areas as a cost saving measure for the managed care organization.

MHA appreciates the opportunity to present our comments to the committee. MHA is available to answer committee questions.

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging SUB-COMMITTEE DATE 1-25-95

BILL NO.__________ SPONSOR(S)__________

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NAME AND ADDRESS	REPRESENTING	Support	Oppose
Garrett T Smith	Bd Invest		
Jean McDonald	MHAM		
Donna Hale	Mont Ch NASW - MMHSC		
Cheryl Jorgensen	Butte Mental Health		
Denise Matheson	Butt MT		
Barbara Mushe	Mental Health Services Inc		
Ahnie Molloy	Project Uplift - G.F.		
Hank Hudson	DFS		
Jan-Jull Mcfadden	DFS State Adv Council		
Patrick S Pope	Meriwether Lewis Inst. Inc		
Mary McCue	Mt Clinical Mental Health Counselors Assn		
Jan McCall	Youth Dynamics		
William McCausland			

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

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CS-14

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging -- SUB-COMMITTEE DATE 1-25-95

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NAME AND ADDRESS	REPRESENTING	Support	Oppos
CANDACE BUTLER	REG V - CMHC		
TERRY SCHROEDER	REG V - CMHC		

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