

MINUTES  
(Approved by the Committee)  
HEALTH CARE TASK FORCE

August 20, 2008

9:00 a.m.

Supreme Court Basement Conference Room  
451 W. State St., Boise, Idaho

The meeting was called to order by **Cochairman Senator Dean Cameron** at 9:10 a.m. Other Task Force members present were **Cochairman Representative Gary Collins**, Senator Joe Stegner, Senator Patti Anne Lodge, Senator John McGee, Representative Sharon Block, Representative Jim Marriott, Representative Carlos Bilbao, Representative Fred Wood, and Representative Margaret Henbest. Absent and excused were members Senator John Goedde, Senator Tim Corder, Senator Elliott Werk, and Representative John Rusche. Staff members present were Paige Alan Parker, Amy Castro, and Juanita Budell.

Others present at the meeting were Kathie Garrett, Partners in Crisis Idaho; Representative Phylis King, District 18; Greg Dickerson, Tami Jones and Lee Barton, Mental Health Provider Association; Dana Garel and Russ Meyers, Lilly; Julie Taylor, Blue Cross of Idaho; Tim S. Olson, Regence/Blue Shield of Idaho; Molly Steckel, Idaho Medical Association and Idaho Psychological Association; Lyn Darrington, Gallatin Public Affairs; Kelly Buckland, State Independent Living Council; Craig Herzog, Cornerstone Psychological; Ross Mason, Dick Schultz, Kathleen Allyn, Dick Armstrong, Scott Tiffeny, and Heather Wheeler, Idaho Department of Health and Welfare; Jim Baugh, Co-Ad, Inc.; Rick Bangeri, Woody Richards, Chuck Christiansen, Jon MacDonald, Laura Bryant, Intermountain Hospital; Sara Stover, Department of Financial Management; Benjamin Davenport, Evans Keane; Whit Jones, William Hazle, Suzette Driscoll, and Steve Peterson, Business Psychology Associates; Delmar Stone, National Association of Social Workers; and Larry Benton, Idaho Mental Health. The WICHE staff members present were Dennis Mohatt, Vice President for Behavioral Health; consultants Deb Kupfer and Kyle Sargent; and Gabriela Montoya, a Policy in Rural Health associate.

**Chairman Cameron** announced that the full committee would meet until approximately 3:45 p.m., after which the subcommittee, chaired by Senator Stegner, will meet to delve deeper and perhaps make a recommendation.

He then asked **Ms. Amy Castro**, Legislative Services Office Senior Budget & Policy Analyst, to brief the committee on SCR 108 and the printed information (binders) provided to the Task Force members.

**Ms. Castro** outlined the following: The Statement of Purpose for SCR 108 recommends that the Legislative Council initiate an independent contract for the development of an implementation plan for the improvement of Idaho's current mental health and substance abuse treatment delivery system. The plan would assess the treatment capacity, cost, eligibility standards and areas of

responsibility of Idaho's current treatment systems and would make recommendations for the coordination and realignment of those systems. The resolution specifies at least seven components to be considered by the plan and directs that the final report and recommendations be delivered to the Legislature next year. The binders have copies of the presentation to be given by the WICHE (Western Interstate Commission for Higher Education) staff, the full report as required by SCR 108, a copy of President Bush's New Freedom Commission on Mental Health, biographies of the WICHE staff, SCR 108 and the WICHE contract.

**Ms. Castro** said that two years ago, the Legislature established an Interim Committee on Mental Health and Substance Abuse. After hearing testimony from the state hospitals, state agencies, community providers and lobbyists, the Interim Committee determined that there was not enough time and expertise to transform the system. The Interim Committee proposed an independent consultant be retained. SCR 108 was then adopted and WICHE was contracted to undertake the study.

**Ms. Castro** then compared Idaho's current substance abuse system, children's mental health system, and adult mental health system. The substance abuse system has 15.6 staff members and contracts with private contractors, who then contract with providers within the state. Health and Welfare manages the licensing and oversees the contractors. The children's mental health system has 70 staff members who provide case management but does not directly provide treatment services. There are two ways that children are served - through the Medicaid entrance and through the regular children's mental health office. It is up to the parents to choose which service they receive. The adult mental health system has 243 staff members and provides treatment services. **Ms. Castro** then asked the WICHE staff members to introduce themselves.

The WICHE staff members were **Dennis Mohatt**, Vice President for Behavioral Health; consultants **Deb Kupfer** and **Kyle Sargent**; and **Gabriela Montoya**, a Policy in Rural Health associate. The biographies for these individuals are on file in the Legislative Services Office.

**Mr. Mohatt** made the presentation to the Task Force, assisted by **Ms. Kupfer** and **Mr. Sargent**. WICHE is comprised of 15 western states. They are: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming. It was started in 1955; the Executive Branch appoints the WICHE commissioners.

A PowerPoint presentation was given. A copy of the PowerPoint presentation is available in the Legislative Services Office, along with a full copy of the WICHE report. The WICHE PowerPoint presentation included the following information:

#### SYSTEM REDESIGN PROJECT

- Direction from Legislature through SCR 108
- January through June 2008
- Strategies

- Research of published materials
- Stakeholder input through:
  - In-person and telephone interviews
  - Web-based survey
  - Stakeholders include: legislators, legislative staff, county representatives, department/state agency staff, Governor's staff, consumers and families, providers
- Comparison with similar western (WICHE) states

#### SCR 108 CHARGES

- Assess:
  - Treatment capacity
  - Cost
  - Eligibility standards
  - Areas of Responsibility
- Specifically address:
  - System for children and their families
  - Separate agency for mental health and substance abuse
  - State hospital capacity and voluntary commitments
  - Agency to conduct offender assessments
  - Number of probation officers
  - Evaluation of a regionally-based treatment delivery system

#### AREAS OF ANALYSIS

- Management structure
- Existing efforts of system integration and transformation
- Delivery systems, including access to services and system capacity, for adults and children
- State Hospital and forensic mental health bed needs and capacity
- Data systems and information sharing
- Financing
- Workforce

#### PROJECT ACTIVITIES

- Five in-state visits
  - Boise (Regions Three and Four)
  - Lewiston, Orofino (Regions One and Two, State Hospital North)
  - Idaho Falls, Blackfoot (Regions Six and Seven, State Hospital South)
- Key stakeholder interviews
  - Over 150 people interviewed
  - Conducted more than two dozen meetings
- Survey of Stakeholders
  - Online, conducted over two months
  - More than 550 survey respondents

#### SURVEY RESPONDENT ROLES

- 2% - Consumer/client/patient
- 4% - Family member
- 38% - Provider
- 1% - Legislator
- 44% - State/County employee
- 12% - Other

#### SURVEY RESPONDENT POSITIONS

- 11% - CMHC
- 2% - Treatment Facility
- 2% - Juvenile Corrections
- 18% - Adult Corrections
- 10% - Court System
- 20% - Division of Behavioral Health (DBH)
- 6% - Department of Health and Welfare (DHW), other than DBH
- 4% - State Psychiatric Hospital
- 9% - County
- 20% - Regional Advisory Council
- 3% - ID Planning Council
- 3% - Not applicable
- 12% - Other

#### APPROACH TO RECOMMENDATIONS

- Focus: Greatest impact on ‘point of care’
- Start with ‘core’ recommendations:
  - Structure
    - Executive Branch - DBH
    - Delivery system
  - Access and Capacity
  - Accountability
  - Financing
- Most recommendations are interdependent

#### RECOMMENDATIONS:

##### (1) TRANSFORMING THE STRUCTURE AND ROLES OF THE DBH

- Comprehensive system transformation
- Focus on the “point of care”
- Lack of consensus on priorities for systems
- Lack of a coordinated, comprehensive, accountable public mental health system
- Clarification of responsibilities is critical

## TRANSFORMATION

- The President’s New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America
  - The report clearly articulates the need for comprehensive system transformation to overcome the fragmented service delivery systems in the states.

## TRANSFORMATION - VISION

- “A successful vision encompasses a sense of urgency to overcome stakeholder complacency. A well-defined vision clarifies the general direction for change, motivates people to take action in the right direction, and helps coordinate people’s actions.”

## SURVEY RESULTS

- The Department’s current administrative structure supports efficient mental health care and substance abuse service delivery in the community.
  - For Mental Health, 1 strongly agreed; 23 agreed; 5 were neutral; 16 disagreed; 22 strongly disagreed, 10 Don’t Know (DK); for a total of 77.
  - For Substance Abuse, 0 strongly agreed; 10 agreed; 2 were neutral; 6 disagreed; 5 strongly disagreed, 8 DK; for a total of 31.
  - For MH & SA, 13 strongly agreed; 93 agreed; 50 were neutral; 97 disagreed; 77 strongly disagreed, 57 DK; for a total of 387.
  - Totals were: 14 strongly agreed; 126 agreed; 57 were neutral; 119 disagreed; 104 strongly disagreed, 75 DK; for a total of 495.
- The Department’s current administrative structure provides sufficient support for DBH for completion of its duties.
  - For Mental Health, 0 strongly agreed; 8 agreed; 9 were neutral; 15 disagreed; 22 strongly disagreed, 23 DK; for a total of 77.
  - For Substance Abuse, 0 strongly agreed; 5 agreed; 1 was neutral; 5 disagreed; 4 strongly disagreed, 16 DK; for a total of 31.
  - For MH & SA, 9 strongly agreed; 45 agreed; 56 were neutral; 69 disagreed; 70 strongly disagreed, 138 DK; for a total of 387.
  - Totals were: 9 strongly agreed; 58 agreed; 66 were neutral; 89 disagreed; 96 strongly disagreed, 177 DK; for a total of 495.

## STRUCTURE

- 1.1: Transform the Division of Behavioral Health into a division that directly and promptly improves the quality of care at the “point of care.”
  - Become a guarantor of care
  - Lead collaborative efforts
  - Integrate operations
- 1.2: Create a statewide ‘transformation workgroup’ to identify and address barriers to transformation.

- Utilize an existing collaboration
- 1.3: Consolidate statutory requirements regarding designated evaluations for involuntary commitment into a:
  - single-step,
  - community-based,
  - evaluation and determination process.
- 1.4: Establish new staff positions to invest in a transformed Division:
  - Clinical - Medical Director and other clinicians
  - Policy planning
  - Data/evaluation
- 1.5: Formalize the criteria for the current community grants
  - Include an official method for selecting programs
  - Use grants as a method for funding innovative programs/practices

## (2) CREATING REGIONAL AUTHORITIES

- Fragmented behavioral health system at the community level closest to the “point of care”
- Specialization into separate governance, administrative, and service delivery systems is especially problematic in rural/frontier areas
- Resources, both fiscal and human, required to operate such a split system diffuses resources so that there is not enough economy of scale for any one segment to effectively operate

### REGIONAL AUTHORITY

- “A centralized system of paying for mental health services is needed. The state needs to step up to the plate and adequately fund mental health treatment in Idaho. Making the counties pay more is wrong - it’s like kicking the cat because the dog peed on the rug! The state has saved countless millions of dollars over the past 25 year by strangling mental health funding. It’s time they pay the piper.” *State/County Employee*

### PRIMARY METHOD STATE MENTAL HEALTH AUTHORITY (SMHA) USES TO FUND COMMUNITY MENTAL HEALTH SERVICES: 2006

- 2 - no response
- 14 - SMHA funds counties/cities
- 27 - SMHA funds providers
- 8 - SMHA operates community

### REGIONAL AUTHORITY

- 2.1: Create a regionally operated, integrated mental health and substance abuse authority - or district - in each of the existing seven regions to:
  - plan, administer, manage and/or deliver services for children and adults.

- 2.2: Ensure that the boards of the regional behavioral health authorities/districts comprise members who
  - represent the various stakeholders
  - do not exceed fifty percent elected officials, providers and other professionals
- 2.3: Collaboratively establish a statewide, prioritized package of services to be delivered within regional behavioral health authorities/districts
  - Required services
  - Optional and innovative services
- 2.4: Transform the existing county behavioral health funding (eg., CAT and general funds) into a fixed match that preserves a maintenance of the current funding for the regional behavioral health authorities/districts.
- 2.5: Use a transformed DBH to fund regional behavioral health authorities utilizing formulized funding, based on factors including historical utilization and population.

### (3) IDENTIFYING GAPS IN THE INTERSECTION OF THE JUSTICE SYSTEMS

- Court or legally-based system (for adults in particular)
- Increased risk for State as system encourages use of court/legal system or involuntary/hospital-based entrance for treatment

### JUSTICE SYSTEMS

- Using the courts (and, subsequently, inpatient hospitals) as the primary entry point for persons with behavioral health disorders is not an efficient use of resources.
- “The current (BH) system is designed to prioritize those patients who create the most problems, rather than those patients with the greatest need,” and went on to state that the system is “reactive rather than proactive.” *Survey Respondent*
- 3.1: Review the mental health and substance abuse programs within the criminal and juvenile justice systems to ensure integration with regionally-based behavioral health authorities/districts.
- 3.2: Collect and share regional practices that have resulted in providing appropriate care to children in the custody of juvenile corrections.

### (4) INCREASING ACCESS TO CARE THROUGH FINANCING, ELIGIBILITY AND WAIVERS

- Relatively restrictive eligibility standards (Medicaid, indigent services)
- Relatively limited funding for services
- Anachronistic system for indigent funding for adults
- Significant bifurcation of systems between
  - adults and children
  - mental health and substance abuse

## ACCESS - SURVEY COMMENTS

- A majority of respondents to the survey felt that the current funding is insufficient to provide quality services.
- “...connecting offenders returning to society with mental health services has been a challenge.”
- “There is not enough access to drug treatment or mental health treatment...if you are not a felon and do not have insurance, or money, you do not get help.” *Correction employee statements*
- However, even felons were noted to have problems with accessing mental health services upon their return to the community.

## FY'05 PER CAPITA SMHA-CONTROLLED EXPENDITURES: MOUNTAIN STATES report

### INCREASING ACCESS

- 4.1: Identify clinical and financial eligibility criteria that support the delivery of timely, quality, cost-effective screening, assessment, early intervention and prevention services.
- 4.2: Amend eligibility criteria for public mental health and substance abuse services to support access to screening, assessment, early intervention, and recovery.
- 4.3: Continue the current effort to identify possible waiver or demonstration programs, with a focus on:
  - integrated providers (mental health and substance abuse)
  - per capita funding mechanism.
- 4.4: Integrate the current efforts towards credentialing providers with the transformed DBH and regionally-based behavioral health authorities.
- 4.5: Consider reinstating targeted funds for the school-based counseling program.
- 4.6: Revise the existing eligibility screening and service delivery contracts for substance abuse to:
  - Create risk-based contract for service delivery, with more local planning and control of service delivery;
  - Clarify eligibility requirements by removing any uncertainty on eligibility decisions; and
  - Separate the eligibility determination function from the service assessment, planning and financing functions.

### (5) ENHANCING THE EFFICIENCY OF THE STATE'S HOSPITAL CAPACITY

- Relatively long lengths of inpatient stays at the State Hospitals
- Very low rates of readmission
- Focus on serving persons in the least restrictive environment

## HOSPITAL CAPACITY - COMPARISONS

- Idaho's overall and community utilization rates per 100,000 population are lower than the Western States and US
- State hospital utilization is within the range of the Western and US rates

## HOSPITAL CAPACITY

The current funding in the mental health and substance abuse systems is sufficient to provide quality inpatient services.

- For Mental Health, 0 strongly agreed; 6 agreed; 7 were neutral; 18 disagreed; 25 strongly disagreed, 18 DK; for a total of 74.
- For Substance Abuse, 0 strongly agreed; 1 agreed; 4 were neutral; 7 disagreed; 14 strongly disagreed, 2 DK; for a total of 28.
- For MH & SA, 3 strongly agreed; 22 agreed; 38 were neutral; 101 disagreed; 159 strongly disagreed, 56 DK; for a total of 379.
- Totals were: 3 strongly agreed; 29 agreed; 49 were neutral; 126 disagreed; 198 strongly disagreed, 76 DK; for a total of 481.

Please rank the following in order of priority for strategies for the mental health system, with one (1) being the highest priority: Increase the number or capacity of inpatient treatment facilities.

- For Mental Health, Highest (1) - 3; 2 - 14; 3 - 7; 9 - 6; Lowest (10) - 5; for a total of 74.
- For Substance Abuse, Highest (1) - 7; 2 - 3; 3 - 6; 9 - 1; Lowest (10) - 1; for a total of 28.
- For MH & SA, Highest (1) - 43; 2 - 62; 3 - 56; 9 - 24; Lowest (10) - 22; for a total of 379.
- Totals were: Highest (1) - 53; 2 - 79; 3 - 69; 9 - 31; Lowest (10) - 28; for a total of 481.

## HOSPITAL CAPACITY

- 5.1: Conduct review of utilization State Hospital data to identify:
  - Lengths of stay by age group and by region
  - Number of individuals who would benefit from community based services and types of services required
  - Costs accrued per day by individuals in the state hospitals
  - Potential cost avoidance.
- 5.2: Allocate specific, acute bed capacity to the regional behavioral health authorities.
- 5.3: Achieve/maintain accreditation for both state hospitals.
- 5.4: Utilize deliberate planning and program development in secure facilities that:
  - ensures civilly committed persons treated in these facilities are served in the least restrictive settings based on their clinical and legal circumstances.

## (6) INCREASING ACCOUNTABILITY THROUGH INFORMATION AND DATA

- Lack of state agency oversight of providers for many services
- Nonexistent, valid data system to track services, outcomes

#### ACCOUNTABILITY

- “One of the biggest gaps involves oversight of local providers. We have a multitude of providers delivering services with varying degrees of competence and effectiveness. Services need to be monitored and authorized at the regional level by Department of Health and Welfare employees.” *Community Activist*
- “...more enforcement/oversight of private providers is needed... the substance abuse system, particularly in the housing/group home environment is both insufficient and open to abuse. I hear too many stories of group home managers... actively using drugs while on the job.” *Provider*
- “We do not need an overhaul of the department, we just need to reduce unnecessary and burdensome regulatory barriers, and add a measure of accountability.” *Survey Respondent*

#### ACCOUNTABILITY - SURVEY DATA

- Key stakeholders informed this review that it was difficult to use the DHW website.
- Providers expressed concern that they were not able to easily and quickly navigate to key sections of the website, notably regulations and forms.

#### ACCOUNTABILITY

- 6.1: Use the recent budget initiative to design and implement a statewide data system that:
  - Has utility at the ‘point of care’;
  - Collaboratively addresses and incorporates ‘legacy’ systems in use currently by providers and other public agencies; and
  - Supports implementation of electronic medical records.
- 6.2: Conduct a study to determine ‘population in need’ of behavioral health services.
- Revamp and improve the accessibility and utility of the DHW website.
- Implement a system of evaluation and reporting for transformation activities, with an emphasis on identifying and analyzing the impacts of change on service recipients.

#### (7) ENHANCING WORKFORCE CAPACITY

Key elements to drive workforce solutions:

1. Build systems that support practitioner development and career ladders
2. Offer evidence-based training programs
3. Provide applied training opportunities
4. Offer current treatment practice information/resources

#### WICHE WORKFORCE REVIEW

- Idaho is one of the many western states projected to have fewer people entering the workforce than leaving it by 2025

- Idaho’s retirement population is growing at a significantly higher rate than its workforce population (156.6% vs. 20%)

**WORKFORCE**

- “While there are still some areas in this state lacking in resources, increasing the number of services available is not needed in most areas. What is needed is ‘appropriate’ services, i.e. providers who are capable of providing quality integrated mental health and substance abuse treatment.” *State/County Employee*
- “We need more staff to meet the needs for those who are seeking treatment. We need to have good benefits that will retain staff, such as low premiums and high level of coverage in insurance. We need to retain staff with excellent retirement benefits and not slash insurance benefits for those who are retiring. The state is going to lose some good employees and services are going to become worse for the clients if this trend continues.” *Provider*

**WORKFORCE**

- 7.1: Create a Workforce Collaborative to manage and coordinate a statewide behavioral health workforce study, which will inform the development of a statewide strategic workforce plan.
- 7.2: Design and implement applied mental health and substance abuse educational - programs that translate into a job in the workforce system.
- 7.3: Increase availability of applied training opportunities in behavioral health professional settings.
- Provide incentives for the recruitment and retention of behavioral health professionals trained to deliver evidence-based treatment interventions.

**CLOSING COMMENTS:**

Step One: Implement “Transformation Workgroup”

- Select “Transformation Workgroup”
- Redefine/expand membership
- Supply contract dollars/staff
- Set Workgroup “charge”

Step Two: Workgroup creates Strategic Plan

- Strategic Plan: 3 years of implementation
- Includes evaluation component
- Addresses:
  - Request for Proposal (RFP) for Regional Authorities/Districts
    - Service Plans, Financing, and Evaluation
  - Transformation at DHW

### Step Three: Implement statutory, budgetary, regulation changes

- Legislature enacts necessary changes for implementing:
  - RFP for Regional Authorities/Districts
  - Studies of population, costs, services required
  - Financing
  - DHW/DBH, “Transformation Workgroup” resources (staff, contractual)

### Year One (September 2008 - June 2009)

- Implement “Transformation Workgroup”
- Create Strategic Plan
- Develop RFP for Regional Authorities/Districts
- Complete studies of needs, costs, services, workforce
- Enact:
  - Statutory changes necessary (Interagency Committee on Substance Abuse (ICSA) membership/charge, RFP, financing, reporting)
  - Funding for Full Time Equivalent (FTE) (ICSA, DHW/DBH)

### Year Two (July 2009 - June 2010)

- Issue RFP
- Implement further changes to:
  - DHW/DBH
  - Regional Authorities/Districts
  - Financing

### Year Three (July 2010 - June 2011)

- Receive initial evaluation/status report of RFP
- Readjust Strategic Plan

**Mr. Mohatt** concluded: The present mental health and substance abuse system is fragmented, confusing to navigate, and provides inadequate services that frustrate recovery. WICHE recommends a transformed system that would be consumer-driven and provide coordinated, ‘no wrong door’ quality services supporting recovery.

Questions asked during the presentation included the following:

**Senator Stegner** asked for clarification of the people involved in the gathering of information relating to the slide of the Survey Respondent Roles. **Mr. Mohatt** responded that slide represents the on-line survey responses; however, there were many more people interviewed throughout the state, representing the entire spectrum of people involved in mental health.

**Chairman Cameron** inquired about the involvement with the Executive Branch. The WICHE team responded that it had met with the Governor’s staff and other major departments, including directors, senior directors and/or deputy directors. Some interviews were one-time while others involved multiple communications.

**Representative Henbest**, referring to the WICHE recommendations on Regional Authorities, items 2.1 through 2.5, asked if WICHE was suggesting that regional authorities be empowered to directly plan and deliver services in their region. The WICHE staff said that their recommendations comprise the core, but there are some additional steps that need to be taken, such as defining the membership of each regional authority, realizing there are differences in each region. **Representative Henbest** then asked if a statutory change was required. The response was “yes.” Following up, **Representative Henbest** asked whether a “Transformation Workgroup” should be charged with overall statewide monitoring as the state moves forward. The WICHE staff felt that there needs to be an entity to facilitate the process and be charged with oversight in getting barriers removed.

**Senator Stegner** said that he wished to clarify that a major component is the mental health delivery system, which should be more uniform in its delivery, resulting in the state no longer being in the business of providing clinical care. The decision of who would be providing that would be made on the regional level. This would be primarily for adult mental health care. The WICHE staff covered some of this in the first recommendation, but they probably should have been more specific. The state should be a guarantor of services, rather than a provider of services. **Senator Stegner** pointed out that when the state provides some services, it is denying the private sector that pool of patients that the private sector needs to survive in more rural areas. By removing the state from the provider function, private providers would be enabled to exist in the rural areas and thus enhance not only efficiency, but availability of services.

**Senator McGee** said it appears that there is a funding deficiency and inquired as to where the money is best spent. The WICHE staff replied that when you are significantly below the national average, that is a cause for concern. A rule of thumb is that the community-based portion of the pie should be 70 to 80 percent, and state hospitals’ portion of the funding would be 20 to 30 percent. Right now, the largest percentage of Idaho’s mental health funds is going to the state’s psychiatric hospitals.

**Chairman Cameron** asked how the quality of treatment/care would improve under the WICHE recommendations. The WICHE staff responded by saying the state needs to be in the business as guarantor of care, as there is currently not adequate monitoring of quality with standards being established and followed.

**Senator Stegner** inquired as to what the term “per capita funding” represented. The WICHE staff said that “per capita funding” could be done three ways: a “categorical grant” (fund an organization to be there); a “fee for service” (the state pays a certain fee for a certain service); or a “case rate” (much like a Diagnostic Rating Group in a hospital). It is a fee per person, per month to serve people.

**Chairman Cameron** announced that the mental health subcommittee would meet following adjournment of this meeting and that the full committee would meet tomorrow morning at 9 a.m. He thanked the WICHE staff for their presentation and the committee members for their attendance and participation. The meeting was adjourned at 2:15 p.m.