MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN DUANE GRIMES**, on March 6, 1995, at 3:00 p.m.

ROLL CALL

Members Present:

Rep. Duane Grimes, Chairman (R)
Rep. John C. Bohlinger, Vice Chairman (Majority) (R)
Rep. Carolyn M. Squires, Vice Chairman (Minority) (D)
Rep. Chris Ahner (R)
Rep. Ellen Bergman (R)
Rep. Bill Carey (D)
Rep. Antoinette R. Hagener (D)
Rep. Deb Kottel (D)
Rep. Bonnie Martinez (R)
Rep. Brad Molnar (R)
Rep. Bruce T. Simon (R)
Rep. Liz Smith (R)
Rep. Susan L. Smith (R)
Rep. Loren L. Soft (R)
Rep. Kenneth Wennemar (D)

Members Excused: None

Members Absent: Rep. Dick Green (R)

Staff Present: David Niss, Legislative Council
Jacki Sherman, Committee Secretary

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

Committee Business Summary:

Hearing:	SB 310, SB 240, SB 223
Executive Action:	SB 240 DO CONCUR
	SB 310 POSTPONED

{Tape: 1; Side: A; Approx. Counter: 000; Comments: n/a.}

HEARING ON SB 310

Opening Statement by Sponsor:

SEN. JUDY JACOBSON, SD 18, Butte, stated that SB 310 changes the Board of Medical Examiners to allow for Schedule II drugs to be prescribed by a physician assistant-certified (PA-C) for up to 34 days. They would like to see the PA-C and the nutritionist have full voting rights.

Proponents' Testimony:

Jennifer Krueger, President of the Montana Academy of Physician Assistants (MAPA), submitted written testimony and information on physician assistants. **EXHIBIT 1**

Randy Spear, PA-C, Member of the Montana Board of Medical Examiners (BOME). EXHIBIT 2

Opponents' Testimony:

Jerry Loendorf, Montana Medical Association (MMA), explained that he was testifying on the opponents' side although he supports Section 2 of the bill. He expressed concern over the expansion of the BOME. Over 90% of the work done by the board applies to physicians. There are nine full members and two public members. He asked to exclude Section 1 of the bill.

Informational Testimony: None

{Tape: 1; Side: A; Approx. Counter: 285; Comments: NA.}

Questions From Committee Members and Responses:

REP. SUSAN SMITH asked what the rationale was to go from 72 hours to 34 days, and why there was a restriction in the first place and why the jump to 34 days.

Mr. Spear replied that there are people who need the Schedule II drugs and are restricted by coming in every three days. They should not have to pay for a doctor's visit that often. In 1989 the legislature made that initial step in concordance with other states to see how it would work. Each state has its own requirements. The figure of 34 days came up for the chronic nature of the disease of some people who needed their medication for one month and two weekends.

REP. BRUCE SIMON asked **Mr. Loendorf** if his concern would be that the PA-C would be voting on issues that would not affect their profession and, therefore, the outcome of votes might change on the board. He replied that the two part-time members only attend for the matters that concern them. There is public representation on the board and there are many specialties who are not represented and when issues come up involving their specialty there is no one there with that particular expertise.

CHAIRMAN GRIMES asked the sponsor why the committee has not heard anything from the nutritionists and could someone give some examples of Schedule II drugs.

SEN. JACOBSON explained that when the bill was brought forward, the PA-C was voting but the vote on the BOME was to let both of the other two members have full voting rights.

Pat England, Executive Secretary for the BOME, listed narcotics and abusable non-narcotics as Schedule II drugs that are administered under the direct or indirect supervision of a physician.

REP. DEB KOTTEL asked and **Mr. Spear** clarified the amount and degree of education of a PA-C according to the MCA, Title 37, Chapter 20.

REP. LIZ SMITH asked what the minimum level of accreditation of the PA-Cs that are practicing in Montana.

Mr. Spear stated that they have graduated from an accredited program and they have passed national certifying boards. They have to maintain 100 hours of continuing education every two years and be recertified by examination every session.

REP. JOHN BOHLINGER asked why the board would object to the other members having voting rights.

Mr. Loendorf told the committee that the board would rather have the privilege go to a specialty physician. The board is large enough already and they don't want to add to the number so they would rather have a more diverse voting member.

REP. KOTTEL stated that 37 other states allow PA-Cs to prescribe Schedule II drugs and asked what the longest period of time was in which a PA-C can prescribe medication.

Mr. Spear replied that many states do not have a stipulation and it is mandated by law that a PA-C practice with a physician.

REP. KOTTEL asked if the prescriptions could be called in over the phone and **Mr. Spear** answered that Schedule II drugs could not be prescribed over the phone.

REP. CAROLYN SQUIRES clarified that the board has a utilization plan that has been established with the physician that outlines what is allowed for them to practice.

{Tape: 1; Side: B; Approx. Counter: 00; Comments: NA.}

The plan is available at the physician's office and at the board's office. **Mr. Spear** concurred with this information.

REP. SQUIRES asked if the 34 days were granted, if that information would be included in the utilization plan at the facility and at the board. **Mr. Spear** agreed that it would be reviewed and written in the standard scope of practice.

REP. SQUIRES inquired that the PA-C must be under the supervision of a physician at all times and who would be responsible if something happened. **Mr. Spear** answered that both the physician

and the PA-C could be disciplined for things that fall outside that scope of practice.

REP. BOHLINGER wondered if PA-Cs and nutritionists were new members on the board or have these associations been a part of the group for some time. **Mr. Spear** explained that the PA-C membership was two years old and the nutritionists have been there a period of time longer than that.

REP. BILL CAREY asked what the specialties of the members of the board who hold degrees were. **Pat England** told the committee that there was an ophthalmologist from Missoula, a family practitioner from Glasgow, a general surgeon from Kalispell, and a family practitioner from Billings

REP. L. SMITH asked if there was a limit on how many times a Schedule II prescription can be refilled and what is the length of the prescription. **Mr. Spear** said that a Schedule II drug could not be refilled; that a doctor would need to write out a new prescription every time. The length would be 34 days.

REP. L. SMITH stated that the board was looking for a parallel with the nurse practitioners' ability to prescribe. **Mr. Spear** replied that was what the board thought would be appropriate.

REP. L. SMITH voiced her concern of the inconsistency of the PA-C credentialing. **Mr. Spear** told her that they could not sit for the national test unless they have graduated from a certified program.

REP. LOREN SOFT clarified the amount of education that the PA-Cs needed. He stated that in testimony he heard that the number of PA-Cs went from 26 to 90 and wondered why the board would not grant voting rights to cover such a large group.

Mr. Loendorf stated that there were 1,800 physicians and they break down into 83 specialties with 17 being large groups that would like representation. The board can only be so big and foregoing.

Closing by Sponsor:

SEN. JACOBSON explained that full voting privileges are recommended by the board because they are very knowledgeable and ought to be voting. It would ease their workload because there will be more of them able to work. The extension of the time drugs are prescribed by a PA-C was done for the benefit of the patient so they don't have to go back into the office and pay for an office visit for a prescription every 72 hours.

{Tape: 1; Side: B; Approx. Counter: 400; Comments: NA.}

HEARING ON SB 240

Opening Statement by Sponsor:

SEN. FRED VAN VALKENBURG, SD 32, Missoula, stated that SB 240 was a proposal to create a restrictive license to practice medicine in Montana. St. Patrick Hospital in Missoula has an opportunity to admit an internationally known physician in the area of heart surgery. Under present law, this doctor would have to take the state medical exams and, as he has practiced for more than 40 years, they do not feel he needed to take the exam again. Very specific conditions would be required so that not just anybody could get the license.

Proponents' Testimony:

Larry White, President of St. Patrick Hospital, Missoula. EXHIBIT 3

Jim Oury, Cardiac Surgeon, Missoula, stressed that the bill had been carefully drafted with the input and support of the BOME and the MMA. It would grant a restrictive license to allow a foreign-trained medical graduate of eminence in his specialty to practice in Montana without taking the entrance exam. Other states have similar exemptions or statutes. The referral base would be broadened to include out-of-state patients, would provide research opportunities and produce revenue for the state of Montana. Attracting quality foreign medical graduates would have a significant positive impact on the quality of care.

Bob Frazier, Legislative Liaison for the University of Montana Campuses, cited the benefits of improving the quality of instruction for the students and being able to upgrade the internships that are offered. They are able to offer a wider range of interdisciplinary study.

Jim Ahrens, President of the Montana Hospital Association (MHA), asked for the committee's support of the bill.

Jerry Loendorf, MMA, supported the bill.

Dr. Gary Elliot, Vice-President of Pharmaceutical Development, Ribo Immuno Chem, Hamilton, stated that by recruiting innovative scientists into the university system a critical mass is developed which allows proprietary information to be developed.

{Tape: 2; Side: A; Approx. Counter: 00; Comments: NA.}

Bio-technology developments and improved patient care are among the possible benefits of passing this bill and it could also be a source of revenue for the state.

Opponents' Testimony: None

Informational Testimony: None

Questions From Committee Members and Responses:

REP. BRUCE SIMON asked for clarification regarding the credentialing process. **Dick Brown, Senior Vice-President of the MHA,** stated that there is a credentialing process and once that process is completed they are eligible for privileges on the hospital medical staff to provide whatever services were approved.

REP. SIMON asked about the restrictions on a person's license that must be stated on their certificate and how that might work in these cases. **Patricia England, BOME,** said that the board could make the language as brief or extensive as it needed to.

REP. SIMON asked her to talk from the board's perspective about the idea of a doctor trying to get credentialed with a hospital before they've been licensed, how difficult that process might be and what would be different coming from another state.

Ms. England explained that physicians must provide proof or documentation that shows what they are licensed for and if they have been involved in any criminal charges or disciplinary actions since high school. She stated that if the physician had a full license in another state, he probably would be able to get a general license rather than a restricted one.

REP. SIMON asked what the board's ability to obtain and evaluate the criteria under which a doctor might be licensed in another country. **Ms. England** mentioned that the board was concerned about that issue and they usually obtained materials from the World Health Organization describing the caliber and curriculum of the school in question. It would be more work to obtain the needed information, but they feel it is worth it to attract people of high caliber.

REP. SIMON clarified that if the board could not obtain the information to their satisfaction then that person would not be granted licensure. **Ms. England** agreed.

Closing by Sponsor:

SEN. VAN VALKENBURG reiterated that this would be a good opportunity to attract someone who can bring significant research dollars to the state.

EXECUTIVE ACTION ON SB 240

Motion/Vote: **REP. CAROLYN SQUIRES MOVED THAT SB 240 BE CONCURRED IN. Voice vote was taken. The motion carried unanimously with REP. GREEN voting by proxy.**

{Tape: 2; Side: A; Approx. Counter: 440; Comments: NA.}

EXECUTIVE ACTION ON SB 310

Motion: REP. JOHN BOHLINGER MOVED THAT SB 310 BE CONCURRED IN.

Discussion:

REP. DEB KOTTEL voiced her concern about the minimal degree of education that was required for PA-Cs to prescribe dangerous drugs in contrast to what is required for other positions. She said she was reluctant to extend that much time for prescriptions.

REP. CAROLYN SQUIRES mentioned that the PA-Cs have a good track record and have abided by the rules and regulations put on them from the beginning. She stated that during this legislature there have been various bills passed that have granted maximum duties to the minimally qualified and expressed wonder that now the committee was questioning the PA-Cs.

CHAIRMAN GRIMES told the committee that he was planning to amend the bill and postponed executive action.

{Tape: 2; Side: A; Approx. Counter: 640; Comments: NA.}

HEARING ON SB 223

Opening Statement by Sponsor:

SEN. TOM KEATING, SD 5, Billings, stated that SB 223 dealt with providing mental health care to recipients of Medicaid. He researched the financing of mental health recipients and found that if they are below the poverty level, they qualify for Supplemental Security Income (SSI) and are eligible for Medicaid. If they work to earn more money they lose their SSI. The law says that if they lose their last dollar of SSI then they lose their Medicaid. SB 223 elevates the eligibility standard of 200% of poverty. In the long run, the costs to the state will be reduced and there will be Medicaid savings. This will enable the recipients to keep working and participating in the treatment programs and thus move out of the system at some point.

Proponents' Testimony:

Peter Blouke, Director of the Department of Social and Rehabilitation Services (DSRS). EXHIBIT 4

{Tape: 2; Side: B; Approx. Counter: 30; Comments: The last part of EXHIBIT 4 ran onto side B.}

SEN. MIGNON WATERMAN, SD 26, Helena, served on the advisory committee that put together the Managed Mental Health Program.

She said that people need to remember that they are talking about managing care and not managing costs. One of the benefits for the state is that the costs of mental health services will be better managed and clients will receive better services. The services are not being expanded. The opportunities for Medicaid to pay are being expanded rather than the services being paid out of the general fund.

Bob Torres, Montana Chapter of the National Association of Social Workers (NASW), submitted written testimony **(EXHIBIT 5a)** and then read testimony on behalf of **Donna Hale. EXHIBIT 5b**

Kathy McGowan, Montana Council of Mental Health Centers, said that Montana was a bit behind the rest of the nation in regard to managed care. People are not satisfied with the way things are now and it is time to try and improve the system.

Hank Hudson, Department of Family Services (DFS), stated that the DFS shares the responsibility for managing the Youth Mental Health Program and supports the concept of improving the mental health system.

Candy Wimmer, Montana Board of Crime Control, representing the Governor's Youth Justice Council and the State Board for the Managing Resources for Montana, stated that juveniles would benefit from this improvement in mental health services.

{Tape: 2; Side: B; Approx. Counter: 425; Comments: NA.}

Kathy Standard, President of the Meriwether Lewis Institute. EXHIBIT 6

David Hemion, Mental Health Association. EXHIBIT 7

Patrick Pope, Executive Director of the Meriwether Lewis Institute, spoke on behalf of the **Montana Alliance for the Mentally Ill. EXHIBIT 8**

Dan Anderson, Administrator of the Mental Health Division in the Department of Corrections of Human Services, supported managed care and SB 223.

Jim Ahrens, President of the Montana Hospital Association, supported the bill.

Gloria Hermanson, Montana Psychological Association, supported the bill.

Bob Ross, Director of Region III Mental Health Center, Billings, mentioned that SB 223 had gained much support and agreement across the mental health community. There is a sweeping change in the mental health services being provided for Montanans. The status quo is not working and the changes that are and will be occurring will be beneficial to the recipients.

Opponents' Testimony: None

Informational Testimony: None

Questions From Committee Members and Responses:

REP. DEB KOTTEL asked of some ways that managed care would save the state $2 million. **Nancy Ellery, Administrator of Medicaid Services Division,** explained that the costs are reduced by better coordinating the services and access to care will be increased.

{Tape: 3; Side: A; Approx. Counter: 00; Comments: NA.}

REP. KOTTEL asked what the chances were of getting the waiver. **Ms. Ellery** answered that there was a good chance of getting the waiver approved, they just don't know when.

REP. BRAD MOLNAR asked if this was the program that was on the video that was going around the state a little while ago and who the contractor would be. **Mr. Anderson** said that it was the video and referred the question. **Ms. Ellery** stated that seven or eight companies have expressed interest but everyone is waiting for the waiver. There are three to four companies with extensive managed care experience.

REP. MOLNAR asked if any of those companies were currently running entire state programs and why couldn't they manage it by themselves. **Mary Dalton, DSRS,** knew of only one that is running a statewide program and that is in Massachusetts. They have been to Montana to talk to the department but haven't placed a bid yet. She stated that they needed to hire a company that will have expertise in managing mental health services and have responsibility on all ends of the continuum instead of trying to manage it by themselves.

REP. MOLNAR stated that he could see holes in what was being proposed. **Ms. Dalton** assured the committee that under the system, the advisory council previously mentioned would also be assisting them and would be open to public comment. An independent evaluator who will come in and make sure of the quality of care is required to have a waiver.

REP. MOLNAR asked if the parents of a child could sue the contractor in an appeals situation and asked about the requests for proposal (RFP). **Ms. Dalton** said she could not give a legal opinion to that question, but thought that the parents could sue. She didn't know how far they would get in the process.

Mr. Anderson stated that they were quite competent to write an RFP for the program and Managed Resources of Montana (MRM) has not come up with an RFP process for children in treatment.

REP. MOLNAR questioned if they lack the capability of doing this on their own with the current in-house staff. **Mr. Anderson**

answered that it would take time and a different staff to do that as a state agency. They do not have the resources.

{Tape: 3; Side: A; Approx. Counter: 530; Comments: NA.}

REP. LOREN SOFT asked for some examples of other states that have done what the state of Montana is trying to do in regard to managed care.

Ms. Ellery mentioned that there were about 22 other states that were looking at or implementing managed care in mental health. Massachusetts is the best example and they have a statewide contract with a behavioral health company and their first evaluation showed that the state saved about $47 million. They had a 22% reduction of their mental health expenditures in one year.

REP. SOFT asked if any of the companies that might bid for the contract were in-state and what would be the estimated annual management fee for the managed care contract. **Ms. Ellery** thought that the Regional Mental Health Centers might be working with the state on a proposal.

Ms. Dalton stated that there was a federal upper limit cap in order to receive a waiver. The contractors would get all the money and they have to be able to administer the program and deliver the services so it won't be broken out as a management fee like other contracts. The contractors would be audited.

REP. SOFT inquired about the other states and if they had been able to pull out the management fee for the services. **Ms. Ellery** stated that Massachusetts had set it up as a full risk basis on the contract. The company can go either full risk or partial risk and reserve for profit and loss.

REP. SOFT asked how the funding will work and what will happen if all the funds were put into the contractor. **Ms. Ellery** stated that there will be three "pots" of money. Each one will be used for a different group. The Medicaid pool will be capitated out on a per client per month basis to the managed care company. This area is going to be expanded. The second pool of money is the expanded population. That money will also go to the managed care company in a fixed amount per month. The third pool is the Warm Springs State Hospital. The state dollars that would have been spent at the hospital also allocated out to the contractors.

REP. SOFT asked what the risks would be for the providers. **Ms. Ellery** thought that the providers would see this as an improved system that won't be tied into Medicaid rates and arbitrary limits. They will negotiate directly with the managed care company for their services.

{Tape: 3; Side: B; Approx. Counter: 00; Comments: NA.}

The contractors are much more flexible and more efficient than the state.

REP. SOFT questioned if the contractors would work with the providers on a per client per month capitated basis. **Ms. Ellery** replied that it would vary according to the service.

REP. ELLEN BERGMAN asked the sponsor if the bill would have to go to appropriations before it could go anywhere. **SEN. KEATING** answered that it had already gone to the subcommittee and there is a $2 million general fund savings on it.

REP. BERGMAN asked if it was expanding the mental health care services and the sponsor said that it was not necessarily expanding services but that the goal would be that more people would be served more appropriately and level the expenses.

REP. SUSAN SMITH asked if the 22% decrease referred to the overall decrease or in the decrease of expenditures plus the cost of the managed care. **Ms. Ellery** answered that it was a 22% difference between what they would have spent without managed care and what their actual expenditures would have been without the program.

REP. S. SMITH asked what incentive the contractor had to do a good job. **Ms. Ellery** stated that they had every incentive to do a good job because they are nationally recognized at what they do and how much the premium would change every year would be controlled.

REP. S. SMITH asked if the goal isn't to have fewer people needing health care and if they are going to get better, then there should be fewer people providing services for them if they are doing a good job and thus reducing the costs.

Ms. Ellery replied that it should reduce costs for some people, but there are going to be some people who aren't getting the services now and money is being spent on them when they end up getting sent to the state hospital where services could be provided. What the contractors would not have control over is how many people become eligible. There has to be some way to account for more people coming into the system than were expected.

REP. S. SMITH inquired how many full-time employees they had now and how many they would add for the managed care center. **Ms. Ellery** answered for SRS and stated that there was one person now and they would need one person when the system was in place.

Mr. Anderson also answered that there were five people in their office in Helena and don't anticipate reducing the number, but by the next legislature will reevaluate the jobs.

REP. MOLNAR asked where they were at currently regarding the poverty level. **Ms. Ellery** explained that it depended on many factors. Medicaid eligibility for a pregnant woman or a child under age six is 133% of poverty. For children from age seven to twelve it is 100% of poverty. For people age twelve and above the federal poverty level goes down to 40.5%. The federal government has mandated that each year one more age group needs to be added on to the 100%. She stated that Wyoming is less than Montana and Utah is going through an expansion of 185%.

REP. MOLNAR described the Supreme Court's ruling that under the right to travel in any state, potential clients are entitled to services. He asked if the surrounding states have a lower poverty level, what would stop them from coming to Montana to receive more mental health services. **Ms. Ellery** replied that someone could do that right now and Medicaid federal law does not allow a residency requirement. The expanded group will have a sliding scale based on the ability to pay.

REP. TONI HAGENER wanted to know how this would work in rural areas with their current staff and facilities and services. **Ms. Ellery** said that this would be a benefit to those in rural areas because the managed care entity has the resources to go out and try to recruit providers that may not be there. The contractors have to ensure statewide access to care, with the use of telecommunications and other resources. They will use the current services plus those that would be beneficial to add for that area and need.

{Tape: 3; Side: B; Approx. Counter: 520; Comments: NA.}

Closing by Sponsor:

SEN. KEATING remarked that in mental health treatment not every patient will get well. There is not a program anywhere that is 100% successful. At one time Warm Springs had 2,000 patients. Then regional mental health centers were established for after care. Warm Springs has been downsized and more treatment is being handled in communities. This includes sub-acute care and acute care which is the most expensive. There are too many different kinds of mental illness to deal with as a whole. Each is individual and unique. Mental illness seems to be generational, so they will never get rid of the product. There will be a demand as long as there are families who are mentally ill. SB 223 is not MRM in any way, shape or form. It is an opportunity to privatize the delivery of mental health care under a program through a private organization that has demonstrated actuarially that they can deliver quality mental health services for much less cost that what is being paid presently.

ADJOURNMENT

Adjournment: 6:10 p.m.

DUANE GRIMES, Chairman

ANDREA SMALL, Recording Secretary

DG/as

HOUSE OF REPRESENTATIVES

Human Services and Aging

ROLL CALL DATE 3-6-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Duane Grimes, Chairman	✓		
Rep. John Bohlinger, Vice Chairman, Majority	✓		
Rep. Carolyn Squires, Vice Chair, Minority	✓		
Rep. Chris Ahner	✓		
Rep. Ellen Bergman	✓		
Rep. Bill Carey	✓		
Rep. Dick Green		✓	
Rep. Toni Hagener	✓		
Rep. Deb Kottel	✓		
Rep. Bonnie Martinez	✓		
Rep. Brad Molnar	✓		
Rep. Bruce Simon	✓		
Rep. Liz Smith	✓		
Rep. Susan Smith	✓		
Rep. Loren Soft	✓		
Rep. Ken Wennemar	✓		

HOUSE STANDING COMMITTEE REPORT

March 7, 1995

Mr. Speaker: We, the committee on **Human Services and Aging** report that **Senate Bill 240** (third reading copy -- blue) **be concurred in.**

Signed: _____
Duane Grimes, Chair

Carried by: Rep. Bohlinger

Committee Vote:
Yes 16, No 0.

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HOUSE OF REPRESENTATIVES

ROLL CALL VOTE

Human Services and Aging Committee

DATE 3-6-95 BILL NO. SB240 NUMBER _____

MOTION: Rep Squires "Do Concur"

unanimous

NAME	AYE	NO
Rep. Duane Grimes, Chairman	✓	
Rep. John Bohlinger, Vice Chairman, Majority	✓	
Rep. Carolyn Squires, Vice Chairman, Minority	✓	
Rep. Chris Ahner	✓	
Rep. Ellen Bergman	✓	
Rep. Bill Carey	✓	
Rep. Dick Green	✓	
Rep. Toni Hagener	✓	
Rep. Deb Kottel	✓	
Rep. Bonnie Martinez	✓	
Rep. Brad Molnar	✓	
Rep. Bruce Simon	✓	
Rep. Liz Smith	✓	
Rep. Susan Smith	✓	
Rep. Loren Soft	✓	
Rep. Ken Wennemar	✓	

HOUSE OF REPRESENTATIVES
COMMITTEE PROXY

DATE 3-6-95

I request to be excused from the NR Committee meeting this date because of other commitments. I desire to leave my proxy vote with Gamm.

Indicate **Bill Number** and your vote **Aye** or **No.** If there are **amendments**, list them **by name and number** under the bill and indicate a **separate vote for each amendment.**

HOUSE BILL/AMENDMENT	*AYE*	*NO*

SENATE BILL/AMENDMENT	*AYE*	*NO*

Rep. Dick Gamm
(Signature)

HR:1993
WP/PROXY

MAPA

Montana Academy of Physician Assistants

EXHIBIT 1
DATE 3/6/95
SB 310

A Constituent Chapter of the American Academy of Physician Assistants

TESTIMONY FOR SB 310

March 6, 1995

My name is Jennifer Krueger - I'm the current president of the Montana Academy of Physician Assistants (MAPA). I am here to speak in support of SB 310, which was initiated to cover two areas: 1) improve Schedule II prescriptive privileges for PAs, and 2) grant full voting privileges for the PA and nutritionist members of the Montana Board of Medical Examiners.

PRESCRIPTIVE PRIVILEGES
Historical Background

- Physician Assistants have provided quality health care services to Montana citizens for greater than 20 years.
- PAs practice medicine with the supervision of a licensed physician. All scheduled drug prescriptions written by a PA are required to be reviewed by the supervising physician.
- PAs are regulated by the Board of Medical Examiners (BOME).
- Prescriptive authority for PAs was authorized by legislation passed during the 1989 legislative session. This law was formulated with the advice, consultation and approval of both the Board of Pharmacy and the BOME.
- DEA registration is mandatory for PAs prescribing scheduled drugs.
- Duplicate prescriptions are mandatory for all scheduled drugs. A copy goes to the BOME to monitor prescribing patterns and compliance with the law.

Since 1989, no incidents have been reported of abuse or misuse of Schedule II drugs by a PA. No incidents have been reported of injury to a patient due to inappropriate prescribing or administration of Schedule II drugs by a PA. The extension of the prescriptive privileges to 34 days will provide better care for Montana citizens, including the acutely injured, chronic pain management (e.g. nursing home residents) and mental health patients (e.g., child or adult attention deficit disorder).

Currently, patients must return to the health care facility every 72 hours to refill Schedule II medications. Particularly for the elderly and rural patients, this is quite a hardship. The extension to 34 days equals one month and two week-ends. Patients on chronic or long term medications are usually seen on a monthly basis to assess ongoing health care needs and the status of their condition.

The change from the current 72 hours to the proposed 34 days will not affect any of the current safeguards. The supervising physician review, the DF ons to the BOME, and th ins unchanged.

EXHIBIT 2
DATE 3/6/95
SB 310

SENATE BILL NO. 310
INTRODUCED BY SENATOR JUDY JACOBSON

TESTIMONY BY BOARD OF MEDICAL EXAMINERS
Randy L. Spear, PA-C

The Board of Medical Examiners (BOME) has thoroughly discussed both elements of this bill and voted unanimously in each case to support such an initiative.

Reasoning for support of an extension of prescribing authority:

1. Physician Assistants (PAs) have demonstrated, through existing oversight mechanisms, the knowledge and expertise to safely and appropriately deliver this class of drugs.

2. PAs have maintained an exceptional record in their use of Schedule II prescription authority over the past five (5) years.

3. There does exist valid medical rationale for the appropriate prescribing of Schedule II pharmaceuticals in excess of 72 hours.

4. All currently existing oversight mechanisms will remain in effect; physician supervision and prescription review, DEA registration and federal monitoring, duplicate prescriptions to the BOME and subsequent review.

5. Patient health care needs could more efficiently be met. The additional time frame of prescriptions will allow for the reasonable delivery of medications to Montana citizens with access to care and safe, quality health care as its foundation.

Reasoning for support of full voting privileges to the PA and Nutritionist members of the BOME:

1. Efficiency of Board Function.

2. Increase public representation without increasing size or cost of Board.

3. Expertise and knowledge of these members have been invaluable. Their ability to express their viewpoints through voting would be welcomed.

4. Nearly all issues coming before the Board are interrelated to some degree. To limit the voting privileges of some fully capable board members is not in the public's interest and is clearly unneccessary.

END OF TESTIMONY

EXHIBIT 3
DATE 3/6/95
SB 240

SENATE BILL 240

For additional information, please contact:
Carole V. Erickson
1-800-228-7271 Ext. 2015
St. Patrick Hospital
500 West Broadway
Missoula, MT 59802

EXHIBIT 4
DATE 3/6/95
SB 223

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MARC RACICOT
GOVERNOR

PETER S. BLOUKE, PhD
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210

TESTIMONY OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES BEFORE THE HOUSE HUMAN SERVICES AND AGING COMMITTEE

(Re SB 223 - An Act Relating to Medicaid Managed Care Mental Health Services)

In conjunction with the Departments of Corrections and Human Services and Family Services, and with the cooperation of the Office of Public Instruction and the Commissioner of Insurance, the Department of Social and Rehabilitation Services has been doing extensive planning for a system of managed care for all publicly funded mental health services in Montana. That planning was required by HB33 as passed by the 1993 Special Session. The bill before you will accomplish a number of changes in law that are necessary to implement the program we have designed.

Working with the Department of Corrections and Human Services we determined that to have an effective and comprehensive managed care program it was necessary to include all state-funded mental health services under the new system. It then became necessary to find a way to include those people whose mental health services are currently paid, in full or in part, by the state general fund. To do so we have proposed to expand Medicaid eligibility, for mental health services only, to Montanans with an income of up to two hundred percent (200%) of the Federal Poverty Level. For a family of four that would equate currently to an annual income of $29,600. Approximately forty percent (40%) of Montana families fall within this standard. We are proposing a graduated fee schedule under which persons qualifying for this expanded eligibility would pay a portion of their mental health treatment costs. This bill will authorize the Medicaid program to accomplish this.

Another important component of our proposed system is to have the managed care contractor perform eligibility determinations for people qualifying under this expanded category. SRS has insufficient personnel available for what will be a large workload expansion. This bill will allow us to have eligibility determinations for mental health managed care performed by an entity other than the county welfare offices.

After consultation with the Commissioner of Insurance, we have determined that some adjustments are also needed in the insurance law to implement our managed care program. First, we are asking that the contractor under the Medicaid mental health managed care program be exempt from requirements that they be licensed as an insurance company. We believe that few of the national managed care companies which have expressed an interest in bidding on our program would be able or willing to meet the extensive requirements for becoming an insurer in Montana. Neither we nor the Commissioner believe it is necessary. We will have extensive financial reporting and solvency requirements in our managed care contract, and the Commissioner's staff has agreed to assist us in evaluating the financial abilities of the bidders and in establishing solvency requirements.

The insurance laws must also be changed in order for us to require that the managed care contractor be responsible for arranging for all Medicaid mental health services. Currently health maintenance organizations are required by law to provide behavioral health services. This bill will remove those services from

the package required of HMOs serving Medicaid clients. Then we can enroll Medicaid recipients in HMOs for physical health care without weakening the effectiveness and comprehensiveness of our mental health initiative. This exemption will avoid the necessity of creating an entire new set of regulations for this unique situation.

This bill also addresses some minor changes needed in the mental health laws to permit the managed care program to work effectively. It authorizes Montana State Hospital and the Center for the Aged to receive payments from the managed care contractor and to use those payments for the operation of the institutions. When the funds normally allocated to them by the legislature are included in the capitation payment to the managed care contractor, this will allow the two institutions to be paid as providers under the managed care system.

Finally, the bill makes two additional minor changes in the mental health statutes. One allows the Department of Corrections and Human Services to designate an entity other than the community mental health centers to screen voluntary admissions to Montana State Hospital. This gives the department additional flexibility in anticipation of a changing array of providers under managed care. Another allows the department to limit services if sufficient funding is unavailable.

This diverse amalgam of changes to existing laws is needed not to authorize a mental health managed care program, which was done by the 1993 Special Session, but to allow the program to go forward as designed and as efficiently as possible. It is important to note that Montana will need to receive waivers to a number of federal regulations in order to implement this program. If this does not come about, all of these changes will have no effect on the operation of the state's mental health system.

On behalf of the Department of Social and Rehabilitation Services, I urge you to pass SB 223. Thank you for the opportunity to speak to this important bill.

Peter S. Blouke, PhD
Director
Department of Social and Rehabilitation Services

EXHIBIT 4
DATE 3-6-95
SB 223

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MARC RACICOT
GOVERNOR

PETER S. BLOUKE, PhD
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210

3/7/95

TO:

Representative Grimes
Representative Bohlinger
Representative Carey
Representative Hibbard
Representative Martinez
Representative Simon
Representative Squires
Representative Liz Smith
Representative Hagener
Representative Ahner
Representative Bergman
Representative Green
Representative Kottel
Representative Molnar
Representative Soft
Representative Wennemar
Representative Susan Smith
Representative Elliott

FROM: Nancy Ellery, Administrator
Medicaid Services Division
Mary E. Dalton acting for

On Monday, March 6, during the hearing on SB 223 before the House Human Services and Aging Committee you asked for more information regarding: 1) AFDC eligibility in surrounding states; and 2) the Massachusetts Medicaid managed mental health program.

I am enclosing a very brief synopsis of the Massachusetts evaluation. Massachusetts is the only state-wide program that I am aware of who has had an independent evaluation of their results. Other states have not been in operation long enough. I have also attached an article about states which are considering managed mental health programs.

I have included the AFDC payments as of 12/93 for all states. Although Montana payments are derived as a percentage of the federal poverty level, other states derive their payments in a variety of different ways. For this reason, comparisons are expressed in terms of payment standards. If you have further questions regarding eligibility, Penny Robbe of the Family Assistance Division or her staff are available to answer your concerns. I do want to reiterate that we will be increasing eligibility **only** for mental health services to 200% of the federal poverty level. The majority of persons who would meet the expanded eligibility criteria are currently receiving services paid for with 100% general fund. People eligible under this provision will not be eligible for other Medicaid benefits. There will be a sliding fee scale used based on income to require recipients to pay a portion of the cost of care.

Please feel free to contact me if you have any other questions. My phone number is 444-4141.

c: Peter Blouke
Penny Robbe
Mary Dalton

quality assurance process to monitor health outcomes.—***May 1994, GAO/HEHS-94-152-BR, 42 pages***
• For copies, call (202) 512-6000 or fax (301) 258-4066.

HHS News

Health Care Financing Administration

The rate of increase in Medicaid spending dropped to 11.5% in fiscal year 1993, down sharply from the 25% rise in FY 1992. Total Medicaid outlays were $131.8 billion in 1993. The number of people covered by Medicaid in FY 1993 rose 8.1% to about 33.4 million between FY 1992 and FY 1993, thus per capita Medicaid spending rose less than 4%. In FY 1992, Medicaid enrollment increased 9.2% to 30.9%. The slowing of the growth rate is attributed by HCFA to cost control measures that have been implemented; redefinition of which tax and donation arrangements are permitted to increase state Medicaid budgets; a stronger economy, which has put people back in the labor force; and greater use of managed care programs for Medicaid enrollees. ***—5/6/94, 3 pages***
• For copies, call HTR at (800) 945-8816.

Evaluation of the Massachusetts Medicaid Mental Health/Substance Abuse Program

Heller School for Advanced Studies in Social Welfare, Brandeis University

A contracted managed care program in Massachusetts, that provides mental health and substance abuse services to 375,000 enrollees in the state's assistance programs, has achieved positive cost savings, but its impact on improving access and quality is uncertain. For FY93, Medicaid mental health and substance abuse expenditures were $46.8 million, 22% lower than projected levels without the managed care program. In 1993, mental health costs per enrollee (adjusted for inflation) declined 19%, while substance abuse costs per enrollee fell 48%. Actual expenditures for ambulatory care were 12.9% below predicted levels and 24-hour care, 38% below, after adjustment for enrollment, utilization trends, and inflation. Because of changes in the provider reimbursement methods, only $42 million of the $46.8 million in total savings could be attributed to managed care. The total number of users per 1,000 enrollees increased by 4.6% between FY92 and FY93, but a survey of 98 providers showed that the providers did not think there has been any change in access under managed care. On the issue of quality, there has been no change based on recidivism rates and provider reports. There was no system in place to evaluate patient satisfaction.—***J. Callahan and D. Shepard, 1/24/94, 200 pages*** (report plus executive summary), $3 (executive summary only)
• For copies, send check to Sylvia Pendleton, Heller School, Brandeis University, P.O. Box 9110, Waltham, MA 02254.

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INDUSTRY STATISTICS: Medicaid Moving Toward Managed Behavioral Health Programs

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Twenty state Medicaid plans are either actively seeking a vendor to manage behavioral health benefits on a risk basis or are developing behavioral health programs. Thirteen states have already entered into agreements with behavioral health utilization review (UR) programs. And, at least four states have risk-based Medicaid managed behavioral health programs in place -- Utah, Massachusetts, Oregon (counties are at risk), and South Carolina (community mental health centers are at risk). These are the results of an *OPEN MINDS* survey of state Medicaid programs, with 38 states participating.

A difficulty in the development of risk-based contracts for Medicaid behavioral health benefits is lack of information about how contract dollars are spent. According to a study by the National Association of State Mental Health Program Directors Research Institute, approximately $1.7 billion were expended on Medicaid behavioral health services by state mental health agencies during fiscal year 1990 -- 58.8% funded by the federal government and 41.2% by the states. Of this $1.7 billion, 0.8% was expended on case management, 18.3% through the clinic option, 7.5% through the rehabilitation option, 24.7% on inpatient hospitalization for those under 21 years of age, 32.9% on inpatient hospitalization for those over 65 years of age, and 15.9% on other services. These figures are of limited use because of difference among states in what Medicaid behavioral health benefits are controlled by state mental health agencies.

States Evaluating Medicaid Managed Behavioral Health

California
Colorado
Florida
Illinois
Indiana
Kansas
Maine
Michigan
Minnesota
Montana
Nevada
New Mexico
North Carolina (children only)
Ohio
Pennsylvania
South Dakota
Vermont (children only)
Washington
Wisconsin (children only)
Wyoming

States With Medicaid Behavioral Health UR Programs In Place

Alaska (Professional Review Of Washington)
Colorado (Colorado Foundation For Medical Care)
Connecticut (First Mental Health)
Idaho (Peer Review Organization Of Washington)
Illinois (Unknown)
Indiana (EDS)
Kansas (Mental Health Consortium & Kansas Foundation For Medical Care)
Kentucky (MOMI)
Montana (First Mental Health)
Nevada (Nevada Peer Review)
New Jersey (BCBS Of Pennsylvania)
New Mexico (BCBS Of New Mexico)
North Carolina (First Mental Health)

During fiscal year 1990, six states (Arizona, Florida, Minnesota, Ohio, Oregon, and Vermont) exercised the Medicaid rehabilitation option, which covers behavioral health services otherwise not covered by Medicaid. Almost 30 states now exercise the option.

Most states have maintained unlimited behavioral health benefits, while eight states have limits:

- Alaska: Limits on rehabilitation, case management, activities therapy, home therapy, and day treatment.
- Colorado: Inpatient treatment limited to 45 days.
- Idaho: Partial hospitalization limit of 56 hours per week.
- Illinois: Inpatient treatment limited to 45 days.
- Kansas: Minimal coverage outside of CMHCs. In CMHCs, partial hospitalization limited to 1,560 hours per year; group/family therapy to 40 hours per year; and individual therapy to 32 hours per year.
- Maine: Inpatient limited to three days for adults.
- Nevada: Inpatient treatment limited to five-day assessment, with additional days preauthorized. No coverage of partial hospitalization.
- Ohio: Inpatient treatment is limited to 10 days.

As state governments evaluate their options for Medicaid, *OPEN MINDS* will continue to keep you abreast of these changes. The study referenced above is available from NASMHPD Research Institute, Inc., 66 Canal Center Plaza, Suite 302, Alexandria, Virginia 22314, 703-739-9333.

By Arthur R. Smith & Monica E. Oss

METHODS USED BY STATES[1] TO DETERMINE THE AMOUNT OF THE ASSISTANCE PAYMENT FOR BASIC NEEDS[2] IN AID TO FAMILIES WITH DEPENDENT CHILDREN, BY STATE, AS OF OCTOBER 1, 1990

State meets the full amount of its need standard for families[3] of all sizes . . . . . .16 States

Alaska	Kansas	New Hampshire	North Dakota
Connecticut	Massachusetts	New Jersey	Oregon
Delaware	Minnesota	New Mexico	Rhode Island
Guam	Nebraska	New York	South Dakota

State meets amount of its need standard for a smaller size family but limits payments to larger families . . . . . 1 State

California — Income is subtracted from the statutory maximum; payment is the deficit. Statutory maximums equal the need standard for families of one through eight. Families of nine or more receive less than the need standard; the highest allowable payment is $1468 for families of ten or more.

State does not meet the full amount of its need standard for families of any size . . . 37 States

Limitations on payments are made by the following methods:

Income is subtracted from the full need standard, and

Payment is the deficit or maximum by family size, whichever is less . . . . . 5 States

Georgia	Maximum equals approximately 66 percent of the full standard.
Maine	Maximum equals 69.4% of full standard.
Michigan	Maximum equals "payment standard"; need standard equals 120% of "payment standard".
Tennessee	Maximum equals 47.5% of full standard.
Wyoming	Maximum equals varying percentage of full standard.

Payment is a percent of the deficit between full need standard and countable income . 4 States

Colorado/84.75%	South Carolina/47.8%
North Carolina/50%	Utah/75%

Payment is a percent of the deficit or the maximum by family size, whichever is less . . 2 States

Kentucky/55% or maximum[4]	Mississippi/60% or maximum

A percentage reduction is applied to the full standard. Income is subtracted from the reduced standard, and

Payment is the deficit . . . . . .21 States

Alabama/varies	Idaho/57%	Montana/81.5%	Puerto Rico/50%
Arizona/47.2%	Illinois/47%	Nevada/60%	Texas/32%
Arkansas[5]/29%	Iowa/85.7%	Ohio/43.05%	Vermont/66%
D.C./60.1%	Louisiana/29%	Oklahoma/68%	Virgin Islands/80%
Florida/varies	Maryland/72.3%	Pennsylvania/68.625%	Wisconsin/80%
Hawaii/62.5%			

Payment is the deficit or the maximum, whichever is less . . . . . 5 States

Indiana/90% or maximum	Washington/55.1% or $985 (8 or more)
Missouri/93.66% or maximum	West Virginia/50% or $477
Virginia/90% or area maximum	

1 Each State sets its own need standards, both in terms of subsistence recognized and in terms of the amounts of money allowed to cover them. The standard is always related to the number of persons in the assistance unit.

2 Those States which set separate standards for basic needs and for special circumstance items and which do not meet 100% of their need standards may combine the amount allowed for special needs with the amount for basic needs before applying any reduction, or they may add the full amount for special needs to the reduced amount for basic needs. This table is based upon payment methods for basic needs only.

3 The word "family" is used loosely to mean the persons comprising an assistance unit as defined by State and Federal regulations.

4 The need standard stops at family size seven; there are no incremental increases for families of more than seven.

5 The need standard stops at family size nine; there are no incremental increases for families of more than nine.

TABLE 2-4. HCFA STATE PROFILE DATA SYSTEM PAGE 1 OF 2

AFDC PAYMENT STANDARDS (DOLLARS)

EFFECTIVE MEDICAID STATE PLAN AS OF 12/31/93

STATE	1-PERSON	2-PERSONS	3-PERSONS	4-PERSONS	5-PERSONS	RURAL VARIANCES
ALABAMA	100.00	123.00	149.00	168.00	194.00	N
ALASKA	498.00	845.00	950.00	1055.00	1160.00	Y
ARIZONA	567.00	765.00	964.00	1162.00	1360.00	Y
ARKANSAS	81.00	162.00	204.00	247.00	286.00	N
CALIFORNIA	326.00	535.00	663.00	788.00	899.00	N
COLORADO	214.00	280.00	356.00	432.00	512.00	N
CONNECTICUT	411.00*	524.00*	649.00*	756.00*	853.00*	N
DELAWARE	201.00	270.00	338.00	407.00	475.00	N
DIST OF COL	450.00	560.00	712.00	870.00	1002.00	N
FLORIDA	180.00	241.00	303.00	364.00	426.00	Y
GEORGIA	155.00	235.00	280.00	330.00	378.00	N
HAWAII	357.00	480.00	602.00	725.00	846.00	N
IDAHO	205.00	251.00	317.00	382.00	448.00	N
ILLINOIS	212.00	268.00	367.00	414.00	485.00	Y
INDIANA	155.00	255.00	320.00	385.00	450.00	N
IOWA	183.00	361.00	426.00	495.00	548.00	N
KANSAS	265.00	347.00	422.00	488.00	547.00	Y
KENTUCKY	162.00	196.00	228.00	285.00	333.00	N
LOUISIANA	72.00	138.00	190.00	234.00	277.00	Y
MAINE	214.00	337.00	453.00	569.00	685.00	N
MARYLAND	179.00	317.00	406.00	489.00	566.00	N
MASSACHUSETTS	392.00	486.00	579.00	668.00	760.00	N
MICHIGAN	305.00	401.00	489.00	593.00	689.00	Y
MINNESOTA	437.00	532.00	621.00	697.00	773.00	N
MISSISSIPPI	218.00	293.00	368.00	443.00	518.00	N
MISSOURI	136.00	234.00	292.00	342.00	388.00	N
MONTANA	235.00	318.00	401.00	484.00	567.00	N
NEBRASKA	222.00	293.00	364.00	435.00	506.00	N
NEVADA	246.00	309.00	372.00	435.00	498.00	N
NEW HAMPSHIRE	388.00	451.00	516.00	575.00	631.00	N
NEW JERSEY	162.00	322.00	424.00	488.00	552.00	N
NEW MEXICO	209.00	283.00	357.00	431.00	504.00	N
NEW YORK	119.10	189.50	253.00	326.70	402.70	N
NORTH CAROLINA	181.00	236.00	272.00	297.00	324.00	N
NORTH DAKOTA	221.00	333.00	409.00	501.00	569.00	N

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TABLE 2-4. (CONT.)

HCFA STATE PROFILE DATA SYSTEM
AFDC PAYMENT STANDARDS (DOLLARS)
EFFECTIVE MEDICAID STATE PLAN AS OF 12/31/93

STATE	1-PERSON	2-PERSONS	3-PERSONS	4-PERSONS	5-PERSONS	RURAL VARIANCES
OHIO	203.00	279.00	341.00	421.00	493.00	N
OKLAHOMA	200.00	251.00	324.00	402.00	470.00	N
OREGON	310.00	395.00	460.00	565.00	660.00	N
PENNSYLVANIA	215.00	330.00	421.00	514.00	607.00	Y
RHODE ISLAND	327.00	449.00	554.00	632.00	710.00	N
SOUTH CAROLINA	124.00	167.00	210.00	252.00	295.00	N
SOUTH DAKOTA	293.00*	368.00*	417.00*	464.00*	512.00*	N
TENNESSEE	95.00	142.00	185.00	226.00	264.00	N
TEXAS	75.00	158.00	184.00	221.00	246.00	Y
UTAH	233.00	323.00	402.00	470.00	536.00	N
VERMONT	465.00	567.00	673.00	755.00	845.00	Y
VIRGINIA	220.00	294.00	354.00	410.00	488.00	Y
WASHINGTON	349.00	440.00	546.00	642.00	740.00	N
WEST VIRGINIA	145.00	201.00	249.00	312.00	360.00	Y
WISCONSIN	311.00	550.00	647.00	772.00	886.00	Y
WYOMING	195.00	320.00	360.00	390.00	450.00	N

* = DATA BASED ON PENDING STATE PLAN AMENDMENT

EXHIBIT 5
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Mr Chairman, members of the committee

My name is **Donna Hale,** I am a licensed clinical social worker who is **self-employed** as a psychotherapist.

Last year, during the special session, the department of Social and Rehabilitative Services introduced a bill for managed care of Medicaid mental health services. I spoke to express the great concern about this measure shared by those mental health providers who are self-employed, in private practice, and who provide the vast majority of Medicaid out-patient mental health services. In response to this testimony and the testimony of many others, the legislature added language to the bill requiring formation of an advisory committee and also requiring that the final drafts of the bill come to this legislature for action. I am here today to report to you on those measures.

We all know that advisory committees can be paper tigers, without any real power. However, although I was initially suspicious of this process, I found that the committee that SRS chose to form indeed represented all those who were concerned or affected by this proposal. Each of the professional associations, the National Association of Social Workers, the American Psychological Association, and the National Association of Professional Counselors was invited to designate a representative to the committee. In addition, the committee included other private providers, representatives from the Mental Health Centers and the State Hospital, consumers, and representatives from the state agencies involved. We were given reams of material to read, we listened to presentations from persons from across the country, met for numerous hours, and were encouraged to make comments and ask questions. Our suggestions and concerns were listened to and responded to. **The measure you have before you represents the first time that I am aware of that the consumers of these services, the providers, both public and private, and the state agencies involved have worked**

together and forged a program that we all agree with. This has required tremendous effort and cooperation and I very strongly urge you to support our work by passing this bill. Finally ~~In addition~~, I have heard a number of comments regarding this bill. First that the status quo is fine and can continue. I want you to know that it is not fine and that those of us who provide the bulk of the outpatient services cannot continue as we have been. In addition, I have heard suggestions that the state could manage this care ~~more~~ at less cost than bringing in a private organization. I believe that this is true, but only if you're willing the add the experience FTE's necessary and provide the financial resources for their training and wait for the several years that would be necessary for them to gain sufficient knowledge to design such a program. Several years that would be very costly. Again, I strongly believe in the process that has been utilized and in this bill. Please provide us with your support.
Thank you.

EXHIBIT 6
DATE 3/6/95
SB 223

Meriwether Lewis Institute

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

For: HUMAN SERVICES & AGING COMMITTEE
Date: March 6, 1995

Mr. Chairman and Members of the Committee:

My name is Kathy Standard and I am serving my second term as President of the Meriwether Lewis Institute. The Meriwether Lewis Institute is Montana's only non-profit corporation that was created solely by and for people who have mental illness. The Board of Directors, the Executive Director, and all voting members have a mental illness. I have a mental illness that I am finally able to manage through a combination of medication, therapy and peer support. I owe much of my current stability to good psychiatric care and an excellent therapist, both provided by the public mental health system. I am also very lucky that I am well enough to fight for what I need from the mental health system - many people with mental illness do not have access to the supports necessary for getting their needs met, and may not even be encouraged to evaluate what their own needs <u>are</u>.

What we currently have in Montana is a care-taking system, where mental health centers, the State Hospital, and other providers have more to gain financially if we are sick than if we are well. This is not particularly their fault. The problem lies with a mental health system based on services that pay money to the <u>provider,</u> not on services designed to help mental health consumers learn to manage their lives and be as independent as possible. One of the basic tenets of the Meriwether Lewis Institute is that every mental health consumer has the <u>right</u> to reach his or her full potential, whatever that may be. Montana's current mental health system, as a whole, is <u>not</u> conducive to helping consumers reach their full potential.

Our Executive Director and I also serve on the Mental Health Managed Care Advisory Group, and have spent many, many hours studying and researching the concept of managed care. The Meriwether Lewis Institute represents a large number of the people who will be affected by mental health managed care, and we have critically evaluated what we've learned. Despite our numerous concerns, we believe that the Montana mental health system's only hope of operating efficiently and effectively is under a managed care plan. Medicaid has included mental health consumers in its planning for managed care, and we believe they will continue to be willing to listen to and address our concerns as they develop a realistic Mental Health Managed Care program. It is our understanding that services will be designed to meet the needs of consumers, and will provide the continuum of care that is missing now but is so desperately necessary to enable consumers to begin healing and to maintain the stability that can keep us alive. If designed correctly, managed care can reduce our dependency on the system and increase our ability to function independently. It could allow many of us to support ourselves and pay taxes again. If we can receive the services we need as individuals, we can finally live our lives with dignity and self-respect, no matter what stage our illness is in.

During the past 5 years of both regular and special Legislative Sessions, mental health services have been cut time and time again. Consumers have stood here and literally begged the Legislature to give us the opportunity to rebuild our lives, yet the programs and services we need in order to even survive are continually damaged by cuts. On behalf of Montana mental health consumers, I ask you to support Mental Health Managed Care and enable us to learn healthier, more effective ways to live with our mental illnesses.

Thank you.

EXHIBIT 7
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TESTIMONY OF DAVID HEMION
PUBLIC POLICY COORDINATOR
MENTAL HEALTH ASSOCIATION OF MONTANA
SB 223 - MENTAL HEALTH MANAGED CARE
March 6, 1995

The Mental Health Association of Montana represents some 1,200 mental health consumers, providers, family members and others interested in achieving victory over mental illness. On behalf of MHA, here are its positions on mental health managed care.

1. MHA SUPPORTS A PRE-PAID MANAGED MENTAL HEALTH PLAN, COMBINING STATE AND MEDICAID FUNDS.

MHA believes that managed care offers a solution to both cost-containment and quality service delivery. The American Academy of Actuaries has concluded that managed care for mental health services can save between 30 to 40 percent over unmanaged fee-for service or minimally managed delivery systems. AAA conducted studies of the Health Security Act of 1993 and estimated that costs for treatment of mental illnesses and substance abuse would drop: from $240 to $305 per person annually for unmanaged care to $45 to $165 per person under managed care.

In actual experience, large corporate health plans track these estimates. Bell South reduced its spending for mental health benefits by 30 percent over three years. Alcan Aluminum reduced its annual mental health per capita claims from $170 to $ $70 over two years.

Public sector experience is similar. A Brandeis University study of the mental health Medicaid managed care system for the state of Massachusetts, implemented in 1991, showed a 22 percent reduction over anticipated costs and actual savings of $23 million.

We need to temper our expectations about Montana's projected system. Please remember that savings for Medicaid-eligible clients may not be as great as general populations, as those included are in varying conditions of poverty, which places them at higher risk for mental illnesses and health problems.

The Brandeis study also found that quality of service did not suffer, as indicated by a decline in recidivism rates of about 20 percent. Access also improved with increases in numbers of users of 22 percent.

Imagine that. A decrease in costs, increase in clients served with quality maintained or improved.

2. MHA SUPPORTS RETAINING SAVINGS WITHIN THE MENTAL HEALTH SYSTEM

We believe that Montana needs to retain funds saved by managed care, at least through initial years, to fund service gaps, improving prevention, early intervention and access, especially for difficult to serve populations, such as those in remote areas.

3. MHA SUPPORTS INCLUDING SERVICES PROVIDED BY MONTANA STATE HOSPITAL IN MANAGED CARE.

MHA expects all patients admitted by MSH, except forensic patients, to be included. We anticipate that managed care will increase treatment of patients at the community level, decrease admissions to MSH and discharge patients sooner and to an improved after care continuum.

4. MHA CONTINUES TO EXPRESS CONCERN REGARDING THE COMBINING OF PUBLIC FUNDS TARGETED TO CHILDREN'S SERVICES WITH FUNDS FOR ADULT TREATMENT.

Our concerns are two-fold. First, Montana is working hard to overcome a past lack of coordination of children's services, primarily through the MRM program. We are concerned that the gains MRM has made may be rolled back, unless funding for children's services is somehow protected. We support the recommendation of Dan Anderson of the Department of Corrections and Human Services to earmark funding for children's services to prevent funding shifts to adult services.

Our second concern is that actions to date in this Legislative session indicate that inadequate funding will be provided for children's services. The 50 percent cut in the MRM program and denial of funding for the Community Impact program are tragic. We urge the legislature to restore funding to levels recommended by the Governor for both these programs.

This concern also extends to adult services. Funding for community level crisis intervention and housing is the only way to prevent costlier hospitalization. The funding requested for these services must be restored by the Legislature.

To ignore this request invites an avoidable disaster for the mental health of the children of Montana. It also assures the failure of managed care, as we doubt any contractor would be willing to take on the task of managing an underfunded system.

5. MHA SUPPORTS EXPANDING COVERAGE TO 200 PERCENT OF POVERTY.

This is in the self-interest of all Montana tax payers, as it allows a shift from general fund-supported services to federal funding. It also provides a preventative measure by

assuring early intervention and treatment of mental illnesses for working Montanans who are uninsured or underinsured.

6.MHA APPRECIATES THE INITIATIVE OF THE DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES IN PURSUING MANAGED CARE AND ITS RESPONSIVENESS TO QUESTIONS AND CONCERNS RAISED BY MHA AND OTHERS.

SRS has been prompt in responding to detailed and extensive questions provided by MHA. We appreciate the opportunity to be represented on the Advisory Council by Joan-Nell Mcfadden, chair of MHA's Children's Committee and Candy Butler, MHA president-elect. We look forward to the opportunity to review and comment upon the RFP and to be actively involved in monitoring the implementation of managed care.

8. WE SUPPORT SB 223 AND URGE YOUR PASSAGE.

EXHIBIT 8
DATE 3/6/95
SB 223

March 6, 1995

Human Services and Aging Committee

Mr. Chairman and members of the Committee,

For the record, my name is Patrick Pope. I serve as Director of the Meriwether Lewis Institute and I am a consumer of mental health services. Marty Onishuk of the Montana Alliance for the Mentally Ill could not get here from Missoula today because of car trouble. I was asked to speak today on behalf of the Alliance.

The Montana Alliance for the Mentally Ill supports the concept of Managed Care. It feels that the current mental health system does not provide a continuum of care for people with mental illness. It is the hope of the Alliance that managed care will provide much improved, comprehensive services for consumers. Thank you.

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services DATE 3-6-95

BILL NO. SB 223 SPONSOR(S) Keating

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Randy Pinsoen	SRS	X	
Bob Olsen	MHA	X	
Donna Hale	NASW	X	
Bob Ross	BIRS MENTAL HEALTH	X	
Gloria Hermanson	MT Psych Assn	X	
David Hemion	Mental Health Assoc.	✓	
Bob Torres	MT-Chap NASW	✓	
Cindy Wimmer	MBCC	✓	
KATHY McGOWAN	MCMHC	✓	
PAT POPE	MLI/MONTAMI	✓	
Dan Anderson	DCFS - MH	✓	
KATHY STANDARD	MERIWETHER LEWIS IDS	✓	
Joan-Nell Macfadden	OFS State Council	✓	

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

Joan-Nell Macfadden

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services DATE 3-6-95

BILL NO. SB 310 SPONSOR(S) Jacobsen

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NAME AND ADDRESS	REPRESENTING	Support	Oppose
Jennifer Krueger 1101 S Montana Butte MT 59701	President, Montana Acad. of Physician Assts	✓	
Pat England	MT Bd of Med Ex	X	
Randy Spear	MT Bd of Med Ex	✓	
J. Leendertz	Not noted	Sec 2	Sec 1

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HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services DATE 3-6-95

BILL NO. SB 240 SPONSOR(S) Van Valkenburg

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NAME AND ADDRESS	REPRESENTING	Support	Oppose
Pat England	MT. Bd of Med Ex	Y	
Larry White	ST. PATRICK HOSPITAL	X	
Jim Drury	St. Patrick Hospital	X	
Gary Elliott	Ribi ImmunoChem	X	
Jerome Loendorf	Mt Med Assn	X	
Bob Frazier	University of MT	X	

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