MONTANA LEGISLATIVE BRANCH

Legislative Fiscal Division

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MINUTES
HJR 35 SUBCOMMITEE

Tuesday, July 25, 2000
Helena, Montana

The fifth meeting of the House Joint Resolution (HJR 35) subcommittee was called to order by Senator Chuck Swysgood, Chairman, on July 25, 2000 at 8:45 a.m., in Room 172 of the Capitol Building. The following HJR 35 members were present:

Senator Swysgood, Chairman
Senator Waterman
Senator Franklin
Senator Keenan
Representative McCann
Representative Barnhart

Representative Taylor and Representative Soft were excused.

Approval of Minutes

Senator Keenan moved that the minutes of the June 7, 2000, meeting be approved as presented. **Senator Waterman** seconded the motion. Minutes were approved as presented.

Status of MSH Construction Project

Tom O'Connell, Chief, Architect and Engineering Division, Department of Administration (DOA), discussed the construction, the funding and the claims status of the new hospital. The original schedule called for a June 30, 1999 completion date. The substantial completion was granted on April 27, 2000. The occupancy permit for staff was obtained on June 12, 2000. The occupancy permit for patients was granted July 20, 2000.

The $21 million appropriation has been exhausted. The supervisory fee for the Architecture and Engineering Division (A&E) was waived to try to make ends meet. Funds also came from the hazardous material abatement fund and year-end operational budget savings. Mr. O'Connell feels the finish line is in site but there are still some outstanding issues that have to be resolved.

There is obvious dispute over who is responsible for the delays. DOA met with Pro Builders several times in an attempt to resolve issues as they arose. In June, A&E and Pro Builders exchanged claims. When the reviews are complete, if a settlement is not reached, the contract provides for arbitration. The state claim to Pro Builders is in the amount of $1.22 million for damages caused by delays. Pro Builders claim to the state is for $3.58 million and 307 days of extended contract time. The state will aggressively challenge the claim.

In summary, the facility is occupied, the funds are nearly exhausted and the claims have been exchanged and are in the process of being reviewed.

Senator Swysgood asked if there would be a settlement by the end of this fiscal year. Mr. O'Connell stated that it is possible but not probable.

Senator Waterman asked if the project were to go in the "red" because of an arbitration settlement or other costs where would the money come from. Mr. O'Connell stated DOA would ask for a supplemental. Mr. O'Connell stated he is hopeful the construction will come through in the "black" but there are no funds for attorney fees and arbitration.

Lois Steinbeck, Senior Fiscal Analyst, Legislative Fiscal Division (LFD) distributed a memo containing information from Judge Larson (Exhibit 1). Judge Larson may appear before the subcommittee at the September meeting.

Standing Agenda Items

Dan Anderson, Administrator, Addictive and Mental Disorders Division, (AMDD) Department of Public Health Human Services (Department) introduced Dr. Novalis, Medical Director, Montana State Hospital (MSH). Dr. Novalis has been with the MSH for approximately a month and he will be responsible for coordinating all the clinical services at the hospital. Mr. Anderson also mentioned that Debra Dirkson, CEO, MSH resigned and the Department is actively recruiting for her replacement.

Mr. Anderson distributed a timeline for the move into the new hospital (Exhibit 2). The staff has carefully planned the move to assure that staff is oriented in the new facility prior to moving patients in.

MSH Population – Mr. Anderson referred to the MSH population report for June 2000 (Exhibit 3). The report includes the year-end total ADP of 159, which is 11 fewer than in 1999. Mr. Anderson has discussed with the MSH and community programs staff that perhaps 135 is too low for an ADP. Both feel with further development of community services and processes to assure people stay in the community, there should be a further reduction in the MSH population. The percent of decrease in fiscal 2000 is fairly substantial in a number of categories with the exception of court ordered detention/emergency detention (COD/ED). There is an ongoing problem with people in an emergency or crisis situation and communities not having an appropriate place to serve them. As a result, a substantial number of those people end up at the MSH. The Department has an EPP proposal that may help to reduce the number going to the MSH.

Representative McCann asked what the capacity of the new facility is. Mr. Anderson stated there is a total of 184 beds. 114 beds in the new facility, 56 beds in the Spratt building and 14 beds in the two existing Transitional Care Unit (TCU)/group homes.

Representative Barnhart asked if the TCU would receive reimbursement at a higher rate than the group home in Bozeman and what the cost per day is in the TCU. Mr. Anderson stated that he does not anticipate the TCU would be reimbursed out of the MHSP or Medicaid. The overall cost per day at MSH is considerably above the cost per day in a group home. The cost per day in the TCU varies by patient depending on what volume of service they receive. The overall hospital operation cost is around $300 per day.

Senator Waterman asked what the amount is in the Department budget for the next biennium for the MSH and will that be based on an ADP of 135 or has the amount been increased. Mr. Anderson stated the amount has not been increased. He did know if the budget was calculated based on the projected population or on the base expenditures plus present law adjustments and new proposals.

Ms. Steinbeck responded that the MSH budget should be similar to the prison budget and should be based on the population anticipated.

Senator Keenan requested a breakdown of the average cost per day for the Psychosocial Rehabilitation Unit (PRU), TCU/group home and the Spratt building for the next meting.

Senator Swysgood requested information on how the commitments and evaluation process will be funded for the new regional facilities in the EPP.

PACT Update – Dan Anderson, Department, reported on the PACT programs (Exhibit 4). The PACT program is doing well. The Billings program has admitted 41 of the required PACT clients. 24 were from the MSH and 17 from community based services. Integration of staff psychiatrist in the Billings PACT continues to be a challenge. Chemical dependency issues are an ongoing problem for the Helena program along with transportation for clients and staff.

Senator Waterman asked Mr. Anderson to comment on staff turnover and family involvement. Mr. Anderson stated there have not been any specific discussions regarding those issues. But an ongoing issue that may be related is the rate in which consumers were brought into the program that resulted in overworked workers. Rate of PACT admissions may be related to the staff turnover and the perception that there hasn't been time to work with families.

PACT Start up Costs – Mr. Anderson referred to the Department's written response (Exhibit 5). No funds were advanced to PACT providers for start up purposes. The original cost anticipated to serve each consumer was approximately $800 per month. Because of the transition period of staggered MSH transfers and enrollment, it was necessary to charge a rate of approximately $1200 per month to meet the program costs in the first six months.

Status of Mental Health Budget Reduction Plan – (Exhibit 6) and Mental Health Budget Background Material – (Exhibit 6A). Mr. Anderson explained in order to move money from the second year biennium to the first year biennium, the Department is required to prepare a plan to eliminate the deficit. The Department should have a final plan to present to the Governor's Office in approximately two weeks.

Senator Swysgood expressed concern regarding the time frame for implementation of some the reductions and whether the $8.0 million in savings is attainable.

Senator Waterman asked Mr. Anderson to explain the partial hospitalization rate decrease. Mr. Anderson responded that only programs located at the hospital site would be considered as partial hospitalization providers. In addition, rates for partial hospitalization services will be reduced by 25 percent.

MHAP Claims Costs – Bob Mullen, AMDD, reported on MHAP claims payments (Exhibit 7). MHAP payments made through June 1999 were $12,476,245. Anticipated claims costs were $12,432,574. The Department has not seen any settlements yet for disputed claims. Medicaid accruals for fiscal 1999 have been expended and non-Medicaid accruals can not be carried forward another year. Mr. Mullen anticipates some unfunded liability. The Department has approximately $225,000 to $300,000 in excess MHAP collections from fiscal 1999 that may be used to meet the non-Medicaid costs.

Senator Waterman asked if Magellan agrees with the Department's total amount of MHAP claims paid. Mr. Mullen referred to a memo from Mike Billings, Administrator, Operations and Technology Division, regarding the reconciliation (Exhibit 8). Magellan records did not include payments for pharmacy costs made by Magellan to its drug program manager. If the drug costs are added to the figures cited by Ms. Lenmark during the June meeting then the totals are the same as reported by the Department.

AMDD Fiscal 2000 Expenditures Compared to Appropriations – Mr. Mullen presented a handout to the subcommittee on Budget and Projected Expenditures – FY2000 (Exhibit 9). The Department is still in the process of closing the books for fiscal 2000. The Department is projecting an additional $1.1 million general fund shortfall after the $4.0 million transfer from the fiscal 2001 appropriations.

Representative McCann asked if MSH and MHAP population information is available for comparison. Mr. Mullen responded the Department would prepare some information that will compare the population being served under MHSP versus the population served by Magellan for the next meeting.

Use of CHIP Funds for MHSP – Nancy Ellery, Administrator, Health Policy and Services Division, updated the subcommittee on the use of CHIP funds for MHSP. Under the current

CHIP program and MHSP program a child may be eligible for both. CHIP reimburses mental health services up to the limits in the CHIP plan and if the child needs additional services, MHSP pays using 100 percent general fund. CHIP has an 80 percent federal match. Several options being considered are: 1) carve out mental health benefit from the CHIP program and the Department would manage the mental health benefit; 2) have Blue Cross/Blue Shield manage all benefits; or 3) CHIP Plus would pay for mental health services in excess of CHIP plan limits at 80/20 percent general fund for dual eligible children (instead of 100 percent general fund). Blue Cross/Blue Shield would continue to manage the CHIP benefit up to the limit. CHIP Plus would cover mental health benefits above regular CHIP limits.

Ms. Ellery stated the existing general fund could be used to obtain the 80 percent federal match. The advantage would be to maximize more federal funds and offset general fund and mitigate the impact of the cuts being proposed. The disadvantage is it would increase the cost of children being served under CHIP because more mental health services would be provided. The overall cost of a child under CHIP would go up and may limit the ability to do future expansions in the CHIP program. The Department has until September 30, 2000 to spend $5.8 million in federal CHIP money or it will be reverted to other states. Services have to be provided by September 30, 2000 in order to use the excess federal money. The federal fiscal 1999 grant of approximately $13.0 million will expire September 30, 2001. The Department is checking with the Health Care Financing Administration (HCFA) to see if it can pay mental health services for dual eligible children from CHIP funds and get the 80/20 rate. A second, less likely alternative, would be to retroactively establish CHIP eligibility for children enrolled in MHSP but not CHIP. The eligibility requirements are virtually the same for both programs.

Ms. Steinbeck reported that information provided by Mr. Poulsen shows two-thirds of the MHSP eligible children are not currently enrolled in CHIP. The only two reasons for not being eligible for CHIP are: 1) children of state employees; and 2) if the family has any kind of health insurance.

Senator Waterman asked if it is now a requirement that children receiving MHSP benefits have to be enrolled in CHIP. Mr. Poulsen responded that making CHIP the first payer has always been the intention and that is the case for children dually eligible. The Medicaid payment system, which is also the MHSP payment system, did not have an edit in place to make sure that

always happened. The system is being fixed and the Department will go back and recover any MHSP dollars that have been spent for CHIP covered services. Currently, it is not a requirement that children be enrolled in CHIP. It would require an administrative rule change to make it a condition of MHSP eligibility.

Senator Waterman also asked how many children presently enrolled in CHIP and receiving mental health services would exceed the cap in the CHIP plan. Ms. Ellery did not have the information but could provide it for the next meeting.

Senator Swysgood asked Greg Petesch, Director, Legal Services Office, Legislative Services Division (LSD) if there is a reason why emergency rules can't be implemented. Mr. Petesch stated in order to adopt an emergency rule the Department has to show imminent peril to the public health, safety or welfare. If services are eliminated for children in the mental health program that would show imminent peril to the public health.

Senator Swysgood suggested the Department try to implement the rule change immediately.

Use of TANF Block Grant or MHSP Toward MOE – Hank Hudson, Administrator, Human and Community Services Division, reported to the subcommittee on use of TANF money or the State Maintenance of Effort (MOE) money in the mental health program. Everyone in the Family Achieving Independence in Montana (FAIM) program who needs mental health services is on Medicaid. There is no general fund money being spent in MHSP that can count towards MOE. There is some limited potential to use TANF money to buy mental health services. TANF funds have to be spent on families, TANF funds have to be spent on non-medical services and TANF funds can not be used for what used to be state expenditures. Currently, approximately 20 percent of the block grant goes into developmental disability services or child welfare services.

Ms. Steinbeck stated that using general fund mental health services expenditures is limited when using CHIP but it is possible that some MHSP general fund expenditures could be counted toward TANF MOE. The mental health expenditures are used to draw down the federal mental health block grant. However, if there are cuts in MHSP, the federal mental health block grant may be lost. If the mental health block grant would be jeopardized than using any remaining potential mental health services expenditures toward TANF MOE could be considered.

Senator Waterman asked if TANF funds can be used to help individuals on welfare who have serious mental illness with the application for SSI eligibility. Mr. Hudson stated that TANF could be used to live on during that period of time. It can not be used for evaluations that are medical in nature. **Senator Waterman** asked if Medicaid could pay for the evaluations while the individuals are on welfare. Mr. Hudson stated not always. Generally an evaluation for SSI is not medically necessary.

Ms. Steinbeck noted that under the proposed mental health service reductions, unless a TANF or FAIM participant is seriously mentally ill they would no longer have access to outpatient mental health services. If an individual is in FAIM because of an abusive situation and needs outpatient services, Medicaid would no longer fund those services under the proposed mental health service reductions.

Status of Recommendations for MHOAC – Laurie Ekanger, distributed a copy of the Department response to the Mental Health Oversight Advisory Council (MHOAC) recommendations (Exhibit 10). All of the recommendations were accepted by the Department with the exception of two. Recommendations #19 and #22 were partially accepted, which is explained in the accompanying handout (Exhibit 11). These two recommendations will be further discussed. A copy of all the recommendations from the Council were mailed prior to the meeting (Exhibit 12). In most cases, some aspects of a recommendation can be implemented without additional funding. All recommendations that require funding continue to be under consideration for EPP except for increasing MHSP eligibility from 150 percent to 200 percent of the federal poverty level.

Senator Swysgood asked for a breakdown of the total costs to the Department with implementation of the recommendations for the next meeting.

Mental Health Ombudsman Report - Ms. Adee presented her report to the subcommittee (Exhibit 13). The first year of operation consisted of 11 months. The volume of requests average 36 per month. In addition to handling contacts, there were a number of meetings and reports requested from the Ombudsman Office. An annual report will be forthcoming.

The types of requests are:

- Informational - 30 percent;
- Coaching - 33 percent;
- Informal investigation or assistance - 25 percent;
- Referral - 10 percent; and
- Other category - 2 percent.

Issues of concern are:

- Access to services (coverage) - 13 percent;
- Treatment quality or quantity - 12 percent;
- Process or system problems - 17 percent; and
- Other - 10 percent.

Ms. Adee's comments on issues and options under consideration by the subcommittee are:

- Support training of law enforcement, require standardized screening for all inmates and continue to strengthen community commitment law.
- Increase psychiatric capacity of system, particularly for children. Reimburse screening exams in the emergency room and link person to community services.
- Attach all treatment costs to child's social security number; give multiple agencies access to accruing cost information. Hold treating agencies accountable for showing progress and/or stability as treatment result.
- Offer families of severely mentally ill children the option to purchase Medicaid or CHIP on sliding scale.
- Establish a mandate for consumer run services.
- Fund ongoing training and support for case managers. Establish levels for case managers based on experience, training and performance, and link the level to reimbursement.

On the back of Ms. Adee's report is proposed language change to Section 2-15-210, MCA.

Medicaid Managed Care Statutes and Community Commitments

Susan Fox, Research Analyst, LSD, discussed the draft bills, LC9001 (Exhibit 14) and LC9002 (Exhibit 15).

LC9001 – revisiting SB 534

The committee approved two directives:

1. To remove the requirement for incremental managed care; and
2. To address the definition of managed care community networks.

Mr. Petesch stated the bill as written allows the state to contract for non-Medicaid services. The bill does not identify the restrictions that have to be in the contract for non-Medicaid services. There is a requirement to determine, prior to entering into the contract, whether the managed care network definition will be met. If the definition will be met then the contract must include certain restrictions. If the definition is not met then the restrictions are not identified in the contract with the exception of enforcement mechanisms.

LC9002 – Community commitment conditions and revocation

This bill is more a reorganization of statutes than substantial changes;

1. Clarifies two basic dispositions – hospitalization or a community commitment;
2. Removes the involuntary medication statutes from 53-21-127, MCA and places them in a separate section with no substantive changes;
3. Section 8 sets forth three basic conditions that can be ordered in a community commitment;
4. Section 9 sets forth the process of beginning a proceeding for a revocation of a community commitment and it parallels the process of a petition for rehospitalization; and
5. Section 10 allows for the revocation of a community commitment to either the state hospital or allows for additional conditions to be placed on the remainder of the period of a community commitment.

Leslie Garvin, Attorney, MSH, expressed concern that the new bill would shorten the length of stay in the hospital if a community commitment were revoked and instead of eliminating the second hearing the draft bill adds another hearing for revocation of a community commitment. Release from the MSH is a conditional release not a community commitment.

Gene Haire, Board of Visitors, responded that what might be confusing the issue is the concept of a conditional release from MSH and a community commitment, and applying the term revoke to a community commitment, which previously has been associated with the concept of a conditional release.

Public Comment

Alexandra Volgerts, Montana Advocacy Program (MAP), expressed the importance of retaining the second hearing because community commitments allow judges to commit people using a lower standard of disability.

Kathy McGowan, Montana Community Mental Health Center, expressed concern regarding the program changes that the Department presented and funding school based services with public mental health dollars. At least half of the program changes are going to have major impacts on rural communities.

Ms. Volgerts distributed the MAP Jail Survey Results (Exhibit 16).

Cost to Increase Mental Health Services Plan (MHSP) Eligibility

Lois Steinbeck, LFD, presented to the subcommittee a report on the cost to expand MHSP eligibility above 150 percent of poverty (Exhibit 17). There are two components to expanding the cost of MHSP eligibility above 150 percent of poverty: 1) the cost to reinstate eligibility from 120 to 150 percent of poverty and reinstate enrollment in MHSP; and 2) the additional cost to raise eligibility above 150 percent of the poverty. The cost to reinstate financial eligibility is estimated to be $9.9 million over the 2003 biennium and the cost to expand eligibility from 150 to 200 percent of the federal poverty level is estimated to add another $3.5 million.

Ms. Steinbeck also discussed cost sharing options for MHSP. The two general categories used in fee-for-service type plans are: 1) premiums; and 2) copayments. Approximately 1/3 of the persons eligible for MHSP live in households with incomes below 50 percent of the federal poverty level and about 68 percent of MHSP eligible persons have incomes below 100 percent of the poverty level. CHIP includes a $215 annual copayment for families with incomes in excess of 100 percent of the federal poverty level. This analysis has not considered whether the copayment should be raised if CHIP funds were used to match all or more of the cost of MHSP services provided to children eligible for both programs. A family with income in excess of 100 percent of poverty with a child eligible for both CHIP and MHSP would pay the same copayments for both programs without changes.

The most obvious advantage of imposing cost sharing in public health programs is the general fund cost offset. Other advantages can include ensuring responsible choices by participants in accessing health services and can better prepare participants to live independently of public programs. The most obvious disadvantage is the potential barrier to accessing services. Other disadvantages can be lower reimbursement to providers or disincentives to a provider's decision to not participate in the program. Also, if participants are unable to consistently make rational decisions for themselves, cost sharing may discourage them from seeking needed medical care. Participation in state funded health services programs is nearly always based on financial eligibility. The decision to impose cost sharing must take into account competing costs and needs. Cost sharing must generate sufficient revenue to be worth the price and management effort to implement the system while not imposing barriers to access for services. LFD staff has not estimated the cost or determined the system impact to implement various cost sharing options.

Representative Barnhart asked what the administrative costs are to implement copayments. Mr. Poulsen reported that the administrative costs of copays are minimal. The Medicaid system withholds the copay from the provider. The cost to the provider needs to be considered because in many cases a copay becomes a provider rate reduction.

MOTION: **Senator Waterman** moved that Ms. Steinbeck and the Department refine the cost for both 180 and 200 percent of federal poverty level utilizing a premium and 5 percent of the cost of services for recipients who fall between 150, 180 and 200 percent of federal poverty level.

AMENDED MOTION: Representative **Barnhart** moved to include premiums for recipients between 120 and 150 percent of federal poverty level to the motion.

Senator Franklin seconded the motion. Motion carried unanimously.

Representative Barnhart reported that the Bozeman Group home will remain open. The county commissioners are organizing an advisory council for all mental health issues in Gallatin County.

Senator Swysgood scheduled a conference call for Friday, July 28, 2000 at 8:00 a.m. to review the Issues/Options Summary.

Next HJR 35 Subcommittee Meeting

The last HJR 35 subcommittee meeting will be a two day meeting beginning at 1:00 p.m. on Wednesday, September 27 in the Capitol.

Adjournment

Meeting adjourned at 3:40 p.m.

Friday, July 24, 2000 Conference Call

The meeting was called to order by Senator Swysgood, Chairman, at 8:05 a.m. in Room 116 of the Capitol Building. The following subcommittee members participated in the conference call:

Senator Swysgood	Representative Taylor
Senator Waterman	Representative Soft
Senator Keenan	Representative Barnhart

Senator Franklin and Representative McCann were unavailable.

Other Attendees

Lois Steinbeck	LFD	Laurie Ekanger	DPHHS
Diane McDuffie	LFD	Randy Poulsen	DPHHS
Susan Fox	LSD		
Christine Perrier	MCC (Montana Catholic Conference)		

Review Issues/Options Summary

Issues and Options for Consideration (Exhibit 1).

1. Local law enforcement issues
    A. Transportation cost to county

Ms. Steinbeck explained Option 1 lists a possibility that local governments that transport Medicaid eligible persons to medical care may receive a 50 percent match for administrative costs. A process for the local governments to submit claims to DPHHS would need to be implemented.

Senator Swysgood asked what services would be jeopardized if Medicaid matches 50 percent of the cost.

Ms. Steinbeck responded that it would not jeopardize any service. It would be a federal match and the county would provide the non-federal match.

Option 1. Adopted

Ms. Steinbeck explained Option 2 is the same idea as Medicaid sharing only it would be a general fund cost share. If the person is MHSP eligible DPHHS would provide 50 percent of the cost. That would impact the budget and it would potentially reduce services available to other persons if the general fund budget for MHSP is not increased.

Option 2. No recommendation will be made.

B. Guidelines on restraints - **No recommendation will be made.**

C. Teleconferencing in lieu of transportation – **No recommendation will be made but will be addressed in a resolution.**

D. Training

Senator Waterman expressed a need for training either in draft legislation or as a resolution.
Senator Swysgood suggested some type of resolution to be considered in the budget process.

Mr. Poulsen reported that the Department and Sally Johnson from the Department of Corrections are planning a joint training effort over the next year.

Option 1. Deferred to next meeting for further discussion.
Option 2. Adopted 6/7/00
Option 3. Deferred to next meeting for further discussion.
Staff will prepare training package recommendation for the next meeting and will ask for comments by agencies.

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2. Psychiatric capacity

A. Nurse practitioners - **No recommendation will be made at this time.**

Staff will work on issues for possible consideration at next meeting.

B. Teleconferencing – **Will be included in resolution.**

C. Service Rates

Mr. Poulsen stated that there is difficulty accessing psychiatrists. The mental health centers can hire psychiatrists but can't afford to support them with the current rates. The Department is considering a rate increase for psychiatrists.

Option 1. Deferred to next meeting for further discussion.

Option 2. **No recommendation will be made.**

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3. Community services for multi-agency children - **Staff will incorporate recommendation from Bonnie Adee, Mental Health Ombudsman, for review at the next meeting.**

   A. State department cooperation in establishing policies to encourage local integration

Staff will prepare draft for review at next meeting.

   B. Projects/service organization as described by Dr. Lourie/Dr. Cole - **No recommendation will be made.**

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4. Mental Health Services Plan

   A. Level of poverty – **Staff will prepare cost estimates for review at next meeting.**

   B. Co-payments – **Staff will prepare cost estimates for review at next meeting.**

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5. Managed care statutes –

   A. Financial solvency/licensure – **Bill draft requested 6/7/00 to clarify which Medicaid contractors should be subject to insurance licensure and financial solvency criteria.**

   B. Mandatory implementation – **Bill draft requested 6/7/00 to remove the requirement to incrementally implement mental health managed care.**

   C. Managed care consultant – **No recommendation will be made.**

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6. Consumer run services

   A. Implementation of consumer run services

Option 1. Adopted with a request that DPHHS provide a report.

Option 2. No recommendation will be made.

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7. Montana State Hospital budget – **Adopted for review at the next meeting.**

Ms. Ekanger reported that the Department is building the budget based on what the average daily population has been.

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8. Funding flexibility – **No recommendation will be made.**

9. Medicaid compliance

   A. Process to ensure compliance with federal Medicaid criteria – **Adopted 6/7/00**

   B. Use of general fund only to fund pilot or demonstration services **– No recommendation will be made.**

10. Tobacco settlement funds

Option 1. Subcommittee will make recommendation.

Option 2. Will be included in Option 1. recommendation.

11. Community commitment

Option 1. - A. Bill draft requested 6/7/00.

Option 1. - B. Included in bill draft request.

12. Standards for case managers – **Staff will develop options for review at the next meeting.**

13. Medicaid eligibility expansion for children only – **Will be reviewed at the next meeting if more information related to cost estimates is available.**

14. Offsets to MHSP general fund cost – **Additional information is needed from the Department for review at the next meeting.**

15. Review Mental Health Oversight Advisory Council Recommendations – **Will review at the next meeting.**

<u>Direction to Staff</u>

The Subcommittee requested that staff prepare draft legislation to incorporate the changes to Mental Health Managed Care Ombudsman statutes for review at the next meeting.

Conference call adjourned at 9:25 a.m.

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Sen. Chuck Swysgood, Chairman

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Diane McDuffie, Committee Secretary