MINUTES OF THE MEETING
FINANCE AND CLAIMS COMMITTEE
MONTANA STATE SENATE

November 20, 1981

The fourth meeting of the Senate Finance and Claims Committee met on the above date in Room 108, State Capitol Building, and was called to order by Senator Matt Himsl, Chairman, at 9:05 a.m.

Roll Call: All members were present.

Senator Himsl expressed concern about the funding situation in Washington, D.C. He said rumors are rampant and asked if anyone had talked to them.

Curt Nichols, LFA, said he had talked to Bill Hagen, NCL, in Washington, D.C. who said the Senate had voted for a 4% across-the-board cut in medical and block-grant programs last night. The cuts did not include Medicaid, Medicare, food stamps, revenue sharing, social security, or the military. The President is allowed to move funds around but not to transfer them or cut any below 5%. They hope to come up with the final version today or Sunday. There are differences in the Senate accepted version and the House accepted version.

Senator Himsl said the committee will not take any final action before hearing the final version, which could be on Monday. He said we are hearing different signals from Washington. He said it would be pointless to bring the bill on the floor before Monday as it wouldn't be prudent to close this up now and have to come back.

Senator Smith: Will we know something final or will there be another decision on Monday with another the next week. Do we plan on staying here until Washington makes up its mind?

Senator Himsl: They have to resolve this one way or another.

Dave Lewis: Normally, it ends the end of the week. Rich Bachtell said this morning there may be a presidential veto. Technically, they have to make the decision by Monday or agencies will have to shut down since they cannot pay anything.

Senator Smith: I would like to put the bill out and let them adjust it if it is needed.

Senator Himsl: We will not close the bill until we know the whole thing. At this time we have the subcommittee report from Committee II and the Honorable Representative Hurwitz is here. Will you please present your section of the bill?

Rep. Hurwitz: If you would turn to A1 of the green book. We reduced federal spending authority but also dealt with several block grants. I would like to refer to A2 on defense of the

coal tax; text A2, Change 2; and gas allocation, A3. On A8 the Workers' Comp judge, and on A9, #5, the Merit System Council.

On B1, Change 1, Maternal and Child Health (MCH) block grant was read; B2, Change 2, Preventative Health Block Grant was read, and he said the amount to fund the microbiology lab, which was taken out, was put back in by the full committee. Change #7 on B4 was read. He said the concern here was the air quality. He also read the Primary Care block grant explanation on B6.

Rep. Hurwitz then went to Section C1 concerning the changes in the Department of Agriculture. He said this was a net loss of $50,000 in 1982 and $108,000 in 1983. C4, Department of Commerce: he said the Legislature made the mistake of appropriating pass-through funds in the last session. Regarding C5, Rep. Hurwitz read Change 2 that the committee recommended that the Department be allowed to transfer the general and federal funds originally line-itemed for economic development grants into operating expenses for the Business Assistance Bureau. The general and federal funds will be distributed between FY 1982 and 1983 (table on C6). The result will be termination of the grant program and reduction of 1/2 FTE per year. After the committee made that recommendation, there were some misgivings among some of the members; it will probably be discussed further at a later date.

C6 and C7, Change 4, Hard Rock Mining Board, asked for $170,000, and the committee decided they could get along with less--they gave them $125,000.

Rep. Hurwitz said that was a brief overview of the committee actions. They took $16,920,000 spending authority away from different departments of state government, and added $93,167 of general funds in 1982 and $181,142 in 1983. There were no changes in Fish and Wildlife, Department of Livestock, or the Department of Natural Resources.

Senator Himsl said the meeting would be open for questions to Rep. Hurwitz from the committee.

Senator Aklestad: On page A8, the Workers Compensation. Is this a lot of workload because he wasn't taking care of it, what happened to have this increase in workload.

Rep. Hurwitz: The judge was there for nearly 15 years. There was much indignation over the incomplete work he left. Because he qualified for so much pay, the Department didn't have that much money to complete the work it was supposed to complete.

Aklestad: We have to pay this after the fact?

Rep. Hurwitz: That is the law.

Aklestad: Which LFA worked on that?

Hurwitz: Barbara Bartell.

Aklestad: Well, I can get together with her after this meeting.

Senator Smith commented that he was sure the committee felt there possibly was some abuse of that privelege and he thought it would have to be changed in the state law so not to be caught in this situation again.

Senator Thomas: He was in the Aeronautics Division before, and all his benefits carried over. Van Valkenburg: This is the bad part. The agency with the small budget had to pick it all up. I think the man expected to be reappointed and he was not. Many of the cases had been heard, and he just said "goodbye" and left. The new judge had to carry it and, since he had not heard the cases, he had to hear them before he could act.

Senator Dover: On the Merit System--we voted to stay within the committee on this. Barbara Bartell: It is my understanding that there are $66,000 in general funds that should not have been for the merit system. This would have to be amended in the other agencies, since this money will no longer be needed because of the decentralization.

Aklestad: Those were all pass-through funds? Barbara: They were user fees the merit system charged to the participating agencies. They would charge the agency as the services were made; these payments have been made.

Senator Himsl: This is unclear to me--we have the changes on A7.

Senator Dover: This is the general fund money appropriation to the Health Department for the Merit System. That is money that can be pulled out since they will not be needing it. I will get a report on this.

Senator Regan: I would check with the agencies to see if this is not money they will need for themselves for the decentralization. I think we should check this.

Senator Himsl asked if there were more questions on the committee report. There were not, so he said we now will hear from the agencies

John Bartlett, Deputy from the Department of Health and Environmental Services, said he would urge the committee to accept Committee II's report. Their only concern is $38,000 that is being lost in the food and drug account under the Food and Consumer Safety Div.

Sen. Van Valkenberg asked to hear some more on the food and consumer thing.

Vern Sloulin said the $38,000 was needed. We are having a very difficult time providing the services for the Health Department. This is in the Sanitarian inspection area. Joan Miles, Helena, has been accepted for a sanitarian position in Lewis and Clark County. She said "Thank God she didn't have to go out and work by herself." We have seven different laws enforced in my bureau and work through the local Health Departments. There are 7,000 licenses from the bureau, inspection forms, assistant training of food service places, elevators, etc. This is a cost-effective program and we have saved you that amount of money. Much clean up was done, but we need inspections to go along with it. This affects the work the sanitarians do. Trailer courts, restaurants, etc. are part of our inspection work.

Van Valkenberg: You have touched on a specific area. You will lose an FTE -- that is basically the main effect on your bureau? The inspectors will still be out there, but they will be untrained. What effect will there be to have not as well-trained inspectors out there? Sloulin: An inconsistency in water pollution rule. Montana restaurants, for example, are concerned about the inconsistency so that they are interpreted the same way. The local sanitarians go with us to inspect elevators if they can go.

Keating: You have 10 FTE's and go to 9. What is the make up? Sloulin: Two in insect control (mosquitos, etc.); 1 hotels and motels, bars, etc.; 1 food and drug control and food service; 1 in food service and consumer safety; and 1 in food service protection. They all also work with all general programs. Keating: Which one would you lay off? Sloulin: I certainly don't intend to cut my Billings man. We have most of them working by themselves. Keating: Do you have a certain man in mind? Sloulin: I will have to rework the entire program before I make a decision.

Aklestad: You put on 11 new FTE's? Sloulin: No, there are 11 new sanitarians hired in local areas by local authorities. Aklestad: How funded? Do you supply training? Sloulin: Yes, they were hired recently. There were 11 vacancies just being filled by new personnel. Aklestad: When you were talking about the grain embargo and taking credit, you are assuming most of the bushels on the embargos would have been contaminated. The last grain embargo had nothing to do with contamination. Sloulin: I would have to look back. Most is routine for rodent or bird damage or for pesticides. Aklestad: I guess I am reluctant to give them all the credit. The last few have had nothing to do with contamination. You imply there is a great need for this additional money. Where is this need?

Sloulin: Local Health Departments. Aklestad: Just the departments? Sloulin: No. Aklestad: Do you have any documentation that others than the departments want this? Sloulin: Yes, Buttrey Foods, restaurants, and elevators, and others. Aklestad: What else do you do? Sloulin: Occasionally on regulations we have to act as an arbitrator when there is a misinterpretation from the local sanitarians.

Wolf: In our committee the Department is not required by law to complete these inspections, not any more. You still want this to be funded anyway? Sloulin: Our laws may not say specifically that "elevators", for example, must be inspected, but it implies it in the law. Wolf: When I asked for a breakdown on what it is to be spent for, there was a lot of training. The training was not "training training." The sanitarian went out and drove around and they called it training. Sloulin: This is "on the field" training. Wolf: Of the $38,000 you requested, would you walk the committee through it? Sloulin: I will give the cost breakdown for salary for one person, contract services, operation, etc.--the department is mandated to provide the services. If you made one trip to every health unit, the $7,500 would not cover it. In some cases I almost have to force the men to go out since they are all family men and don't want to be out in the field. The travel budget is not for unnecessary travel, and this part is certainly not in excess. Mr. Sloulin left some information, Exhibit 1, attached.

Senator Himsl said the committee will recess to go into session at 10:30 and the plan is to reconvene and continue.

The committee reconvened at 10:45 a.m. Senator Himsl said he had had a request from the Montana United Indian Association to make a statement. Mr. Michael Walsh made the statement, and it is attached, Exhibit #2.

Questions from the Committee to Walsh:

Senator Regan: You made the statement that the urban Indian program does not duplicate services that already exist. It is my understanding there are facilities available. Walsh: The reason I make this statement is that there is an element of discrimination that comes into play and is picked up by a report (read from a decision cited) that shows Indians have been refused help, delivered babies in parking lots, been forced to wait long periods for medical attention, etc. We do not feel this is good health care.

Senator Regan: The amount of money is so small. With one center in Great Falls, one in Helena, and one in Missoula, how do you propose to have that money accomplish all you intend? Walsh: We

have other sources of funding that are building up. A private group wants to put money in--$38,500 from private institutions and there are projections for more. They wait to see how the money is spent in two years' time. Regan: A one-time shot? Walsh: We would ask for this money now to help us so we can get money from other sources later.

Hurwitz: The eloquent plea Mr. Walsh makes--that it will make a great thing in the future--I would think these continual hand-outs for Indians do nothing for them. We think it is time to treat them equally.

Dr. John Anderson, Health Department, said their interpretation is that the money will have to be cut on the categories within it. Money that goes through the counties will have to be audited. It is not clear as to how they could spend their money for some of these other things.

Sen. Jacobson: When your committee came to you and the conclusion was that the Indian Health Services would be using the community health services, were they available? Was there any discussion of any task force in there? Obviously they need help, and to just jump them in there is a little harsh. Hurwitz: It was the intent to put language in the bill for this. Then it was pointed out that it is against the law to discriminate, so we left the language out.

Van Valkenburg: When we talked about it in the subcommittee in the preventative health programs, then the subcommittee said general fund. Where do you get the money now?

Walsh: What Dr. Anderson says is correct. We did not intend to take it from this block grant. We were advised to go to the sub-committee on this. Welfare clinics and some others are available throughout the state. There is a vast difference between 1) what the state offers and 2) primary care. We talk about primary health care. The money--wherever you combine--perhaps from the use of alcohol and some from the general fund. It should be interesting to look at it from 2 years of self-sufficiency. I would not call that handing out anything.

Senator Wolf: If I remember correctly, part of your proposal was to fund the clinics. Then $45,000 was to go to Anaconda, Butte, and Miles City for the urban Indians to the health clinic. Now I do not see any transportation for the urban Indians. Has the budget cost dropped that much for the centers? Walsh: Under the present plans, (model budget, #2, page 9) there is only direct labor involved here. No administration costs, no extras. $3,319 clinic--5 hours a week--which is very minimal. We are looking for support; we are looking to charitable institutions and, if we follow through, IBM for one will give us a charitable contribution.

Wolf: Before you had a total budget; now you are saying you are playing a hunch and saying charitable organizations will give you the money to support them. Walsh: Yes, we have had pledges

coming in. Wolf: I would like to address this to the Billings physician, Dr. Sheckleton. The Billings Health Department is not connected in any way with the other health organizations? Walsh: No connections. Wolf: As a physician receiving $50/hr for 5 hours, how do you handle this in regard to the other health department doctors? Walsh: He is in no way connected with the other doctors and I do not know what he receives for pay. I am not aware of what he makes.

Van Valkenburg: In summary of the presentation of the Health block grant, LFA office basically says these funds are for comprehensive public health services. Why doesn't that fit that area? Anderson: I don't know. I have been told it has to be spent on those categories.

Van Valkenburg: Could I ask JanDee? Is this particular proposal unfundable in that area? JanDee: We know on the outside they took money from the preventive health block and funded the lab. Maybe a similar question could be asked from Washington. The sheet you are reading came from Washington. Van Valkenburg: I would like the LFA to contact her staff in LCL and get the answer. Our purpose in Helena is to help the state be able to meet the needs and not have the feds tell us everything.

Keating: We see a list that has grants to local health agencies. We were coached by our legal counsel that it is unlawful to appropriate any money to private organizations. I would suggest we research the legal aspects of this. Regan: If possible to address the needs even though we frequently contract with a private organization, i.e., DD, Mental Health; I think I support Van Valkenburg in his question.

Senator Himsl: The difference--the appropriation can be made directly to a private contractor. Story: If it is decided that this could be done, haven't we already spent the money?

Van Valkenburg: A lot of money went to EMS. In the subcommittee I made a motion to take it from there. Hurwitz: If the committee decides we can do this, we can call Washington and change this. JanDee: The hypertension--the Health Dept. does contract with 5 of the alliance agencies now. Some 3 others that contract with the alliance contract with the alliance and they contract back to the health department for services.

Nancy Leifer, Dept. of Commerce, said they support the bill that came out of committee and appreciate the legislature making an appropriation for the hard-rock mining. If future questions come up on the LEA funds, she would be available for questions.

Aklestad: Do you have any duplication of effort with the health department in people going out quarterly to check grain elevators?

Gordon McOmber, Director of the Department of Agriculture, said they have people to check the financial records and ascertain the grain is there. They do not get directly involved in the same area as the health department, but check fertilizers and weights to see they are proper.

Van Valkenburg: In our subcommittee we talked about the Cooney Dam and where it stood on land and conservation reports. Where do we stand in terms of that on this bill?

Leo Berry, Director, Department of Natural Resources, said that originally Cooney Dam was supposed to expend some $260,000 from Fish, Wildlife, and Parks. Water users have received a loan to reconstruct. The water construction fund has been zeroed out. We got bids for less than the 145.

Van Valkenburg: You talked about losing potential money in the energy and MHD money we are going to get. Berry: I don't know the status of energy conservation money. I had recommended that it not be reduced. Congress had not recommended it. Bonneville is required to invest in plannable conservation, and we recommend the budget be left as was. About MHD, in 1979 $500,000 was appropriated to be used as a state's share to encourage the ETF being built in Montana. Federal legislation on the potential that says if built it should be built in Montana. Reagan has zeroed this out. There is still some money in the budget and Butte is to get about 5. MURDY and Montana Power Co. submitted a request for money to be used on the proposed project in conversional power system Resources 89 in Great Falls. If it becomes available, it will be integrated into the study they are sponsoring. I have some questions and I think it would be a good expenditure of the funds. We would be that much further ahead of the other states. I do have some questions about the expenditure of $342,000 for base line work, and I would be inclined to see if we could get federal money or private money to go on with the 2nd part of the grant.

The hearing was closed on Subcommittee III and the members were told to stand at recess until we reconvene at 3 p.m. or the call of the chair.

The committee reconvened at 3:10 p.m. Purpose of this part of the meeting: Hearing House Bills 4, 5, 6, 7, and 8. He asked Representative Keyser to present HB 5.

Representative Keyser said this bill deals with the aid to dependent

children and pregnant women. The payment will begin no earlier than the third month prior to the month in which the child is expected to be born, or the third trimester. This is a $577 reduction in 1983. This does not affect the aid or care of the prior dealings with Medicaid. They get this from month 1, as do such programs as WIC, welfare, etc.

Proponents of the bill:

Dr. Gary Blewett, SRS. He said this is a change in SRS rules. Presently payments are made on behalf of children. Now they are made on behalf of pregnant women on the basis of unborn children. To conform to the federal, we need to change this.

Dr. Sidney Pratt, Maternal and Child Health Services Bureau said he would like to have some additional material given to the committee. He said he did not feel this is in keeping with sound health care, that the first months of pregnancy are often the most important to the health of the unborn, and that he would like to go on record as expressing the concerns of the Health Department. It was requested later that Dr. Pratt's testimony be listed as an opponent, rather than a proponent of the bill.

Scott Felderman gave testimony opposing the bill and said he represented the Montana Pro-Choice Coalition. His testimony is attached as Exhibit #1--P.M.

Questions from the committee:

Senator Regan: As I look at this, a pregnant woman without adequate support would not qualify for AFDC; then the next step would be to seek general assistance at the local level? Keyser: I would assume that would be one of the areas, also assume that she could receive some from the rent subsidy program, though they have probably been tightened. Senator Regan to Carlson: I guess what the feds have done we can't do anything about. Is that what happened here? Judy Carlson, SRS: Yes, in order to make our law conform, it was based not only on the needs of the unborn child; they do not allow an unborn child to qualify, and county relief is the next place to turn if they are low-income people and meet the other requirements. Regan: If a young woman discovers she is pregnant, has no means of support, and goes to the county level, must they grant her assistance? Carlson: If she has no other means of support and no assets that would be true-the counties would have to provide it. Regan: The whole thing is troubling me. Before, we had the federal program and the state picked up part of the cost and the local 6%. Now the feds have passed it on and left it to the counties to come up with the bucks.

Senator Himsl: My opinion from an audit report is that it has an optional program for the state to see how much. In Montana, from the 8th month or moment of discovery. Oregon is covered only the last month. We really don't have any choice in the matter. Regan: When we leave, it is my understanding that SRS is working on guidelines which will be used in determining eligibility. I would hope the department would stress to the locals the importance of this. The first trimester is when you can get into all kinds of trouble.

Wolf: I hear Senator Regan's concern about a visible means of support. What is a clear-cut method of discovering they have no visible means of support? What does this really mean? J. Carlson: I am sure the job part would be one aspect. If the home and family were able to support her, this would be another. When you deal with each individual case, the circumstances are different, and it is hard to put strict definitions on it.

In closing, Rep. Keyser said he would like the record to show that Dr. Pratt spoke as an opponent of the bill. We have heard all sorts of comments on this bill including such versions as stating a woman is thinking of AFDC payments at the time of conception. This amount of money does not have strings saying it must be used for food, drugs, or whatever. This does bring us into compliance with the federal law, and that is why it is introduced.

Rep. Keyser, District 81, sponsor of HB 6, said it was introduced at the request of SRS. It allows SRS to consider the income of a stepparent and others in determining the income toward the household. It will save $378,000 in 1983 and $523,000 in 1982. It is inconceivable if a stepfather living with the lady and supporting the child to consider aid is needed from the State of Montana. The department is not interested in taking aid away from people who really need it.

Gary Blewett spoke for the SRS and said this would save the state money and still give aid to the ones who really need it.

Senator Jacobson: Can you tell me, in this particular rule from the state government, how much of the scope is federally mandated? Blewett: Step-children. Jacobson: How do you decide what other individuals? Blewett: Common law, we would be looking at any demonstration of assistance to the household, parents, whatever. Jacobson: Aren't you aware of some of the "live-ins"? Blewett: I am aware of it. Aren't you afraid someone may come in and complain you are not complying with the law? Blewett: We would administer it only as far as with the federal program.

Dover: How about a girl living with her parents? Blewett: It could qualify if the parents are taking care of her. In some cases the parents cannot or will not. In some cases, the children care for parents.

Van Valkenburg: The Department of Revenue program which attempts to collect support programs a spouse is supposed to be making as part of the AFDC payments to the state -- what effect will the passage of this law make? Blewett: That program is mostly absentee fathers and they would still have a financial obligation to the child. Van Valkenburg: Say you have a divorced situation, the father is supposed to make support payments, and the stepparent is there. Six months have gone by with no payments collected on the AFDC; the Department of Revenue will have no right to support the child-support program that is court decreed. Carlson: It is my understanding that the Dept. of Revenue can still do it.

Senator Regan: Suppose a woman has a very healthy mother living on a small pension. Because the daughter is home to live with her the mother is kept out of a nursing home because she is there and she has a small child. The income is minimal, and it seems to me you have to enforce this law equitably. What would you do? Blewett: I would have to look at the definition of the rules and do it. Regan: That is my real problem. If you want to nail the stepparent and the "sin-in-law" would you have any problem in trying to put in some "sin-in-law" language? If we want to leave the door open, it might be better to strike "and other individuals." Would it materially affect the amount of money you perceive you will be going to save? Blewett: No, it was figured on the stepparent only.

Senator Himsl: Isn't this permissive part to give you more leeway in case of judges? Blewett: Yes.

Rep. Keyser closed by saying that the battle had been fought in the House with "other individuals" passing. He wanted the language left there as they felt it would help.

Senator Himsl declared the hearing closed and asked Rep. Winslow to present his bill.

Representative Winslow, District 65, chief sponsor of House Bill 8 said the bill was on behalf of the Department of Health and addresses a law in the books now that says every health-care facility needs to be inspected every 2 years. This bill says they will be inspected every 1, 2, or 3 years. This will not affect the standard health care. The good facilities do not have to be inspected each year. Their staff has been cut from 12 to 6. An annual renewal is still needed with reports being filed, but the actual visual inspection will not have to be made.

Warren Brass, Department of Health Facilities, said they did some preliminary work based on going in on a 1-, 2-, or 3-year basis.

Brass gave a report on requirements, different kinds of inspections made, and numbers and types of facilities inspected. He said they would receive a rating (the rating could be changed if they did not keep up the standard), any complaints would be investigated; they could change the ratings depending on the results they received from the facility.

There were no further proponents, no opponents, and Senator Himsl declared the hearing closed following the sponsor's summary. Rep. Winslow said this would give the Department of Health more flexibility. He said there would be no danger to the public since the renewals were on an annual basis, there were many checks, and if they had a reason to go in, they could do so.

Senator Himsl called on Representative Shontz to explain his bill, House Bill 4.

Rep. Shontz said this bill does two things: 1) changes the definition of a dependent child in the instance of AFDC, and 2) eliminates the unemployed parent as an eligibility criterion for that aid in households where two unemployed parents of the household are there. In most instances, in Montana, they have been receiving unemployment for several months; these payments go into effect after unemployment has run out. The program does not encourage people to go to work. Neighboring states do not have this program and some people come into the state to get on the program. In August 1981 there were 461 households on the program. If this amount were not on the roles, there would be a $6.2 million saving to state, federal, and counties.

Blewett: I would like to clarify the section that changes the age. Under the age of 19. The number of 19- and 20-year-olds is small, but we ask this since there are no federal funds here. Over $6 million in savings from all funds equates to $2 million of general funds over the biennium. Twenty-five states do not cover this; this is an optional program under the federal block. The basis for this is that 2/3 of the unemployed parents have had the benefit of six months of unemployment compensation. The availability of AFDC may be a disincentive to seeking employment outside of one's field. They could conceivably go to general assistance in counties. Counties have the ability of putting them on a work program. Passage of the bill will save general fund money and help balance the budget.

There were no further proponents, no opponents, and questions from the committee were called for.

Van Valkenburg: Would it be possible to write this bill so to deny AFDC to unemployed parents who had received other public compensation, such as unemployment insurance, for the preceeding 6 months?

Blewett: I can conceive of writing it, but I am not sure of the legality of it. It hasn't been considered by the Department.

Senator Haffey: The one-third you talked about who have not received 24 weeks of unemployment, they would go to the county general assistance? Blewett: Yes, they would still go to the county and would have to go through the eligibility process for general assistance, then through the county programs in order to receive assistance. Haffey: The two-thirds who probably had some unemployment could also do this? Blewett: Yes. Haffey: Finding this door closed, where do they go? Do they see if the county fathers have something to offer? Blewett: Yes.

Senator Regan: If one of three currently on the program were to go for general assistance once again the county, instead of paying 6.15% of the cost of AFDC, will be paying 100% of the cost of the program. Blewett: It could be a lesser amount on the county welfare, depending on the amount you have. If there are no other means available, then the exact amount of rent or transportation must be identified as needed. In AFDC they get standard care regardless of the circumstances. It could be higher support. There is the option to establish a work requirement saying they will perform work of the services at some grade and level in order to receive the grant. It is believed this will cut the amount of recipients.

Senator Regan: This is an optional program currently by the federal, but you have chosen to drop it in order to make the necessary cuts that came down? Blewett: Yes. Regan: What is to prevent the couple getting a divorce and living in sin?

Rep. Shontz: In response to Sen. Regan's comment, if an AFDC is all that holds a couple together, I can't say much for its success anyway.

Senator Himsl declared the hearing closed on House Bill 4 and asked Representative Steve Waldron to present House Bill 7.

Rep. Waldron: All of the bills you have heard, with the exception of the nursing homes, causes some impact on local governments. With this bill, in a minimal fashion, we will do something for the counties. First, it puts into effect something so that local government could set their own eligibility standards for general assistance with SRS approval. Then SRS assures that the plan adopted will be administered fairly. Presently, SRS has to adopt them and imposes them on the counties; SRS is reluctant to do this.

I will give you an example. Someone living in a house and the parents have allowed them to live there free. The other is renting. The county says one is renting; we will give them more funds since they have to pay the rent. If a fair hearing were held the county will lose the case and they will have to give them rent money anyway. The only standard is the AFDC standard. The county is wasting money by paying more than necessary.

Second, (there is some criticism of this -- counties will have separate eligibility standards); on the other hand, perhaps they know the needs in their counties better than the state. There are emergency situations that AFDC and Medicaid do not meet. This is a safety net we have. This would reimburse the person by allowing the county to give warrants or checks or disbursement orders (vouchers). There are problems with paying the warrants, but it allows the county flexibility. Vouchers have a problem of sometimes taking a long time to receive payment.

Gary Blewett said this bill represents one of a two-part approach SRS is suggesting to help counties. This focuses on the county's ability to manage the relief bill and the budget. He said this would give flexibility to the counties to make rules. The state has left much of this to the county commissioners, and lately some of the court cases have forced payment where there was not real need. The cutback will eliminate over 1000 families from support. The cost to county governments could increase beyond the ability of the taxpayers being willing or able to support; therefore, we need the county rules to eliminate the unnecessary expenditures ordered by courts. Passage of this bill will help counties to be able to control their property tax base.

Professor Beverly Gibson, MaCO, said this gives the counties the local flexibility to handle local problems; the SRS will see that the program adopted by the counties is administered fairly. She said they believe it is a step in the right direction in tightening welfare programs so that only the needy receive aid.

There were no further proponents, no opponents, and Senator Himsl opened the hearing for questions.

Sen. Himsl: Rep. Waldron said this gave the counties an opportunity to exercise some form of rules--yet this bill provides for a uniform policy. Are there different structures for different counties? Blewett: Every county would have to respond to a pattern of eligibility that would be able to set amounts. How much, resources, etc. Sen. Himsl: The eligibility would not be the same then? Blewett: Probably very different, but if the state

funds in it are limited on the agreement, it could be 56 different eligibility standards. Himsl: What about migration by the counties? Blewett: This is a possibility. Now they can. It is much like they are operating now, but not in the law now. We don't see it causing all that now, and don't expect it to in the future.

Sen. Smith: If a recipient receives a voucher, is there an assurance it will be taken to the right place? Blewett: It specifies who it will be paid to and only that person gets paid on the basis of the voucher.

Representative Waldron closed by saying he didn't see this as a very controversial bill. Now, with different rules, we see some migration. Some of the general assistance in rural counties consist of a bus ticket to Missoula. This will not address that problem. It is generally the larger counties that have the jobs and more opportunities. It allows them to pay a specific cost item such as rent, gas for the car, or whatever. Now it is a fair hearing, they would have to pay, and the county is going to be in trouble.

The hearing was closed. Senator Himsl asked the committee to be prepared for executive action on the bills.

EXECUTIVE ACTION:

MOTION by Senator Dover that House Bill 4 BE CONCURRED IN. Voted, passed by roll call vote 13-3. Senator Dover to carry the bill.

MOTION by Senator Aklestad that House Bill 5 BE CONCURRED IN. Comment by Sen. Van Valkenburg: I will vote for this bill because we have no choice. We can fund this through state funds. I think in the long run the adoption of this standard will cost the public a good deal of money.

The question was called, the motion was voted and passed unanimously.

MOTION by Senator Dover that House Bill 6 BE CONCURRED IN.

AMENDMENT by Senator Regan: I think that in view of the testimony of Mr. Blewett indicating it would not have impact on the state fund and that I think it will raise more problems for the department by people challenging the law (such as the examples of the mother and daughter with the child), I will amend House Bill 6 by striking on line 8 "and other individuals in the home," and on line 16 the same language. If we delete these words, we will then simply consider the results of the stepparent.

Senator Jacobson: I was at the National Conference of State Legislators and listened to people from Washington discussing this rule and going through the future. They have tried what is in your bill with "these other people" and they did not feel it was worth the effort of getting into the field. If we put this in the bill, even if it says "may", it sounded like they were pretty sure it wasn't possible to execute it.

Senator Story: With this amendment, you are leaving the door wide open. We would be endorsing communal living. Regan: No, mother and daughter perhaps, when some neighbor challenges that there are "other individuals".

Senator Etchart: I would speak in support of Senator Regan's amendment. I know of a situation with a working family where a daughter came back with a child and was on AFDC. With the language in this bill, the working family was having trouble making it as it was, and if they had been forced to pick up the cost of the daughter and child, it would have put them under.

Senator Dover: I think Gary was also saying that it could be taken care of in the rules.

Senator Keating: That was my question. The bill reads the Department "may" consider the income and resources of others living in, etc. It does not say they are required to do so. If the rules then say what "others" this would handle it. Taking it out could lead to mischief.

Senator Smith: Actually, the Department "may" consider the resources of stepparents and others. I have enough faith in the department that if they say this as a problem, they would consider it.

Sen. Jacobson: Does your department have any intention of enforcing it if the federal government does not come through with anything else? Judy Carlson: It would be our intent to comply with the federal. Jacobson: If someone came to you and said, "My next-door neighbor is getting AFDC payments, and I am having to have my husband's salary considered." What would you say? Judy Carlson: There could be a problem, but we would interpret it according to the rules.

Sen. Aklestad: I think you will be promoting a "live-in situation" with this amendment.

Sen. Regan: I really don't think there's that much difference--they either get married or not. I have a "sin-in-law" in my family. I don't think all this stuff enters their mind. Striking

"other individuals" is a reasonable approach. I do not see the federal government suddenly coming in and admitting this is creating a greater problem. We will still pick up $1.378 million. If you marry, you pay income tax unfair to married people anyway. Let's just vote on it.

Sen. Story: Our estimates are based on this bill passing? Regan: But only on stepparents. Story: No fiscal impact? Blewett: Our estimate of savings did not consider "others."

The QUESTION was called, to amend the title and body of the bill to delete the words "and others"--"and other individuals living in the home", lines 8 and 9 and 16 and 17. Voted, failed 11-5, roll call vote.

MOTION (original) That House Bill 6 BE CONCURRED IN--voted, passed unanimously. Senator Keating will carry the bill.

MOTION: Motion by Senator Dover that House Bill 7 BE CONCURRED IN. Voted, passed unanimously. Senator Jacobson to carry the bill.

MOTION: by Senator Keating that House Bill 8 BE CONCURRED IN. Voted, passed unanimously, Senator Wolf to carry the bill.

Senator Himsl announced that the latest rumor which appears out of Senator Melcher's office, through Budd Gould, is that there are to be figures out tonight or tomorrow morning.

Senator Keating: Are we going to work on the other parts of House Bill 2 to get other parts out of the way?

Senator Himsl: We will wait until tomorrow.

Senator Himsl adjourned the meeting as the result of a motion. He said we would be back at 9:00 a.m. to look at the situation. The meeting was adjourned at 4:48 p.m.

_____
Senator Matt Himsl, Chairman

ROLL CALL

FINANCE AND CLAIMS COMMITTEE

47th LEGISLATIVE SESSION - - 1981 Date 1/20/81

NAME	PRESENT	ABSENT	EXCUSED
Senator Etchart	✓		
Senator Story	✓		
Senator Aklestad	✓		
Senator Nelson	✓		
Senator Smith	✓		
Senator Dover	✓		
Senator Johnson	✓		
Senator Keating	✓		
Senator Boylan	✓		
Senator Regan	✓		
Senator Thomas	✓		
Senator Stimatz	✓		
Senator Van Valkenburg	✓		
Senator Haffey	✓		
Senator Jacobson	✓		
Senator Himsl	✓		

DATE 11-20-81

COMMITTEE ON Finance & Claims

House Bills 4, 5, 6, 7 + 8

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
S.C. Pratt MD	DHES	HB5		
Mike A. Males	Environmental Info Cntr			
[illegible]	Helena [illegible] Adv. Council			
David Lackman	Lobbyist, MT public Health Ass'n.	HB2	X as recc. by Subcomm.	
[illegible] Davis	LWV of Mt			
Jacqueline McKnight	DHES	HB8	✓	
Leo M. [illegible]	DHES	HB8	✓	
Shirley Thennis	MNA	HB5-[illegible]		
Shirley [illegible]	D.D. Leg. Action Comm.			

(Please leave prepared statement with Secretary)

HB2 DATE 11-20-81 AM

COMMITTEE ON Finance & Claims

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One Support	Oppose
NANCY LEIFER	MT DEPT. OF COMMERCE	HB2		
Suzanne Nybo	Dept Health	HB2	✓	
[illegible]	[illegible]	HB2		
Steve Meyer	MACD	HB2	✓	
[illegible]	DHES	HB2		
Charles [illegible]	DHES	HB2	✓	
John W Bartlett	DHES	HB2	✓	
Carolyn Doering	OBPP	HB2	✓	
Leo BERRY	DNRC	HB2	✓	
John Armstrong	DNRC	HB2	✓	
[illegible]	AP			
Dave Dodson	MPEA			
[illegible] Olson	OPI	HB2		
T. Cohea	OBPP	HB2		
Tom Crosser	OBPP	HB2		
John Anderson	DHES	HB2	✓	
Mary Evans	Agriculture	HB2		
[illegible] Felderman				
Ron Weiss	OBPP	HB2		
[illegible] Welsh	M.V.I.A.	H.B.2	✓	
Ed Kennedy	M.V.I.A.-H.I.A.	H.B.2	✓	
[illegible]	H.I.A. Urban Health	HB2	✓	
[illegible]	[illegible]			

(Please leave prepared statement with Secretary)

H.B. 2

REQUEST FOR FISCAL 1983 SUPPLEMENTAL FUNDS IN THE AMOUNT OF $38,000
FOR THE FOOD & CONSUMER SAFETY BUREAU

The $38,000 is being requested to replace monies which we previously received under contract from the Federal Food and Drug Administration for an inspection program involving grain storage facilities, food warehouses, food salvage dealers, and bakeries. At our budget hearings for 1982 we had no idea that the FDA contract monies might not be available for Fiscal 1983. This money is used to support all programs administered by this Bureau. This is a cost effective program.

In 1970 the Bureau, in cooperation with the Federal Food & Drug Administration, conducted several meetings in Montana on elevator sanitation. During those meetings information on insect control, rodent control, and proper maintenance of elevators was presented. Significant improvement was made with the elevators, especially relating to exterior cleanup. However, there was no followup inspections to go with this educational program, and many of the elevators reverted back to the conditions that they were in in 1970.

Up to 1977 we had been receiving information from the states of Washington and Minnesota indicating that there were a large number of embargoes being issued on grain shipments from Montana. Our records, which are incomplete in that not all embargoes were reported to us, indicated that in 1977, 6,964,650 pounds were embargoed. Estimates that we have received from shippers indicate there is an approximate loss of 56 cents a bushel when grain is embargoed. This provides us with an estimate of approximately $65,000 per year which has been lost or saved, whichever way you choose to look at it.

Last year, 1980, the amount of grain embargoed was one-tenth of that which was embargoed in 1977 (600,600 lbs.)

Because of the many embargoes that were occurring we requested assistance from FDA, and FDA agreed by providing monies enough to make unannounced inspections about every two years. There was no limit on the period of time that FDA agreed to provide these monies. There has been some indication that this was a five-year phase out program; however, we have never received any information of this nature from FDA.

Through receipt of these monies from FDA we have been able to initiate and maintain a much more efficient program of administration of the Montana Food, Drug, and Cosmetic Act which requires inspections as part of the administrative responsibility (Section 50-31-106, M.C.A.).

There has been a statement that inspections are not required. This is not true, in that we are charged with the responsibility for administration of a law that requires that we provide surveillance to ensure that food is not adulterated or misbranded. The only way that we can carry out this charge is by making inspections and investigations.

These monies have permitted us to maintain our present staff level, which was decreased by approximately 25% from Fiscal 1981 staff level. This reduction has created an extreme hardship on our bureau in that one of our prime functions is to provide training and assistance to local health units, and local health department staff has been increasing over the years and therefore requests for assistance have been increasing. As an example, just recently there have been ten new sanitarians employed locally. Six of these positions are ones related to units in which there is only one inexperienced sanitarian. So all the training and consultation which is available to them is obtained from the State Department of Health & Environmental Sciences.

A number of years ago the Food & Consumer Safety Bureau funding was entirely from general fund sources. This was changed to primarily federal funds in order to release state funds which could be matched with federal funds for initiating and expanding programs in other divisions and bureaus of the department. This is why the Food & Consumer Safety Bureau took such a severe loss in Fiscal 1982, with the loss of 314D funds.

The granting of the supplemental funds in the amount of $38,000 will permit us to retain staff at the 1982 level, which will permit us to continue reasonable, effective programs including food and drug control plus assistance to local health units.

Endorsement of this program has been received from Mel Sobolik, President of the Montana Grain Elevators Association; Walter Ulmer, Custer County Commissioner; Ron Andersen, Director of Sanitation of Safety for Buttreys Food Stores; as well as the Local Health Officers Association and all local health units. There has also been endorsements by individual warehouse managers and food salvage facility owners.

County of Custer

Custer County Courthouse
1010 Main
MILES CITY, MONTANA 59301

November 13, 1981

Mr. Ed Smith, State Senator,
Helena, Montana 59601

Dear Ed,

The Custer County Commissioners have been advised that there might be a problem with the Department of Health receiving the approximately $38,000.00 for the continuation of their inspection programs for Montana grain. It is our understanding that they inspect our grain for contamination and see to it that when grain is shipped from Montana that it does not meet rejection at the various terminals that it is sent to, thereby earning for Montana producers considerably more money.

It seems that the department also uses some of the monies generated by this fund to help fund their program for assisting county sanitarians. I know that Custer County recently had to hire a new sanitarian and we depend heavily on the department of health for guidelines in such a situation. The Department of Health is going to provide a weeks period of schooling for our new sanitarian, together with several new sanitarians, and they also provide help for a new person in the position thru their district field offices.

The County Commissioners feel that we need the assistance we get from the department, particularily since we are in a growing area and find the sanitarian services needed on a regular basis.

The Custer County Commissioners, together with all of the Commissioners in the State of Montana, will truly appreciate your doing everything you can to see that the Department of Health gets the funds needed to continue both these necessary programs - the inspection of our exportable grain to prevent unnecessary embargos by holding down contamination and the training for our local health officials.

Sincerely,

Walter J. Ulmer, Jr.

WALTER J. ULMER, Member
Custer County Commissioners

WJU:ljs

CC: Mr. Vern Sloulin,Dept Health, Food & Consumer Bureau,Helena MT

Buttrey
FOOD STORES

DIVISION OF JEWEL COMPANIES, INC.
601 SIXTH STREET S.W.
GREAT FALLS, MONTANA 59403

P.O. BOX 5008

AREA CODE 406
761-3401

November 10, 1981

Mr. Vern Sloulin, Chief
Food & Consumer Safety Bureau
Dept. Health & Environmental Sciences
Cogswell Building
Helena, MT. 59620

Dear Mr. Sloulin:

We favor the continuation of the Food Storage Facilities inspectional program by the Montana State Department of Health and Environmental Sciences and would encourage that state funding be allocated to fund this program should federal funding not be forthcoming.

Our compnay has recognized the problems that can develop in a food storage facility and has expended a significant amount of time, money, and effort in developing a strong internal inspectional and preventative sanitation program in our facilities to preclude such problems. We feel this is a vital necessity in protecting the consumers food supply.

The regulatory branch through its inspectional activity can provide guidance in developing sanitation programs, interpretation of the regulatory criteria to be met, and where necessary the impetus to establish such programs.

Through their travel necessitated by other responsibilities, it would appear that state health department personnel are in a position to provide more frequent inspections than their federal sequels with a more efficient use of travel monies. With their frequent and close associations with local sanitarians they are also in a position to provide ongoing training and consultation to local sanitarians who might be involved in such inspections, again with the most efficient use of monies. The uniform application of regulatory criteria, which is of utmost importance to the regulated industry, is greatly enhanced through frequent inspections and proper training.

Sincerely,

Ron A. Andersen
Director Sanitation & Safety

RA/sn

C O P Y

To Representative Francis Bardanouve

I have just been informed that the Food & Consumer Safety Bureau of the Department of Health & Environmental Sciences is requesting supplemental funds to replace monies which they have been receiving via contract from the Federal Food & Drug Administration. I am thoroughly familiar with the specific program that this money supports as well as all the other programs of the bureau, and therefore would like the opportunity to comment on this request.

This bureau suffered a loss of two professional staff members and a secretary between Fiscal 1981 and Fiscal 1982. We sanitarians working alone in the field have experienced the result of this loss of staff in that we are not getting the same amount of assistance that we used to. My understanding is that if the bureau does not receive replacement funds for the FDA Contract funds they will lose additional staff, and this would create a real shortage of assistance to local health departments.

Just recently there have been a number of new sanitarians employed in local health departments, and they are inexperienced and therefore in need of as much assistance as they can get. The monies that are received from FDA are used to support all programs of the bureau in that it provides travel and support funds for other than the specific inspections that are required by the contract.

I would appreciate very much if you would support this request for supplemental funds, not only on my behalf, but on the behalf of all other sanitarians throughout the state.

Sincerely yours,

John C. Herndon
Blaine County Sanitarian

MUIA SENATE HEALTH DATA

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3	Effectiveness of Urban Indian Health Centers
4 & 5	Duplication of Services
6	Preventive Health Contrasted with Primary Health Care
7	Health Fact Sheet
8	Model Budget 1 $133,197.00 3 Clinics
9	Model Budget 2 $ 99,057.00 3 Clinics
10	Model Budget 3 $ 80,000.00 1 Statewide Clinic
11	FY 80-81 Funding From Indian Health Service
12	Distances To Reservations - One Way
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The Montana United Indian Association (MUIA) was incorporated in 1971 as a non-profit organization representing urban Indians throughout the state of Montana. Eight local Indian alliances and the MUIA joined forces to create a consortium to provide needed services in their respective communities. Those alliances were: Anaconda, Billings, Butte, Great Falls, Havre, Helena, Miles City and Missoula.

Seven alliances currently offer services to the urban Indian population which include health care, housing, job placement assistance, educational opportunities, outreach, transportation, mental health counseling and other supportive services.

The MUIA central office, located in Helena, is responsible for the administration of state and federal programs. MUIA provides technical assistance, guidance, counseling and advocacy for the consortium and the estimated 16,000 urban Indians of Montana. A major responsibility of the MUIA is to procure funding to continue existing programs and to expand services to the urban Indian population of Montana.

In the past the MUIA has successfully obtained health funding from the Indian Health Service as a result of Public Law 94-437, "The Indian Health Improvement Act." As a result of this legislation passed in 1976, the alliances were enabled to provide the following services:

* A data needs assessment
* Establishment and provision of direct medical care on site
* Removal of the multiple barriers accessing health care
* Provision of preventive health care education

Public law 94-437, Title V, Section 501, The Indian Health Care Improvement Act, reads "The purpose of this title is to encourage the establishment of programs in urban areas to make health services more accessible to the urban Indian population;" the Congress of the United States, recognizing the severity of the urban Indian Health status, passed the public law to ensure health services provision.

Since reauthorizing Public Law 94-437 in 1980, the Congress has been exhorted to indiscriminately cut social service programs regardless of need or their accomplishment. The Office of Management and Budget (OMB) has issued several misstatements of fact about urban Indian health organization, namely "Urban Health projects largely provide referral, rather than medical, services; (they) are not required by treaty obligation; and (they) are over and above services available to the general population." In the detailed Health Proposal for fiscal year 1982, we successfully address these "artificial" issues. The documentation that follows is a skeleton outline of the needs and accomplishments of Urban Indian Health Centers.

You should be acutely aware of the life and death ramifications of immediate access to quality health care. Urban Indians face deprivation of urgently needed health care services every day. The efforts of urban Indian health care professionals will be for nought if projected cuts of one hundred percent elimination in Fiscal Year 1982 are enacted.

The Health Advisory Committee of the Montana United Indian Association has prepared the following data summary for your personal attention: Indian programs will suffer a disproportionate share of the proposed budget cuts. Indian programs, which account for only .4% of the total federal budget, would absord nearly 3% of the national budget cut.

It cannot be disputed that American Indian people are the neediest of Montana's poor. In this, the most affluent country in the world, Indian people rank at the bottom of every social and economic statistical indicator:

* lowest per capita income
* highest unemployment rate
* lowest level of education
* shortest lives
* worst health conditions
* poorest housing
* highest suicide rate
* family poverty 300% greater than national average

Contrary to OMB justifications, Block Grants to states will not guarantee provision of Urban Indian Health Care Services to our population. All of the truly remarkable accomplishments achieved by Urban Indian health care programs in the past five years will be utterly negated - clinics will cease to exist, trained Native American health care personnel will not be able to fulfill their committment to Indian people and, worst of all, another successful Urban Indian program will be eliminated precisely at the moment of fruition.

We can no longer look to the Federal Government to meet all our financial needs. Proposed budget cuts from the Reagan Administration will zero out urban Indian health care in Fiscal Year 82. We are requesting financial support from the State of Montana so that the MUIA may continue its commitment to all urban Indians in the State of Montana.

THE EFFECTIVENESS OF UTILIZATION OF URBAN INIDAN HEALTH CENTERS

Urban Indian Health Care Centers are a vital key to meeting the health needs of urban and rural non-reservation Indians. In meeting those needs, Montana's urban Indian health centers have demonstrated an ability to be:

* cost effective and well utilized.
* developing and/or maintaining a quality assurance program
* improving the health status of American Indians
* developing linkages with other providers

I. Cost Effective

In a study on several health centers, it was shown that:

* per patient costs are lower than national norms
* $19.50 was the average cost of a patient encounter
* health care centers can deliver quality care at reasonable costs. Last year's average administrative costs was 19.74%, below the 20% criteria
* for every dollar of Title V funds, a dollar or more was matched by other sources of revenue
* financial audits have indicated strong financial management
* productivity rates are in keeping with standard norms. An average 2.6 patient encounters per hour was maintained by several of the health centers

II. Utilization

Urban Indian Health centers have shown a marked increase in medical and dental encounters over the years and are leveling off at full productivity. Since 1979, the health care centers have had an average 55 percent overall increase in services provided. This remarked increase is attributed to:

* institution of more comprehensive health services where none existed before. More health centers have moved from Phase II to Phase III, increasing the level of health care.
* Changing patterns of utilization of expensive episodic health care (emergency rooms, hospitalization, for preventive diseases) to prevention and early intervention primary care.

III. Quality Assurance

Initiative has been taken by the health centers to improve and maintain a high degree of professional training and responsibility. This is being achieved by:

* peer review
* on-going continuing education
* implementing of services, where careful review has shown a need
* patient evaluation of centers
* treatment compliance reveiw process

IV. Improving the Health Status of American Indians

In the past American Indians have been the victim of non-existent or poor medical-dental services. Consequently Indians suffered from a higher death rate, higher infant death rate, and higher preventable death rate.

* statistics have shown that the death rate of Indians is 841.4 deaths per 100,000, this in contrast to the overall USA population which is 606.1 per 100,000.

Montana United Indian Association

M U I A

hone:
443-5350

846 Front Street
Helena, Montana
59601

MONTANA UNITED INDIAN ASSOCIATION POSITION PAPER

DUPLICATION OF SERVICES

By far the most controversial aspect of Minority oriented social service programs is the question of duplication of services, or in the jargon of the bureaucrat, "duplicative" services.

Opponents of urban Indian health programs are fond of loudly and persistenly exclaiming that these programs duplicate services available to "everybody" through "private sector" health care providers. This issue has become an emotional area since detractors of the program's progress make the claim without examining the facts.

Fact: The United States Government policy of relocating reservation Indians to the country's urban and rural areas in 1952 left those people in a "limbo" status insofar as health care provision is concerned. There were no health care services waiting for the relocated Indian people. Indians who have lived off-reservation for 180 days are no longer eligible for health services. The Indian Health Service does not universally care for all Indian people. There is no "Indian Insurance Card" which will provide free health care to urban or rural Indians. Where "free" health care has been provided through Public Health Service projects and charitable institutions, blatant discrimination has caused extreme resentment among Indians. A person should not have to suffer degradation at the hands of tax supportive institutions' personnel in order to secure health care. The public blithely assumes that Indians' health care is provided for ... this is not the case.

Fact: Public Law 94-437, reauthorized by the Congress of the United States in 1980, states categorically that: "The purpose of this title is to encourage the establishment of programs in urban areas to make health services more accessible to the urban Indian population." In the opinion of the 94th and 95th Congresses of the United States, urban Indian health programs are not duplicative.

Fact: The American Indian Policy Review Commission in their "Report on Indian Health," does not see urban Indian health programs as duplicative

since they recommend that: "Congress appropriate sufficient funds for the continuance of present Indian centers in urban areas which assist Indians in obtaining medical ... services; and should encourage, with funds and guidance, the establishment of additional such centers in all urban areas where Indians live."

Fact: Health Departments in many states recognize the necessity of urban Indian health centers and contract with them for delivery of services to the Indian population that would not otherwise be provided at all. This would not occur if the states considered these programs duplicative.

Fact: Transportation and referral alliances provide urban people with the means of accessing health care. It is hardly a duplication of services to transport Indian people to a health care provider since no alternative exists.

Fact: If a patient does not have the financial resources to visit a private provider of medical care, that provider will cease to deliver services. It is not then duplicative to provide medical services to that patient.

Fact: The American Public Health Association (APHA) has acknowledged the severity of (urban) Indian health in their meetings on November 1 through November 5, 1981. The opinion of the APHA is that these programs are not duplicative.

Fact: Preventive health provision in lieu of episodic and emergency room usage reduces duplication by eliminating an increasing burden on the taxpayer. In this sense, the programs are financially non-duplicative and cost-efficient.

Therefore, it is apparent that urban Indian health programs do not duplicate services, but provide medical services where none have existed before and at a lower per patient rate than available in the private sector.

References: Montana Senator Max Baucus
American Indian Policy Review Commission
American Public Health Association
State of Montana Department of Health
The Congressional Record - October 27, 1981
California Urban Indian Health Council
Montana United Indian Association

MONTANA UNITED INDIAN ASSOCIATION

1) We understand that information has been given to the Committee to effect that public clinic services are available to the general public and therefore urban Indian individuals. According to John Bartlett, Deputy Director of the State Department of Health, only the following preventive services are available in the context of public preventive health:

(1) well child clinic
(2) women, infants and children
(3) child nutrition
(4) hypertension programs*
(5) VD screening & control
(6) family planning*

These programs are strictly education & prevention.

*Indian participation

2) No primary care services such as:

JIA Clinics provide all of these services.

(1) physical exams, prenatal & school screening exams
(2) minor surgery
(3) acute & episodic treatment for strep throats, broken limbs, flu, EKG monitoring, routine lab services, otitis media, etc.
(4) surgical referral
(5) anemia screening
(6) diabetic screening
(7) contract pharmacy services
(8) home nursing visit
(9) post surgical treatment
(10) total primary diagnostic services
(11) plus all preventive services noted in 1) above.

HEALTH FAC. SHEET

OCTOBER, 1980 to SEPTEMBER, 1981

	GREAT FALLS	HELENA	MISSOULA
ULATION SERVED	11,651	7,291	1,785
VICES PROVIDED *	(4) contracting physicians Hypertension Screening Urinary Screening Physical Exams Diet Counseling Diabetic Counseling Nutrition Counseling Transportation Prescriptions Referral	10,191 Services Provided: Outreach Transportation (2) Contracting Physicians Nurtition Counseling Physical Exams Hypertension Screening Referral Elderly Nutrition Prescriptions Contracting Dentists Urinary Screening	Outreach (2) Contracting Physicians Prescription Services Dental Exams Optometric Exams Nutrition Services Preventative Outpatient Care
LTH EMPLOYEES	Health Director Registered Nurse Medical Assistant	Health Director Registered Nurse Receptionist	Health Director Health Outreach Worker Clinic Receptionist (9 month period only)
CENT OF ELDERLY	3%	25%	17% Average = 14.25%
T PER ENCOUNTER	$7.13**	$19.50	$17.60

* Total number of services provided during FY 81 is 21,327

** Represents the average of all services provided; the cost per patient for the three clinics averages $18.08

(7)

REDUCED MODEL BUDGET #1
MONTANA UNITED INDIAN ASSOCIATION
HEALTH CLINICS
FOR EACH OF THREE CLINICS
(GREAT FALLS, HELENA AND MISSOULA)

1. DIRECT LABOR		
Registered Nurse	2080 hours x 7.70	$16,016.00
2. FRINGE		
17.5%		$ 2,803.00
	DIRECT LABOR/FRINGE TOTAL	$18,819.00
3. CLINIC SUPPLIES		
Expendable clinic supplies $165 mo. x 12 mo.		$ 1,980.00
4. CONTRACT PHYSICIANS AND CARE		
A. Physicians $50 hr. x 7 hr./wk x 52 wks		$18,200.00
B. Contracted Care Services		
1. Pharmacy $150.00 mo. x 12 mo.		$ 1,800.00
2. Dental $150.00 mo. x 12 mo.		$ 1,800.00
3. X-ray/Lab $150.00 mo. x 12 mo.		$ 1,800.00
	CONTRACT PHYSICIANS AND CARE TOTAL	$23,600.00
	SINGLE CLINIC TOTAL	$44,399.00
	GREAT FALLS, HELENA AND MISSOULA GRANT TOTAL	$133,197.00

NOTE: This budget represents a sub-subsistence level - it excludes optical care and eliminates two full time equivalents and one part time position. No provision is made for rent, office supplies, xerox, telephone or training. The assumption in that funding for the above will be found through private sources.

REDUCED MODEL BUDGET #2
MONTANA UNITED INDIAN ASSOCIATION
HEALTH CLINICS
FOR EACH OF THREE CLINICS
(GREAT FALLS, HELENA AND MISSOULA)

1. DIRECT LABOR		
Registered Nurse 2080 X $7.70		$ 16,016.00
2. FRINGE		
17.5%		2,803.00
	DIRECT LABOR/FRINGE TOTAL	$ 18,819.00
3. CLINIC SUPPLIES		
Expendable clinic supplies $100.00 mo. X 12 mo.		$ 1,200.00
4. CONTRACT PHYSICIANS AND CARE		
A. Physicians $50.00 hr. X 5 hr./wk X 52 wks		$ 13,000.00
	SINGLE CLINIC TOTAL	$ 33,019.00
	GREAT FALLS, HELENA AND MISSOULA GRANT TOTAL	$ 99,057.00

NOTE: This budget represents a sub-subsistence level - it excludes optical care and eliminates two full time equivalents and one part time position. No provision is made for rent, office supplies, xerox, telephone or training. The assumption is that funding for the above will be found through private sources.

MODEL BUDGET REQUEST #3
MONTANA UNITED INDIAN ASSOCIATION
HEALTH CLINIC
(ONE STATEWIDE LOCATION)

1.	DIRECT LABOR		
	Executive Director	20%	$ 3,600.00
	Clinic Health Director	100%	15,750.00
	Registered Nurse	2080 X $7.69	15,995.00
	Clinic Receptionist	2080 X $4.62	9,610.00
2.	FRINGE		
	17.5%		7,850.00
		DIRECT LABOR/FRINGE TOTAL	$ 52,805.00
3.	MATERIALS AND SUPPLIES		
	A. Expendable Clinic Supplies	$166.67 X 12 mo.	$ 2,000.00
	B. Office Supplies	$100.00 X 12 mo.	1,200.00
		MATERIALS/SUPPLIES TOTAL	$ 3,200.00
4.	CONTRACT PHYSICIANS AND CARE		
	A. Physicians	$50.00 hr. X 5 hr./wk X 52 wks	$ 13,000.00
	B. Contracted Care Services		
	1. Pharmacy	$150.00 mo. X 12 mo.	1,800.00
	2. Dental	$150.00 mo. X 12 mo.	1,800.00
	3. X-Ray/Lab	$150.00 mo. X 12 mo.	1,800.00
		CONTRACT PHYSICIANS/CARE TOTAL	$ 18,400.00
5.	EQUIPMENT/RENTAL		
	A. Rent of Office Space	$150.00 X 12 mo.	$ 1,800.00
		EQUIPMENT/RENTAL TOTAL	$ 1,800.00
6.	OTHER DIRECT COST		
	A. Xerox	$100.00 mo. X 12 mo.	$ 1,200.00
	B. Telephone	$175.00 mo. X 12 mo.	2,100.00
	C. Training	Continuing Medical Education-R.N.	495.00
		OTHER DIRECT COST TOTAL	$ 3,795.00
		GRAND TOTAL	$ 80,000.00

NOTE: This budget represnets a subsistence level - it excludes optical care and provides minimal contract physician's services.

EXHIBIT C

Montana United Indian Association

(11)

Phone:
443-5350

P.O. Box 5988
Helena, MT
59601

M U I A

November 10, 1981

Chairman Burt Hurwitz
Legislative Committee #2
Room 104
State Capitol
Helena, MT. 59601

Dear Chairman Hurwitz:

This letter is written in response to requests for additional information from your committee members.

Senator Wolf requested a breakdown of last year's Indian Health Service funding and the relative percentages delineated below:

FY 1981
INDIAN HEALTH SERVICE CONTRACT

ALLIANCE	
Anaconda	$22,619.00
Butte	$22,619.00
*Great Falls	$83,092.00
*Helena	$39,266.00
Miles City	$22,122.00
*Missoula	$34,845.00
Montana United Indian Association (MUIA)	$43,762.00
FY 79'-80' Supplemental Carry Over	$32,336.00
GRAND TOTAL	$321,815.00

*Clinic Alliances

Given the awesome inflationary trends in the field of medical service provision, the MUIA's total budget request to the Indian Health Service (IHS) for Fiscal Year 1982 was $461,412.00. MUIA's request to the State for funding alternative #1 ($345,000) equals a 25% cut from the IHS request.

Alternative #2 equals a 38.3% cut from that request.

Since the actual funding received from the Indian Health Service for FY'81 equals $321,815, funding alternative #1 to the State Legislature equals an extremely modest 7% increase; alternative #2 equals an 11.5% decrease over last year's actual funding.

In response to Senator Van Valkenburg's question asked on November 9, 1981 regarding why all these clinics were proposed to be funded at $75,000 each, one can see that Great Falls received a larger share of the monies to upgrade their clinic operations in FY'81. Likewise, Helena had previously received improvement funds from a one-time source called Norton-Sound monies. Therefore, it is the MUIA's position that Missoula should be allowed to achieve parity with the other two clinics. However, the budget could be restructured if so desired.

Vice-Chairman Smith cited an example (near Fort Peck) of Indian people receiving reservation benefits while living off-reservation. The MUIA does not have specific knowledge of this example, but we wish to state that the people we serve through the urban clinics located in Great Falls, Helena, and Missoula are solely urban people who live, work and recreate in Montana's cities. The approximate one-way distances from the nearest reservation to each of the urban health centers is detailed below:

Great Falls to Rocky Boys' = 87 miles
Helena to Flathead = 173 miles
Missoula to Flathead = 61 miles

It is important to note that very few Montanans would drive 174, 346 or 122 miles in the summer to receive Primary Health Care, even if they could afford the gasoline, to say nothing of making the same trip in the winter.

Equally important is the fact that appointments have to be made for the service delivery which many times involve planning weeks ahead. In addition, if urban Indians had the money for the gasoline to travel those distances, they could pay for local non-Indian primary care.

After all of the above stipulations are met, the last hurdle is one of tribal affiliations; the tribe's ability to absorb twice as many patients (even if they wanted to) in this year of budget cuts.

The MUIA wishes to thank you, Chairman Hurwitz, and your committee for allowing us the opportunity to present our proposal and for offering us an eminently fair hearing.

Should your committee require further information relative to our testimony, please contact us at your convenience.

Sincerely,

Mike Welsh
Health Director

Edward Kennedy
Chairman
Health Advisory Committee

Montana United Indian Association

Phone:
443-5350

P.O. Box 5988
Helena, MT
59601

M U I A

November 10, 1981

Ms. Jan Dee May
Legislative Fiscal Analyst
State Capitol
Helena, Montana 59601

Dear Ms. May:

In accordance with Committee #2 Chairman Hurwitz's directive this date, the attached line item budget represents a model budget for each of the Montana United Indian Association's clinics located in Great Falls, Helena and Missoula.

Should you require any further information, please feel free to contact me.

Sincerely,

Mike Welsh
Health Director

MW/jw

cc: Chairman Burt Hurwitz
Leona Williams
Edward Kennedy
Carol Owens
Sue Schield

MODEL BUDGET REQUEST
MONTANA UNITED INDIAN ASSOCIATION
HEALTH CLINICS

1.	DIRECT LABOR		
	Executive Director	20%	$ 3,600.00
	Clinic Health Director	100%	15,750.00
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	A. Physicians	$50.00 hr. X 5 hr./wk X 52 wks.	$13,000.00
	B. Contracted Care Services		
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	C. Training	Continuing Medical Education-R.N.	495.00
		OTHER DIRECT COST TOTAL	$ 3,795.00
		GRAND TOTAL	$80,000.00

NOTE: This budget represents a subsistence level - It excludes optical care and provides minimal contract physician's services.

- 3,000 FOR OPTICAL
- 5,408 CONTRACT PHYSICIANS

6% CUT IN DIRECTOR'S CURRENT SALARY

NO PERSONNEL INCREASES

[4110-84]

Title 45—Public Health

CHAPTER I—DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PART 36—INDIAN HEALTH

Subpart C—Contract Health Services

AGENCY: Department of Health, Education, and Welfare.

ACTION: Final rule.

SUMMARY: This rule establishes contract health service delivery areas, and uniform eligibility, notice and related requirements for the provision of contract health services to eligible Indians and other beneficiaries within these areas. The purpose is to clarify eligibility and responsibility in the administration of this program.

EFFECTIVE DATE: August 4, 1978.

FOR FURTHER INFORMATION CONTACT:

James Mitchell, Contract Health Services Branch, Indian Health Service, Room 5A-2', 5600 Fishers Lane, Rockville, Md. 20857, 301-443-4700

SUPPLEMENTARY INFORMATION: On October 22, 1976, a notice of proposed rule-making (NPRM) was published in the FEDERAL REGISTER (41 FR 46792 et seq.) proposing to revise subpart C of 42 CFR Part 36 to establish contract health service delivery areas, and eligibility and related requirements for the provision of contract health services within these areas. Interested persons were given until December 21, 1976, to submit written comments, suggestions, or objections.

A. CHANGES MADE FROM THE PROPOSED RULES

After full and careful consideration of all comments received, certain provisions of the proposed rules have been revised as noted below:

1. For ease of use the definitions have been placed in alphabetical order.

2. The definition of "alternate resources" formerly § 36.21(i) has been renumbered as § 36.21(a).

3. The term "personal resources" has been deleted from the definition of "alternate resources." Numerous commenters suggested deletion on the basis that: Historically the Indian Health Service (hereinafter, IHS) as a matter of practice, has not applied a means test for services; has not excluded persons from receipt of contract health services because they had "personal resources"; and "personal resources" was not defined.

IHS does not nor does it intend to apply a means test as a condition for receipt of services. Personal resources have, historically, been utilized to assist or supplement the cost of medical care services when funds available to IHS were insufficient to cover the total cost of services provided and the Indian or his tribe had such resources to voluntarily use. This practice may continue in the future when agreed to by the parties involved, but it is felt that inclusion of "personal resources" in the definition of "alternate resources" is not warranted, and has been eliminated. The elimination of this term should also ease the fears of those commentors who consider the term as jeopardizing the unique relationship of the Indian with the Federal Government.

3. A definition of "appropriate ordering official" has been substituted for the definition of "authorizing official" and designated as § 36.21(b). This change was made to accommodate changes made in section 36.24 (discussed later).

4. The definition of "contract health services," renumbered as § 36.21(e), has been changed to clarify that the term applies to services provided by facilities other than those of IHS.

5. As a result of several comments pointing out that § 36.24 would be impossible to administer without a definition of "emergency," such a definition has been added as § 36.21(f). When possible, the decision as to the state of emergency will be made by appropriate IHS medical authority. Otherwise, the decision will be made by the appropriate non-IHS medical authority attending the patient.

6. The definition of reservation renumbered as § 36.21(i), has been changed to that used by the Bureau of Indian Affairs in its regulations governing financial assistance and social services programs (25 CFR 20l(v)) for purposes of increased consistency and because it is considered more precise.

7. For purposes of clarification, a definition of the work "Service" to mean the Indian Health Service has been added as § 36.21(h).

8. As a result of the decision to designate the State of Oklahoma as a contract health service delivery area (discussed later), a definition of "traditional Indian country," formerly numbered as § 3621(e), is no longer needed and it has been deleted.

9. Due to changes made in § 36.23(a) to reference § 36.12 of 42 CFR (discussed later), the definition of "Indian," formerly designated as § 36.21(f), has been deleted since it is no longer needed.

10. The State of Nevada has been designated a contract health service delivery area in § 36.22(a). This designation is based on a number of comments and tribal resolutions which pointed out that the county option approach would result in an unintended exclusion of an estimated 30 percent to 40 percent of Nevada Indians from IHS contract health services. This result was a factor of both the small size and scattered location of the reservations and colonies in Nevada and the particular social structure of the Nevada Indian population.

11. The entire State of Oklahoma has been designated a contract health service delivery area in § 36.22(a). This is a change from the NPRM which included only traditional Indian country in Oklahoma which, in effect, meant the entire State except for the cities of Tulsa and Oklahoma City. This change is due to the high incidence of utilization of and dependence on IHS facilities by eligible Indian residents of Tulsa and Oklahoma City. Under the NPRM, if eligible residents of the two cities presented themselves to an IHS facility, they would be eligible for care but if the IHS facility for any reason could not provide the needed direct care, the individuals would not be eligible for contract health services. This makes neither administrative nor programmatic sense due to the reliance the affected population places on IHS for health care services.

12. A number of counties in the State of Michigan have been designated a contract health service delivery area in § 36.22(a). This designation was made as a result of a number of comments from tribal representatives which pointed out that the Sault Ste. Marie Tribe of Chippewa Indians have traditionally occupied a seven-county area where they currently receive contract health services but have tribal land in only one county. The county option proposal would result in an estimated 50 percent of the service population being declared ineligible for contract health services. This would be counter to the intent of the regulation and current service patterns as well as the intent of Congress which provided funding for a seven-county program.

13. An area consisting of 14 counties in the State of Wisconsin and 1 county in the State of Minnesota has been designated a contract health service delivery area in § 36.22(a). This designation was made as a result of a resolution by the Wisconsin Winnebago Business Committee which pointed out that there is no defined reservation area, as such, for Wisconsin Winnebago Indians and that tribal land is scattered over a 15-county area traditionally occupied by the Wisconsin Winnebago people who currently reside on or near those lands.

14. Section 36.22(b), providing for redesignation of contract health service delivery areas, has several revisions. It

has been revised to clarify that only areas or communities "within the United States" may be redesignated as a part of a contract health service delivery area. This clarification was prompted by a number of comments pointing out that there was no specific prohibition to including non-U.S. territory.

Also, as a result of a number of comments, the words "or other Indian" have been deleted from § 36.22(b) to require consultation only with tribal governing bodies with respect to area redesignation. In addition, the words "people native to the reservation" and "members of the tribe" have been deleted from § 36.22(b) (1) and (2) respectively to bring this section into conformity with § 36.23(a) as revised. As revised, § 36.22(b) (1) and (2) requires consideration of the number of Indians (not just those native to the reservation) in the proposed area and the social and economic affiliation of these Indians with the reservation tribe. The current language permits the initiation of redesignation procedures by a tribal resolution as one commenter suggested. Detailed procedures are inappropriate because of the divergent situations that might call for a redesignation.

15. Section 36.22(c) has been revised to simply provide that redesignations will be made in accordance with the Administrative Procedure Act (5 U.S.C. 553) rather than spelling out a requirement for an NPRM and a public comment period. These are generally provided for in the Administrative Procedure Act but the revised language would allow for the utilization of any exceptions permitted under that act if it were appropriate.

16. Section 36.23(a) has been revised to replace the phrase "any Indians, and the non-Indian wife and dependent members of the household of any such persons" by referring to persons described in § 36.12 of 42 CFR, which describes persons eligible for services at IHS facilities. This change, along with deletion of a definition of "Indian" for purposes of contract health services, will achieve consistency between §§ 36.23(a) and 36.12 and simplify the regulations governing IHS services. The change indicates that § 36.23(a) imposes eligibility requirements for contract health services in addition to, rather than independent of, § 36.12.

The change in § 36.23(a) to refer to persons described in § 36.12 is made recognizing that the Department plans to issue a separate notice of proposed rulemaking to amend § 36.12 with respect to the non-Indian husband of an eligible Indian and the non-Indian dependent members of an eligible Indian's household. Section 36.12, as did proposed § 36.23(a), includes the non-Indian wife, but not the non-Indian husband, of an eligible Indian. Several comments were received objecting to exclusion of non-Indian husbands in proposed § 36.23(a) on the ground that their exclusion constituted discrimination based upon sex. Non-Indian dependent members of an eligible Indian's household are presently served by the IHS, although § 36.12, adopted in 1966, has not been updated to include them. These issues will be dealt with in the notice of proposed rulemaking to amend § 36.12.

17. Section 36.23(a) has also been amended to make persons described in § 36.12 eligible for contract health services when they reside within a contract health service delivery area but do not reside on a reservation and are either members of or maintain close economic and social ties with the tribe or tribes located on the reservation or for which the nearby reservation was established.

A number of commentors pointed out that the proposed rule would exclude many Indians residing near a reservation within a contract health service delivery area who were not native to the area and members of the local tribe, but who had been receiving services from IHS and were members of the local Indian community. Several comments suggested that contract health services should be provided to Indians regardless of where they reside. Other comments spoke in favor of the original membership requirement. The above revision reflects the resources available to IHS, the recognition of the part the tribe plays in the relationship between the Federal Government and the Indian community, and a viable position between those who recommended retention of the tribal membership requirement and those who wanted neither tribal membership nor geographical criteria.

18. The term "on or near a reservation" has been deleted from § 36.23(b). It was redundant and confusing since a student or transient who was eligible for services "at the place of their permanent residence" would have had to reside "on or near a reservation."

19. Section 36.23(b)(3)(ii) has been renumbered as § 36.23(c) and revised so that the language dealing with the period of eligibility when an individual leaves the contract health service delivery area more closely conforms to equivalent language in § 36.23(b)(1) dealing with a similar period covering students who no longer meet the special conditions of eligibility for students. The words "• • • or until alternate health care resources are available and accessible, whichever occurs earlier" are deleted because this is provided for by action of § 36.23(f) which was formerly § 36.23(c)(3).

20. As a result of a number of comments, a new section, § 36.23(d), has been added which provides for the continued eligibility of Indian children after they are placed in foster care outside a contract health service delivery area when conditions involving previous eligibility and an order by a court of competent jurisdiction have been met. As was pointed out in the comments, this potential loss of eligibility placed undue and unnecessary burdens on Indian foster children and overly restricted the viable choices available to social service agencies and the courts in dealing with very difficult situations.

21. Section 36.23(c)(1) has been renumbered as § 36.23(e) and revised to omit the words "and access to other arrangements for obtaining the necessary care." This change is intended to make clear that priorities for contract health services will be determined on the basis of relative medical need. The accessibility of alternate resources is not solely a matter for consideration in establishing priorities when there are insufficient resources but rather is a factor of general applicability.

Former § 36.23(c)(2) has been renumbered as § 36.23(f) and titled "alternate resources."

22. Renumbered § 36.23(f) has also been revised by adding to the end the words "• • • or would be available and accessible upon application of the individual to the alternate resources." This was done to clarify that failure to apply for alternate resources that are accessible and available does not mean that the resources are not accessible or available.

23. Former § 36.23(d), Evidence of tribal membership, has been deleted as no longer necessary in light of the changes in § 36.23(a) referring to persons described in § 36.12.

24. Section 36.24, Authorization for contract health services, prompted a large number of comments and suggestions, some of which indicated a lack of clarity on the part of the proposed rule. This section has been extensively revised. As revised, the section provides that no payment will be made for medical care and services delivered by non-Service providers or in non-Service facilities unless a purchase order has been issued by the appropriate IHS ordering official after that official has been notified as spelled out in this section. This revision required the addition of a definition of "appropriate ordering official", designated as § 36.21(h) (see item 4 above). These changes address the expressed concern that nonmedical personnel might authorize medical treatment. A definition of "emergency" was added as § 36.21(f) to aid in the administration of this section (see item 5 above).

The notification requirements have been clarified and include a provision allowing, for good cause, a waiver of prior notice in nonemergency cases. In response to a comment, the notification requirements were revised to provide that an individual or an agency acting on behalf of the Indian may give the necessary notice.

A suggestion that all requirements for prior authorization are unreasonable and can result in burdensome requirements was not accepted due to the need to manage IHS resources and assure that only eligible individuals receive care under the IHS program. It was suggested that instead of prior authorization and notice IHS should issue Indians I.D. cards to indicate to providers the individual's eligibility, and a written description of the benefit package of health care services covered. This suggestion was not adopted because, in the absence of a congressional appropriation to fund such a benefit package, I.D. cards would have no purpose.

Many suggestions for greater detail were rejected as dealing primarily with interpretative and administrative matters and, therefore, more appropriate for inclusion in later manual issuances. For example, it was suggested that a standard form be developed so that individuals will know what must be disclosed to become eligible for contract health services. Guidelines will have to be developed which inform both IHS staff and applicants what information is appropriate to establish eligibility.

25. Comments on § 36.25, Reconsideration and Appeals, were made that 10 days was insufficient time to prepare and submit a request for reconsideration. The section has been changed to allow 30 days for submitting a request for reconsideration.

The procedures were revised to provide that in cases where the applicant submits additional supporting information not previously submitted, the applicant may obtain a reconsideration by the Service Unit Director who had made the original denial. Otherwise, the applicant may appeal directly to the Area or Program Director. This procedure was adopted to allow the Service Unit Director to make a determination based on all available information. It seems inappropriate to appeal to a higher echelon when the original denial was based on what might turn out to be incomplete information.

26. Section 36.25(c) was added to the regulations. It provides for a final appeal to the Director of the Indian Health Service. The decision of the Director will constitute the final administrative action by IHS. This additional level of appeal was added to provide a common point for appeals which should help assure greater uniformity in determining eligibility. It also adds an additional measure of protection to an applicant's potential right to service.

Several comments were received that suggested that the final appeals should be made to the tribe and that any other approach is an infringement on the ability of the tribes to govern themselves. This suggestion was not adopted because, in our view, current law would not permit such an approach. Another comment was received which suggested that the appeals process would be enhanced if there was a provision for appeal to another agency. This suggestion was not accepted because the addition of the Director of the Indian Health Service as the last level of administrative appeal of a denial of contract health services is considered adequate administrative protection of an applicant's rights.

B. Discussion of General Comments

A number of comments were received that dealt with relevant issues but of a general nature. A discussion of these follows:

(1) A number of commentors stated that they were opposed to the entire concept of the "on or near policy." The reasons were varied but included the charges that the proposed regulations: violate the Snyder Act which provides for services for Indians throughout the United States; illegally limit eligibility of Indians by establishing contract health service delivery areas; violate the intent of Congress as expressed in the Indian Health Care Improvement Act (Pub. L. 94-437); are an illegal attempt to limit the Federal obligation to provide health services to Indians; and, by restricting participation of otherwise eligible Indian persons solely on the basis of residence, are thereby discriminatory and contrary to the original intent of the Federal Government.

There is no question as to the fact that IHS has authorizing legislation (Snyder Act, etc.) to provide contract health services to "Indians throughout the United States." However, in appropriating funds, Congress has provided funds for services to federally recognized Indians who live on or near Federal Indian reservations with certain exceptions, such as where funds have been specifically earmarked for urban Indian projects or particular tribal groups.

(2) Several respondents opposed the definition of contract health service delivery areas since county jurisdictional boundaries do not necessarily have any historical significance or meaning to Indians or their reservations. Section 36.22(b) permits tribal and other governing bodies of affected reservations to request appropriate redesignation of their contract health service delivery area. This provision is consistent with Indian self-determination and was favorably commented on by several tribal representatives.

(3) Several respondents requested implementation of the proposed regulations be postponed for various periods, ranging from a few months to indefinitely. Requests were made to provide Indian people more time to respond to the proposed regulations.

The proposed regulations, which were under development for more than two years, have received extensive public exposure and discussion through at least five national meetings and numerous communications between interested parties specifically to discuss developing regulations. Additionally, 60 days were allowed for comment after publication of the NPRM. Therefore, it is not deemed necessary to postpone publication of final rules.

(4) Objections were raised to the Indian Health Service program being a residual resource on the basis that such a position is illegal; is contrary to intent of the Snyder Act; and that it discriminates against the poor who are forced to use state and other available services. It was recommended that IHS should be the primary source of health services for Indians.

The position that resources of the Indian Health Service are residual to other health care delivery systems or health care payment mechanisms available and accessible to the Indian is neither illegal nor does it violate IHS authority. This position does not adversely discriminate against the poor since it maximizes the resources available for health care for all eligible Indians.

The Indian has a dual relationship to Federal, State and local governments stemming from his rights as a citizen and his rights as a member of a federally recognized Indian tribe. Indians and other native Americans are entitled under the Fifth and Fourteenth Amendments to the Constitution of the United States and under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000-d et seq.) to equal access to State, local and federally assisted programs available to other eligible members of the general population. Services available from the Indian Health Service cannot be considered as an alternative resource which could preclude the eligibility of Indians or other Native Americans for services under other programs or benefits or under contracts with health care providers or insurance carriers.

The required use of alternate resources does not jeopardize the Indians' unique relationship with the Federal Government, but merely maxi-

ensure the health care services that can be provided with limited resources. Though an Indian may be eligible for an alternate resource, if it is not available and accessible to him, this otherwise eligible Indian will not be denied contract health services.

(5) Questions were raised regarding methods of carrying out IHS's responsibilities under the regulations (e.g., who is the local authorizing official; how will local policy be publicized?).

These and similar questions and issues concerning administrative procedures and program implementation are appropriate for Headquarters, Area and Service Unit issuances and policy statements. Policy will be posted and published locally and otherwise disseminated to assure the highest possible awareness among potentially eligible Indians.

(6) The National Indian Health Board (NIHB) took issue with the statement in the NPRM that the NIHB was unsuccessful in obtaining consensus among tribal groups. The NIHB considered this as reflecting a lack of understanding as to the NIHB's function (see 41 FR 46732, October 22, 1976). The statement in the proposed regulations may have been misleading. The NIHB commented that it is only a dissemination point for information for Board members and therefore it did not comment on the proposed regulations. It further stated that it was successful in its mission to disseminate information on the proposed regulations to its members.

(7) Some respondents reported that the proposed definition of "reservation" would guarantee IHS services to Indians located in places where IHS has not been funded by Congress to provide services. Section 36.22(a)(4) establishes contract health service delivery areas only with respect to reservations "within the funded scope of the Indian health program." This is applicable even under the revised definition of "reservation" contained in the final rule.

(8) Several legal aid groups took issue with limitation of services to members of federally recognized tribes, since the Snyder Act, as IHS's authorizing legislation, does not specifically contain this limitation. These commenters maintain that any Federal, State, or otherwise recognized group that is culturally identified as Indian comes within the Snyder Act authority for services from the IHS. It was not the purpose of the Snyder Act to extend benefits to Indians not federally recognized, but rather to authorize appropriations for Bureau of Indian Affairs' programs serving federally recognized Indians.

(9) A number of comments were made that the probability of an affected Indian person having access to the Federal Register is small and therefore the Federal Register is an extremely poor vehicle through which to reach Indians with a proposed regulation. It was suggested that these proposed regulations be published once a week for 3 consecutive weeks in a newspaper of general circulation within the affected localities. This suggestion was not adopted in light of the great effort which had been made to inform and to receive comments from the Indian community. Copies of the notice of proposed rulemaking were widely distributed to tribal governments and other interested groups for the purpose of explaining the proposed rules and seeking their input. Additionally, articles on these proposed regulations appeared in virtually every Indian newspaper in the country. Sufficient opportunity to respond to the NPRM has been provided to the Indian community.

C. Discussion of Miscellaneous Recommendations

The Secretary does not agree that the proposed rules would be improved as suggested by some commenters and has rejected the following suggestions.

1. A question was raised as to the meaning of "close economic and social ties" in reference to the tribal membership requirement appearing in § 36.12(a)(2) of the NPRM. It was suggested that this regulation contain additional material explaining these terms. As was discussed above, the strict tribal membership requirement has been eliminated. There is still, however, a valid question as to the meaning of this phrase since it remains as element in the eligibility criteria. The phrase is from the Supreme Court language in *Morton* v. *Ruiz*, 94 S.Ct. 1055, 415 U.S. 199 (1974). However, the Court did not define these terms for us. It is acknowledged that IHS will have to provide guidance to enable the appropriate IHS official to determine when the "close economic and social ties" criteria has been met but this is more appropriately left to administrative guidelines.

2. It was suggested that the terms "residing" and "resides" be defined. In general usage, a person "resides" where he or she lives and makes his or her home. In practice, these concepts can be very involved. Determinations will be made on generally applicable legal principles with the described appeals process as a protector of their proper application. Inclusion of definitions would, in our opinion, neither clarify nor simplify the application of this criteria.

(3) Several commenters suggested that a U.S. citizenship requirement should be added to the eligibility criteria for contract health services. This suggestion was rejected because the requirements that an applicant for contract health services be of Indian descent and maintain close economic and social ties with the nearby tribe are considered sufficient criteria to ensure that the available resources will be used for the health of the Indian communities within the funded scope of the program.

(4) It was pointed out that the proposed regulations did not address the problem of which contract health service delivery area or service unit will be responsible for or will be charged for the cost of contract health services. We do not consider this an appropriate topic for regulations since it is an administrative function.

(5) It was recommended that the State of Arizona be declared as "Traditional Indian Territory." The basis for this recommendation seems to have been the concern that many Indians currently eligible would not be eligible because they are not members of the nearby tribe even though virtually the entire State of Arizona is included in one contract health service delivery area or another. The change in the criteria dropping the strict tribal membership requirement should mitigate this problem. In addition, changes in the boundaries of contract health service delivery areas are possible under the regulations and this will permit any needed adjustments. The entire State was not designated a contract health service delivery area because this would have been a major departure from the situation proposed in the NPRM and there was not sufficient indication of tribal wishes.

(6) It was suggested that present service unit boundaries be utilized for designation of "near." The county option combined with the flexibility for redesignation was finally proposed and is being adopted as a result of a great deal of consideration of other possibilities.

(7) One commenter recommended that enrolled tribal members should be considered within the scope of the local service unit contract health service program if they return to their native community to receive health care. The funded scope of this program covers federally recognized Indians who reside on or near reservations. If a tribal member did not reestablish residency on or near a reservation, the tribal member would be beyond the funded scope of the program.

(8) It was recommended that household members should be considered eligible rather than restrict eligibility to dependents. This issue will be dealt with under proposed revision to § 36.12, as explained above.

(9) It was recommended that provision be made to continue coverage when people must move in order to be near specialized care. Coverage would

be maintained as long as the person's "residency" did not change, if they were in transient status, or for 180 days if they fall under § 36.29(b)(3).

(10) The recommendation that the 45-day grace period for obtaining alternate resources be reduced to 30 days was not adopted. The 45-day period is considered more appropriate to ensure proper health service coverage.

(11) The suggestions that separate definitions for "students" and "transients" be included was not accepted because they are considered adequately described in § 36.29(b) (1) and (2). The suggestion will be kept in mind if experience indicates a need that cannot be met by administrative guidelines.

(12) It was recommended that urban Indian groups near reservations be included in the eligible population. Urban Indians could be included if they reside in a contract health service delivery area and meet all other eligibility criteria. Urban Indians are not eligible as a [illegible] because [illegible] scope.

D. Commenters Errors Seen:

Several comments were received that went beyond the scope of the notice. They include suggestions:

1. That IHS seek funding to provide health care coverage, possibly through a type of health insurance, to Indians throughout the United States.

2. That a pro rata share of funds from other programs (e.g., medicare and medicaid) equivalent to that spent on Indian clientele be withdrawn from those programs and committed to IHS.

3. That supplemental funds be obtained from Congress to provide health care to eligible students and that these funds not affect the present IHS contract medical care budget.

4. That students be notified that when they make application for higher education financial assistance, they need to obtain any student health care plan available at the particular education institution.

5. That tribes issue identification cards so IHS and its contract health providers could recognize eligible members.

6. That IHS retain administrative procedures currently in effect in the Portland area Indian Health Service.

NOTE.—The Department of Health, Education, and Welfare has determined that this document does not contain a major proposal requiring preparation of an inflationary impact statement under Executive Order 11821 and OMB Circular A-107.

Dated: April 13, 1976.

Jerome B. Rasmussen,
Assistant Secretary for Health.

Approved: July 22, 1976.

HALE CHAMPION,
Acting Secretary.

Part 36 of title 42 is amended by revising subpart C as follows:

Subpart C—Contract Health Services

Sec.
36.21 Definitions.
36.22 Establishment of contract health service delivery areas.
36.23 Persons to whom contract health services will be provided.
36.24 Authorization for contract health services.
36.25 Reconsideration and appeals.

Subpart C—Contract Health Services

§ 36.21 Definitions.

As used in this subpart:

(a) "Alternate resources" means resources other than those of the Indian Health Service contract health services program, available and accessible to the individual, such as health care providers and institutions (including facilities operated by the Indian Health Service), health care payment sources, or other health care programs for the provision of health services (e.g., medicare or medicaid) for which the individual may be eligible.

(b) "Appropriate ordering official" means, unless otherwise specified by contract with the health care facility or provider, the ordering official for the contract health service delivery area in which the individual requesting contract health services or on whose behalf the services are requested, resides.

(c) "Area Director" means the Director of an Indian Health Service area designated for purposes of administration of Indian Health Service programs.

(d) "Contract health service delivery area" means the geographic area within which contract health services will be made available by the IHS to members of an identified Indian community who reside in the area, subject to the provisions of this subpart.

(e) "Contract health services" means health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service.

(f) "Emergency" means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.

(g) "Indian tribe" means any Indian tribe, band, nation, group, Pueblo, or community, including any Alaska Native village or Native group, which is federally recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(h) "Program Director" means the Director of an Indian Health Service "program area" designated for the purposes of administration of Indian Health Service programs.

(i) "Reservation" means any federally recognized Indian tribe's reservation, Pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), and Indian allotments.

(j) "Secretary" means the Secretary of Health, Education, and Welfare and any other officer or employee of the Department of Health, Education, and Welfare to whom the authority involved has been delegated.

(k) "Service" means the Indian Health Service.

(l) "Service Unit Director" means the Director of an Indian Health Service "service unit area" designated for purposes of administration of Indian Health Service programs.

§ 36.22 Establishment of contract health service delivery areas.

(a) In accord with the congressional intention that funds appropriated for the general support of the health program of the Indian Health Service be used to provide health services for Indians who live on or near Indian reservations, contract health service delivery areas are established as set out below:

(1) The State of Alaska;
(2) The State of Nevada;
(3) The State of Oklahoma;
(4) Chippewa, Mackinac, Luce, Alger, Schoolcraft, Delta, and Marquette Counties in the State of Michigan;
(5) Clark, Eau Claire, Jackson, La Crosse, Monroe, Vernon, Crawford, Shawano, Marathon, Wood, Juneau, Adams, Columbia, and Sauk Counties in the State of Wisconsin and Stanton County in the State of Minnesota.
(6) [illegible] within the funded scope of the Indian Health program, the contract health services delivery area shall consist of a county which includes all or part of a reservation, and any county or counties which have a common boundary with the reservation.

(b) The Secretary may, from time to time, redesignate areas or communities within the United States as appropriate for inclusion or exclusion from a contract health service delivery area after consultation with the tribal governing body or bodies of those reservations included within the contract health service delivery area. The Secretary will take the following criteria into consideration:

(1) The number of Indians residing in the area proposed to be so included or excluded;

(2) Whether the tribal governing body has determined that Indians residing in the area near the reservation

are tortally and economically affiliated with the tribe;

(3) The geographic proximity to the reservation of the area whose inclusion or exclusion is being considered; and

(4) The level of funding which would be available for the provision of contract health services.

(c) Any redesignation under paragraph (b) of this section shall be made in accordance with the procedures of the Administrative Procedure Act (5 U.S.C. 553).

§ 36.23 Persons to whom contract health services will be provided.

(a) *In general.* To the extent that resources permit, and subject to the provisions of this subpart, contract health services will be made available as medically indicated, when necessary health services by an Indian Health Service facility are not reasonably accessible or available. Persons described in and in accordance with section 36.12 within part if those persons:

(1) Reside within the United States and on a reservation located within a contract health service delivery area; or

(2) Do not reside on a reservation but reside within a contract health service delivery area, and: (i) Are members of the tribe or tribes located on that reservation or of the tribe or tribes for which the reservation was established, or (ii) maintain close economic and social ties with that tribe or tribes.

(b) *Students and transients.* Subject to the provisions of this subpart, contract health services will be made available to students and transients who would be eligible for contract health services at the place of their permanent residence within a contract health service delivery area, but are temporarily absent from their residence, as follows:

(1) Students—during their full-time attendance at programs of vocational, technical, or academic education, including normal school breaks, such as vacations, semester or other scheduled breaks occurring during their attendance, and for a period not to exceed 120 days after the completion of the course of study.

(2)(i) Transients (persons who are in travel or are temporarily employed, such as seasonal or migratory workers), during their absence.

(ii) Other persons outside the contract health service delivery area. Persons who leave the contract health service delivery area in which they are eligible for contract health services and are neither students or transients may be eligible for contract health services for a period not to exceed 120 days from such departure.

(d) *Foster children.* Indian children who are placed in foster care outside a contract health service delivery area by order of a court of competent jurisdiction and who were eligible for contract health services at the time of the court order shall continue to be eligible for contract health services while in foster care.

(e) *Priorities for contract health services.* When funds are insufficient to provide the volume of contract health services indicated as needed by the population residing in a contract health service delivery area, priorities for service shall be determined on the basis of relative medical need.

(f) *Alternate resources.* Contract health services will not be authorized by the Indian Health Service when, and to the extent that, alternate resources for the provision of necessary medical services are available and accessible to the individual requesting the services or would be available and accessible upon application of the individual to the alternate resource.

§ 36.24 Authorization for contract health services.

(a) No payment will be made for medical care and services obtained from non-Service providers or in non-Service facilities unless the applicable requirements of paragraphs (b) and (c) below have been met and a purchase order for the care and services has been issued by the appropriate ordering official to the medical care provider.

(b) In nonemergency cases, a sick or disabled Indian, or an individual or agency acting on behalf of the Indian, or the medical care provider shall, prior to the provision of medical care and services, notify the appropriate ordering official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility. The requirement for notice prior to providing medical care and services under this paragraph may be waived by the ordering official if:

(1) Such notice and information is provided within 72 hours after the beginning of treatment or admission to a health care facility; and

(2) The ordering official determines that giving of notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.

(c) In emergency cases, a sick or disabled Indian, or an individual or agency acting on behalf of the Indian, or the medical care provider shall, within 72 hours after the beginning of treatment for the condition or after admission to a health care facility notify the appropriate ordering official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services. The 72-hour period may be extended if the ordering official determines that notification within the prescribed period was impracticable or that other good cause exists for the failure to comply.

§ 36.25 Reconsideration and appeals.

(a) Any person to whom contract health services are denied shall be notified of the denial in writing together with a statement of the reasons for the denial. The notice shall advise the applicant for contract health services that within 30 days from the receipt of the notice the applicant:

(1) May obtain a reconsideration by the appropriate Service unit director of the original denial if the applicant submits additional supporting information not previously submitted or,

(2) If no additional information is submitted, may appeal the original denial by the Service unit director to the appropriate area or program director. A request for reconsideration or appeal shall be in writing and shall set forth the grounds supporting the request or appeal.

(b) If the original decision is affirmed on reconsideration, the applicant shall be so notified in writing and advised that an appeal may be taken to the area or program director within 30 days of receipt of the notice of the reconsidered decision. The appeal shall be in writing and shall set forth the grounds supporting the appeal.

(c) If the original or reconsidered decision is affirmed on appeal by the area or program director, the applicant shall be so notified in writing and advised that a further appeal may be taken to the Director, Indian Health Service, within 30 days of receipt of the notice. The appeal shall be in writing and shall set forth the grounds supporting the appeal. The decision of the Director, Indian Health Service, shall constitute final administrative action.

[FR Doc. 78-21331 Filed 8-3-78; 8:45 am]

Montana United Indian Association

Phone:
443-5350

846 Front Street
Helena, Montana
59601

MUIA

November 16, 1981

ADDRESS TO THE HOUSE APPROPRIATIONS COMMITTEE

MR. CHAIRMAN, MR. VICE-CHAIRMAN AND MEMBERS OF THE COMMITTEE: MONTANA UNITED INDIAN ASSOCIATION (MUIA) IS GRATEFUL FOR THIS OPPORTUNITY TO ADDRESS YOU THIS AFTERNOON:

THE MUIA IS HEREBY SUBMITTING A REVISED REQUEST FOR FUNDING TO MAINTAIN HEALTH SERVICES PROVISION TO THE URBAN INDIANS OF MONTANA. THE MUIA RECOGNIZES THAT THIS LEGISLATURE IS HEAVILY BURDENED WITH REQUESTS FROM VARIOUS SOURCES ATTEMPTING TO OFFSET THE WIDESPREAD HUMAN SERVICES BUDGET CUTS PROMULGATED BY THE DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET, DAVID STOCKMAN. HOWEVER, THE MUIA WISHES TO POINT OUT THAT THERE ARE SEVERAL REASONS THAT MAKE THE CLINIC FUNDING REQUEST NOT ONLY VALID, BUT ESSENTIAL:

1) IT HAS BEEN AMPLY DEMONSTRATED BY THE MUIA'S EXPERIENCE, THE CONGRESS OF THE UNITED STATES, THE MONTANA SUPREME COURT, BY TESTIMONY GIVEN AT THE BLOCK GRANT HEARINGS ON OCTOBER 28TH AND 29TH AND AT THE HEARINGS OF SUB-COMMITTEE #2 ON NOVEMBER 9TH, 10TH AND 11TH OF THIS YEAR THAT PROVISION OF HEALTH CARE SERVICES TO NATIVE AMERICANS IN MONTANA HAS NOT ACHIEVED PARITY WITH THE MAJORITY OF THE STATE'S POPULATION;

2) When urban Indians are allowed access to health care, the cost of that care is far beyond the means of the majority to pay due to the low incidence of employment and the resultant lack of insurance coverage by third party payors. The approximate one-way distances form the nearest reservation to each of the urban health centers is detailed below:

Great Falls to Rocky Boys' = 87 miles
Helena to Flathead = 173 miles
Missoula to Flathead = 61 miles

It is important to note that very few Montanas would drive 174, 346 or 122 miles in the summer to receive Primary Health Care, even if they could afford the gasoline, to say nothing of making the same trip in the winter.

Equally important is the fact that appointments have to be made for the service delivery which many times involve planning weeks ahead. In addition, if urban Indians had the money for the gasoline to travel those distances, they could pay for local non-Indian primary care.

3) The Indian Health Service (IHS) has two pertinent funding regulations which are difficult to interpret due to the number of significant exceptions possible and the variability with which the seven reservations in the state treat each regulation, to wit:

a) The so-called "On or Near" policy basically states that Indian people residing on or near a reservation are entitled to IHS contract care. The operative clauses of this policy state that eligibility for contract care on a specific reservation depends, in part, upon an otherwise eligible

INDIVIDUAL'S PLACE OF RESIDENCE. IF AN ENROLLED MEMBER OF A TRIBE OTHERWISE ELIGIBLE TO RECEIVE CONTRACT CARE RESIDES IN A COUNTY ADJOINING AN INDIAN RESERVATION OR IN A COUNTY INTO WHICH THE BOUNDARY OF AN INDIAN RESERVATION PROTRUDES, THAT INDIVIDUAL MAY RECEIVE CONTRACT CARE, EVEN IF HE OR SHE DOESN'T RESIDE UPON THE RESERVATION PROPER.

THE NUMBER OF INDIAN PEOPLE QUALIFYING FOR "NEAR" RESIDENCY IS SO MINIMAL THAT THEY ARE NOT COUNTED IN MUIA'S URBAN POPULATION DATA BECAUSE IN FACT, THESE PEOPLE ARE, UNDER THE RULES, RESERVATION RESIDENTS.

B) THE "ONE HUNDRED-EIGHTY DAY" RULE STATES THAT IF AN INDIVIDUAL WHO IS OTHERWISE ELIGIBLE FOR CONTRACT CARE SERVICES HAS LIVED OFF (NOT "NEAR") THE RESERVATION FOR MORE THAN 180 DAYS, THAT PERSON MAY BE DENIED CONTRACT CARE UNLESS HE OR SHE RE-ESTABLISHES RESIDENCY PRIOR TO PROVISION OF CARE.

BOTH OF THE ABOVE REGULATIONS ARE SUBJECT TO INTERPRETATION BY THE TRIBE PROVIDING THE HEALTH SERVICE. FOR EXAMPLE, SOME TRIBES ALLOW ENROLLED TRIBAL MEMBERS LIVING OFF-RESERVATION (BEYOND THE LIMIT PROSCRIBED BY THE ON OR NEAR POLICY) TO ENJOY CONTRACT CARE SERVICES IF THEY ARE WORKING FOR THE TRIBE IN A CAPACITY THAT NECESSITATES LIVING IN A PLACE BEYOND THE ON OR NEAR POLICY'S PURVIEW. SECONDLY, MOST RESERVATIONS WILL PROVIDE PRIMARY CARE OR FIRST AID AS NECESSARY FOR EMERGENCY CASES AND WILL PROVIDE REFERRAL TO HEALTH CARE PROVIDERS AND FACILITIES OUTSIDE THE RESERVATION, BUT IN THESE CASES <u>WILL NOT PAY</u> FOR THOSE SERVICES NOR REIMBURSE EITHER THE VICTIM OR THE PROVIDER WHO RENDERED THE SERVICE.

NOTES

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4) THE COST OF HEALTH CARE PROVISION NATIONWIDE HAS BALLOONED IN EXCESS OF 19% IN THE LAST FISCAL YEAR, IN MONTANA, THIS COST HAS RISEN BY 11% DURING THE SAME PERIOD. THE URBAN INDIAN HEALTH PROGRAMS THAT ARE ADMINISTERED BY THE MUIA HAVE OPERATED EFFICIENTLY AND EFFECTIVELY (CONFIRMED BY A NATIONALLY RECOGNIZED MANAGEMENT CONSULTANT FIRM) ON A CONGRESSIONAL APPROPRIATION THAT HAS NOT CHANGED FOR TWO FISCAL YEARS, NAMELY AN AVERAGE OF $217,073.17 FOR EACH OF 41 URBAN INDIAN HEALTH PROJECTS ACROSS THE UNITED STATES. A MEASURE OF THE EFFECTIVENESS OF MUIA'S PROGRAMS CAN BE SEEN IN THE FACT THAT WE PRODUCED A CARRYOVER SURPLUS IN FISCAL 1980 WHICH WAS APPLIED TO THE PAST FISCAL YEAR'S PROGRAM NEEDS. DUE TO A CHANGE IN CONTRACTING PROCEDURES FOR FISCAL 1981, CARRY-OVERS NOW REVERT TO THE U.S. TREASURY IF NOT UTILIZED OR ENCUMBERED DURING THAT CONTRACT YEAR.

5) THE STARK REALITY OF THE FEDERAL HUMAN SERVICES BUDGET CUTS IS THAT THERE ARE MORE HOLES IN THE "SAFETY NET" THAN THERE IS "NET." THE SAFETY NET CONCEPT WILL ULTIMATELY DEVOLVE UPON MONTANA'S 56 COUNTIES WHO WILL BE FOOTING THE BILL FOR SHARP IN-CREASES IN THE PAYMENT FOR ACUTE EPISODIC AND EMERGENCY ROOM CARE THAT WILL INEVITABLY OCCUR IF THE URBAN INDIAN HEALTH PROGRAMS ARE NOT FUNDED. IN ADDITION TO ASSUMING FINANCIAL RESPONSIBILITY FOR THE DRASTIC CUTS IN OTHER SERVICES, MONTANA'S COUNTIES WILL BE HARD PRESSED TO PAY FOR EMERGENT URBAN INDIAN HEALTH CARE BE-CAUSE THE URBAN INDIAN POPULATION WILL NOT SEEK PREVENTIVE HEALTH FROM NON-INDIAN CLINICS DUE TO THE HISTORICAL HUMILIATION, DEPRI-VATION AND DISCRIMINATION SUFFERED AT THE HANDS OF MANY MEDICAL PROVIDERS. THE LAW OF THE LAND STATES THAT THIS SHOULD NOT HAPPEN;

HOWEVER, IT IS WELL KNOWN THAT FIRMLY ROOTED ATTITUDES AND PREJUDICES CANNOT BE LEGISLATED OUT OF EXISTENCE.

6) THE MONTANA SUPREME COURT, INTERPRETING THE LAW OF OUR LAND, POINTEDLY DEMANDED LAST THURSDAY (NOVEMBER 12, 1981) "A GREATER INSULATION OF INDIAN VALUES FROM WHITE INFLUENCES AND AUTHORITY..." AND THE COURT SAID "THE ACT (INDIAN CHILD WELFARE ACT OF 1978) WAS PASSED BY CONGRESS IN RESPONSE TO A SIGNIFICANT THREAT TO THE INTEGRITY OF INDIAN CULTURES IN THIS COUNTRY." THE SUPREME COURT ALSO STATED, "INDIAN PEOPLE, *whether residing on a reservation or not*, ARE IMMERSED IN AN ENVIRONMENT WHICH IS IN MOST RESPECTS ANTITHETICAL TO THEIR TRADITIONS." (EMPHASIS ADDED.) IN ADDITION, THE COURT NOTED THAT "...CULTURAL DIVERSITY AMONG INDIAN TRIBES IS PROFOUND BUT NOT FULLY APPRECIATED OR PROTECTED IN WHITE SOCIETY, BUT THE MONTANA CONSTITUTION RECOGNIZES THE NEED TO PRESERVE THE UNIQUE CULTURAL HERITAGE OF INDIANS." FINALLY, THE COURT DECLARED, "IN APPLYING OUR STATE LAW...WE ARE COGNIZANT OF OUR RESPONSIBILITY TO PROMOTE AND PROTECT THE UNIQUE INDIAN CULTURES OF OUR STATE FOR ALL FUTURE GENERATIONS OF MONTANANS."

IT MUST BE NOTED THAT ALL FOUR MEMBERS OF MONTANA'S CONGRESSIONAL DELEGATION FULLY SUPPORT THE MUIA'S HEALTH PROGRAMS AND HAVE SENT US LETTERS STATING THEIR POSITION ON THIS ISSUE. MUIA REPRESENTATIVES HAVE MET WITH EACH DELEGATE PERSONALLY REGARDING THE NECESSITY FOR CONTINUING OPERATION OF THE CLINICS. THE DELEGATION WAS HIGHLY VISIBLE IN ITS SUPPORT OF INCLUSION OF THE URBAN INDIAN HEALTH PROGRAMS IN THE INTERIOR BILL WHICH RECENTLY EMERGED FROM THE SENATE/HOUSE CONFERENCE COMMITTEE.

7) AS CAN BE CLEARLY SEEN BY THE ATTACHED TESTIMONY AND

BUDGETS PREPARED AT THE INVITATION OF SUB-COMMITTEE #2, THE MUIA HAS REALISTICALLY TRIMMED THE AMOUNTS NECESSARY TO OPERATE AND STAFF THE CLINICS FOR FISCAL YEAR 1982. HOWEVER, IN THE INTEREST OF PRESENTING A REQUEST TO A LEGISLATURE WHICH FINDS ITSELF SEVERELY LIMITED BY FEDERAL BLOCK GRANTS, THE MUIA PROPOSES THREE MODEL FUNDING BUDGETS (ATTACHED) TWO OF WHICH REFLECT SERVICE DELIVERY ONLY; I.E., NO ADMINISTRATION, OFFICE MATERIALS AND SUPPLIES, RENT OR OTHER DIRECT COST. THE RATIONALE BEHIND THIS APPROACH EMINATES FROM LIMITED ENCOURAGEMENT FROM PRIVATE FOUNDATIONS AND OTHER CHARITABLE INSTITUTIONS WHO HAVE INDICATED AN INTEREST IN CONTINUING THE CLINICS BUT, LIKE THE STATE, CANNOT SUPPORT THE ENTIRE COST OF MAINTAINING THEM. SINCE THE MUIA BROUGHT THE ISSUE BEFORE SUB-COMMITTEE #2, CASH AND PLEDGES TOTALING NEARLY $35,000.00 HAVE BEEN RECEIVED.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH GRANT

IN SUMMARY, YOU HAVE BEFORE YOU A COMPLETE PACKET DELINEATING THE HISTORY OF THE MONTANA UNITED INDIAN ASSOCIATION, THE HEALTH SERVICES CURRENTLY PROVIDED BY THE MUIA'S CLINIC ALLIANCES, THE FUNDING PROPOSAL MADE TO THE STATE DEPARTMENT OF HEALTH, THREE DISTINCT BUDGET PROPOSALS, A HEALTH SERVICES FACT SHEET, LETTERS OF SUPPORT FROM CONSUMERS AND PROVIDERS OF MEDICAL CARE, LETTERS FROM THE MONTANA CONGRESSIONAL DELEGATION, MATERIALS PREPARED FOR THE APPROPRIATIONS SUB-COMMITTEE, COPIES OF NEWSPAPER ARTICLES, A TRANSCRIPT OF PERTINENT TESTIMONY FROM THE SUB-COMMITTEE AND A TRANSCRIPT OF AN INTERVIEW AIRED ON KTVG NEWSLINE 12. THE DELIBERATIONS AND RECOMMENDATIONS OF YOUR COMMITTEE WILL HAVE A SIGNIFICANT IMPACT ON THE HEALTH STATUS OF NOT ONLY THE MORE THAN 16,000 URBAN INDIAN PEOPLE IN THE STATE, BUT ON THE NON-INDIAN POPULATION AS WELL.

THE MONTANA UNITED INDIAN ASSOCIATION WISHES TO THANK THE CHAIRMAN, VICE-CHAIRMAN AND MEMBERS OF THE APPROPRIATIONS COMMITTEE FOR THIS OPPORTUNITY TO TESTIFY IN THE INTEREST OF THE CONTINUING PROVISION OF QUALITY HEALTH CARE TO MONTANA'S URBAN INDIAN PEOPLE.

QUA-QUI
CORPORATION MISSOULA INDIAN CENTER
508 Toole Avenue ◇ Missoula, Montana 59801
Phone: (406) 329-3905

November 16, 1981

Representative Ed Smith
Montana State Legislature
Capitol Building
Helena, Montana 59601

Dear Representative Smith,

I am writing in response to an article published in the Missoulian last week, November 12, 1981. It seems you mentioned that some of your Indian friends told you they are still receiving annual check-ups and major medical care from reservations.

Recently I became very ill, while residing in Missoula, and was put in the hospital immediately. In telephoning my tribe and explaining the emergency of my situation and the need for assistance, the contract officer responded by saying they would have to deny me any assistance because I wasn't living on the reservation. Unfortunatly in view of my emergency my Dr. didn't feel it would be wise for me to travel 500 miles to receive major medical services from my home reservation. The closest reservation hospital from Missoula, (45 miles away) also told me I could not get help from them because I was not a member of their tribe.

Contrary to your "friends" beliefs and consequently yours, not all Urban Indians qualify for services on reservations. In fact, hardly any of my Indian friends living in Missoula, qualify for any services on any reservation.

I hope this will clear up some misinterpretations concerning this matter.

Very sincerely

Harold Hamilton

Harold Hamilton

cc..Mr. Ben Bushyhead, Executive Director
Montana United Indian Association

(30)

November 16, 1981

Representative Ed Smith
Montana State Legislature
Capital Building
Helena, Montana 59601

Dear Representative Smith,

The recent article in the Missoulian dated November 12, 1981 has prompted me to write this letter.

A few months ago I was visiting my home reservation in Browning. During that time I became extremely ill and had to be transported by ambulence to a subcontracted unit of the Blackfeet tribe in Kalispell. Since then, I have been notified that my statis as an Urban Indian would make me inelligible for payment of services even though I became ill while visiting my home reservation.

Therefore, your beliefs that Urban Indians receive health care on reservations is unfounded. I know I am but one of numourous Indian people choosing to reside in an urban setting who has been refused health services from any reservation.

Please take this letter into consideration next time you generalize about all Urban Indians receiving annual checkups and major medical care whenever needed.

Sincerely,

Susan Tatsey

Susan Tatsey

cc. Mr. Ben Bushyhead, Executive Director
Montana United Indian Association

economic conditions in rural areas, the percentage could be even higher.

Indians were not received in the cities with health care waiting for them, and currently the Indian Health Service of the Department of Health and Human Services will not provide direct health care to urban Indians.[4] Individuals cannot afford to go to a reservation health center in most instances, and because people assume the Federal Government provides for its Indian wards, there are no urban health care delivery systems which have served Indian people.[5] Where there are free health care systems, Indians are denied their services.[6] It has also been found that there has been gross discrimination against Indians in tax-supported institutions.[7] In other words, urban area facilities simply assume Indians have been provided for, and some discriminate against Indian people for reasons too lengthy and complex to comment upon here.

As a result of this situation, Indian and urban community leaders attempted to establish part-time volunteer community clinics. While those experiments were noteworthy and noble, they found that the health needs of urban Indians were larger than anticipated, due to the numbers of people to be served and due to the frequency and kinds of ailments to be treated. Thus they found they simply could not go further without outside funding.[8]

As a result of this situation, we enacted the Indian Health Care Improvement Act, which was designed to bring Indian health to an acceptable level.[9] Funding for programs under the act did not begin until fiscal year 1978, and now that the programs has gotten off the ground for funding urban Indian health programs, it is in great danger of death at an early age.

Our American Indian Policy Review Commission looked at these problems in a great deal of detail, and it developed the expertise to tell Congress what is needed to address some of the problems I mentioned earlier. On the issue before us the Commission recommended:

> Congress appropriate sufficient funds for the continuance of present Indian centers in urban areas which assist Indians in obtaining medical and other social services; and should encourage, with funds and guidance, the establishment of additional such centers in all urban areas where Indians live.[10]

That is some of the background to the problem, but what is the current problem?

Of the 50 percent of all American Indians who live in cities, over 50 percent of that number are children of school age or younger.[11] In other words, 25 percent of all American Indians are urban children. They, along with other urban Indians, have an unusual incidence of special medical problems.[12] Some of the more recent studies of Indian health problems show that the No. 1 ailment among Indians is otitis media, an ear infection which is related to poverty and which can cause deafness.[13] Reports show this ailment to be quite high in children, with 63.6 percent of the children having it being under the age of 5.[14] If those little children are untreated they will have hearing problems which will cause them to do poorly in school, leaving more people in the vicious cycle of poverty. The No. 2 disease is strep throat, a highly infectious disease.[15] It only makes public health sense to make certain there are facilities which can check the spread of this disease. The next highest ailment consists of intestinal infectious diseases, and we know these can cause a great deal of pain and even death.[16] I will not go through the full list, which is available to you in government reports, but the fourth highest ailment is impetigo, a staphylococcal skin disease, the fifth is pneumonia, and the sixth is influenza. These are all serious ailments and many of them are very highly contagious. However you can see they are ones which can be treated easily and effectively in a clinic setting. If they are caught early through checkup programs and the encouragement of parents and others to come in, the community is protected and, more importantly, Indian people can obtain the medical care they deserve.

That is the background. We owe a duty to the Indian peoples who were sent to our cities, we owe a duty to the cities to assist them in providing services, and the nature of the ailments treated requires public attention for the sake of the community at large. This program is one for the truly needy, it is fundamental, and it is in line with the history of the special relationship of the Federal Government to Indians. It is also a step toward a better future. As one of my Indian constituents put it, "I have a vision of a day when being Indian and poor in America is not dangerous to your health."

Mr. President, it is, thus, with great concern that I note the action of the Senate Interior appropriations to totally eliminate funding for the urban Indian health program.

The House, however, has seen fit to fund the urban Indian health program. And it recommended $9.78 million for fiscal year 1982. When the Interior measure goes to conference, I want to strongly urge my colleagues to adopt the House figures for this very important health care program.

FUNDING FOR URBAN INDIAN HEALTH CENTERS

Mr. BAUCUS. Mr. President, I have been hearing the concerns of Indian people who are not only from my State but from other States with significant Indian populations. What I am hearing is evidence Indians are indeed among the truly needy. Indians fall at the bottom of every social and economic indicator. They have the shortest life expectancy; they have the highest suicide rate; their poverty is 300 percent of the national average; they have the lowest per capita income; they have the highest unemployment rates; they have the lowest level of education; they have the poorest housing; and they have the worst health conditions and health care. It is little wonder there is an acute need for health care in urban areas.

How did this problem come about? In 1952, the Government policy of relocating reservation Indians to urban areas caused about one-third of American Indians to move to cities.[1] As a consequence of that policy it is estimated that about one-half of all American Indians live in urban areas.[2] Those estimates were made in 1978 and given the present

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[4] *Id.*

[5] *Id.*

[6] American Indian Policy Review Commission, *Final Report*, p. 385.

[7] *Report on Indian Health*, supra, p. 148.

[8] *Id.*

[9] Final Report, supra, p. 386.

(32)

PAT WILLIAMS
MONTANA
WESTERN DISTRICT
MAJORITY WHIP AT LARGE

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CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

COMMITTEES:
EDUCATION AND LABOR
ELEMENTARY, SECONDARY AND VOCATIONAL EDUCATION
LABOR STANDARDS
HUMAN RESOURCES
INTERIOR
PUBLIC LANDS AND NATIONAL PARKS
ENERGY AND ENVIRONMENT

September 28, 1981

Mr. Ben Bushyhead
Executive Director
Montana United Indian Association
846 Front Street
Helena, Montana 59601

Dear Ben:

I just wanted to let you know that I've written to the conferees meeting on the Interior Appropriations Bill for FY 82 in support of the $9.7 million for Title V of the Indian Health Care Improvement Act.

Best regards.

Sincerely,

Pat

Pat Williams

Enclosure

PAT WILLIAMS
MONTANA
WESTERN DISTRICT
MAJORITY WHIP AT LARGE

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INTERIOR
PUBLIC LANDS AND NATIONAL PARKS
ENERGY AND ENVIRONMENT

September 15, 1981

The Honorable Sidney R. Yates
Chairman
Subcommittee on Interior
Committee on Appropriations
B308 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Yates:

As you prepare to go to Conference regarding the FY'82 Interior Appropriations Bill, I urge you to insist on the House version regarding Title V of the Indian Health Care Improvement Act - dealing with Urban Indian Health.

There are currently more than 240,000 Indian people living in urban areas--many of them forced to urban centers because of the lack of employment on the reservations. With the severe impact of the budget cuts for Indian programs on the reservations, we can expect to see more Indian people moving to urban centers to seek employment. Whereas the $9.7 million as contained within the House Interior Appropriations Bill is not nearly enough to meet the health care needs of our urban Indian population, it will allow the work and success of the program to date to continue.

Monies spent in the Urban Indian Health Care Centers has been one of the best uses of federal monies evident. For every dollar of Indian Health Service funding to Urban Indian Health Centers, projects have been able to match funds from other sources. The health of urban Indians has improved and per-patient costs are well below the national norm.

My thanks for your help.

Best regards.

Sincerely,

Pat Williams

Member of Congress

Pat Williams

(33)

United States Senate

SELECT COMMITTEE ON INDIAN AFFAIRS
WASHINGTON, D.C. 20510

July 31, 1981

Ben Bushyhead
Executive Director
Montana United Indian Association
846 Front Street
Helena, Montana 59601

Dear Ben:

Thank you for your recent letter regarding the budgetary problems facing urban Indian health programs. As you may know, the House of Representatives has passed the Interior Appropriations bill which includes $9.79 million for urban health programs. Although the Senate Interior Approrpriations Subcommittee has not provided any funds for Indian urban health care, the Senate bill has not yet been presented to the full Senate.

Although I am not a member of the Senate Appropriations Committee and therefore will not be a conferee on this bill, I know that urban Indian health programs has provided vital health care to many people, and I will do what I can to preserve these worthwhile programs.

Best regards.

Sincerely,

John Melcher

John Melcher
Ranking Minority Member

RON MARLENEE
MONTANA

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Congress of the United States
House of Representatives
Washington, D.C. 20515

July 27, 1981

Ben Bushyhead, Executive Director
Montana United Indian Association
846 Front Street
Helena, Montana 59601

Dear Ben:

Thank you for your letter regarding funding for Title V of Public Law 94-437, the Indian Health Care Improvement Act. I appreciate knowing of your concerns on funding for urban and rural Indian Health Care Programs.

As you may recall, I wrote to Congressman Yates of the Interior Appropriations Subcommittee and requested that funding be restored for Title V Indian Health Care Programs. The $9.79 million was then adopted by the Full Committee on Interior Appropriations.

I will not be a member of the House-Senate Conference on Interior Appropriations, and I would suggest that you contact Senator Melcher and Senator Baucus on this matter. The House of Representatives did vote to retain $9.79 million for Urban Indian Health Care Programs, but the Senate has not yet voted on the Interior Appropriations bill.

Ben, I appreciate your letting me know of your concerns on this matter, and I hope you will always feel free to call on me regarding any issue of interest to you.

Sincerely,

Ron

(35)

Indian health clinics denied money

JAMES DeWOLF
Standard State Bureau

HELENA — By a one-vote margin, a legislative Appropriations subcommittee has scalped a group urban Indian health ervice providers.

But, the Montana United Indian Association says it n't give up yet and pro ably will resubmit its nding request to the entire Legislature.

The 6-5 decision came fter Sen. Ed Smith, R- agmar, said he had checked with Indian friends who told him that laims about urban In- ians not qualifying for medical care on all reservations are untrue.

Smith said some of his riends have left their reservations for decades and still are returning for annual checkups and major medical care. "I think we've been misled a little bit," said Smith.

Association officials said the rule for Indian Health Service care is that it can't be given to anyone who has lived away from a reservation for more than 180 days. They said money for Montana's seven reservation health programs is drying up and strict enforcement of eligibility rules is becoming more common.

THE GROUP is seeking $345,000 for each of two years to continue the operation of Indian health clinics in Great Falls, Helena and Missoula, along with outreach transportation programs in Anaconda, Butte and Miles City. The Indian group says it could operate the clinics for $285,000 a year.

Backers say the clinics are necessary because urban Indians often are poor and routinely are denied the health services available to other Montanans.

Up until now the health programs have been federally supported. But, federal cuts in funding may run as high as 100 percent and the association says if that happens, Indian centers and the clinics may fold.

Legislators said there simply wasn't enough money available in a federal block grant for preventative health care to continue funding state and county health programs while providing for the urban Indian clinics.

A tenative motion urging county health departments to make sure Indians are not left out of county health programs failed to get even to the voting stage. Some legislators argued that funding the clinics would create an excuse to continue racism.

SEN. FRED Van Valkenburg, D-Missoula, chided the Indian group for being unrealistic in opposing his earlier suggestion that the state could fund one of the clinics for $80,000 a year.

"You missed the boat in Washington D.C.," said Van Valkenburg, before making a surprise motion to fund just one clinic.

The proposal was voted down. Afterwards, Ben Bushyhead, executive director of the asciation, said there is a discrimination problem that federal laws have failed to remedy. He said urban Indian clinics were told to expect block grant funding earmarked for them, but that it was never approved at the federal level.

"If (this committee) had given us $30,000, it would have been OK," he said.

Panel turns down Indian-clinic funds

Missoulian State Bureau

HELENA — By a one-vote margin a legislative Appropriations subcommittee has turned down a funding request from a group of urban Indian health service providers.

But the Montana United Indian Association says it can't give up yet and will probably resubmit its funding request to the entire Legislature.

The 6-5 decision came after Sen. Ed Smith, R-Dagmar, said he had checked with Indian friends who told him that claims that urban Indians can't qualify for medical care on all reservations are untrue. Smith said some of his friends have lived away from reservations for decades and are still returning for annual checkups and major medical care.

Association officials said Indian Health Service care is not supposed to be given to anyone who has lived away from a reservation for more than 180 days. They said money for Montana's seven reservation health programs is drying up so strict enforcement of eligibility rules is becoming more common.

The group seeks $345,000 for each of two years to continue the operation of Indian health clinics in Great Falls, Helena and Missoula, along with outreach transportation programs in Anaconda, Butte and Miles City. It says it could operate just the clinics for $285,000 a year.

Legislators said there simply wasn't enough money available in a federal block grant for preventative health care to continue funding state and county health programs while providing for the urban Indian clinics.

Sen. Fred Van Valkenburg, D-Missoula, chided the the association for being unrealistic in opposing his earlier suggestion that the state could fund one of the clinics for $80,000 a year.

That proposal was voted down.

After that vote, Ben Bushyhead, executive director of the group, said there is a discrimination problem that federal laws have failed to remedy. He said urban Indian clinics were told to expect block grant funding earmarked for them but it was never approved at the federal level.

"If you (this committee) had given us $30,000 it would

Indian health service request is scalped

Thursday, Nov. 12, 1981 The Billings Gazette

By JAMES DeWOLF
Gazette State Bureau

HELENA — A legislative appropriations subcommittee scalped by a one-vote margin a request from a group of urban Indian health service providers.

But the Montana United Indian Association says it can't give up yet and will probably resubmit its funding request to the entire Legislature.

The 6-5 decision came after Sen. Ed Smith, R-Dagmar, said he had checked with Indian friends who said claims that urban Indians can't qualify for medical care on all reservations are false.

Smith said some of his friends have left their reservations for decades and are still returning for annual checkups and major medical care. "I think we've been mislead a little bit," he said.

MUIA officials said Indian Health Service rules say it can't be given to anyone who has lived away from a reservation for more than 180 days. They said money for Montana's seven reservation health programs is drying up and strict enforcement of eligibility rules is becoming more common.

The MUIA is seeking $345,000 for each of two years to continue the operation of Indian health clinics in Great Falls, Helena and Missoula along with out-reach transportation programs in Anaconda, Butte and Miles City. The MUIA says it could operate just the clinics for $285,000 a year.

Backers say the clinics are necessary because urban Indians are often poor and are routinely denied the health services available to other Montanans.

Up until now the health programs have been federally supported. But federal cuts in funding may run as high as 100 percent and the MUIA says if that happens Indian centers, as well as the clinics, may fold.

Legislators said there simply wasn't enough money available in a federal block grant for preventative health care to continue funding state and county health programs while providing for the urban Indian clinics.

A tentative motion urging county health departments to make sure Indians are not left out of county health programs failed to even get to the voting stage and some legislators argued that funding the clinics would create an excuse to continue racism.

Sen. Fred Van Valkenburg, D-Missoula, chided the MUIA for being unrealistic in opposing his earlier suggestion that the state could fund one of the clinics for $80,000 a year.

"You missed the boat in Washington D.C.," said VanValkenburg before making a surprise motion to fund just one clinic.

The proposal was voted down and afterwards Ben Bushyhead, executive director of the MUIA, said there is a discrimination problem that federal laws have failed to remedy. He said urban Indian clinics were told to expect block grant funding earmarked for them but it was never approved at the federal level.

"If (this committee) had given us $30,000 it would have been OK," he said.

Indian health clinic funding request denied

By CHARLES S. JOHNSON
Tribune Capitol Bureau

HELENA — By a 6-5 vote, a legislative budget committee rejected a scaled down request Wednesday to finance a health clinic for urban, non-reservation Indians.

The Indians also were told by one senator that they would be better off using existing health facilities designed to serve all people instead of establishing their own clinics.

Separate facilities serve only to encourage animosity and will not help Indians overcome discrimination, Sen. Thomas Keating, R-Billings, said.

The urban Indians originally had sought $690,000 in state money over the next two years for the state to pick up financing of health clinics in Great Falls, Helena and Missoula and some referral operations in other cities.

These clinics are financed primarily with federal money now, but the Montana United Indian Alliance found out only recently that the federal government is cutting off their money. The clinics currently receive no state money.

The Indians had pleaded with the committee earlier this week for [illegible] $690,000 request was [illegible] committee.

At that [illegible] officials told the Indians that the request was for more than half of the total money granted to the state for all preventive health programs.

Sen. Fred Van Valkenburg, D-Missoula, told the Indians their original request was unrealistic in light of the budget cutbacks facing the state.

"You missed the boat in Washington, D.C.," he said.

Van Valkenburg then tried to appropriate $80,000 a year to pay for one clinic, which he said probably belonged in Great Falls, which has the most landless, non-reservation Indians who would be served.

His motion failed on a 6-5 vote.

Joining Van Valkenburg in support of the proposal were Reps. Francis Dussaault, D-Harlem; Andrea Hansen, R-Great Falls; and Sens. Bill Thomas, D-Great Falls, and Lawrence Stimatz, D-Butte.

Successfully opposing the attempt were Reps. Burt Hurwitz, R-White Sulphur Springs; Rex Manuel, D-Fairfield; Chris Stobie, R-Thompson Falls; and Sens. Ed Smith, R-Dagmar, Keating; and Jan Wolf, R-Missoula.

After losing their attempt Mike Welch, health director for the Indian group, said the organization would make another pitch before the full House Appropriations Committee next week.

He and other association officials said the group would be willing to accept any money from the state, even as little as $50,000, to try to keep the programs operating.

Their arguments on behalf of the programs fell on generally deaf ears.

Smith said he believed the Indian officials had tried to mislead the committee previously when they said most Indians who left their reservation for six months lost their right to free medical and dental care.

"Everyone I've talked to said they'd never been denied services" on reservations no matter how long they had been gone, Smith said.

Although policies vary, Keating said the government generally applies if the reservation received Indian Health Service money from the federal government.

Ben Bushyhead, executive director of the Montana United Indian Association, said the reservations' first priority is to serve those Indians still living on the reservation.

Other legislators questioned why Indians couldn't obtain medical service from county health departments like other needy people.

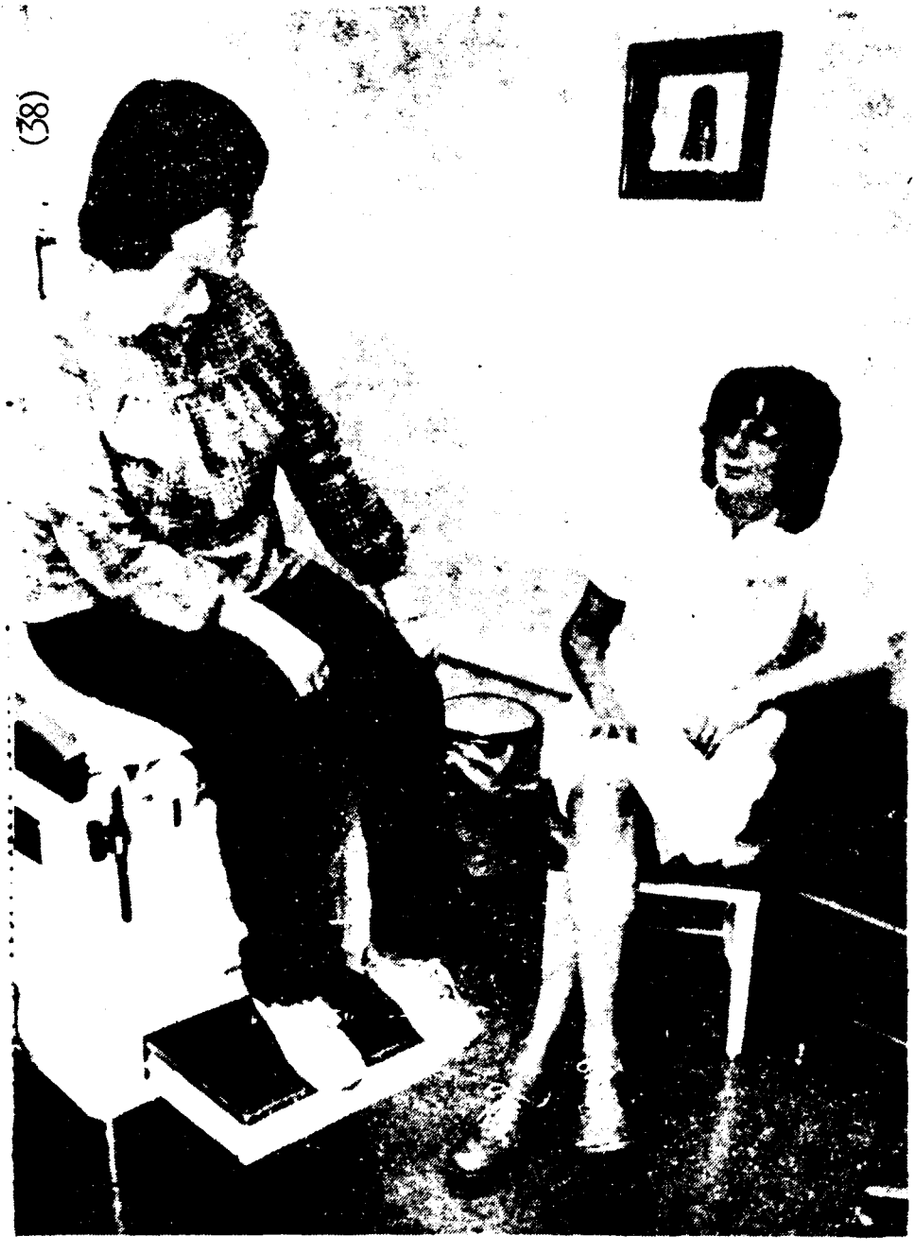
At the previous hearing, association officials said Indians often have trouble obtaining adequate medical services from private physicians and government programs.

If Indians are being turned away from county health departments, they should file lawsuits because it constitutes illegal discrimination, said Bob Johnson, Lewis and Clark County health officer.

The committee considered inserting a provision stipulating that the preventive money distributed by the state was to serve all persons regardless of their race. But that motion was ultimately withdrawn as meaningless since the state constitution and laws already ban such discrimination.

But Bushyhead told reporters after the meeting that "you can't legislate discrimination out of practice."

Discrimination still exists despite enactment of the 1964 U.S. Civil Rights Act and other laws, he said.



Clinical Services Director Jennifer Topash (left) and registered nurse Yvonne Blackburn may work for half-pay at the Helena Indian Alliance clinic if the alliance fails in its bid for state financial help.

Urban Indians lose health skirmish

BY JAMES DEWOLF
IR State Bureau

By a one-vote margin a legislative appropriations subcommittee has scalped a group of urban Indian health service providers, including those in Helena.

But the Montana United Indian Association (MUIA) says it can't give up yet and will probably resubmit its funding request to the entire Legislature.

The 6-5 decision came after Sen. Ed Smith, R-Dagmar, said he had checked with Indian friends who told him that claims that urban Indians can't qualify for medical care on all reservations are untrue.

Smith said some of his friends have left their reservations for decades and are still returning for annual checkups and major medical care.

"I think we've been misled a little bit," said Smith.

MUIA officials said the official rule for Indian Health Service care is that it can't be given to anyone who has lived away from a reservation for more than 180 days. They said money for Montana's seven reservation health programs is drying up and strict enforcement of eligibility rules is becoming more common.

The MUIA is seeking $345,000 for each of two years to continue the operation of Indian health clinics in Great Falls, Helena and Missoula along with out-reach transportation programs in Anaconda, Butte and Miles City. The MUIA says it could operate just the clinics for $285,000 a year.

Backers say the clinics are necessary because urban Indians are often poor and are routinely denied the health services available to other Montanans.

Up until now the health programs have been federally supported. But federal cuts in funding may run as high as 100 percent and the MUIA says if that happens Indian centers, as well as the clinics, may fold.

Legislators said there simply wasn't enough money available in a federal block grant for preventative health care to continue funding state and county health programs while providing for the urban Indian clinics.

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The proposal was voted down and afterwards Ben Bushyhead, executive director of the MUIA, said there is a discrimination problem that federal laws have failed to remedy. He said urban Indian clinics were told to expect block grant funding earmarked for them but it was never approved at the federal level.

"If (this committee) had given us $30,000 it would have been OK," he said.

But Helena's 'invisible' ones are heard

By STEVE HINTZ
IR Staff Writer

They are in some ways an invisible people, Helena's landless Indians. The U.S. Census Bureau doesn't acknowledge the existence of many, and the state of Montana has been hardly aware of the half of its Native American population living off reservations, according to Ed Kennedy, director of the Helena Indian Alliance.

But the alliance tried at legislative hearings this week to convey an image of urban Indian needs. And even though an appropriations subcommittee Wednesday voted down 6 to 5 a request for health care funds, Kennedy sees the close vote as "a victory of sorts."

"We were able to get a fair hearing. We're going to regroup and approach the full House Appropriations and Senate Finance committees" during the session that begins Monday.

The alliance hopes to receive at least $45,000 in block grant money to keep its medical clinic in full operation in the face of federal budget cuts. The request is included in a larger plea for $345,000 from Indian groups in six Montana cities.

At issue in Helena is whether the desperately poor landless Indians can continue to receive health care in a clinic run by their own people.

The alliance has turned to the state because Reagan administration budget recommendations call for the total elimination of Indian Health Service funds for such clinics.

Thus, the battle to educate government about the needs of urban Indians, won at the federal level just prior to the coming of Reagan budget cutters, must now be waged again before state officials, Kennedy notes wearily.

(More on INVISIBLE ONES, page 2B)

Invisible ones (Continued from page 1B)

Sitting at his desk above the clinic at 436 N. Jackson earlier this week, Kennedy was chagrined over the block grant process. If you believe the logic behind the program, he notes, it's the states, not the federal government, that know best who their needy citizens are.

But in the reports prepared for the upcoming session by the Governor's Office and the Office of the Legislative Fiscal Analyst, the landless Indians were not mentioned, he said.

Federal programs, on the other hand, have documented the problems of landless Indians: an unemployment rate ranging from 30 to 50 percent; a life expectancy of only 55 (15 years shorter than the average); an abnormally high suicide rate; poor housing.

Binding all these problems together is the double-faced tape of poverty and poor health.

Acting on the problems, the Indian Health Service gave the alliance money early this year to start and run the clinic. It is staffed full-time by a registered nurse by a doctor three afternoons a week.

Since January, 1,300 treatments have been received by members of a Indian population numbering about 3,000 in Lewis and Clark, Broadwater and Jefferson counties. (The latest census counted only about half that many, however. The canvassers miss many, and many Indians ignore the forms out of fear or resentment towards the government, Kennedy says.)

The clinic's work fills a vacuum, he belives. As members of tribes that never had a reservation, or that left the reservations in the 1950s to follow the dream of a better life in the cities promised by the Bureau of Indian Affairs, the Indians here don't have the resources available on those on reservations, he adds.

Most landless Indians have no health insurance. And even those on welfare entitled to Medicaid often resist going to white clinics; many who have tried have been refused, Kennedy claims.

Right now, the clinic — and the whole range of services offered by the alliance — are reeling from already enacted budget cuts. When the CETA program was cut, the alliance cut its staff from 30 to 7.

Reductions in Indian Health Service appropriations in October forced the cutting of several services at the clinic that were paid for on a contract basis. The clinic's doctors, David Jordan and Katherine Dawson, began working about 10 hours a week for free.

After the October crisis, local sources responded generously. Two local churches offered a total of $9,000, the United Way came up with $4,600 and God's Love Incorporated has promised $5,000.

If the state doesn't offer any help, the private funds will allow the clinic to pay about one half its costs. The staff insists it will work full-time for half pay.

"It's not easy for a local chruch to come up with $600 a month. The community believes in what we're doing. It's a Christian effort," Kennedy says.

Also, he stresses the clinic would not become a perpetual drain on state resources. He says the clinic was about one year away from becoming fully reliant on private funds.

The battle in the legislature is not lost yet, Kenneday says. The 6 to 5 vote against could be reversed, and money for health care exists in other block grants.

Much is at stake in the battle to keep the clinic open, he adds. "What we're talking about is our youth growing up with loss of hearing, with untreated intestinal diseases, with untreated diabetes... or not growing up at all."

INDEPENDENT RECORD
SATURDAY
November 7, 1981
Helena, Montana
Vol. 38 No. 342
Single copy 25c

Indian clinics will seek state money

By JAMES DeWOLF
IR State Bureau

A new and expensive burden will be dropped in the laps of state legislators Monday when operators of three non-reservation Indian health clinics make their case for first-time funding.

Spokesmen for the Montana United Indian Association say they have no choice but to ask for state money because they are facing an anticipated 100 percent reduction in federal funding.

The MUIA will present legislative testimony seeking $345,000 for each of two years. The money would pay for health clinics in Great Falls, Helena, and Missoula and transportation and referral programs in Anaconda, Butte and Miles City.

If the Legislature opted to fund only the clinics, the cost would be reduced to $285,000 annually and patients would be required to provide their own transportation from the outlying areas.

The urban health program is aimed at the more than 50 percent of Montana Indians who have left their reservations and no longer are eligible for tribal and Indian Health Service programs.

Urban Indians should be able to get medical services from doctors and programs that serve the rest of the population. But Ed Kennedy, director of the Helena Indian Alliance, said it doesn't work that way.

(More on CLINICS, page 12A)

Clinics (Continued from page 1A)

Kennedy said most of the patients his clinic serves are poor and they have difficulty convincing regular physicans they can pay for the service, even when they are enrolled in welfare assistance programs.

"The first question always is, 'How are you going to pay for this?' " Kennedy said. "We had a case yesterday in which a mother took her child to a Helena clinic for treatment of an epileptic seizure. She is an approved welfare patient but she didn't have the paper with her and they wouldn't treat the child.

"After a couple of occurences like that our people won't go to a regular physician unless they are very sick or about to die."

Because of poor health care the MUIA says middle age in the Indian population begins in the 30s with only a small percentage reaching senior citizen status, which begins at age 45.

Administrator Mike Welsh said the clinics are moving toward self sufficiency in fund raising from foundations, churches, medical insurance reimbursements and local charities.

"We are asking for a hand up, not a hand-out, for two years until we can become self supporting," Welsh said. "It was always our plan to get away from the federal funding but these cuts just hit too fast."

The clinics hire doctors and nurses on a part-time basis to provide preventive care and minor medical treatment. The average cost per patient visit is $18 and Montana has more than 100,000 potential patients.

Welsh said the clinics often prevent serious medical complications. The prevention reduces the cost to other welfare programs that pay the major medical expenses of the poor, he said.

Funding for the urban Indian health programs has been criticized since January. Congress has extended the program for another two years but the president is expected to veto the appropriation.

Kennedy said promises that block grants would make up the lost federal funding have fallen flat in the past few weeks.

"This is a long shot," he said of the state request. "But we have to try it."

KTVG INTERVIEW AIRED ON FRIDAY, 11-13-81
@ 5:30 & 10:00 p.m.

"The Montana United Indian Association says it will resubmit its funding request to the entire legislature on Monday. The action follows their 6 to 5 narrow funding defeat by a legislative sub-committee. John Deering has more." "Following the 6 to 5 defeat by legislative sub-committee, Montana United Indian Association Executive-Director, Ben Bushyhead, said his association will resubmit its funding request on Monday.

The defeat came after Senator Ed Smith, a Republican from Dagmar, said he had checked with unnamed Indian friends who told him that Indians not living on reservations were indeed receiving medical attention on reservations.

But as Mike Welsh, the Health Director of MUIA says, the existing law does not require Indians to actively live within reservation boundaries. 'John, this is a very complex issue and I would simply respond that Senator Smith may have asked his friends who are not privy to the Indian Health Service regulations and may also be living on or near the reservation. "On or near" is a concept that says that Indian Health Service contract services may be given to those people who live in a county adjoining an Indian reservation or in a county into which the boundary of an Indian reservation protrudes'.

Welsh said another official rule for Indian Health Service care is that it can't be given to anyone who has lived away from a reservation for more than 180 days. The MUIA is seeking 345,000 for each of two years to continue the operation of Indian Health Clinics in Great Falls, Helena and Missoula along with outreach transportation programs in Anaconda, Butte and Miles City. From the Montana United Indian Association, John Deering reporting for Newsline 12."

1- PM

November 20, 1981

To: Members of the Senate Finance and Claims Committee
From: Scot Felderman, Montana Pro-Choice Coalition Coordinator

In Opposition To HB 5: Changes in AFDC Grants to Pregnant Women

HB 5 would, ostensibly, only result in the limitation of AFDC grants to eligible women to the last trimester of her first pregnancy. It would, if enacted, affect 140 low-income women, with budget savings to the state of approximately $260,000 in 1982 and $577,000 in 1983.

But behind this innocuous facade lies a mueh more insidious bill. By its very definition this bill is directed at needy pregnant women. This is yet another attempt to balance the budget on the backs of those who can least afford it.

Montana Pro-Choice has long supported to concept of responsible reproductive choice. It is our firm belief that the decisions affecting pregnancy are among the most important any person can make. We also hold that should that decision be to carry pregnancy to term, that it should be done under the best circumstances possible in terms of the woman's physical and emotional well-being. This includes proper medical and nutritional attention, as well as a minimum of emotional distress over concerns such as housing and financial matters. We are vigorously opposed to any program cuts which would subject needy pregnant women to financial and emotional uncertainty and indeed advocate for continuation of support systems for her.

It has been argued that sufficient 'safety net' provisions, in terms of such programs as WIC, food stamps and subsidized housing, are adequate protection. Let it be understood, however, that those women who qualify for AFDC are, for all intents and purposes, destitute. It should also be understood that there are numerous gaps in the existing, shrinking, safety-net. WIC cutbacks are presently jeopardizing a program which, for example, is only able to meet the needs of approximately 20% of th...

women. In addition, the demand for subsidized housing already far exceeds supply and it is doubtful that a woman without children is eligible for such housing. Finally, it must be recognized that Food Stamps do not, and are not intended to, meet the true nutritional needs of those receiving stamps. It is a nutrtional supplement program.

Thus, it is not only questionable that these programs would be able to meet these basic needs, it is also questionable whether many people are even aware of these options. I might also add that the emotional distress in dealing with these programs is considerable and certainly we would not, given the option, want to subject either ourselves, friends or loved ones to that situation.

It should also be noted that it is often difficult for pregnant women to find suitable employment, if employment can be found at all.

In summation, Montana Pro-Choice supports whatever decision a pregnant woman makes regarding her pregnancy within the reasonable guidelines of Roe vs. Wade. We support a woman's decision to take her pregnancy to term and we support programs which provide the best possible circumstances.

As a final point, we would suggest that this decision (to pass HB 5) may result in some short term savings but eventual long term costs in so far as poor nutrition, and stress, do adversely affect both the woman and her developing fetus. As a simple matter of cost-benefit analysis it may prove prudent to continue funding for pregnant AFDC eligible women throughout the course of their pregnancy.

Respectfully submitted,

Scot Felderman
MPCC Coordinator
Box 902
Helena, Mt. 59624

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
DIVISION OF HOSPITAL AND MEDICAL FACILITIES

TED SCHWINDEN, GOVERNOR

COGSWELL BUILDING

STATE OF MONTANA

(406) 449-2037

HELENA, MONTANA 59620

November 20, 1981

TO: Senator Jan Johnson-Wolf
and Members of the Finance and Claims Committee

FROM: Bureau of Licensing and Certification
George M. Fenner, Administrator

Over two years ago, the Bureau of Licensing and Certification, Department of Health and Environmental Sciences, proposed a demonstration project to modify the annual survey requirements for hospitals. The project was still under consideration when the Department of Health and Human Services also became concerned about regulatory burdens imposed upon health care providers. As a result, the procedures now used to certify health care facilities for participation in the Medicare and Medicaid programs are being modified for less frequent surveys. There has already been a reduction of financial resources which has decreased survey staff and operating budget.

Montana has developed and submitted to the Health Care Financing Administration a plan to modify the survey frequency. This plan allows survey cycles of from one to three years.

The Bill is necessary to amend Section 50-5-204, MAC, which now requires annual surveys for licensure, so that the Bureau's survey activities will not be in violation of current state law.

House BILL NO. 8 (SSI)

INTRODUCED BY _____

BY REQUEST OF THE DEPARTMENT OF
HEALTH AND ENVIRONMENTAL SERVICES

A BILL FOR AN ACT ENTITLED: "AN ACT TO CHANGE INTERVALS BETWEEN INSPECTION OF LICENSED HEALTH CARE FACILITIES FROM 1 TO 3 YEARS; TO REQUIRE REPORTS FROM FACILITIES APPLYING FOR LICENSE RENEWAL IN ORDER TO DOCUMENT THAT THEY MET MINIMUM STANDARDS; AMENDING SECTION 50-5-204, MCA; AND PROVIDING AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 50-5-204, MCA, is amended to read:

"50-5-204. Issuance and renewal of licenses -- inspections. (1) ~~On~~ After receipt of a new or renewal application, and a determination by the department ~~or its authorized agent shall inspect the facility. If~~ that the facility meets minimum standards ~~are met~~ and the proposed or existing staff is qualified, the department shall issue a license for 1 year. If minimum standards are not met, the department may issue a provisional license for less than 1 year if operation will not result in undue hazard to patients or residents or if the demand for accommodations offered is not met in the community. The minimum standards which home health agencies must meet in order to be licensed shall be as outlined in 42 U.S.C. 1395 x(o), as amended, and in rules implementing it which add minimum standards.

(2) The department must inspect a new facility before an initial license is granted.

(3) An application for renewal of a license must be accompanied by a report, on forms provided by the department, containing such information as the department considers necessary to determine whether minimum standards are being met.

(4) The department may inspect a licensed health care facility whenever it considers it necessary and shall inspect each licensed facility at least once within the 3 years following the date of its last inspection.

~~(2) Licensed~~ The entire premises of a licensed facility shall be open to inspection, and access to all records shall be granted at all reasonable times."

Section 2. Saving clause. This act does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before the effective date of this act.

Section 3. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect

in all valid applications that are severable from the invalid applications.

Section 4. Effective date. This act is effective on January 1, 1992.

-End-

Montana
October 23, 1981

This Plan is proposed as a modification of total annual surveys requiring site visits. Modifications are necessitated by the reduction of financial resources which has decreased surveyor staff and operating budget.

PLAN

Hospitals and Long-Term Care Facilities

The Agency, after due consideration, has decided to adopt the HCFA proposal of one, two and three-year survey cycles.

For all hospitals and long-term care facilities, records containing the latest HCFA-2567 A, B, and E were reviewed. Criteria for the review was established involving all surveyor staff, and administration.

For each type of provider, a list of conditions and standards was used as a guide for file review. In the hospitals, the "statutory" standards were noted. A consensus was reached on key standards. At this point, we received a copy of a list of Key Requirements developed by the Central Office. This list introduced Class A, B and C requirements.

Class A requirements are those which, if not met, are most likely to have an immediate adverse effect on patient health and safety; Class B requirements, if not met, will likely adversely impact patient health and safety over a longer period; and Class C are all other requirements.

Consideration of these lists led to acceptance of the designations Class A, B and C as an addition to the lists we had developed.

Cycles were established:

3-year - all conditions, standards, statutory met
2-year - all conditions, key standards, statutory met
1-year - all conditions and statutory met, acceptable plan of correction for all key standards

Validated complaints will move a facility from a 2 or 3-year cycle to a 1-year.

Identification, by whatever means, of significant problems likely to have an adverse effect on patient health and safety will result in a partial or complete survey, or at least a written Plan of Correction.

Other Providers

Home Health Agencies

After the initial survey, a survey will occur within 12 months. If all conditions are met, a complete survey will be made every three years.

Independent or Out-Patient Physical Therapy

Initial survey only. Complaints or significant problems may dictate a survey.

End-Stage Renal Dialysis Units

Survey for initial certification and at one year. Then every three years unless expansion, relocation, or complaints trigger a full or partial survey.

Independent Laboratories

Initial certification and one year survey. Then every three unless additional specialties/sub-specialties are requested. If monitoring of quality control shows tests out of control for two consecutive quarters, a full or partial survey or at least a written Plan of Correction will be required.

Staffing Reports

Quarterly staffing reports will be required of long-term care providers.

Fire

Annually, all facility providers will be directed to submit information on fire safety: systems checks, fire drills, construction modifications.

Full or partial fire safety surveys will be done when physical plant modifications are completed.

STANDING COMMITTEE REPORT

November XX 20 19 81

MR. President

We, your committee on Finance and Claims

having had under consideration House Bill No. 4

Shontz (Dover)

Respectfully report as follows: That House Bill No. 4

BE CONCURRED IN

~~DO PASS~~

SENATOR HIMSL Chairman.

STATE PUB. CO.
Helena, Mont.

SENATE COMMITTEE FINANCE AND CLAIMS

Date 11/20 IN Bill No. 4 Time 4:20

NAME	YES	NO	ABSENT	EXCUSED
Senator Etchart	✓			
Senator Story	✓			
Senator Aklestad	✓			
Senator Nelson	✓			
Senator Smith	✓			
Senator Dover	✓			
Senator ~~Johnson~~ Walt	✓			
Senator Keating	✓			
Senator Boylan	✓			
Senator Regan		✓		
Senator Thomas	✓			
Senator Stimatz	✓			
Senator Van Valkenburg		✓		
Senator Haffey	✓			
Senator Jacobson		✓		
Senator Himsl	✓			
	13	3		

Sylvia Kinsey
Secretary

Senator Himsl
Chairman

Motion: Pass

STANDING COMMITTEE REPORT

November 20 1981

MR. President

We, your committee on Finance and Claims

having had under consideration House Bill No. 5

Keyser (Aklestad)

Respectfully report as follows: That House Bill No. 5

BE CONCURRED IN

SENATOR HIMSL Chairman.

STATE PUB. CO.
Helena, Mont.

STANDING COMMITTEE REPORT

November 20 19 81

MR. President

We, your committee on Finance and Claims

having had under consideration House Bill No. 6

Keyser (Keating)

Respectfully report as follows: That House Bill No. 6

BE CONCURRED IN

~~DO PASS~~

SENATOR HIMSL Chairman.

STATE PUB. CO.
Helena, Mont.

SENATE COMMITTEE FINANCE AND CLAIMS

Date 11/20/81 N. Bill No. 6 Time 4:38

NAME	YES	NO	ABSENT	EXCUSED
Senator Etchart	✓			
Senator Story		✓		
Senator Aklestad		✓		
Senator Nelson		✓		
Senator Smith		✓		
Senator Dover		✓		
Senator ~~Johnson~~ Walt		✓		
Senator Keating		✓		
Senator Boylan		✓		
Senator Regan	✓			
Senator Thomas		✓		
Senator Stimatz		✓		
Senator Van Valkenburg	✓			
Senator Haffey	✓			
Senator Jacobson	✓			
Senator Himsl		✓		
	5	11		

Sylvia Kinsey
Secretary

Senator Himsl
Chairman

Motion: Amend. Reg to delete "and others living etc"
as

STANDING COMMITTEE REPORT

November 20 19 81

MR. President

We, your committee on Finance and Claims

having had under consideration House Bill No. 7

) Waldron (Jacobson)

Respectfully report as follows: That House Bill No. 7

BE CONCURRED IN

~~DO PASS~~

SENATOR HIMSL Chairman.

STATE PUB. CO.
Helena, Mont.

H.C.

STANDING COMMITTEE REPORT

November 20 19 81

MR. President

We, your committee on Finance and Claims

having had under consideration House Bill No. 8

Winslow (Wolf)

Respectfully report as follows: That House Bill No. 8

BE CONCURRED IN

~~DO PASS~~

SENATOR HIMSL
Chairman.

STATE PUB. CO.
Helena, Mont.

fc