MINUTES OF THE MEETING OF THE HUMAN SERVICES COMMITTEE
March 11, 1983

The meeting of the Human Services Committee held Friday, March 11, 1983, 12:30 p.m. in Room 224A of the Capitol Building was called to order by Chairman Marjorie Hart. All members were present except Reps. Seifert and Solberg, who were absent, and Rep. Brand, who was excused.

SENATE BILL 209

SEN. DOVER, sponsor. This bill is an act to provide criteria for admissions to the Montana Center for the Aged; Revising the transfer and discharge procedure. He said SENATE BILL 209 would identify the centers function as one for elderly with mild psychiatric impairment associated with the aging process - make clear to the courts and other mental health facilities, the general public and legislators as to -- the centers responsibilities and capabilities, and sets up guidelines for development of staffing programs and administrative staff. This change is consistent with the Department of Institutions goal of clarifying the specific mission of each state institution. As the mission of the Center for the Aged has changed to fit within the overall continuum of services, it is important that such change receive legislative sanction.

PROPONENTS:

CURT CHISHOLM, Deputy Director, Department of Institutions, said this piece of legislation was introduced because they wanted to clarify and get away from the ambiguity that has been surrounding the Center for the Aged for a number of years, especially since the passage of the Mental Health Act in 1975. We do not want to limit admission only to those people who are in Warm Springs or Galen. This legislation would clarify the mission of the Center and indicate it as a nursing home.

OPPONENTS: None

QUESTIONS:

REP. FARRIS: Are people in temporary need of nursing home care sent there and then back to Warm Springs or Galen, or is this a permanent placement for these individuals.
CURT CHISHOLM: It is a permanent placement.

REP. SWIFT: This wouldn't impact the younger age group from obtaining treatment?
CURT CHISHOLM: That is correct.

REP. FABREGA: The way I read this--without the amendments, you could only transfer people there who had been committed to Warm Springs and not from Galen.
CURT CHISHOLM: That is correct.

REP. HANSEN: If a patient was younger than 55 years and needed temporary treatment, could they use this facility?
CURT CHISHOLM: Not in the way we have designed this piece of legislation. If an adult is under the age of 55, there are plenty of private nursing home care facilities. This would not be a place that could be used for emergency detention.

CHAIRMAN HART closed the hearing on SENATE BILL 209.

REP. SCHULTZ will carry the bill in the House if the bill is passed out of Committee.

SENATE BILL 200

SEN. VAN VALKENBERG, sponsor. Senate Bill 200 requires the Department of Health and Environmental Sciences to adopt rulesetting standards for participation in and operation of programs to protect the health of children and mothers, and handicapped children. The reason for the rulemaking authority--there is going to be a reduction of federal funds and that is going to mean less services are going to be provided. Some people receiving those services may not receive them in the future. There should be a public process by which the rules are established to determine eligibility criteria--what services the department can provide and what they cannot.

PROPONENTS:

DR. SIDNEY PRATT, Chief of the Clinical Programs Bureau of the Division of Health Services and Medical Facilities of the State Department of Health and Environmental Sciences, spoke in support of SENATE BILL 200 (EXHIBIT 2).

OPPONENTS: None

SEN. VAN VALKENBERG closed.

QUESTIONS:

REP. BROWN: On page 3, line 14 of the bill--was that amended out in the Senate and does that make any difference to the bill?

SEN. VAN VALKENBERG: It was amended out in the Senate. That amendment strikes the provision in the bill that the department had intended to utilize to set a percentage of payment for services. In the past, physicians who had provided services under the handicapped children's program had received about 60% of the normal and reasonable charges. That worked a considerable hardship on them. The department had made a commitment to physicians that they would raise that level to the same level that they were paying hospitals--90%. A representative of the hospital association appeared before the Senate and sought that amendment. It was made on the floor of the Senate with a one vote margin.
REP. BROWN: Is that an important thing to the department?
DR. PRATT: In trying to do what the impossible is--to balance the budget, it does have a definite impact. By having a reduced payment to providers by a definite percent, that left the limited amount of dollars to be spread farther among all the children of the condition we are covering. If the full charges were mandated to be paid, there would be a lot less money.
SEN. BROWN: Also addressed the same question to CHAD SMITH.
CHAD SMITH: Said he did not speak as an opponent to the bill with the bill as it was presented to the Committee. They argued against the amendment in the Senate. They would do the same in the House. What the amendment would do is impose price fixing on providers. They do not feel that price fixing is proper in a free society. There is nothing in the law that prevents the Board of Health from shopping for whatever facility they want to employ and to negotiate with that hospital or physician to come up with a fee that they feel is fair for the service. It was disclosed in the course of the testimony, they intended to impose a percentage-type discount or mandate a 90% charge basis which we strongly object to. If you have the costs apportioned in a nonprofit hospital and government comes in and insists as a mandatory limitation that the fee cannot exceed 90%, that means that the balance of that cost has to pour over to the other people that are using the services of that hospital. That is wrong--it is unfair. The option in a free society is to shop for the services you want and negotiate for the services you feel you should pay and then do business with the particular provider that gives you the best deal. This is designed to employ the type of discount that you now find in the medicaid system. Every time the government gets a discount, somebody else has to pick up the balance. He urged the Committee to follow the lead of the Senate

REP. DRISCOLL: The testimony of Dr. Pratt that because of lack of funds, they might have to lower from 185% to 150% of poverty level. Yet you are testifying that those people ahead of poverty level shouldn't take their cuts.
CHAD SMITH: We have no problem with the rules foreligility. We are entirely opposed to the system to have government come in without any justification and dictate what we are going to pay for a particular service from a privately owned provider.

REP. FABREGA: What are the mechanics of the bill. For instance a parent takes a small child for something they qualify--do they come to the department first for approval or go to the hospital?
DR. PRATT: The mechanism set up works primarily through the public health nurses in the various counties. The individual applies either by telephone or by word of mouth--the physicians know there is a condition that might be covered. They write to the department and the department responds with a letter saying take this form to your public health nurse. She helps them fill out the form which includes their income and a complete description. The form is sent back to the department. If they fit the eligibility criteria, then the next step is to write to the physician and get a diagnosis and treatment plan. If the diagnosis is something that fits into the medical conditions to be covered and they are in the eligibility criteria and we have the money, then we sign the authorization. In cases of emergency, with a telephone call, we will say the condition is covered and you go ahead. If you fit the financial criteria, then we will be able to pay.
REP. FABREGA: In most cases, you would have the ability to negotiate the cost on each individual case.
DR. PRATT: It is conceivable.
REP. FABREGA: On emergency cases, you are stuck with whatever the bill is.
DR. PRATT: That is correct. One of the situations that MR. SMITH brought up--we could shop around from hospital to hospital. That would be a real problem for people in Bozeman since there is only one hospital.

REP. FABREGA: When someone doesn't have insurance and the system doesn't pick up the tab, what happens to the bill?
CHAD SMITH: It becomes a bad debt and bad debts are added in as an additional cost of doing business.

REP. FABREGA: What you are saying--you would rather settle for zero than 80-90%.
CHAD SMITH: Our objection is if there is no negotiation, it becomes dictatorial.
REP. FABREGA: How do you negotiate after the fact in an emergency situation?
CHAD SMITH: The negotiation comes before the fact. The Department of Health is put in the position of working out these negotiations. We are not to set up the fees that they feel are fair and deal with the institutions that provide the fees. Most of the sophisticated types of services that you are talking about are not going to be performed in every hospital in the state. They are talking about certain services that require a great deal of skill. They will negotiate with those hospitals to perform those types of service. Emergency service can also be negotiated.
REP. FABREGA: You are saying that the department could actually negotiate beforehand for all cases that might come before the schedule of reimbursement based on 80%.
CHAD SMITH: Whatever they agree on.
REP. FABREGA: That could be done both for emergency and referral.
CHAD SMITH: As long as it is by agreement.
REP. FABREGA: The price you pay is sometimes you get zero and you put it to the rest of us.

REP. DRISCOLL: You may have to cut from 185 to 150%. Without this bill, can you still do that.
DR. PRATT: We could. It will just make it legal.
REP. DRISCOLL: If this bill died?
DR. PRATT: It could be contested.
REP. DRISCOLL: With the amendment the Senate put in, we are holding a safety net. The people between 185% and 150%, they just fall through yet the doctors and hospitals get full reimbursement.

REP. WINSLOW: Isn't there a limited amount of funds available?
DR. PRATT: That is correct. We have in round figures $550,000 per year at this time. We have a policy--first-come, first-served basis. We do have an encumbrance aspect to it. If we feel there is a $10,000 case, we cover the $10,000. If we find that insurance covers 80%, we can disencumber money and move on to the next people on the waiting list.

REP. FARRIS: Page 3, line 14--since there are only three communities in the state of Montana that have more than one hospital, then the argument that state government should operate on the free enterprise system is ridiculous.

REP. FABREGA: At the present time, our financial eligibility policy is that we accept those who are 185-150% poverty level now. Who has determined the eligibility policies?
DR. PRATT: Different federal programs have different levels. We have specified certain accredited proper federal limitations that put on through whatever program. The WIC program is based on 185% of poverty.
REP. FABREGA: Can you deviate from federal standards if state law authorizes you to do so.
DR. PRATT: You can.
DR. DRYNAN: In this particular program, these are block grant dollars from the federal government.
REP. FABREGA: You could do this with or without the bill. The bill gives you the rulemaking authority.
DR. DRYNAN: Without the bill, we are doing an illegal act.
REP. FABREGA: If the block grant doesn't give you guidelines, how do you establish guidelines?
DR. DRYNAN: The block grant gives you the programs and what these dollars can be used for within maternal child health.
REP. FABREGA: Do they say at 185% of poverty or lower if authorized by state law?
YVONNE SULLIVAN: I believe the maternal child and health block grant regulations state that you shall use a federally established poverty guideline as approved by the Office of Management and Budget. When these programs were categorical grants--as handicapped children's program was--there were specific regulations tied to the operation of that program. This is where the categories of care establishing maximum dollar amounts originated. Now, with the block grants, that particular item is gone so there is no authority to continue on even in federal regulations.

REP. DRISCOLL: In answer to REP. FABREGA's question, we continue them but they are illegal. If we do them, what is the punishment?
DR. DRYNAN: We are looking at contested court cases. Without this, we have the possibility of suit against the state.
REP. DRISCOLL: Or you can adopt rules that would take all of those people at 185% of poverty level until the money is gone.
DR. DRYNAN: I think before that would occur, the advisory council would begin eliminating the different types of handicapping conditions we could take care of.

REP. FABREGA: On whose authority did you set up the 185%?
DR. PRATT: The authority of the block grant gave us in the regulations that stated that we could work with a poverty level
REP. FABREGA: To be on the safe side, you use the maximum.
DR. PRATT: It seemed by going through charts and getting people who knew what those figures meant, we could give the best care to the largest amount of children.

REP. WINSLOW: What kind of guidelines did we have when these were categorical.
YVONNE SULLIVAN: We had a complex method of determining eligibility to receive services. We used the slide scale and we discounted if the family had large medical bills.

REP. WINSLOW: It would difficult to see where they would be on the scale.
YVONNE SULLIVAN: The 185% of poverty is a high level. The truly needy do fall within the 150-185% of poverty level because they are not eligible from any other payment from any other source.

CHAIRMAN HART closed the hearing on SENATE BILL 200.

SENATE BILL 293

SEN. HAGER, sponsor. This bill revises the laws relating to certificates of need for health care facilities. The bill revises the provisions relating to when a certificate of need is required, and the process for obtaining the certificate. He stated there have been considerable changes in health care technology, health care demands and health care costs since 1979. The most recent available consumer price index indicates costs of goods and services have increased 25% while costs for medical care has increased by 11%. There is no question that some of the health care increases have been brought about by advancement in diagnosis and treatment technology. A good part of what certificate of need is all about is to see that those sizeable investments in technology and new services are made in a fair and logical manner in Montana. He discussed the proposed amendments.

PROPONENTS:

STEVEN PERLMUTTER, Attorney, Department of Health and Environmental sciences, read through the bill page by page. He stated that in drafting this bill, they attempted to achieve compliance and consistency. Their main concern was to address the needs of the state of Montana.

GARY WALSH, Administrator for the Economic Assistance Division for SRS, presented two amendments they would like to offer in relation to this legislation.

1. Page 12, line 24.
Following: "~~50,000~~"
Strike: $100,000
Insert: $50,000

2. Page 22, line 18.
Following: "conditions"
Strike: ", BUT ONLY IF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS APPROVED AN AMENDMENT TO THE STATE'S MEDICAID PLAN, ADOPTED PURSUANT TO 42 U.S.C. 1396A, ALLOWING FOR THE IMPOSITION OF SUCH CONDITIONS"

KEN RUTLEDGE, Vice-President, Montana Hospital Association, said since there appears to be genuine agreement on this bill with the exception of the two proposed amendments, he would not restate his reasons for supporting this legislation. He stated in changing the operating figure of $100,000 back to $50,000, they were talking about capital costs or depreciation costs associated with new services. Plus, they were talking about any kind of interest costs associated with financing and also those supplies that are needed. They were also talking if it requires the addition of staff--salary and benefits of that person. What they are saying, with the threshold of $50,000 is that if you have one person and a few supplies and you add your capital costs, it would mean that just about any addition of services in a hospital--a minimal type of equipment would be covered. He checked to see what the neighboring states had in the area of thresholds for new institutional house services. The lowest was New Mexico with a figure of $200,000. The majority of the states have figures in the amount of $300,000 to $400,000 before new institutional house services have to be reviewed. He thought the $100,000 figure is very reasonable.

ROSE SKOOG, Executive Director, Montana Health Care Association, said they would like to go on record as supporting SENATE BILL 293. There is one area of concern to them in the bill and it has to do with the amendment proposed by the Department of SRS--on page 22, where the medicaid budget is tied to the certificate of need process. They support the bill as it is. They urge not to adopt the amendment offered by SRS. This provision applies only to long-term care facilities. If there was to be a new long-term care facility

of if there was to be an addition of beds to an existing long-term care facility, a certificate of need is required and we need to go through a particular process--make application, provide supporting documents and go through the hearing process. The certificate of need is then granted or denied based on whether or not the state health plan shows that there is a need for long-term care beds. The medicaid provision in this legislation says if there is a need determined but if SRS does not feel that the medicaid budget could afford for people to be in those beds, there could be a restriction placed on the certificate of need that says--yes, you may bill those beds because they are needed but medicaid recipients can't use them. Only people who can afford to pay for their own care can use them. It doesn't seem right that you would limit access to medicaid eligible people. Federal medicaid requirements preclude a state from limiting access of medicaid eligible people to a service. Because we were concerned that this provision was contrary to federal law, we did get a legal opinion from a Washington, D. C. law firm that deals with certificate of need problems on a regular basis (EXHIBIT 3). The opinion we are getting is that this kind of limiting of access is probably contrary to medicaid law but also to health planning law which makes sure that low-income people have access to care. We offered the sentence that is in there as a compromise. We feel that this provision is contrary to medicaid law and it would not be approved by the Secretary of Health and Human Services if the department submitted it. Rather than take that provision out completely, we said to put a provision in to make certain that they do go to the Department of Health and Human Services with a planned amendment. If the Department of Health and Human Services says that this scheme is legal, then it will be operational. If the planned amendment is not approved, this particular provision in this bill would not be able to become operational and we would continue to be in compliance with the federal medicaid law. When she offered the amendment to the Senate Committee, the Committee asked Mr. LaFavor whether or not that provision would be acceptable to him. He said it would. A couple of days later, he sent a memo over to the Committee saying he changed his mind. He talked to the feds and we don't really want to do this. She found out the representative that Mr. LaFavor talked to and found out she had strongly urged them not to be trying to put this kind of provision in place because it would probably wouldn't pass muster with the federal medicaid program.

She sent word back to the Committee and explained that she had information slightly different from what they were getting some place else. If the department is so certain that it is an allowable process, she didn't know why they were so adamantly opposed to having drafts but she thought the provision was in there as a protection to make sure that they are in compliance with their medicaid program. If the feds decide it is all right, it will go into place. If it isn't, then we should not be out of compliance with the federal medicaid law, anyway. She strongly urged this bill be concurred in in its present form and not to accept the amendment.

ADA WEEDING, chairman of the eastern Montana Subarea Advisory Council and a member of the governing board of the Montana Health Systems Agency, said it is very important that, as a consumer, she have some input as to the health care system in this state, and more importantly, in her own local area (EXHIBIT 4).

SHARON DIEZIGER, representing the Montana Nurses' Association, said that during the past four years, the certificate of need law has served to reduce duplication of services, protect the stability of existing services, encourage long-range planning and promote cooperative service development. The stability offered by the certificate of need program has promoted private investment and acquisition while encouraging operating efficiencies. SENATE BILL 293 contains the series of amendments to the certificate of need law which have been developed to streamline the processing of applications and reduce the administrative burden on providers while maintaining the integrity of the certificate of need process as a cost control system. She opposed any attempt to amend this bill at this point (EXHIBIT 5).

JERRY LOENDORF, Montana Medical Association, said he supported the bill but would oppose the amendments offered today.

GEORGE FENNER, representing the Health Services and Medical Facilities Division of the Department of Health and Environmental Sciences, stated that all too often legislators are expected to balance the needs of conflicting interests. They are pleased to have contributed to the development of this compromise legislation and they urge its approval by this Committee in the form it is presently written (EXHIBIT 6).

OPPONENTS: None.

SEN. HAGER closed saying the Committee did adopt the second amendment (page 22). It would give the Department of SRS an out and it did seem to satisfy the problems with the other people.

QUESTIONS:

REP. DRISCOLL: If there is a need for more rule, but there isn't any money, what are we going to do.
SEN. HAGER: This has to do with the medicaid budget. To make this budget, they figure how many beds they will have in the state. It is for them so they would be able to keep from having to O.K. more beds than they would have funds for.
REP. DRISCOLL: As I read the bill, it has to be approved for a certificate need for more beds for long-term care facilities. If that need is established, but there are no funds to pay--when patients go into those rooms and the Secretary of the U. S. Department of Health has not approved the amendment, then what does SRS do?
SEN. HAGER: The department has a right to make these rules if the federal government says we can do that.
ROSE SKOOG: The reason we are asking that this be approved through Health and Human Services is because federal law makes no provision for a state not to fund medicaid eligible people in a medicaid service once the state decides to opt into the medicaid program and provide that service. We think this is contrary to federal medicaid law.
REP. FABREGA: What happens if you get 100 more cases than what you anticipated in the biennium.
GARY WALSH: We have those outside limits and we have to live within that budget. If the amount of money we have available is not sufficient, we are obligated to cut back in terms of service in order to accomplish that to keep the program within the amount of budget we have.
REP. FABREGA: What you're saying is that by refusing to allow the availability of additional beds, you are going to be able to close your eyes to those that would be qualified because the beds don't exist.
GARY WALSH: Our intent is to come up with some provision that would allow us to contain the cost.
REP. FABREGA: Is it realistic to say if we could prevent the beds from developing, we have prevented the demand.
GARY WALSH: Our interest is primarily a financial one. We are obligated to stay within the budget as set forth in the Legislature.

REP. FABREGA: If the individuals qualify for medicaid beds, can you say--sorry, you qualify but there is no bed available.
GARY WALSH: There are some different factors to play into that. If an individual is eligible, then the access cannot be restricted to the service they are eligible for. It is our anticipation that we are able to tie in the number of beds to the budget.

REP. WINSLOW: I believe we put language into that--rather than cut those services, you are to come to the next legislature for supplemental monies. I know the department did not want to do that but it is the intent of this Legislature that those people receive those services.
GARY WALSH: Our concern is that the state law doesn't allow us that provision.
REP. WINSLOW: That is what you have been instructed to do.

REP. FABREGA: As I understand it, the long-term care is the number one mandate, is that correct?
GARY WALSH: Approximately half of the medicaid budget does go for long-term care. Under the existing medicaid plan, there are twelve mandatory as well as optional programs provided.
REP. WINSLOW: Does SRS have the right to drop optional services without legislative intent?
GARY WALSH: We would have to go through the administrative rules process.

REP. FABREGA: The language that you inserted in the Senate says that unless the Secretary of Health and Human Services approves a limitation of availability of long term care, that would not be a condition that SRS could impose.
ROSE SKOOG: That is correct.
REP. FABREGA: And your position is that medicaid long term is the priority in mandating?
ROSE SKOOG: Our position is that what the department is trying to do isn't permissible under the medicaid program.

REP. FABREGA: What is the cost of financing equipment?
HOSPITAL PERSONNEL: We are looking at taxable financing--higher rates--13 or 14%. The tax exempt rate would be below 10%. The majority of the construction that goes on is done at tax exempt financing.

REP. FABREGA: Are the limits once a year or per project?
HOSPITAL PERSONNEL: The $750,000 is per project.
REP. FABREGA: Is that on an annual basis?
HOSPITAL PERSONNEL: We are only talking about the offering of a service that has not been previously offered. The $750,000 applies to any kind of capital expenditure regardless of what its purpose is. The $500,000 figure refers to the purchase of a single piece of equipment.

CHAIRMAN HART closed the hearing on SENATE BILL 293.

EXECUTIVE ACTION

SENATE BILL 200

SEN. VAN VALKENBURG, sponsor. This bill requires the Department of Health and Environmental Sciences to adopt rules setting standards for participation in and operation of programs to protect the health of children and mothers, and handicapped children.

REP. FARRIS: Moved that SENATE BILL 200 BE CONCURRED IN.

REP. DRISCOLL: Moved that on page 3, line 14, insert stricken language.

REP. FABREGA: While I would agree in spirit that that is one way to stretch the money; if you pass on arbitrary reimbursement, there could be refusal except in cases for emergency.
REP. DRISCOLL: One group wants to have the department reimburse them at full costs of their expenses. If you reinsert that language and adopt rules for payment of services and if they are going to adopt rules for everything else, why not for that.
REP. WINSLOW: You are then saying you are willing to pick up the costs. If you don't have the money to operate, you are going to have to shift the costs to someone else.

REP. FARRIS: I speak in support of the amendment. All during December, people were talking to me about hospital cost containment. For hospitals or doctors, for that matter, to say to a state agency that they refuse to take medicaid or medicare patients simply because they feel they are not getting proper reimbursement for services, there has to be some way to cap these costs that go up and up. It is easiest to look at staff costs but there are areas of slack in all budgets that could be addressed.

I think reinserting the language is a way to tell people we are not in a time of expansion any longer and everybody is going to have to take a good hard look at where the money is going.
REP. FABREGA: I disagree. Because the majority of these services are provided, there is a time frame where somebody calls to find out if they are qualified in an emergency situation. What SRS can do is negotiate with the hospitals on a collective bargaining arrangement. I think by rule-making, they could do it arbitrarily.
REP. WINSLOW: REP. FARRIS said these people should not be able to set the price. Well, who should set the price? Should the state sit up and decide how much it costs to handle the services in some facility. I don't think that is right.

The vote was taken to reinsert the stricken language. The motion FAILED with REPS. FARRIS, DARKO, DOZIER, DRISCOLL, HANSEN and MENAHAN voting yes and REPS. BROWN, CONNELLY, FABREGA, KEYSER, JONES, SWIFT, WINSLOW and CHAIRMAN HART voting no.

Question was called on the original motion that SENATE BILL 200 BE CONCURRED IN.

The motion PASSED with REP. DRISCOLL voting no.

SENATE BILL 209

SEN. DOVER, sponsor. This will would permit the Department of Institutions to adopt rules concerning admission to the Montana Center for the Aged. The bill also gives the department responsibility for discharging patients from the Center rather than the state hospital superintendent.

REP. FABREGA: Moved SENATE BILL 209 BE CONCURRED IN.

REP. HANSEN: The 55 years bothers me. Does that mean someone 54 years can't get in if they need to be
REP. MENAHAN: The Home for the Aged is 55 so they don't put other people in there who don't belong there.

The motion was voted on and PASSED with REPS. DRISCOLL and CONNELLY voting no.

SENATE BILL 107

SEN. BLAYLOCK, sponsor. This bill would require disability insurance policies and contracts to provide basic levels of benefits for the treatment and care of mental illness, alcoholism, and drug addiction. Currently, such coverage must be made available by insurer, but is not required in group policies. The bill would apply to policies and contracts delivered or issued after December 31, 1983.

REP. FABREGA stated he wanted to submit some amendments that would segregate alcoholism from the coverage and it would allow $4,000 in any 24 month period and $8,000 for any life time benefit. I discussed it with the providers of insurance and also with the providers of service. Unless you want the rate to go completely out of control, I think it would be prudent that we mandate a given exposure level so they can develop the rates based on that exposure rather than make possible assumptions and increase premiums.

It was suggested that SENATE BILL 107 be held until Monday.

SENATE BILL 193

SEN. CONOVER, sponsor. This bill would change the standard of medication for mentally ill patients from those advocated by the U. S. Food and Drug Administration to those "consistent with current medical practice".

REP. FARRIS: Moved that SENATE BILL 193 BE POSTPONED FOR THE DAY.

The meeting adjourned at 2:25 p.m.

Marjorie Hart
CHAIRMAN MARJORIE HART

Gene Brusett
Secretary

Ex 1
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SENATOR HAROLD L. DOVER

SENATE BILL 209

AN ACT TO PROVIDE CRITERIA FOR ADMISSIONS TO THE MONTANA CENTER FOR THE AGED; REVISING THE TRANSFER AND DISCHARGE PROCEDURE; AMENDING SECTIONS 53-21-411 THROUGH 53-21-413, MCA

Senate Bill 209 has been introduced to clarify the mission of the Montana Center for the Aged in Lewistown and to establish basic admission procedures.

The statutes currently define the Center as a mental health facility. This obligates the center to meet the same treatment and transitional goals as Warm Springs State Hospital.

SB 209 clarifies the role of the center in the overall health service delivery system. It states - page 1, lines 14-18, "The primary function of the center is the care and treatment of persons 55 years of age or older. Priority must be given to patients referred from Warm Springs state hospital or Galen state hospital."

The center provides long term care for individuals, as stated on page 2, lines 17-21, "...persons unable to maintain themselves in their homes or communities due to mile psychiatric impairments associated with the aging process but who do not require the intensity of treatment available at Warm Springs or Galen state hospital." For the vast majority of these people, the psychiatric disability is of a chronic nature, often accompanied by physical deteriation that is associated with old age. The

function of the center is to provide a safe and human environment which recognizes human dignity as these elderly people adapt to long term care at the center. The center is not a transitional mental health facility.

SB 209 would identify the centers function as one for elderly with mild psychiatric impairment associated with the aging process - make clear to the courts and other mental health facilities, the general public and legislators as to - the centers responsibilities and capabilities, and sets up guidelines for development of staffing programs and administrative staff. This change is consistent with the Department of Institutions goal of clarifying the specific mission of each state institution. As the mission of the Center for the Aged has changed to fit within the overall continuum of services, it is important that such change receive legislative sanction.

Ex 2
SB 2

TESTIMONY BEFORE THE HOUSE COMMITTEE ON HUMAN SERVICES

Madam Chairman and Members of the Committee: For the record, I am Dr. Sidney Pratt, Chief of the Clinical Programs Bureau of the Division of Health Services and Medical Facilities of the State Department of Health and Environmental Sciences. Among my responsibilities are administration of the Maternal and Child Health and Handicapped Children's Programs. I am here to support S. B. 200.

The objectives of the Handicapped Children's Program, in particular, are the early detection, diagnosis and rehabilitation of children with chronic handicapping conditions. These activities include initial evaluation and diagnosis as well as payment of hospitalization and medical expenses for those conditions which Handicapped Children's Services covers. Recognizing that it would be ideal to cover all conditions for children between ages 0-18, we must also realize that fiscal limitations make such total coverage impossible. We have developed a list of covered conditions with the assistance and advice of the Advisory Committee made effective July 1, 1982. It should be noted specifically that acute conditions are not covered and that respiratory distress syndrome, a result of prematurity and the principle cause of premature death, as well as no conditions of the gastrointestinal tract are covered.

At the present time, our financial eligibility policy is that we accept those who are at 185% of poverty level as defined by the federal government. This may necessarily be reduced to 150% of poverty level in order to even meet the needs of those people we are presently covering. This could be forced on the program if the cost of medical care and hospitalization continues to rise and our federal allocations do not keep up with this cost increase.

We have also established the policy that, after third party payment, we pay hospitals, physicians, and dentists at 90% of the usual and customary fee. When they sign the agreement to take care of any one patient, they agree to accept this as payment in full and not bill the family for the differential. This would be difficult to enforce if this policy is challenged.

In addition, a maximum payment of $10,000 for any one child in any one calendar year has been set.

An additional policy has been developed and adhered to over a period of years that payment will be made for services rendered only by board eligible or by board certified physicians except under emergent or special conditions. The rationale behind this is that these delicate patients should receive only the best of care.

At the request of committee members, with the approval of the chair, I will be pleased to respond to any questions.

Thank you.

VISITOR'S REGISTER

HOUSE HUMAN SERVICES COMMITTEE

BILL SENATE BILL 200 DATE 3-11-83

SPONSOR SENATOR VAN VALKENBURG

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP-POSE
E.C. Pratt	Helena	DHES	X	
Sylvia	Helena	DHES	X	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

FORM CS-33

Ex 3
S6 29

Pierson, Ball & Dowd

Client Memorandum

TO: American Health Care Association

DATE: February 3, 1983

RE: Validity of State Legislation Limiting Certification of Medicaid Beds Through Certificate Of Need Authority

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You have requested our opinion as to the legality under federal law of legislation currently being proposed in Montana. This legislation would effectively authorize the state to place a limitation on the number of Medicaid-certified beds in long-term care facilities through use of the state's certificate of need authority. Under this proposal, the state would, under certain circumstances, be permitted to restrict the beds available for Medicaid beneficiaries. Ostensibly, the state would accomplish this through its certificate of need legislation and would not amend its Medicaid state plan, thereby attempting to circumvent the plan approval authority of the Secretary of the United States Department of Health and Human Services ("Secretary"). Montana's proposed legislation raises many of the same issues posed in several other states when authority was sought, through an amendment to the Medicaid state plan, to establish a cap on the number of Medicaid-certified beds.

Montana's proposed legislation and similar proposals pending in other states raise the following questions which are addressed in this memorandum: (1) whether a state that seeks to restrict Medicaid certification of long term care beds through its certificate of need authority must reflect this restriction in a Medicaid state plan amendment and, if not, whether such a restriction is still reviewable under Medicaid statutory and regulatory requirements; (2) whether, assuming the appropriateness of Medicaid reviewability, such a restriction conforms to Medicaid requirements (and who bears the burden of establishing conformity or lack of conformity); and (3) whether such a restriction, if either not reviewable under Medicaid requirements or in conformity with those requirements, violates federal health planning laws. In each section discussing these issues, we have summarized the legal arguments that would be relevant to resolution of these issues.

I. Reviewability Of The Proposed Legislation Under Medicaid Requirements

Section 50-5-304(2) of the proposed Montana legislation provides in effect that, as to new long term care beds, the state department of social and rehabilitation services may restrict the number of Medicaid-certified beds by inserting a "certified bed" limitation in the facility's certificate of need if the department finds that an increase in certified

beds would produce increased Medicaid utilization for long term care facilities, causing the state to exceed its Medicaid budget. Under the proposed legislation, the availability of Medicaid funding could be the basis for imposing such a condition, but it could not be the sole basis for denying a certificate of need.

It may be argued that this proposal cannot become effective unless it is incorporated into and approved by the Secretary as part of the state's Medicaid plan. Under 45 C.F.R. § 205.5(a):

> A State plan under title...XIX of the Social Security Act must provide that the plan will be amended whenever necessary to reflect...material change in any phase of State law, organization, policy or State agency operation.

Imposing a limitation on Medicaid-certified beds in long term care facilities arguably constitutes a "material change" in state law because of its potential effect on eligible Medicaid beneficiaries who may require nursing care but are precluded from receiving such care due to the unavailability of certified beds resulting from certificate of need limitations. Thus, the proposed law seems to represent a material change that must be reflected in the state plan as an amendment if the state wishes to continue participating in the Medicaid program. See also Kentucky Association of Health Care Facilities v. Department for Human Resources, No. 80-49 (E.D. Ky. Mar. 31, 1981), reported in CCH Medicare & Medicaid Guide

¶ 30,995 (1981-1 Transfer Binder) (where, although Court did not rule on merits, it suggested that there was probably a violation of federal law because of failure to submit Medicaid bed quota as Medicaid plan amendment for Secretary's approval).

In addition, under 42 U.S.C. § 1396c, the Secretary is empowered to review the operation and administration of Medicaid state plans to ensure that they comply with legal requirements. Thus, even if the Secretary did not review the proposed restriction as part of a Medicaid plan amendment, the Secretary could nevertheless use Medicaid requirements to evaluate that restriction as it affects the operation of the Medicaid plan. See also PIQ-MMB-77-5 (Aug. 18, 1977) at pp. 2-3 (in which the Secretary, in response to an inquiry concerning Medicaid certification limits, stated that the Medicaid program -- rather than certificate of need authorities -- is responsible for decisions concerning providers).

II. Limitations On Medicaid-Certified Beds May Be Illegal Under Medicaid Law

The restrictions on Medicaid-certified beds proposed under the Montana legislation and under similar legislative schemes in other states could conflict with Medicaid law and thus be illegal, regardless of whether they are properly introduced as an amendment to a state plan.*/ The applicable

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*/ It should be noted that the Secretary has disapproved proposed amendments to the state plans of Mississippi and South Carolina where those amendments would have authorized the state to limit the number of Medicaid-certified beds. In each instance, the state requested a hearing as to the disapproval but ultimately withdrew the proposal. Kentucky proposed a similar limitation but withdrew it before the Secretary reviewed it. The legal arguments discussed in this section were the bases for the Secretary's actions in Mississippi and South Carolina.

Medicaid provisions that could invalidate this type of limiting legislation are summarized in this section of the memorandum.

A. The "Reasonable Promptness" Provision

Under § 1902(a)(8) of the Social Security Act, 42 U.S.C. § 1396a(a)(8), a state plan for medical assistance under the Medicaid program must provide:

> that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals; (Emphasis supplied.)

This statutory requirement that Medicaid beneficiaries be provided medical assistance with reasonable promptness suggests that any substantial delay in making requested medical assistance available to an eligible beneficiary is directly contrary to Medicaid law. A state statute authorizing a cap on Medicaid-certified beds might well produce a demand for beds from eligible Medicaid beneficiaries that exceeds the limited number of beds available to them. This excess demand would necessitate the creation of waiting lists for certified beds. If a state cannot make a bed available to an eligible beneficiary with reasonable promptness, the resulting delay would be contrary to Medicaid law.

B. Amount, Duration, And Scope Requirements

Under an applicable Medicaid regulation, 42 C.F.R. § 440.230,

each service that a state provides under its Medicaid program must be sufficient in amount, duration, and scope to achieve its purpose. Under this regulation:

> (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service...to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

Most states, including Montana, provide both skilled nursing and intermediate care in their Medicaid plans. Where they are part of a state's Medicaid plan, these services must be made available in sufficient amount, duration, and scope to achieve their purposes. If a medical determination is made that a particular beneficiary requires long term nursing care, but such care is not readily available because of state limitations on Medicaid-certified beds, the duration of that beneficiary's ultimate stay could be reduced substantially. Such a reduction in duration of a required Medicaid service would be arbitrarily applied to patients in need of long term care (as opposed to beneficiaries in need of other types of care or services) and, therefore, would be contrary to this Medicaid regulation.

C. Required Certification Absent Good Cause

In the Mississippi and South Carolina cases, the Secretary took the position that the Medicaid regulation governing provider agreements with certified facilities, 42 C.F.R.

§ 442.12(d), requires a State either to enter into a provider agreement for all certifiable beds in a facility or to decline to enter into a provider agreement at all. A state may refuse to enter into a provider agreement with a facility only for "good cause." According to the Secretary, "good cause" to refuse to enter into a provider agreement may be found under only three circumstances:

1. a facility fails to meet certification requirements (i.e., conditions or standards of program participation);
2. the facility is located in an "overbedded" area; or
3. the facility charges excessively high rates.

A state's budgetary constraints, therefore, are not a recognized reason for refusing to certify a facility or its certifiable beds. Since Montana's proposal and similar pending legislation are tied to budgetary concerns, this is not sufficient reason to refuse to certify "certifiable" beds in a facility.

D. Burden Of Proof

In the Mississippi and South Carolina proceedings as well as in PIQ-MMB-77-5 (Aug. 18, 1977), the Secretary indicated that, in instances where the state imposes restrictions on Medicaid certification of beds, the state bears the burden of proving that these restrictions do not violate Medicaid requirements. This means that such restrictions will not be

approved unless the state first demonstrates through relevant data and evidence that the restrictions will not contravene the requirements that have previously been discussed.*/ Mere undocumented assertions by the state that the restrictions are not unlawful are not sufficient to obtain approval.

III. Legal Considerations Under Federal Health Planning Requirements

Assuming that proposed legislation like Montana's is either not subject to review under Medicaid requirements or is held to conform to those requirements, there is still substantial question whether it meets federal health planning requirements. Under these requirements, the state -- in deciding whether to issue certificates of need -- must consider the effect which its actions would have on the population's accessibility to health care and, in particular, the accessibility which traditionally underserved groups (including low income groups) would have to such care.

For example, in the Congressional findings contained in the National Health Planning and Development Act, Congress stated that there was an inadequate supply or distribution of health resources, that equal access for everyone to such

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*/ In PIQ-MMB-77-5 (Aug. 18, 1977), the Secretary also suggested that the state would have to show as well that the restriction: (1) does not discriminate against patients requiring nursing care; (2) does not interfere with patients' freedom of choice of provider (see 42 U.S.C. §§ 1396a(a)(23) and 1396n); (3) does not violate the requirem that the plan be statewide in operation, including providing reasonable access on a geographic basis (42 U.S.C. § 1396a (a)(1)); and (4) does not discourage, by virtue of fee structures, enlistment of sufficient providers to assure that beneficiaries receive care at least to the extent it is available to the general population (42 C.F.R. §447.204).

resources was not a reality, and that a maldistribution of health care facilities and manpower existed. 42 U.S.C. § 300k(a)(2) and (3)(B). Congress also specified that, in addition to any other regulatory criteria established by the Secretary, health systems agencies, state health planning and development agencies, and statewide health coordinating councils were to consider, among other things, the need that the population to be served has for the proposed services and the extent to which the proposed services would be accessible to all residents in the service area. 42 U.S.C. § 300n-1(c)(3) and (6)(E).

In the federal regulations governing state certificate of need laws like Montana's, the Secretary has enumerated a number of criteria which the states must consider when administering those laws. Although the states have flexibility to add additional criteria, those provisions may not be inconsistent with the Secretary's criteria. 42 C.F.R. § 123.402(a). Among the Secretary's criteria are the following considerations (42 C.F.R. § 123.412(a)(5)(i) and (6)):

> the extent to which all residents of the area, and in particular low income persons, racial and ethnic minorities, handicapped persons, and other underserved groups and the elderly, are likely to have access to those services.
>
> * * *
>
> [t]he contribution of the proposed service in meeting the health related needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services (for example, low income persons, racial and ethnic minorities, women and handicapped persons)....

Moreover, detailed findings as to access must be made. 42 C.F.R. § 123.413.

It may be argued that Montana's proposed legislation contravenes these requirements because it essentially compels the state to deny or delay low income persons (i.e., Medicaid beneficiaries) access to long term care in instances where there is an undeniable need for such care. Under federal law, the need for such care is supposed to be one of the factors employed when a certificate of need is issued. Montana's proposal, however, would require that where there is a finding of need, coupled with an impending budget crisis, access of certain groups to that care should be curtailed. In sum, it is difficult to square Montana's proposal -- which would restrict access when there is a utilization need -- with federal laws seeking to assure access if there is a demonstrated need for care.*/

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*/ Montana may argue that its proposal does not prevent issuance of a certificate of need but merely imposes certain conditions on it. As to low income groups, however, a certificate of need which forbids or seriously limits Medicaid participation differs in no material respect from an outright denial of the certificate of need. Interestingly, a comparison of Montana's proposed certificate of need criteria (Section 5-5-304(1)(a)-(n), MCA) with the Secretary's regulatory criteria (42 C.F.R. § 123.412(a)(1)-(21)) shows that the proposal has, in fact, deleted much of the language concerning the access criterion.

IV. Summary

In the absence of detailed findings and evidence of which we are unaware, it is doubtful that Montana's proposed legislation complies, either on its face or as it would be applied in particular instances, with federal Medicaid and health planning requirements.

SB243

EX 4
SB2

I AM ADA WEEDING. MY HUSBAND AND I OPERATE A RANCH OUTSIDE OF JORDAN, MONTANA.

I AM CHAIRMAN OF THE EASTERN MONTANA SUBAREA ADVISORY COUNCIL AND A MEMBER OF THE GOVERNING BOARD OF THE MONTANA HEALTH SYSTEMS AGENCY. I ALSO REPRESENT CONSUMER INTERESTS AS A MEMBER OF THE GOVERNOR'S STATEWIDE HEALTH COORDINATING COUNCIL.

I THINK IT IS VERY IMPORTANT THAT, AS A CONSUMER, I HAVE SOME INPUT AS TO THE HEALTH CARE SYSTEM IN THIS STATE, AND MORE IMPORTANTLY, IN MY OWN LOCAL AREA.

THE CERTIFICATE OF NEED PROCESS AFFORDS THE OPPORTUNITY FOR CONSUMERS TO PROVIDE NECESSARY TESTIMONY AND STATEMENTS WHICH HELP DIRECT THE DECISION-MAKING PROCESSES REGARDING THE HEALTH CARE SYSTEM AND DELIVERY OF SERVICES.

THANK YOU.

I AM SHARON DIEZIGER. TODAY I AM REPRESENTING THE MONTANA NURSES' ASSOCIATION, HOWEVER, I AM ON THE MONTANA HEALTH SYSTEMS AGENCY GOVERNING BOARD AND THE GOVERNOR'S STATEWIDE HEALTH COORDINATING COUNCIL. I HAVE BEEN ACTIVE IN THESE ORGANIZATIONS FOR MANY YEARS.

DURING THE PAST FOUR YEARS, THE CERTIFICATE OF NEED LAW HAS SERVED TO REDUCE DUPLICATION OF SERVICES, PROTECT THE STABILITY OF EXISTING SERVICES, ENCOURAGE LONG-RANGE PLANNING AND PROMOTE COOPERATIVE SERVICE DEVELOPMENT. IN ADDITION, THE STABILITY OFFERED BY THE CERTIFICATE OF NEED PROGRAM HAS PROMOTED PRIVATE INVESTMENT AND ACQUISITION WHILE ENCOURAGING OPERATING EFFICIENCIES.

SENATE BILL 293 CONTAINS A SERIES OF AMENDMENTS TO THE CERTIFICATE OF NEED LAW WHICH HAVE BEEN DEVELOPED TO STREAMLINE THE PROCESSING OF APPLICATIONS AND REDUCE THE ADMINISTRATIVE BURDEN ON PROVIDERS WHILE MAINTAINING THE INTEGRITY OF THE CERTIFICATE OF NEED PROCESS AS A COST CONTROL SYSTEM.

THIS BILL IS THE RESULT OF SUCCESSFUL NEGOTIATION AND COMPROMISE BY REGULATORY AGENCIES, HEALTH CARE PROVIDERS AND CONSUMER REPRESENTATIVES. I URGE THIS COMMITTEE TO APPROVE SENATE BILL 293.

THIS COMMITTEE NOW HAS THE RESULTS OF TWO (2) MONTHS OF NEGOTIATIONS AND COMPROMISES IN SENATE BILL 293. SUCH ORGANIZATIONS AS THE DEPARTMENT OF HEALTH, THE MONTANA HOSPITAL ASSOCIATION, THE MONTANA NURSES ASSOCIATION, THE MONTANA MEDICAL ASSOCIATION, THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES, THE GOVERNOR'S OFFICE AND THE MONTANA HEALTH SYSTEMS AGENCY HAVE ALL COOPERATED ON THIS PROJECT.

ALL TOO OFTEN LEGISLATORS ARE EXPECTED TO BALANCE THE NEEDS OF CONFLICTING INTERESTS. WE ARE PLEASED TO HAVE CONTRIBUTED TO THE DEVELOPMENT OF THIS COMPROMISE LEGISLATION AND WE URGE ITS APPROVAL BY THIS COMMITTEE.

THANK YOU VERY MUCH.

Ex 5
SB293

I AM SHARON DIEZIGER. TODAY I AM REPRESENTING THE MONTANA NURSES' ASSOCIATION, HOWEVER, I AM ON THE MONTANA HEALTH SYSTEMS AGENCY GOVERNING BOARD AND THE GOVERNOR'S STATEWIDE HEALTH COORDINATING COUNCIL. I HAVE BEEN ACTIVE IN THESE ORGANIZATIONS FOR MANY YEARS.

DURING THE PAST FOUR YEARS, THE CERTIFICATE OF NEED LAW HAS SERVED TO REDUCE DUPLICATION OF SERVICES, PROTECT THE STABILITY OF EXISTING SERVICES, ENCOURAGE LONG-RANGE PLANNING AND PROMOTE COOPERATIVE SERVICE DEVELOPMENT. IN ADDITION, THE STABILITY OFFERED BY THE CERTIFICATE OF NEED PROGRAM HAS PROMOTED PRIVATE INVESTMENT AND ACQUISITION WHILE ENCOURAGING OPERATING EFFICIENCIES.

SENATE BILL 293 CONTAINS A SERIES OF AMENDMENTS TO THE CERTIFICATE OF NEED LAW WHICH HAVE BEEN DEVELOPED TO STREAMLINE THE PROCESSING OF APPLICATIONS AND REDUCE THE ADMINISTRATIVE BURDEN ON PROVIDERS WHILE MAINTAINING THE INTEGRITY OF THE CERTIFICATE OF NEED PROCESS AS A COST CONTROL SYSTEM.

THIS BILL IS THE RESULT OF SUCCESSFUL NEGOTIATION AND COMPROMISE BY REGULATORY AGENCIES, HEALTH CARE PROVIDERS AND CONSUMER REPRESENTATIVES. I URGE THIS COMMITTEE TO APPROVE SENATE BILL 293.

~~THIS~~ Your COMMITTEE NOW HAS THE RESULTS OF TWO (2) MONTHS OF NEGOTIATIONS AND COMPROMISES IN SENATE BILL 293, by all of the groups mentioned by previous speaker SUCH ORGANIZATIONS AS THE DEPARTMENT OF HEALTH, THE MONTANA HOSPITAL ASSOCIATION, THE MONTANA NURSES ASSOCIATION, THE MONTANA MEDICAL ASSOCIATION, THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES, THE GOVERNOR'S OFFICE AND THE MONTANA HEALTH SYSTEMS AGENCY HAVE ALL COOPERATED ON THIS PROJECT.

ALL TOO OFTEN LEGISLATORS ARE EXPECTED TO BALANCE THE NEEDS OF CONFLICTING INTERESTS. WE ARE PLEASED TO HAVE CONTRIBUTED TO THE DEVELOPMENT OF THIS COMPROMISE LEGISLATION ~~AND WE URGE~~ Since this is the 1st Agreement that has been reached in 8 years that has got to be progress ~~YOUR APPROVAL BY THIS COMMITTEE.~~ & the passage

I would oppose any attempt to amend this bill @ this point. by SRB

~~THANK YOU VERY MUCH.~~

The Cat of Rock is not one of the most popular bills that has ever come before the leg. - further Compromises could jeopardize the entire bill.

Since this is the 1st Agreement Amongst providers in 8 years - that has got to be progress. Therefore I urge you to support the passage of SB 293.

Thank you very much.

I would oppose

Ex 6
SB 293

TESTIMONY BY GEORGE M. FENNER ON SENATE BILL 293
BEFORE THE HUMAN SERVICES COMMITTEE, HOUSE OF REPRESENTATIVES, MARCH 11, 1983

CHAIRMAN HART, MEMBERS OF THE COMMITTEE:

MY NAME IS GEORGE M. FENNER. I REPRESENT THE HEALTH SERVICES AND MEDICAL FACILITIES DIVISION OF THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES.

THIS COMMITTEE NOW HAS THE RESULTS OF more than TWO (2) MONTHS OF NEGOTIATIONS AND COMPROMISES IN SENATE BILL 293. SUCH ORGANIZATIONS AS THE DEPARTMENT OF HEALTH, THE MONTANA HOSPITAL ASSOCIATION, THE MONTANA NURSES ASSOCIATION, THE MONTANA NURSING HOME ASSOCIATION, THE MONTANA MEDICAL ASSOCIATION, THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES, THE GOVERNOR'S OFFICE, AND THE MONTANA HEALTH SYSTEMS AGENCY HAVE ALL COOPERATED ON THIS PROJECT.

ALL TOO OFTEN LEGISLATORS ARE EXPECTED TO BALANCE THE NEEDS OF CONFLICTING INTERESTS. WE ARE PLEASED TO HAVE CONTRIBUTED TO THE DEVELOPMENT OF THIS COMPROMISE LEGISLATION AND WE URGE ITS APPROVAL BY THIS COMMITTEE. In the form it is presently written.

THANK YOU VERY MUCH.

George M Fenner

VISITOR'S REGISTER

HOUSE HUMAN SERVICES COMMITTEE

BILL SENATE BILL 293 DATE 3-11-83

SPONSOR SENATOR HAGER

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
Jan Toverud	Helena, Mt.	Mt. medical assn	✓	
Sharon Wiegand	Great Falls	Mt. Nurses assoc	✓	
Ada Deering	Gordon, MT.	M. H. S. A.	✓	
Linda Skelton	Helena MT	Legislative Liaison MSH		
Jim Pickett	Helena MT	SRS.	✓	
Steve Seidensticker	Helena	DHES	✓	
Peg McGeever	"	"	✓	
Jim Casey	Helena		✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

FORM CS-33

STANDING COMMITTEE REPORT

March 11 19 83

MR. SPEAKER

We, your committee on HUMAN SERVICES

having had under consideration SENATE Bill No. 200

third reading copy (~~blue~~ gold)

A BILL FOR AN ACT ENTITLED: "AN ACT TO CLARIFY THE GENERAL POWERS AND DUTIES OF THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES; AND GIVING THE DEPARTMENT THE AUTHORITY TO ADOPT RULES TO IMPLEMENT STATE AND FEDERAL HEALTH PROGRAMS FOR MATERNAL AND CHILD HEALTH AND FOR HANDICAPPED CHILDREN; AMENDING SECTION 50-1-202, MCA."

Respectfully report as follows: That SENATE Bill No. 200

BE CONCURRED IN

~~DO PASS~~

STATEMENT OF INTENT ATTACHED

MARJORIE HART Chairman.

STATE PUB. CO.
Helena, Mont.

federal program requirements which mandate standards be set for fair hearing, property management, etc. The Department has, therefore, had to set the required standards for those programs without having the authority under state law to adopt binding rules for them.

Consequently, it is the intent of the legislature that the Department be expressly authorized to adopt rules covering the following:

1. Eligibility criteria for program participation, e.g. income levels, nutritional status, and age;

2. Criteria which must be met by providers of care as a condition of reimbursement, including professional qualification;

3. Conditions included or excluded for coverage;

4. Policies included in state plans, such as the allocation of funds within a program, evaluation procedures and reporting procedures relating to fiscal and programmatic responsibilities;

5. Standards to ensure quality of care, such as care plans and objectives;

6. Fair hearing procedures;

7. Reimbursement rates;

8. Eligibility standards for food program providers;

9. Property management requirements.

MARJORIE HART Chairman.

STATE PUB. CO.
Helena, Mont.

Geri Brusett copy

SENATE BILL 200

March 11, 19 83

MR. SPEAKER

WE, YOUR COMMITTEE ON HUMAN SERVICES, HAVING HAD UNDER CONSIDERATION SENATE BILL 200, THIRD READING COPY (BLUE), ATTACH THE FOLLOWING STATEMENT OF INTENT:

STATEMENT OF INTENT
SENATE BILL NO. 200

A statement of intent is required for Senate Bill 200 because it amends Section 50-1-202, MCA, to authorize the Department of Health and Environmental Sciences to adopt rules implementing existing programs promoting maternal and child health and providing handicapped children's services.

The Department has since 1967 been mandated to develop and administer maternal and child health programs and handicapped children's services, programs which by their nature require standards to be set for such areas as appropriate medical treatment, eligibility for financial assistance and program participation, and reimbursement for services. Those programs presently include the Women, Infants, and Children (WIC) supplemental food program ensuring proper nutrition for young children and low-income pregnant and nursing women; the Child Care Food Program providing food assistance to children in day care; family planning; the Improved Pregnancy Outcome Project; and the Handicapped Children's Program. In addition, all of the present programs receive federal funding and are subject to

STATE PUB. CO.
Helena, Mont.

MARJORIE HART Chairman.

STANDING COMMITTEE REPORT

March 11, 19 83

MR. SPEAKER

We, your committee on HUMAN SERVICES

having had under consideration SENATE Bill No. 209

third reading copy (blue)
Color

A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE CRITERIA FOR ADMISSIONS TO THE MONTANA CENTER FOR THE AGED; REVISING THE TRANSFER AND DISCHARGE PROCEDURE; AMENDING SECTIONS 53-21-411 THROUGH 53-21-413, MCA."

Respectfully report as follows: That SENATE Bill No. 209

BE CONCURRED IN

DEXXXXX

MARJORIE HART
Chairman.

STATE PUB. CO.
Helena, Mont.

STANDING COMMITTEE REPORT

March 14, 19 83

MR. SPEAKER

We, your committee on HUMAN SERVICES

having had under consideration SENATE Bill No. 293

third reading copy (blue color)

A BILL FOR AN ACT ENTITLED: "AN ACT TO GENERALLY REVISE AND CLARIFY THE LAWS RELATING TO CERTIFICATES OF NEED FOR HEALTH CARE FACILITIES; AMENDING SECTIONS 50-5-101, 50-5-301, 50-5-302, 50-5-304 THROUGH 50-5-306, AND 50-5-308, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE.

Respectfully report as follows: That SENATE Bill No. 293

BE CONCURRED IN

MARJORIE HART Chairman.

STATE PUB. CO.
Helena, Mont.

COMMITTEE SECRETARY