MINUTES OF THE MEETING
HUMAN SERVICES SUBCOMMITTEE
MONTANA STATE
HOUSE OF REPRESENTATIVES

February 15, 1985

The meeting of the Human Services Subcommittee was called to order by Chairman Cal Winslow on February 15, 1985 at 7:36 a.m. in Room 108 of the State Capitol.

ROLL CALL: All members were present, with the exception of Representative Bradley, who was excused.

Chairman Winslow announced that the subcommittee will be able to do a committee bill for the SRS accounting where the 12 mills would go directly to general fund, rather than to SRS. He said there does need to be a motion to that effect.

Senator Manning made a motion to that effect.

The motion PASSED.

A copy of the final language worked on in relation to Specialized Family Care was given to the committee. Chairman Winslow mentioned this in the previous day's meeting (EXHIBIT 1).

E X E C U T I V E A C T I O N

DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES

Vocational Rehabilitation (EXHIBIT 2)

Representative Rehberg made a motion to accept the general fund modified request funding of $75,000 in FY86 and $75,000 in FY87 with the appropriate adjustments made for Industrial Accident Rehabilitation and Vocational Rehabilitation Grants.

The motion PASSED.

Representative Rehberg made a motion to accept the Extended Employment general fund modified request funding of $50,000 in FY86 and $50,000 in FY87.

The motion PASSED.

Representative Rehberg made a motion to accept the Special Disabled Populatioks modified request funding of $100,000 in FY86 and $150,000 in FY87.

Representative Rehberg said that he would like to see less FTEs and more for benefits. The motion is to include that it is the intent of the committee to accept only 1 FTE and that the remaining increase to go to direct benefits.

The motion PASSED.

John Larson (47:A:260), chief of the Medicaid Financing Bureau, discussed Medicaid and nursing home and long-term care reimbursement. He gave everyone a handout listing a brief overview of Medicaid (EXHIBIT 3) and outlined this in his presentation.

He also gave everyone a handout that lists the number of certified beds in five state operated facilities in Montana (EXHIBIT 4). These facilities are certified for Medicaid reimbursement to The Department of Institutions.

Discussion followed concerning the size of the facility and the danger of basing the figures on a large facility for the small facilities.

There was additional discussion concerning swing beds and a definition of swing beds.

Joyce DeCunzo (47:B:151), an administrative officer for the Medicaid Services Bureau, discussed the Home & Community Services Program. She read from her prepared testimony (EXHIBIT 5) and gave everyone a set of informational pamphlets concerning Home & Community Services (EXHIBIT 6). She also discussed and highlighted a set of charts and tables with various figures for the Home & Community Services program (EXHIBIT 7).

Lowell Uda (47:B:673), chief of the Medicaid Services Bureau, discussed the Priorities for People Initiative S-3, Home & Community-Based Services under Medicaid. He gave everyone a handout listing his presentation, the Initiative Summary Sheet, and a graph showing the cumulative and projected caseload for actual and cumulative caseloads (EXHIBIT 8).

Discussion followed concerning the amount of money allocated per case management team, whether they are responsible for 20 people of 60 people, and how many case management teams are in certain towns.

Testimony was heard from the following people:

Shelley Oksness (48:A:303), a registered nurse with the Northern Rocky Mountain Easter Seal Society, discussed the elderly case management team in Cascade County. She

spoke about the client and screening process, all the services with Home & Community Services (HCS), and listed all the steps and services with the HCS program. She gave two letters from people that have received HCS services (EXHIBIT 9,10).

Jane Rogers read from her prepared testimony (EXHIBIT 11).

Patricia Wood read from her prepared testimony (EXHIBIT 12).

Roberta Nutting (48:A:582) discussed people going into nursing homes. She said there needs to be encourgement for people to stay, and she would like to see the HCS services expanded.

Mildred Ewing spoke about her mother-in-law coming to live with her family and how it became harder to take care of her. She said the Home Care people were very cooperative in caring for her mother-in-law.

Zana Smith (48:B:010), representing the Montana Independent Living Project, supports the expanded Medicaid waiver program and submitted written testimony (EXHIBIT 13).

Bob Johnson, director of the Lewis & Clark County health department, discussed the co-sponsors of the case management team program. He said this is a complex and difficult program to get started and administer. He said his caseload is small and has grown slowly; they now have 21 clients on their caseload. He also said that SRS has been extremely helpful.

Judy Carlson said this program is a large item on their Priorities for People list.

Chairman Winslow announced that the committee will hear the nursing home program on Monday, February 18.

Dave Lewis said that the people from WestMont would like the opportunity to conduct a tour for the committee at Cedar Street group home because those people are very similar to those still at Boulder.

The meeting was adjourned at 9:52 a.m.

Cal Winslow

CAL WINSLOW, Chairman

DAILY ROLL CALL

Human Services Subcommittee

49th LEGISLATIVE SESSION -- 1985

Date 2-15-85

NAME	PRESENT	ABSENT	EXCUSED
Rep. Dorothy Bradley			X
Sen. Chris Christiaens-Vice Chair	X		
Sen. Richard Manning	X		
Rep. Dennis Rehberg	X		
Sen. Pete Story	X		
Rep. Cal Winslow, Chairman	X		

Exhibit 1
2-15-85

SPECIALIZED FAMILY CARE

1) In addition to the severity of a child's disability and the degree of stress caused by the care for a child, for purposes of client selection, higher priority will be given to children who are more likely to move to a more restrictive setting.

2) Any service or assistance available to a foster family would also be available to a natural family with the exception that natural families may not receive normal foster home payments.

PBLEG:sfc 2-14-5

Exhibit 2
2-15-85

Modified Requests

Rehabilitation Services

During the 1983 session, over $500,000 per year of general fund was replaced by Workers' Compensation funds and other federal funds. Due to limitations on these funding sources, many individuals did not receive services in fiscal 1984 and 1985. Additional funds are requested to restore the 1983 service level.

	FY 1986	FY 1987
Benefits	$461,646	$583,724

FUNDING	FY 1986	FY 1987
General Fund	$150,000	$150,000
Industrial Accident Rehab.	30,392	14,652
Vocational Rehab.--Grants	281,254	419,072
Total	$461,646	$583,724

1. Committee Issues

_____

_____

_____

_____

Committee Action--Benefits

_____

_____

_____

_____

Extended Employment

This program currently funds 58 severely disabled individuals in seven workshop facilities who are not capable of competitive employment due to residuals of mental illness, brain stem injury, neurological disability or visual disabilities. Funds are requested to serve an additional 20 persons currently on the waiting list.

	FY 1986	FY 1987
Benefits	$100,000	$100,000
General Fund	$100,000	$100,000

Special Disabled Populations

Funds are requested to provide services to those persons who are not eligible for services through vocational rehabilitation and are not considered developmentally disabled, including head injured, spinal cord injured, multiply disabled, respiratory disorders, multiple sclerosis, and muscular dystrophy.

1. Committee Issues

Committee Action--Benefits

	FY 1986	FY 1987
FTE	2	2
Personal Services	$ 52,205	$ 52,228
Communications	1,600	1,600
Travel	4,800	4,800
Rent	3,360	3,360
Other	5,600	5,600
Benefits	221,682	213,164
Total	$289,247	$280,752

Funding

General Fund	$193,247	$280,752
Federal Funds	96,000	-0-
Total	$289,247	$280,752

1. Committee Issues

Committee Action--Benefits

PBLEG:vr 2-13-5

Exhibit 3
2-15-85

MEDICAID

Nursing Home Reimbursement

HISTORY:

1) Prior payments to nursing homes were based on the cost of providing service.
2) Settlements were made at the end of the year to make payments consistent with costs.

CURRENT SYSTEM:

Prospective - rates are established for providing care; no later settlements are made. Providers are allowed to keep funds they do not spend.

PAYMENT RATE; Two Parts:

1) Operating Rate
2) Property Rate

All facilities begin with the same operating rate. That rate is then modified by the:

a) size of facility
b) geographic location of facility
c) care required by patients
d) inflation rate

The result is a unique operating rate for each facility.

PROPERTY RATE:

The property rate is developed by inclusion of the following factors:

a) age of facility
b) type of construction
c) inflation rate

The assumption made is that new facilities deserve higher rates than old facilities; and masonry and steel construction lasts longer than wood.

QUALITY OF CARE:

Quality care is assured by:

1) Annual inspections of care by Montana Foundation
2) Annual certification survey by Department of Health
3) Semi-annual surveys of patient assessment

MA/o

Exhibit 4
2-15-85

MEDICAID DEPARTMENT OF INSTITUTIONS

Facility	Hospital Beds	Nursing Home Beds	Ment. Retard Beds
Boulder			242
Eastmont			55
Galen	33	185	
MT Center/Aged		199	
Warm Springs		60	

Nursing Home and hospital services are reimbursed just as other facilities are. Mental Retardation facilities are reimbursed on a "cost" basis.

Reimbursement Mental Retardation Facilities:

1. Facilities are paid a rate during the year based on an estimate from a prior year cost.

2. At year end costs are examined and compared to rate estimate already paid.

3. A settlement is completed to reconcile differences between cost paid and actual cost.

Budgeting:

Department of Institutions (D of I) appropriation is made separate from other health care facilities.

D of I operating funds come directly from the general fund.

SRS reimburses the general fund for services performed by D of I.

WB/006

Exhibit 5
2-15-85

Mr. Chairman, Members of the Committee:

I am Joyce DeCunzo from the Department of Social and Rehabilitation Services. I am here today to give a status report on the Home and Community Services Program, more commonly known as the "Medicaid Waiver".

In 1981, Congress decided to allow states to apply for a waiver of Medicaid regulations. The Federal intent was to allow states to serve persons at home, if they otherwise would require nursing home care. A waiver, then, is simply permission from the Federal government to spend Medicaid money in a different way. In Montana, this means we decided to pay for a set of services that we believe will help people remain in their own homes and stay independent longer and more cost-efficiently than if they entered an institutional setting.

The services available under the waiver program, if called for in a plan of care, are: case management, homemaker services, respite care, adult day care, personal care attendant services, habilitation, medical alert, transportation, meals and modifications to a home.

The people eligible to receive these services are those who:

- are developmentally disabled, physically disabled or elderly (age 65+);
- are financially eligible for Medicaid;
- require the level of care of a Skilled Nursing Facility, Intermediate Care Facility or Intermediate Care Facility for the Mentally Retarded;
- reside in specified service areas; and
- can be served in the community safely and for a cost that can be expected to be less than the cost of institutional care.

Our current waiver is one waiver including all three groups of people. However, I will discuss only the portion of the waiver program that relates to elderly and physically disabled persons.

Several parameters for the program are important to list because they guide us in meeting expectations. The Federal regulations demand that:

- the person to be served must be a person who meets level of care requirements - that is, they are or would be eligible for Medicaid payment in an institutional setting;
- this eligible person must then be allowed a choice - community or institutional setting - where he will receive services;
- the person must be assured of having his health and safety needs met; and
- the Medicaid cost of serving people in the community does not exceed the Medicaid cost of serving a person in an institutional setting.

In addition, people and groups within Montana wanted to count, in the cost limitations, the amount of public funds used by clients of the waiver program besides Medicaid money. I hope to show that SRS has met all these parameters in the implementation of the program as our rationale for our request to continue the waiver program and to expand it.

In order to explain the parameter regarding level of care, I need to explain the level of care process - what we call preadmission screening.

Preadmission screening is a process to determine who is or is not eligible for Medicaid payment for long term care, according to specific criteria set by Federal and State regulations. The criteria is based on a person's need for medical care that can be met in an institutional setting, such as an intermediate or skilled nursing home. Montana has been doing preadmission screening for many years, deciding who is eligible for nursing home care according to medical need, so this is not a new function. We often refer to the process as "gatekeeping" - a process of deciding who "enters" the Medicaid payment system for long term care needs.

Since we must assure that only "nursing home eligible" people are served by the waiver program, we use exactly the same preadmission screening process and criteria for the waiver program as we have used for many years for the nursing home program. Even though this process would seem to indicate that

anyone getting through the "gate" of eligibility really requires the services, we decided to look at how waiver clients compare to nursing home clients in some key areas. That information is on Table I. The nursing home information presented here comes from both national and state studies of the characteristics of nursing home patients. The waiver information is from the first 160 clients served by the program.

As the table shows, patient sex and age breakdowns are very similar, as is pre-program residence. The pre-program residence statistics all relate to people in Montana nursing homes. Numbers of conditions of clients in the one, two or three condition categories are also closely related. The types of conditions listed and the nursing home percentage rates are from a national survey; the waiver statistics are actual. It is interesting to note that some major categories of conditions are very similar in rates: glaucoma/cataracts, both categories of paralysis, arthritis, diabetes and heart trouble.

This information is not conclusive, but it seems to indicate that in a number of ways, waiver and nursing home clients look a lot alike. Certainly, each person served by the waiver, because they meet level of care according to our criteria, could have chosen a nursing home setting and Medicaid would have paid for that service. These points will be important to remember when we consider the costs of the program.

One additional point I want to make is that some persons have been denied waiver services. The only reasons for denial are: (1) the cost of the person's care in the community, based on his needs, exceeds the maximum allowable cost, or (2) the person's health and safety needs cannot be met in the community.

With this background, I would now like to discuss the financial side of this program.

The Federal cost formula against which the waiver is measured is the cost of institutional care less room and board costs. The amount for room and board is not specified. We proposed, and it was accepted, that $285 per month is the offset for room and board costs. This amount is approximately 22% of

the cost of nursing home care. Federal limits for cost-effectiveness of this program then, allow us to spend up to 78% of the cost of nursing home care on the waiver client. For FY 84, the maximum allowable cost under the waiver was $11,600, or $31.78 per day. For FY 85, the allowable cost is $12,753 or $34.93 per day.

An additional factor involved is the cost of other government-funded programs used by the waiver client. This is one of the state-initiated parameters I mentioned earlier. Besides counting the Medicaid expenditures for waiver clients, we also count the value of services the client receives from funding sources such as Medicare, Social Services Block Grant, Agency on Aging and other city, county or state governments.

Therefore, the information regarding costs of plans of care and total program costs that follow include Medicaid expenditures plus the value of services received from any of these funding sources.

Table II shows the range of plans of care developed for the first 160 people enrolled in the waiver program. These are projected costs. In order to decide if it is possible for a person to be served within cost limitations, case management teams must develop a plan of care. This means the team must have a thorough understanding of the client's current needs, project what services the client will need for a year's period, then determine the costs, on an annual basis, of all needed services. If the cost projection is under the maximum, the client may be served. If it is over the maximum, the client is denied the choice of being served by the waiver.

While this table shows projected costs, we have noted that actual expenditures - for clients who have been served six months or longer - are usually at or below projected costs.

The information on this chart is not absolute, then, but it is interesting to see the range of plan costs. I cannot explain exactly why the cost ranges are so spread out. I do know that many factors can impact cost, such as type and amount of services needed, amount of family support available and how independent the client is.

Table III shows the plan of care costs in a different manner. Here we have determined, by team, the average annual plan cost with a concurrent average daily rate. Using 78% of the average cost of institutional care, which equals $33.32 per day, we can see the percentage that waiver costs are of institutional care. This comparison shows that, on the average, we can provide services to a person in the community for 50% of the cost of institutional care.

In order to determine total costs of the waiver, the following tables will explain services costs and state general fund start-up costs. Table IV lists, by team, the services costs through 12/31/84, with a comparison to services costs in an institutional setting. It does not include start-up costs.

Table V shows all services costs plus start-up funds, to yield a total cost for the waiver program.

Table VI shows the actual costs of the waiver, through 12/31/84, plus the projected costs through 6/30/85.

Let's go back to Table IV. Through 12/31/84, the total number of Medicaid patients served used 16,860 days. The "XIX expended" column is the actual amount of Title XIX dollars paid on behalf of these clients for waiver services. The "other counted" column represents the value of services received from other government funded sources. Services for waiver clients cost $242,262. As compared to the institutional value for services, this table would indicate a savings of $319,514.

Table V includes the start-up funds used for the waiver, through 12/31/84. The $289,805 were used to support case management teams. When a case management team has built up a caseload of Medicaid clients, then it can be supported by Medicaid funds. However, the general fund dollars are needed to keep the team in place until that time. The $144,000 of start-up funds (Big Bear) were allocated for new service provision for certain physically disabled persons in Missoula. The new figure for waiver costs then becomes $676,067, which is higher than the institutional value shown on Table IV of $561,776.

This methodology is somewhat misleading in terms of comparisons. Because case management teams were phased in the patient day count, through 12/31/84, was low. You can see that the Miles City team had very few Medicaid patient days and Sidney had none, yet together they received $51,458 in start-up funds. The $144,000 for physically disabled were all allocated by December 31, but services did not begin until October of 1984.

If we look at the start-up funds spread over the biennium, and calculate the projected patient days, we get a different picture of the cost comparisons. Table VI shows the number of patient days we project will be used by the end of the biennium. The total services cost then becomes $884,278 and the total institutional value becomes $1,725,143.

During this period of projection, we will expend another $28,000, bringing the total of start-up costs to $461,805. Total waiver costs become $1,346,083. This indicates a savings, over the biennium to the Medicaid program, of $379,060.

The start-up funds will all be expended by June 30, 1985. At that time, all teams will need to be self-supported by caseload size to continue to offer services. While the savings for this current biennium are small, we would expect substantial savings in the coming biennium. Assuming that plan of care costs continue at 50% of the cost of institutional care - and with no start-up funds to consider - it is reasonable to believe that the real savings from this program are yet to come.

The one area that we cannot price is the independence this program allows the people it serves. It has been a slow-growing program - vulnerable elderly people are not quick to trust promises of good care - but the program is growing as that trust develops. It is a hopeful program and I am glad to be part of it.

MSB3/1

Exhibit 6
2-15-85

A CHOICE • health care for the aging

As a health-care professional, you know that Montana's aging citizens over the years have had few choices in handling their health-care needs:

• to remain at home, needing help in nutrition, house and personal care, loneliness and general neglect as self-care becomes more difficult;

• to live with relatives or others who are sometimes poorly equipped to deal effectively with the particular problems and needs of the aging;

• to be placed in a full-service nursing facility.

Time after time and year after year, none of these choices has been entirely satisfactory.

A CHOICE • medicaid

But there is a choice for the aging. Recent changes in the Medicaid structure have made a new choice possible in the care of the elderly.

If eligibility guidelines are met, elderly applicants can choose full-time care in a full-service facility or to remain at home with the security of Home and Community Services' coordinated system of care.

Either way, Medicaid will pay.

The Montana Department of Social and Rehabilitation Services has designed a program called Home and Community Services (HCS) to make the Medicaid option more accessible to the elderly in your community. A private sector Case Management Team (CMT) makes the program work by pulling together and coordinating the community's health care services in a plan tailored to the needs of individual clients.

On your referral — or application by the potential recipient — a pre-admission screening team of professional health care specialists evaluates the health care needs of the applicant. The evaluation process employs a nationally validated screening process to determine the level of care needed.

The applicant can then choose either admission to a full-service nursing facility or community-based care in the home. If the choice is for home care, the application goes to the Case Management Team in your community. If eligibility guidelines are met, Medicaid will pay for either choice.

A CHOICE • private pay individuals

Home and Community Services is also designed for private-pay individuals who may be in need of long-term health care and assistance. The Case Management Team is a private business and operates much like any other health care business.

The HCS program works by pulling together and coordinating the community's health care services in a plan tailored to the needs of the individual patient.

how it works...

HERE'S HOW IT WORKS

The Case Management Team is composed of licensed, qualified professionals, registered nurses and medical social workers, under contract to the Montana Department of Social and Rehabilitation Services as a private business.

The CMT develops a plan of care tailor-made to the needs of the client. The plan incorporates qualified health care agencies existing in the community as well as other health and social services that are available.

The plan of care must be approved and signed by the client, his or her family (if applicable) and by the client's physician.

After the plan is approved, the CMT contracts with agencies in the community to provide the services needed by the individual, and monitors the services provided to be sure they continue to meet those needs properly.

The health care plan for each client must be reviewed at least every 90 days. If the individual's health condition changes, the plan must be revised to accommodate the changes.

With the planning, coordination and supervision of the CMT, the client can be assured of adequate nutrition, health care, transportation, homemaker services, and other essential services.

The CMT, as a private business, focuses the health care agencies and coordinates their services on a one-to-one basis with their clients.

There are numerous benefits. Not only do the aging who wish to stay at home benefit; the program is particularly valuable as an interim plan for individuals making a gradual transition between living at home and living in a full-service facility. Broader use is made of health-care and other appropriate services existing in the community. The aging and their families have the security of health care programs that are custom-designed to meet the needs of each person and are constantly monitored to assure they remain effective.

To refer an elderly client to the HSC program — or just for more information about the program — phone or write the CMT in your community:

Many of Montana's aging citizens want to stay at home and are unable to do so simply because they are unable to maintain adequate day-to-day care for themselves. With the Home and Community Services program — and the direct services of the Case Management Team — many aging Montanans can stay at home and still maintain a high-quality standard of life.

for these citizens, Home & Community Services may mean

home is where the health is

HOME & COMMUNITY SERVICES

Home is where the health is.

If you — or someone you are close to — are among the elderly faced with leaving home to get adequate health care, then you should know *there is a choice.* The choice is Home and Community Services.

Your Case Management Team can help. The health professionals on the CMT will prepare a health care plan that is correct for you.

Find out about HCS now!

Because home is where the health is . . . if that's where you want it to be.

10,000 copies of this public document were published at an estimated cost of 5¢ per copy, for a total cost of $500.00, which includes $500.00 for printing and $.00 for distribution.

HOME IS WHERE THE HEALTH IS

If you are senior citizen, you are an expert on growing older. You probably also know that reliable health care isn't always among the blessings of aging.

Health needs usually increase as people grow older. And, all too often, those increasing health care needs mean a hard choice: the worry and potential neglect of haphazard health care in your home on one hand or leaving your home to live in a full-service nursing facility on the other.

NOW THERE IS A CHOICE

It is now possible for you to stay in your own home, with the security of an individually planned health care program utilizing the services available in your own community.

The program is called Home and Community Services (HCS). It's designed by the Montana Department of Social and Rehabilitation Services and operated for you by a Case Management Team (CMT) in your own community.

In the Home and Community Services program a team of health care professionals will evaluate your needs according to nationally established guidelines. If you are paying yourself, the individual plan of care will document the cost of the health care plan. If you are a Medicaid client and if eligibility guidelines are satisfied, then you can choose either care in your own home or admission to a full-service nursing home. Medicaid will pay either way.

SERVICES AVAILABLE TO YOU

If you choose home care, the Case Management Team in your community will develop a plan designed for your individual health needs. Your program might include:

- homemaker services
- personal care attendant services
- transportation service
- respite care
- adult day services
- attention to your nutritional needs

or a host of other services available to you in your own home, in your own community.

Your tailor-made health service will be carefully coordinated and supervised by your local, professional Case Management Team. And it will be reviewed every 90 days to be sure your needs continue to be met properly.

With your own health care program, you may be able to stay home and still have the reliable, competent health care you need.

HOME & COMMUNITY SERVICES

HOME is where the Health is

THE CHOICE IS YOURS

If you want to live at home as you grow older. . .
If you want to be as independent as possible for as long as possible. . .
If you need help with your health care and with your daily activities. . .

Home and Community Services may mean that:

Home is where the Health is – If that is where you want it to be.

For information about Home & Community Services and the Case Management Team in your community, get in touch with:

10,000 copies of this public document were published at an estimated cost of 4¢ per copy, for a total cost of $400.00, which includes $400.00 for printing and $.00 for distribution.

home is where the health is

Montana's aging citizens have a lot in common.
They want to remain independent.

But they need assistance with their health care and help with their daily needs. Now there is a program that can help meet those needs...and allow Montanans to remain independent as they grow older.

THE MONTANA DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES' HOME & COMMUNITY SERVICES PROGRAM PROVIDES A CHOICE BETWEEN LIVING IN A FULL-SERVICE FACILITY AND LIVING AT HOME WITH PLANNED AND SUPERVISED HEALTH CARE.

Many services for the aging are available in your community now:

- Personal care
- Adult day care
- Meals
- Home nursing
- Respite
- Transportation

and other essential services as well

With the Home and Community Services program, a Case Management Team in your community puts these services together in a plan designed to individual needs. . . supervises the program. . . helps with any special problems. . . and checks to be sure each individual program of care continues to meet those needs.

Some programs offered by the state and federal government may help pay for needed care, and some insurance companies are able to help. But the choice is yours.

Exhibit 7
2-15-85

Table I

Characteristics of Long Term Care Patients

			Nursing Home	HCS
I.	SEX	female	69%	70%
		male	31%	30%
II.	AGE	65-74	18%	24%
		75 +	82%	76%
III.	Pre-program residence			
	Alone, with spouse or relative		68%	57%
	Institution, with non-rel., or supv. living		32%	43%
				(22% from NH
				18% from Hosp
				3% from Other)
IV.	Number of Conditions			
		No condition	2%	0%
		One condition	15	26
		Two conditions	22	35
		Three conditions	22	20
		Four or more conditions	39	20

TABLE I

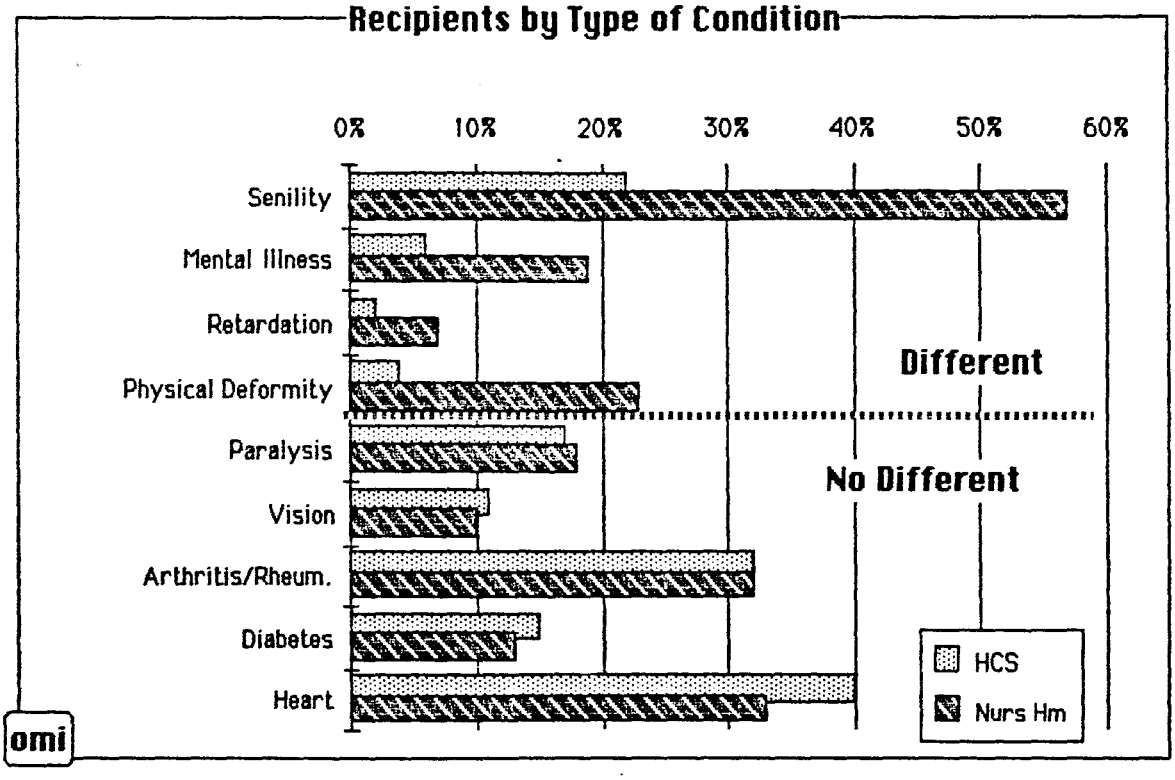

Recipients by Type of Condition
0%
10%
20%
30%
40%
50%
60%
Senility
Mental Illness
Retardation
Physical Deformity
Paralysis
Vision
Arthritis/Rheum.
Diabetes
Heart
Different
No Different
HCS
Nurs Hm
omi

TABLE I

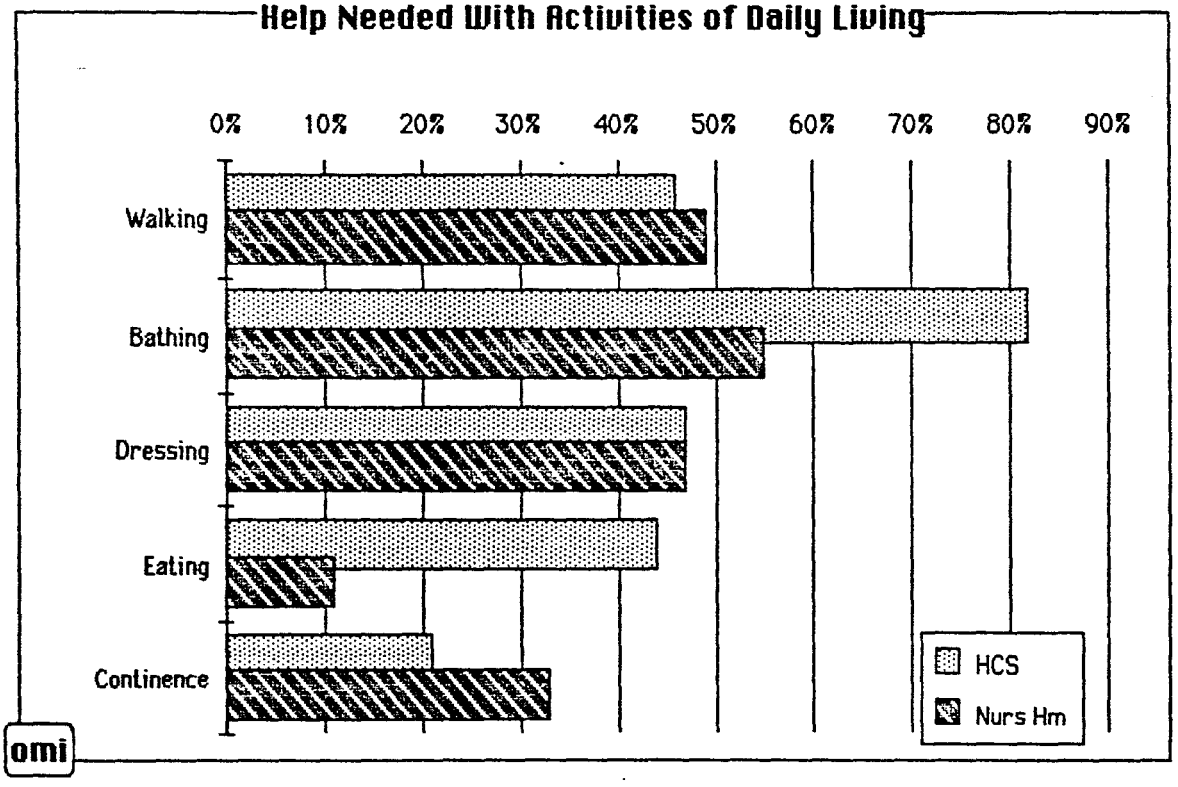

Help Needed With Activities of Daily Living
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
Walking
Bathing
Dressing
Eating
Continence
HCS
Nurs Hm
omi

TABLE II

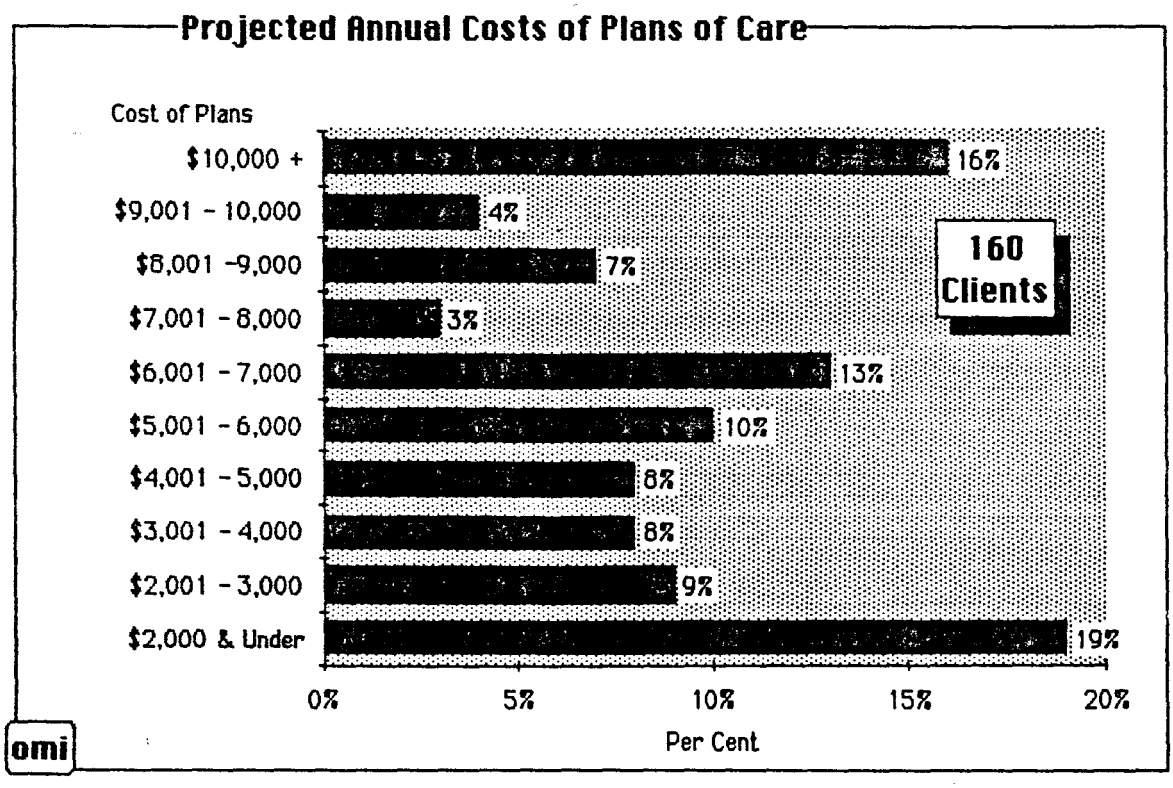

Projected Annual Costs of Plans of Care
Cost of Plans
$10,000 +
$9,001 - 10,000
$8,001 -9,000
$7,001 - 8,000
$6,001 - 7,000
$5,001 - 6,000
$4,001 - 5,000
$3,001 - 4,000
$2,001 - 3,000
$2,000 & Under
16%
4%
7%
3%
13%
10%
8%
8%
9%
19%
160 Clients
0%
5%
10%
15%
20%
Per Cent
omi

TABLE III

Average Plan of Care Costs
Start to 12/31/84 Summary
XIX Clients

Case Management Team	Daily Average Rate-All Services	Average Annual Cost of Plan	As Percent of Institutional Care @33.32/day
Missoula	$ 14.15	$5,165	42%
Missoula (PD)	13.99	5,106	41%
Billings	20.82	7,599	62%
Great Falls	18.45	6,734	55%
Helena	19.08	6,964	57%
Bozeman	16.79	6,128	50%
Miles City	15.30	5,584	45%
Sidney	-0-	-0-	-0-
State Average	$16.94	$6,183	50%

TABLE IV

Services Costs
Start through 12/31/84

CMT	Start Date	Total XIX Days	XIX $ Expended	Other Counted	Expended Cumulative Total	Institutional Value @ 33.32/Day
Missoula	10/1/83	3,415	$ 47,774	$ 540	$ 48,314	$113,788
Missoula (PD)	10/1/83	6,052	51,750	-0-	51,750	201,653
Billings	1/1/84	3,247	67,611	-0-	67,611	108,190
Great Falls	4/1/84	1,551	25,018	3,592	28,610	51,679
Helena	5/1/84	1,227	22,891	543	23,434	40,884
Bozeman	4/1/84	1,085	18,018	194	18,212	36,152
Miles City	7/1/84	283	4,075	256	4,331	9,430
Sidney	7/1/84	-0-	-0-	-0-	-0-	-0-
		16,860	$237,137	$5,125	$242,262	$561,776

Savings: $319,514

TABLE V

Services and Start-up Costs
Start through 12/31/84

	XIX CMS Expend.	XIX Home Health Expend.	XIX Other Waiver	Other Counted	State Start-up Expend.	Total
Missoula	$ 29,456	$ 497	$ 17,821	$ 540	$ 45,578	$ 93,892
Missoula (PD)	39,293	1,251	11,206	-0-	36,413	88,163
Billings	17,001	-0-	50,610	-0-	50,604	118,215
Great Falls	11,545	-0-	13,473	3,592	35,196	63,806
Helena	11,895	565	10,431	543	33,915	57,349
Bozeman	9,981	-0-	8,037	194	36,641	54,853
Miles City	2,760	-0-	1,315	256	30,000	34,331
Sidney	-0-	-0-	-0-	-0-	21,458	21,458
	$121,931	$ [illegible],313	$112,893	$ 5,125	$289,805	$532,067
Big Bear					144,000	$676,067
					$433,805	

TABLE VI

Biennium HCS Costs
Actual and Projected through 6/30/85

Area	Patient Days	HCS Daily Rate	HCS Total	NH Total @ 33.32/day
Missoula	6,993	$ 14.15	$ 98,951	233,007
Missoula (PD)	13,658	13.99	191,075	455,085
Billings	10,073	20.82	209,720	335,632
Great Falls	9,500	18.45	175,275	316,540
Helena	6,688	19.08	127,607	222,844
Bozeman	4,863	16.79	81,650	162,035
Miles City		-Insufficient Data to Calculate-		
Sidney		-Insufficient Data to Calculate-		
	51,755		$884,278	1,725,143

51,775 days x HCS per day cost = 884,278

51,775 days x NH per day cost of 33.32 = 1,725,143

MSB3/k

Exhibit 8
2-15-85

PFP INITIATIVE S-3,
HOME AND COMMUNITY-BASED SERVICES UNDER MEDICAID
--Presentation Outline--

I. Background

A. Sponsored by the Senior's Budget Building Team

B. Placed in Tier 1

C. Included in Executive Budget

II. Summary of Initiative

A. Provides for 400 additional home and community-based slots over the biennium for the elderly and the physically handicapped as an alternative to nursing home care

B. Biennial cost: $4.7 million ($1.8 million GF)

C. Phase-in activities and cost by SFY

III. Need for Initiative

A. Physically handicapped caseload currently at maximum--to serve more individuals, to provide the service in other communities, more physically handicapped slots are needed.

B. To serve more elderly individuals in other communities, more elderly slots are needed according to caseload projections (see attached graph)

C. By making choice between home-based care and institutional care possible, the bias toward institutional care is reduced and use of the least restrictive environment is furthered.

IV. Conclusion

A. A good program, desired by the elderly and the physically handicapped as demonstrated by high PFP priority.

B. Request for program by other communities (e.g., Kalispell, Butte, Lewistown)

PRIORITIES FOR PEOPLE

SOCIAL & REHABILITATION SERVICES

INITIATIVE SUMMARY SHEET

Date: June 1, 1984
AMENDED

X SRS program change

___ SRS policy change

___ recommendation to SRS on regulation or law change

Initiative Title: Home and Community-based Services

Contact Person(s): John Bebee

Constituent/Budget Building Team: Seniors

Program/Service Affected: Medicaid

STATEMENT OF NEED:

Population to be Served: Elderly individuals 65 and over and physically disabled individuals to whom, as determined by a formal screening/assessment process, nursing home placement should be optional.

Current Level of Service: Nursing homes currently care for about 6,000 clients in Montana every year at a cost of about 40 million per year to Medicaid. Community Services Division, SRS, contracts about $2 M per year of Title III aging funds and state general fund for in-home services including home, health, homemaker, home-chore, and home-delivered meals. The 1983 legislature authorized 410 slots for the Home and Community-based Services program for fiscal year 1984 and 1985.

Description of Problem: There are approximately 121,000 Montanans 60 and over, of which approximately 85,000 are 65 and over. Of the 85,000 individuals 65 and over, approximately 6,000 are in skilled nursing or intermediate care facilities at the beginning of the year and approximately 12,000 will be at risk of placement in such facilities during that year.

There are an estimated 100 physically disabled Montanans requiring services (See Initiative D-6). Physical disability is certified by the Disability Determination Bureau of SRS. Most individuals so certified are also Medicaid Eligible. Brain stem injured, Alzheimer's Disease, stroke victims, acute alcoholism are among some of the diagnoses for this disabled population. The great majority of these individuals are not eligible for services under the State DD definition, and services are currently obtained from a wide variety of sources - nursing homes, frequent hospitalization, county assistance, Medicaid, third party insurers, and others. Initiative D-6 attempts to rectify a portion of this problem for individuals who would not qualify for assistance otherwise. This initiative would include an estimated 40-60 Medicaid eligible physically disabled individuals.

While there are funds available for in-home services, they are not sufficient and not necessarily targeted to those most in need. This initiative would provide for alternatives through Home and Community-based Services for a

targeted population. In addition, this initiative provides for a case management function providing for more efficient use of all resources and service.

Under this initiative, services would include:

1. Case management services
2. Homemaker services
3. Personal care attendant services
4. Respite care
5. Adult day services
6. Additional services, including medical alert, congregate meals, meals on wheels, transportation and minor physical modifications to the home.
7. For the disabled only, rehabilitation services (OT, PT, speech and hearing therapies) are available under the federal waiver for Medicaid.

INITIATIVE STATEMENT: This initiative would provide for 400 additional Home and Community-based slots over the biennium as an alternative to nursing homes. The elderly population, age 65 and over, is growing. Medical technology and better health habits continues to lead to an increased life span. However, the elderly do have increasing needs for adequate health care. The commitment to deinstitutionalization demands that a person receive necessary care in the least restrictive setting. Rising health care costs demands that services be provided in the least expensive setting, while still maintaining a quality level and amount of care.

Because of the bias toward institutional care brought about by the available payment mechanisms, the state and federal governments have combined forces to provide necessary care in a less costly manner. In addition, home care takes full advantage of natural helping networks - family, volunteer and donated services - which helps to decrease costs. These helping networks are most often lost when a person is institutionalized. Home care maximizes the person's independent status. It enables a person to live on his own means for a greater length of time, as home care is not as expensive as institutionalization.

INITIATIVE IMPLICATIONS:

Number to be Served: The revision of the [1]Montana State Health Systems Plan April 1983, identified that by the year 1990 there will be a need for 6,453 beds for skilled and intermediate nursing care. This projection was based on an estimated growth of 33% in the Montana population over age 65. Inherent in this projection is a 15% adjustment for individuals for whom nursing home placement should be optional or about 967 slots. In other words, the total projection was 7,420 slots less the 15% or 967 slots which will equal the 1,990 projection of 6,453 beds.

[1] These estimates are being reviewed by SRS. There may be revisions before finalization of an estimate of needs.

The following table illustrates this:

Montana Health System Total Projection for 1990	7,420
Less 15% for Alternative Placements	(967)
Montana Health Systems Slot Projection for 1990	6,453

To begin to meet this 967 slot demand this initiative would provide for 400 slots over the 86-87 biennium. There would be 240 slots established in SFY86 and 160 slots in SFY87.

How it Meets the Needs of Constituency: The population to be served largely lives on a fixed income, at a time when their health care needs take a larger portion of their available income. Fixed income, frequently in the form of SSI, is also a major concern for the disabled population. Cost containment is a major issue with this group. Choice of living situation is paramount. This initiative would allow both needs to be fulfilled.

Short- and Long-term Effects: One long-term impact will be in maintaining or increasing the amount of independence and quality of life of an individual. Also an effective home-based service has no capital expenditures - if a service outlives its usefulness, there are no buildings left to take care of just because the service is no longer needed.

Initiative Impact on Other Programs: Providers of Title III Aging Services and Social Services Block Grant (Title XX) are an integral part of Home and Community-Based Services (HCBS). Costs for these Title III and Social Service Block Grant (Title XX) funded services are calculated toward the total cost of HCBS services. Coordination of services and cooperation of providers is vital if persons are to be maintained in their homes. The case management function will enable better cooperation, coordination and maximization of all resources.

For Medicaid eligible individuals, all regular Medicaid covered services are available whether they are enrolled in HCBS, admitted to a nursing home or other institutional placement, or living independently. It is not foreseen that HCBS enrollees would have any different Medicaid utilization pattern than other Medicaid eligible individuals.

IMPACT ON BIENNIUM BUDGET:

___ increase ___ decrease ___ adjustment General Fund, Medicaid Source

Total Biennium	$4,663,000	FY 86:	$1,444,000	FY 87:	$3,219,000
One Time (Start Up) Cost	$ 385,000	FY 86:	$ 220,000	FY 87:	$ 165,000

Assumptions

400	Cases
60	Cases/Case Management Team
$55,000	Start Up Costs/Team
1	SRS FTE Per Team At $30,000/Year
400	Cases = 7 Teams
60	Team

This initiative provides for an increase of Home and Community-based slots of 400 over the 1986-87 biennium. There would be a phase in of 4 teams of SFY86 and 3 teams in SFY87. The following table illustrates the projected cost of the 400 slots for Home and Community-based Services.

	SFY 86	SFY 87	SFY 88	SFY 89	TOTAL
[1]Total Community Based Service	$1,384,000	$3,159,000	$3,690,000	$3,690,000	$11,923,000

Definition of Unit: Depends on services provided.

Cost per Unit: Depends on services provided.

Impact on SRS: Increase of 2 FTE for state administration at a cost of $30,000/FTE (includes salary, benefits, travel, supplies, communications, rent and miscellaneous). These positions are funded with 50% general fund and 50% federal Medicaid.

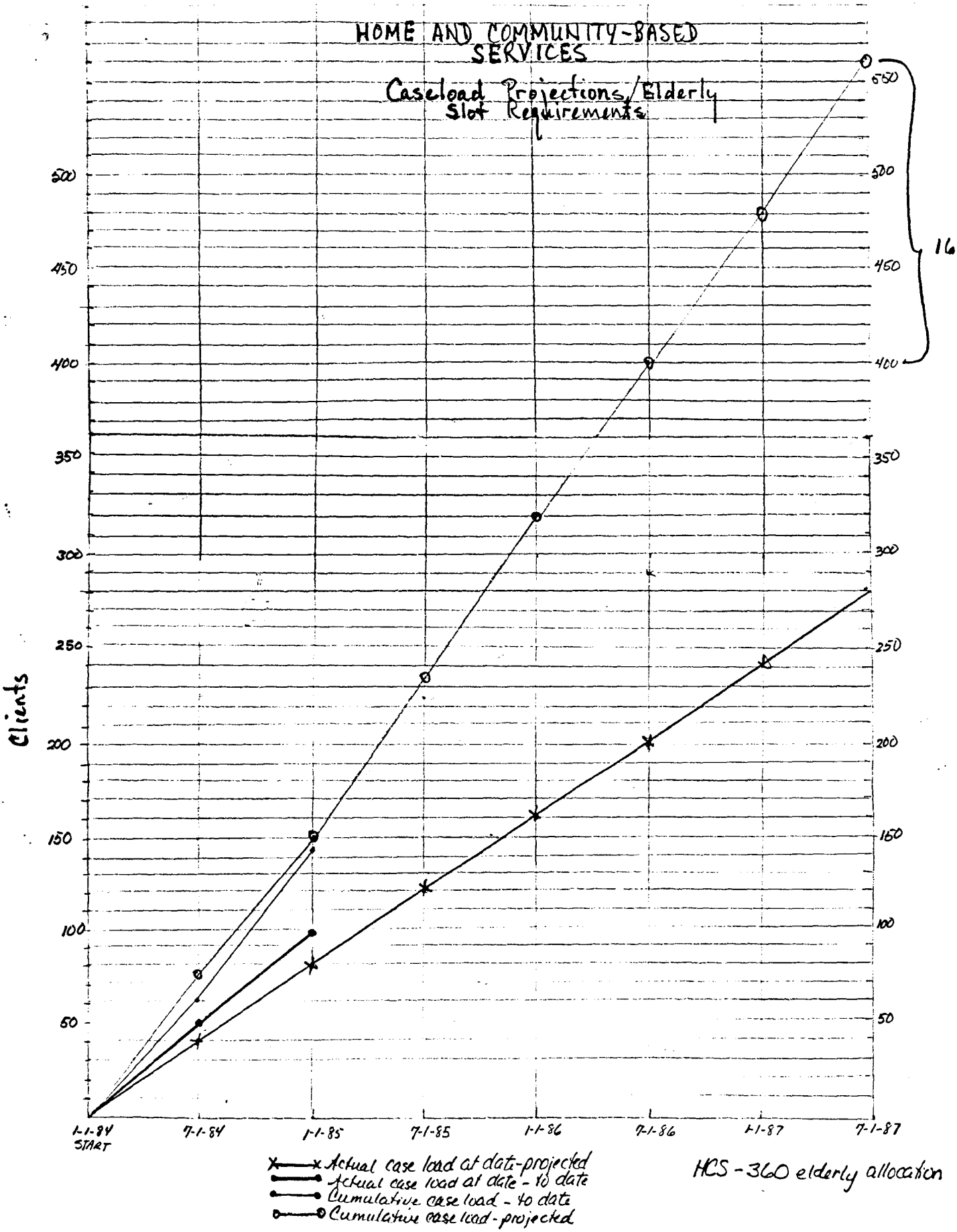
2 Years x 2 FTE x $30,000 = $120,000
$ 60,000 General Fund
$ 60,000 Federal

[1] Includes 400 slots, start up costs and 7 SRS field staff.

PFP/aa

HOME AND COMMUNITY-BASED SERVICES

Caseload Projections/Elderly Slot Requirements



HCS - 360 elderly allocation

Based on 12 mos. service by 3 CMTs (180 clients) YEAR I
Length of stay = 108 days average
Turn over rate = 47%
Retention rate = 53%

Exhibit 9
2-15-85

February 14, 1985

To Whom It May Concern:

James Cunningham came to live with us one year ago, after having lived in Southern California for a number of years with another member of the family.

When he arrived here, he could not get from one end of the living room to the kitchen without stopping to rest. He was overweight and generally very ill. His speech was not understandable at all due to a stroke two years before.

For six months we endured such behavior from him, as running away, curling up in a fetal position for hours, yelling and cursing, wouldn't take his medication, not bathing, he wouldn't talk, ignored us, pretended he couldn't hear, pretended he couldn't see, talked of killing himself, to name a few.

He was uncontrollable, so I was looking for a rest home to put him in, and heard of this day care program. We decided to try the day care instead of a rest home because we still felt a family atmosphere would be good for him.

If this program had not been available, we would have had to put him in a rest home. He has been in the day care program since August 1984. His self-esteem is great. He now cares about how he looks, he takes baths, his behavior at home is very acceptable to our family. He laughs and jokes. We can understand his speech, he had lost weight and is feeling very well for an 85 year old man who has a pacemaker, has had a major heart attack, and had cancer. He gets around great. We even had to cut back on his high blood pressure medicine because the more stable and rewarding environment lowered his blood pressure.

If this program were not available, Jim would probably be in a rest home or would have curled up and died. He did not have any reason for living before. Now he loves to go to Day Program. He attends from 8 to 4 five days a week.

This program also does tremendous things for our family. We now have enough privacy in our day to satisfy us. The improvement in his behavior and his health is a joy to us.

If this program were cancelled Jim would not have a purpose for living or anything to look forward to each day. I'm sure there would be a decline back to despondent behavior.

Sincerely,

Ginger Wheeler

R. Wheeler

2/14/85

In June of 1984 my sixty-six year old mother-in-law came to live with us.

Suffering from a very crippling form of arthritis (Ankylosing Spondylitis) she has had limited mobility at best. Early in the year she had fallen and lost her remaining movement. Her family where she lived in New Jersey cared for her a short time, but wanted no responsibility for her long term care. We arranged for her to enter a rehabilitation unit. When the benefits available in New Jersey ran out, we had no choice but to move her here to Montana.

I was giving her minimal care myself, but on top of caring for my two small children, doing extensive renovation on our historic old home, and working part-time, it quickly proved to be too much.

The extent of mental, emotional and physical strain of caring for someone bed and wheelchair ridden has been most surprising. The home care provided by Easter Seal has saved us from the agonizing decision of confining this otherwise vital woman to a nursing home.

William & Jennifer Hicks

EXHIBIT 10
2-15-85

Exhibit 11
2-15-85

Bob and Jane Rogers
8385 Green Meadow Drive
Helena, MT. 59601

Representative Cal Winslow
House Budget Committee
Capitol Station
Helena, MT. 59620

Mr. Chairman and Members of the Committee-

For the record, my name is Jane Rogers of Helena.

In early 1984 my mother suffered 2 strokes which left her unable to care for herself. For 5 months I took care of her myself with very little help. She couldn't walk, dress, ~~herself~~ or by herself, eat and her mind was affected so she didn't always know where she was or who we were. She'd be fine one minute and crying the next- and imagining things. By the end of the 5 months I was totally exhausted. I felt sick myself, and I knew I couldn't go on.

After counseling with my mothers doctor, I decided (reluctantly) to try a local Nursing Home. She entered the nursing home Aug. 8 (her birthday) and it lasted only 4 days. She was admitted under "skilled care". There were many incidents, but finally on a Saturday afternoon when I returned from a short absence, I found her sitting in her easy chair with her head slumped against a metal nightstand- she was wet and messed and had spit up mucus and was crying for me to help her. I told her I was taking her home. I called my husband and in ~~½ an hour~~ a short while, we had her belongings loaded in the pickup and were on our way home.

I didn't give any thought to how I was going to manage but I knew I loved her and would do all I could. It meant sacrificing my own personal life with my husband, four children and 12 grandchildren. I was totally tied to her and my home and could rarely leave.

Finally one day Diane English and Gwen Barry-from SRS, called me and told me there was a new program recently OK'd by our legislature that my mother would be eligible for. She would fall under the medicaid waiver and be eligible for programs that would relieve some of the pressure of home care. We received nursing and personal care respite care, and senior companion. All the people we have had to deal with are excellent..For 4½ hours each morning I was finally free to do a few of the things I had been missing for 7 months. I can't express the gratitude I have for you making this program possible. Through working closely with Jean Underhill and Joan Taylor from Home Care my mother is able to stay home and the financial burden is lifted. You wouldn't believe the gains she has made caring for her at home where she feels secure and loved. Her mind has improved, she feeds herself, dresses herself, brushes her teeth and <u>almost</u> walks unassisted. Although she still needs round the clock care, my mother is happier, healthier, and is determined to regain her self-respect by caring for herself.

I beg you to keep this program available for us and other families. I know there are other families who would keep their elderly at home if they just had a little help. It is an alternative to skilled nursing home care that works and is successful. There is much that I have not stated due to time. I hope this is sufficient to help you in your decision.

I have to give much credit to others for helping me through this past year..... God I call on every single day... My new friends at home care and West Mont... My family for all their love, help, and support....I could not have made it with out them. Thank you.

Respectfully Yours,

Mary J. (Jane) Rogers

Exhibit 12
2-15-85

February 15, 1985 Hearing on Home and Community Service
Chairman - Rep. Winslow

Mr. Chairman and members of the committee:

My name is Patricia Wood. My mother has been under the Home Care Program since November of last year.

She was hospitalized in September of last year, then spent six weeks in a nursing home. She has substantial memory loss. However, we have been able to prove that with the help of home care she is perfectly capable of functioning adequately in her own home environment.

She needs daily assistance with medication and other care. I have no brothers or sisters. I live out of town on a working ranch. Without the Home Care people there would be no one to give my mother the daily assistance she needs.

I am a firm believer in Home Care because I KNOW my mother is more secure mentally and emotionally in her own home.

This is the best program for care of the elderly that has come along in many years, and I know that without it my mother will be in a nursing home, a severe blow to her.

Put yourself in her place. You have worked hard all your life. You are 84. You need some assistance each day because you can't remember. But you do know your home and you know your own things and you desperately want to remain there.

I would urge your support of this program that will keep her and others like her there--in their own homes.

Thank you

Patricia C. Wood

Exhibit 13
2-15-85

Honorable Chairman & Members of the Committee:

My name is Zana Smith. I am here representing the Montana Independent Living Project (MILP). MILP serves physically disabled Montanans, representing a wide range of disabilities (MS, MD, Spinal Cord Injury, Head INjury, etc). I would like to affirmour agency's support of the intent and design of the expanded Medicaid Waiver Program, as this program offers potential both in providing much needed services in the community and long range budget savings.

The transfer of Medicaid resources from the institutions to community ~~differently~~ specific result in increased independence, self-esteem and productivity for the consumers. We believe the program is a model endeavor. Under its current design it provides flexibility to meet individual needs as well as organized service responses to providing group services for specific disabilities. At this time our agency works with 14 individuals outside the Missoula and Yellowstone County areas who would eligible for this program. The service would be used to maintain them in their homes in the community or would be the system which would be used to bring persons currently in nursing homes or the state institution back to their communities. We work with three women under the age of 45 years, who have dependent children, their children are currently in foster care, because adequate support is not available in their communities.

We encourage you to support community based services which enable the physically disabled to remain in the community with services designed to support each individual at appropriate levels of independence.

VISITORS' REGISTER

Human Services Sub COMMITTEE

BILL NO. _____ DATE 2-15-85

SPONSOR Home & Community Services - SRS

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Dave Depew	MPEA		
Mary J. Rogers	8385 Grn Mdw Dr Helena	✓	
Susan K. Rogers	4704 Carol Dr Helena	✓	
Mildred Ewing	1090 N. Montana Helena, Mt	✓	
Robert K Johnson	316 S Park, Helena	✓	
Roberta Hatting	Eureka, MT	✓	
Diane English	623 Logan Helena	✓	
Patricia Wood	DOA, E. Helena	✓	
Tana Smith	Montana Independent Living Project	✓	
Molly Munro	MONTANA - Helena	✓	
JUDITH H CARLSON	NASW - HELENA	✓	

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.