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

February 19, 1985

The meeting of the Human Services Subcommittee was called to order by Chairman Cal Winslow on February 19, 1985 at 7:04 a.m. in Room 108 of the State Capitol.

ROLL CALL: All members were present.

Chairman Winslow introduced several people who requested to speak on the Domestic Violence funding issue.

Caryl Wickes Borchers, from the Montana Coalition Against Domestic Relations, discussed the positive aspects of maintaining shelters throughout Montana. She gave everyone a handout with information on the Domestic Violence program in Montana, along with five letters from people supporting the program (EXHIBIT 1).

Noreen Dever (51:A:082), a staff member of the Great Falls Mercy Home, read excerpts from two letters from people voicing their support for the Domestic Violence program (EXHIBIT 1).

Leslie Oakland (51:A:123), a board member for the Great Falls Mercy Home, read a letter from a battered spouse.

Sue Bennett, who has a private practive as a counselor in Helena, discussed those people that have been battered themselves, and stated that unless they get help, they will probably batter someone else. She discussed the women that seek shelter from being battered.

Kelly Chandler, representing the Women's Lobbyist Fund, spoke on behalf of two women from Women's Place in Missoula and read two letters from them supporting the allocation to domestic violence programs (EXHIBIT 2).

Lenore Taliaferro, a staff member at the Friendship Center in Helena, said she is very impressed with the quality of services that people receive at the Friendship Center. She gave everyone a summary of the services the Friendship Center offers (EXHIBIT 3). She said these services can save dollars in the long run.

Gail Kline spoke from her prepared testimony (EXHIBIT 4).

Bob Olson (51:A:338), a program officer for the Medicaid Financing Bureau for SRS, gave everyone a summary of his testimony on DRG's (EXHIBIT 5) and a more detailed description of Diagnostically Related Groups (EXHIBIT 6).

He reviewed and discussed this information.

John Larson discussed the proposed increase in staff to operate the DRG system, which is PFP Initiative EN-8 in Tier 2; it consists of four additional FTEs for the Medicaid Financing Bureau to administer the hospital reimbursement program. He gave everyone a handout listing general information on this initiative (EXHIBIT 7).

Lowell Uda (51:A:044), chief of the Medicaid Services Bureau of SRS, discussed the PFP Initiatives EN-10, EN-3, and EN-2 and gave everyone an SRS initiative summary sheet for each of those initiatives (EXHIBITS 8,9,10).

Jack Ellery (51:B:458) discussed the Medical Assistance operation. He said the program currently has 21 FTEs, and is administered by the Medicaid Financing and the Medicaid Services bureaus. He discussed each of the bureau's responsibilities, the number of FTEs in each bureau and their duties. He also discussed the Indian Health Program and the Department of Health Services contract which is required by federal law to certify Montana hospitals and nursing homes for Medicaid and Medicare reimbursement.

Jack Ellery pointed out that the LFA does not include anything for the Medicaid waiver; this is a major difference of approximately $1 million.

Lee Tickell (52:A:061) gave a brief overview of the State Medical program and its history. He pointed out that the court case in Butte against SRS puts the State Medical program at risk because the department may have to pay for many of the same services that are currently authorized under the Medicaid program. He also pointed out that the State Medical program does not require a copayment because the department has tried to maintain general assistance as a need-based program; if they added a copayment basis in the State Medical program, they would have to increase GA payments.

Lee Tickell discussed the fact that people served under State Medical are different from those served under GA; 70 percent of the expenditures in the State Medical program are hospital costs, and only $185,000 out of a $300,000 program was spent on able-bodied people.

The meeting was adjourned at 8:48 a.m.

Cal Winslow

CAL WINSLOW, Chairman

DAILY ROLL CALL

Human Services Subcommittee

49th LEGISLATIVE SESSION -- 1985

Date 2-19-85

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		

February 2, 1985

Exhibit 1
2-19-85

Capitol Station
Helena, Montana 59601

Dear Legislators,

I am writing to ask you to support the continuation of additional funding of the Domestic Violence Grant Program with the 4% General Fund Monies in the Executive Budget over and above the Marriage License Fee monies that we have totally funded the Domestic Violence Grant Program with since July of 1979.

In February of 1977 the Montana Legislature started working with us to start solving the problem of Domestic Violence by a Senate-House Joint Resolution which mandated Crime Control to study Spouse Abuse in Montana. That Study was made and called 'SPOUSE BATTERING IN MONTANA'. In April 1978, A STATE TASK FORCE ON SPOUSE ABUSE was established to read and study 'THE STUDY' and make recommendations to the 1979 Legislature. In addition to the Legislation that has been passed by you in the last 4 Legislatures, the Montana Task Force on Spouse Abuse has been able to have written a STATE TRAINING PACKET ON SPOUSE ABUSE developed for Mental Health Professional and Clergy; a SPOUSE ABUSE PROTOCAL in the 61 State Hospitals; and a RAPE PROTOCAL in the 61 State Hospitals; a booklet with the STATEWIDE SERVICES entitled 'BATTERED WOMEN RIGHTS AND OPTIONS IN MONTANA'; do COMMUNITY INTERVENTION WORKSHOPS sponsered by the LAW ENFORCEMENT ACADEM plus spearhead GRASS ROOTS EDUCATION on the problem in Communities; do State Workshops in TRAINING ADVOCATES; training in the use of the STATE TRAINING PACKET; and a workshop in the latest research on the BATTERER and the CONTINUING CYCLE of DOMESTIC VIOLENCE.
In October 1982, the MONTANA COALITION AGAINST DOMESTIC VIOLENCE was formed and incorporated. We are continuing the GRASS ROOTS EDUCATION statewide(I do 60 Educational workshops and talks each year)plus have continued our State Workshops such as: Dr. Lenore Walker's latest RESEARCH on the BATTERED WOMEN and BATTERER; the"RELIGIOUS RESPONSE TO DOMESTIC VIOLENCE;"and THE BATTERERS PERSPECTIVE" at our Montana Coalition Against Domestic Violence State meetings.

The Great Falls Mercy Home, Inc. opened in May 1977, our first Shelter in Montana and one of 30 in the United States addressing the problem of Spouse Abuse. We have been able to give technical assistance and spearhead 6 other Shelters in the State and 12 Spouse Abuse Task Forces who have Safe Homes (private homes for 3 day intervention) and network with the Shelters if needed, in addition to having grass roots education and outreach to all parts of the State. Listed below are recent updated services and educational outreach.*asterisk denotes Shelters.

Hi-Line Help for Abused Spouses has done education and outreach to:Joplin, Box Elder,Ft. Belnap Reservation, Rocky Boy Reservation, Chinook, Hingham, Kremlin, Rudyard,State Worksh
**GreatFalls Mercy Home has done education and outreach to: Belt(trained an outreach Group Facilitator), Cascade, Stockett, Ulm, Vaughn, Sand Coulee, Choteau, Fort Benton, Universit of Montana (2 classes), Browning, Shelby, CutBank, Conrad, Lewistown, State Workshop.
** Missoula BWShelter has done outreach and education to: Stevensville, Hot Springs, Hamilton, Darby, Seeley Lake, Ronan, Frenchtown, Milltown, Potomac.
Kalispell Rape Action Line has done education and outreach to: Bigfork, Whitefish, Columbia Falls, Olney, Pablo-Ronan, Dayton, Libby.
Glasgow, Glendive and Miles City have had a 17 County State Grant until this past year when they did individual Grants but they have done outreach to: Sidney and Glasgow did outreach to Richland, Nashua, Malta
Glendivedid outreach and education to Wibaux, Terry, and Circle
** Helena Friendship Center has done education and outreach to Boulder, Townsend, Augusta and Whitehall
** Bozeman has done education and outreach to: Belgrade, Ennis, Livingston, West Yellowstone, Big Sky, White Sulpher Springs, State Workshop.
Dillon has done education and outreach to: Melrose, Sheridan, and Lima
** Butte Safe Space has done education and outreach to:Whitehall, Twin Bridges, Sheridan, Anaconda, Deer Lodge.
**Pablo-Ronan Shelter supported by some Salish-Kootenai Monies opened in 1982 in Pablo-Polson, Ronan Area.
**Billings Shelter did outreach and education to: Ft. Belnap Reservation, Cheyenne Reservation Crow Reservation and Colstrip.
Colstrip-Victims of Violence Task Force
Lewistown- Spouse Abuse Emergency Services (SAVES)
Libby - LincolnCt.Womens Help Line for Eureka and Troy
Twin Bridges- has a 24 hr.Crisis Line/Information
Whitehall - Jefferson Ct.Spouse Abuse Program

In September 1981, Bill Curry, staff writer for the LOS ANGELES TIMES-WASHINGTON POST came to Great Falls and did a front page story in the L.A. TIMES about Mercy Home and Montana and how the Montana Legislature raised the marriage license fee to fund Domestic Violence programs. Then, CBS NEWS did a similar story on Mercy Home, which was aired on Dan Rather's CBS NEWS on December 31,1981, as well as on the MTN NEWS in the state several times.

There are now 15 states who have modelled their Domestic Violence funding after Montana and the marriage license fee. However, some states have other funding, such as Wyoming, which has 1.5 million in Oil Impacted monies to fund Domestic Violence programs. A shelter as large as Mercy Home (which can accomodate 22-27 women and children) in other states is funded for $220,000, compared to Mercy Home's 1985 budget of $78,400 (an increase of $740. from 1984). While the other shelter has a staff of 11, we have four and must rely on innovative, supportive staff through the Jesuit Volunteer Corps staff, college and nursing interns. In addition, I had to write 14 grants to fund our 1985 budget, and the director in Wyoming does not have to write any.

The Great Falls community has been one of great support to the Mercy Home, since we first began operation in 1977. Last year, we received a total of $93,796 In-Kind contributions, $50,000 of which was donated services and volunteer hours which have enabled us to keep our staffing costs low and to also strengthen our counseling services.

I have personally continued Community Coalition Building and involvement through our Community Food Bank. I was recently re-elected to the Board of Directors and I have written several grants which have brought assistance to the Food Bank from out-of-state foundations.

Our 1985 budget of $78,400, is only a 2% increase from the 1984 budget, a budget with which we served 570 women and children in the shelter, and an additional 789 families through outreach. This was an increase in client load of 28% from the year before. Because of our educational efforts, we are doing much more prevention and work with families outside the shelter.

In May 1983, the Executive Director of Public Welfare Foundation (a Washington,D.C. foundation) came to Great Falls to see our program at Mercy Home, for which they have funded two $12,000 grants. We were told "Our shelter was the best shelter program their foundation has funded!" These two grants are part of the $250,000. in grants which I have generated into Great Falls through private church and foundation monies over the past 7 years. I cannot generate this type of funding without good community and state support.

I am very proud of the ways in which our 'grass roots' plans have developed into strong programs of human services and education, through the cooperation of the past four legislatures, the past two governors, and the Department of Social and Rehabilitation Services in the STATE OF MONTANA. Due to ecomonic conditions and high unemployment (a triggering event for Domestic Violence), we are all seeing a tremendous increase in our client loads. With some General Fund monies we will be able to continue to stretch every penny to benefit the entire state as we have been for the past six years.

Sincerely yours,

Caryl Wickes Borchers

Caryl Wickes Borchers
Executive Director, Great Falls Mercy Home
Chair,Montana State Task Force on Spouse Abuse (1978-1982)
Rep., Montana Coalition Against Domestic Violence

February 4, 1985

Dear Legislators,

Domestic violence programs and shelters are needed because they are a fundamental tool for breaking the cycle of domestic abuse.

A battered woman first and foremost needs a place to go where she'll be safe--shelters offer this. If a woman has no safe place to go, she'll very likely stay in the situation.

I lived in an abusive situation for many years, not knowing where to go, or who to turn to. You don't usually want to involve your friends and family because of the shame and fear you are going through.

When I heard about Mercy Home, it was like a light being seen at the end of a long, black tunnel. I decided next time my spouse abused me I would call them. So I did. I was able to come in with my children, made very comfortable, breathe a sigh of relief, and start for the first time to put the abuse in perspective. I was offered food, shelter, clothing and counseling without cost. This is imperative, because many women and their children come to shelters with nothing but the clothes on their backs. When a battered woman decides to flee her situation, safety for herself and her children in the only thing racing through her mind.

The counseling I received at Mercy Home was much needed. For the first time ever, someone understood what I was going through without being judgemental. They explained about abuse being learned behavior, and I realized this was learned behavior I was now subjecting my small children to.

They explained the different stages of the abuse pattern to me and I could see them applying to what had happened to me. At last I could see why I felt I had no control over the abuse incidents. If my husband was ready to abuse, nothing I could do or say would stop him. I was able to put the abuse in perspective. It wasn't my fault anymore. I could do something about my situation and eventually I was able to get out ot if. I couldn't have done it without the help of the Mercy Home staff and their caring, advise and direction.

They showed me the different alternatives I could take. I chose to give my husband another chance, if he attended counseling for both the abuse and his alcoholism. I did not return to the situation until he had, indeed, signed up for them. When I did return home, what could have been the road to recovery for my spouse turned out to be "The getting back into the house Game." Things improved for a short time before the counselling stopped and the abuse continued. I was back and forth a couple of times after that, staying with my mother and friends in between, going home to high hopes and so many promises that were never kept.

I returned to Mercy Home for the second and final time again as a safe place to go where I could start, little by little, rebuilding my life, my self-esteem, and the home life I knew I wanted for my children.

Today I look back to how helpless I felt, thinking "What do I do to cause my husband to treat me this way?" "Why is this happening?" It was a nightmare that happened over and over again.

Why do we need shelters and other domestic violence programs? Because these crimes touch everyone in some way. Spouse abuse can be directly related to child abuse, incest, sexual abuse and practically every other type of crime there is.

These programs and shelters give answers and solutions to problems we have only recently admitted we have. An answer to the nightmare of spouse abuse.

Julie D. Ferguson

Julie D. Ferguson

February 1985

Capitol Station
Helena, Mt. 59601

Dear Legislator,

I am writing in reference to the need for more support of battered spouse centers, and equally important, for the need of more adequate protection for women in battered situations.

In the 2½ weeks after my last battering, I lived in a state of chronic fear before I was finally able to tie up all of my loose ends and leave town. I feel that the laws at this time are inept in dealing with the rampantly growing problem of family violence.

There is no doubt in my mind that my husband would have succeeded in ending my life if my children had not awaken and heard my pleas for help. If I had pressed charges, my husband would have spent a short time in jail and then would have probably finished what he had not ended.

I had no financial means of obtaining a lawyer in order to obtain a restraining order for my husband. My children and I were forced to leave our home, town, schools and employment to be safe. There is no way I can express to you the emotional stress this has subjected our family to.

In closing, I would like to make a statement about what the battered shelters (we have stayed in Billings and Great Falls) have done for me. They have given me hope, that there is and will be a better way of life for my children and myself. They have helped me find the resources available, new directions to take, and most importantly, once again I feel like a whole person, instead of the shattered and fragmented woman I was before I finally sought help.

Sincerely,

Melissa

February 1985

Capital Station
Helena, Montana 59601

Dear Legislator,

I am 7 years old. I ~~wish~~ and I want to help people so mothers won't get hurt by there husbands. My sister has got problems because my mother's get beat up by my dad. Please help so we can live in a better life.

Dusty

February 1985

Capitol Station
Helena, Montana 59601

Dear Legislator,

I am ten years old and I'm writing about supporting the home and all the people that have had family problems.

I hate seeing my mom get beat up, and if you don't help support us it well get very bad. My little brother and sisters are really hurt by my mother and father fighting. Now we have somewhere to stay .Please help the home of battered women and childen.

Sincerely,
Shawn
Shawn

The Sub-committee on Human Services
Representative Cal Winslow, Chair.

In reference to the 4% General Fund Monies in the Executive Budget over and above the Marriage License Fee

(Senator Christiaens, I am a consituent of yours in Great Falls)

I was a victim in an extremely battering relationship. Had it not been for the Mercy Home in Great Falls, I would not have gotten the necessary counseling so vital in order to rise above the hell I went through while married. Although I did not need to stay at the shelter because I had family in Great Falls, there are many women who have absolutely nowhere to go. Therefore, it is extremely important the necessary funds are there to give these women the support they need through the refuge of a "shelter".
Thank you.

Melinda Garcia

Exhibit 2
2-19-85

February 19, 1985

Human Services Appropriations
Subcommittee
Montana Legislature
Helena, Mt 59620

Dear Chairman Winslow and Committee Members:

I am testifying on behalf of Women's Place in Missoula, a center for counseling and education on issues of violence against women. We are concerned about the proposed cutback in statewide domestic violence funding. Our domestic violence program has been improving and expanding over the past ten years, and we are deeply disturbed about the possibility of having to cut back or eliminate any of our services. At the present time, we have only one half-time staff person who coordinates our domestic violence program. This program includes 1) a 24-hour crisis line, 2) ongoing counseling and support groups, and 3) public education programs through churches, schools, senior citizens' centers, the University of Montana, and Women's Place office.

Our domestic violence program is having a positive impact on the community. This is evidenced by not only the increasing numbers of requests we receive for education programs, but also the increasing numbers of men who call to request counseling to control their violent tendencies. We feel that with this complete program of intervention in immediate crisis situations via the 24-hour crisis line, the ongoing support and counseling for survivors of domestic violence, and the public education, we are offering options for women to overcome violent and dangerous situations. We would like to be able to continue offering this broad range of services. However, with any further cuts, we are afraid we will not be able to do so.

Please support the allocation to domestic violence programs from the General Fund, and support our efforts to end violence against women.

Sincerely,

Susan Wall-MacLane

Susan Wall-MacLane
629 Phillips Street
Missoula, MT.59802

Representative Windbow:

This letter is addressing the critical issue of funding for the state domestic violence programs. I am a crisis counselor with Women's Place in Missoula. We are an agency concerned with stopping domestic violence against women; wife battering, sexual assault, and incest. Over the last year, our funding, has been cut by private agencies from which we receive money for our programs. We are now facing extreme difficulties in raising money to sustain the programs we now offer to women. The services we provide will be limited if our funding is cut any further.

I urge you, and plead with you for the sake of oppressed women, to support the executive budget recommendation for 4% funding from the General Fund. Granted, this is a 2% cut, yet it will be enough to continue the domestic violence programs.

Thank you.

Kiara Moffitt
257 W Front
Missoula, MT

Exhibit 3
2-19-85

Friendship Center of Helena, Inc. Jill Kennedy, Director 442-6800
1503 Gallatin
Helena, Montana 59601

February 19, 1985

TO: Members of the Sub-Committee, House Appropriations-Human Services

FROM: Friendship Center, Shelter and Counseling for Domestic Violence serving Lewis & Clark, Jefferson and Broadwater Counties.

SUBJECT: FUNDING NEEDS FOR DOMESTIC VIOLENCE PROGRAMS/SHELTERS.

During the fiscal year of 1984, Friendship Center provided shelter to 115 families. This number does not include any duplication. Actual numbers served, including children in abusive situations total 456. By the end of the current fiscal year, this number will be exceeded significantly.

The abused individuals who come to Friendship Shelter have no where else to go. While at the Center, the families are provided a warm and safe place, They are also provided with assistance in obtaining needed social services, employment referral, personal counseling while at the Center, and appointments are set up with mental health services and needed health care. We provide clothing and some assistance with food.

Families can stay for a period up to six weeks in order to attempt to get on their feet and get established independently. For all of these services, we received a total of $8,400.00 from the State. On a daily rate, we are reimbursed 3, 4, or 5 dollars per day. $5.00/day is the maximum for families of 6 or more members. It is not difficult to see that this falls far short of what actual costs would be in any other setting.

The Friendship Center has plans to open additional housing for battered women and children. All work on this house has been donated, but without additional funding to meet the demands, it will not be possible to open the new shelter, and, in fact may require current services to be reduced, or, eliminated. The cost of not dealing with the problem at a time when future abuse can be prevented by teaching women and children that this behavior is not normal, and that it is not a way to solve problems, will become phenomenal. Child abuse leads to spouse abuse, and spouse abuse leads to elder abuse. Domestic violence program is where real prevention can be achieved for children, adults, and elderly.

Our Center already finds it necessary to turn people away. At best, we attempt to find very short-term housing, but we have limits. We have 6 people in one room and that is not that uncommon. We have children ranging in age from 2 months through 10 years right now. If there is no place for people to go, what price will all of us pay if abuse is allowed to continue.

On behalf of those people served by a center such as the Friendship Center, we urge you to fund these programs adequately. The centers do have the opportunity to stunt the growing incidence of child abuse and prevent situations of abuse in the spousal relationships of the future.

Family protection is of utmost concern. The prevention of domestic violence is the goal. Until this occurs, the needs of the victims must be dealt with.

To fund these centers adequately seems a small price to pay for the mending and healing of severely bruised bodies and souls.

Respectfully submitted,

Lenore F. Taliaferro

LENORE F. TALIAFERRO
DOMESTIC VIOLENCE PROGRAM
STAFF/COUNSELOR

Jill Kennedy

JILL KENNEDY
DIRECTOR OF FRIENDSHIP
CENTER

Exhibit 4
2-19-85

WOMEN'S LOBBYIST FUND

Box 1099
Helena, MT 59624
449-7917

February 19, 1985

Testimony for the Women's Lobbyist Fund by Gail Kline, before Human Services.

Mr. Chair and other members of Human Services

For the record my name is Gail Kline, representing the Women's Lobbyist Fund (WLF) speaking in favor of the continuation of additional funding of the Domestic Violence Grant Program.

The second quarter FY 85 report on domestic violence programs show 6,989 persons have been reached so far this year. That is almost 7,000 persons in six months. This figure includes services to 859 children.

Dr. Mark Rosenberg (Chief of National Centers for Disease Control, Violence Epidemiology Branch. Daily Inter Lake, November 27, 1984 - From a study on violence as a major public health problem) said, "Attacks by husbands on wives result in more injuries requiring medical treatment than rapes, muggings and auto accidents combined."

A recent client, fifty years old, who had a severe concussion, broken jaw and broken knee cap was recently told by a doctor that she couldn't work again. We will be paying each year of her life for medical and welfare expenses.

In addition, her husband is serving 8 years in the Montana State Prison and we will be paying $12,600 each year to have him in prison due to his violent "learned behavior." His imprisonment will cost our state over $100,000 over the eight year period not counting interest and at today's prices.

By funding domestic violence, spouse and child abuse, the state is making a good investment with our tax dollars on our state's future. We can't ignore the fact that the seeds of family violence are being sown and the cycle of violence grows. It will continue to grow without the help of state finances.

The WLF urges you to pass the additional funding of the Domestic Violence Grant Program.

Exhibit 5
2-19-85

FLAT RATE REIMBURSED WITH DIAGNOSTICALLY RELATED GROUPS (DGRs)

I. INTRODUCTION:
- A. Montana's hospital cost increased 51% from 1980 to 1983.
- B. Medicare has introduced a modified flat rate payment system for inpatient hospital care known as DRGs.
  1. Montana relies on federal rules and the Medicare agent Blue Cross of Montana for audit and administration services.

II. THE CURRENT MEDICAID SYSTEM FOR PAYING FOR HOSPITAL CARE:
- A. Rates paid during the year estimate the cost of providing services.
- B. A year end financial report is audited to determine the hospitals actual cost of caring for Medicaid patients.
  1. Total payments made throughout the year are adjusted to equal the actual cost of care.
- C. This system must change because of the federal rule changes.
  1. If the current system is not changed the state will likely come under a substantially increased financial and administrative burden shifted to the state by the federal government.

III. ALTERNATIVE SYSTEMS:
- A. An SRS Task Force reviewed five alternative payment systems.
- B. Criteria used to evaluate the alternatives stressed maximizing efficiency incentives while minimizing financial and administrative impact.
- C. Only some form of DRGs met the evaluation criteria.
  1. The other alternatives required too many new resources or were not compatible with the Montana Provider Community.
  2. Adopting the Medicare DRG system without modification would be too expensive. Medicare's system uses national data for rate purposes.
  3. Using the Medicare DRG framework with Montana cost experience would be less expensive and minimize the administrative impact.

IV. HOW DRGs WORK:
- A. DRGs are simply a vehicle for making payments for hospital care based on the patient's diagnosis.
  1. Each diagnosis group has its own payment amount.
  2. The amount of the payment is related to the severity of the illness treated.
  3. There are 468 distinct diagnosis groups.
  4. The hospital keeps any profit or absorbs any loss associated with providing the service.
- B. DRGs only cover inpatient hospital care.
  1. Additional payments are made for capital costs and outpatient care.
  2. Additional payments may be made for unusually long lengths of stay or unusually expensive cases.

V. A DRG SYSTEM FOR MONTANA MEDICAID
- A. The Medicaid program would closely follow the Medicare format except use Montana hospital data.
  1. Continue to rely to the greatest extent on existing administrative structures.
  2. The system will require expanded administrative effort by the State in order for the system to operate successfully.
- B. At the urging of the Legislative Finance Committee SRS retained Compass Consulting Group to review alternative payment systems.
  1. Compass concurred with the SRS Task Force recommendation to design a DRG system. They further recommended the State acquire the necessary resources for that purpose.

Exhibit 6
2-19-85

FLAT RATE REIMBURSEMENT
WITH DIAGNOSTICALLY RELATED GROUPS (DRG's)

Introduction

Health care costs in the United States have experienced rapid escalation in the past several years. Inflation in the health care sector has consistently been higher than that in non-health care sectors of the economy. Health care as a percentage of Gross National Product has increased from 6 percent in 1965 to 10.5 percent in 1982. Over the calendar years 1980-1982 the average rate of increase in medical costs has been 11 percent.

Of special concern are Montana hospital costs which have increased at a faster rate than the national hospital industry average. Medicaid expenditures for hospital care in Montana have increased 51 percent from fiscal year 1980 to 1983. Total expenditures by the Medicaid Program for the fiscal year ended 6/30/84 for hospitals are projected to exceed $19.5 million, with inpatient hospital care accounting for $17.5 million.

The Federal Department of Health and Human Services (HHS) has introduced the Medicare Prospective Payment System for inpatient hospital care. Under the system adopted by HHS, hospitals are reimbursed a predetermined fixed fee per service based on the patients medical diagnosis. This system is commonly referred to as Diagnostically Related Groups or DRG's.

Montana has previously relied on federal rules for reimbursement and the Medicare fiscal intermediary (Blue Cross) for audit and administrative services.

Because of the rapid cost escalation in health care and the mandated actions due to changes in federal rules Montana Medicaid must reevaluate the way in which hospitals are reimbursed.

To accomplish this evaluation SRS formed a Task Force headed by Jack Ellery to evaluate alternative reimbursement methods. The criteria used to compare various alternatives were:

1. Contains overall hospital costs within:
   a. federal and state regulations; and
   b. current expenditures, plus a targeted percentage inflation increase.
2. Does not adversely impact the number of services used or the average cost per service.
3. Provides incentives for efficient operation of facilities.
4. Insures adequate delivery of medically necessary services.
5. Allows reasonable access to hospital care.
6. The program is not easily "gamed" or manipulated:

a. prevents cost shifting or other activity which diminishes the cost containment efforts.

7. Impact on administration is reasonable:

   a. required FTE staffing is minimal;

   b. uses existing staff as much as possible;

   c. uses existing administrative structures, even if outside the Department;

   d. program is easily administered and understood;

   e. does not create extensive appeals or litigation; and

   f. adaptable to budget projecting.

8. Program should be reasonable and defensible:

   a. the Medicaid program must allow for adequate reimbursement for "efficiently and economically operated facilities".

Present Organization Summary

The Montana Medicaid Program for hospital reimbursement is currently administered with reliance on federal Medicare policies and regulations. In order to understand the organization of the state program, one must be familiar with the following organizations and terminology:

1. The Health Care Financing Administration (HCFA) is a division of the U.S. Department of Health and Human Services and is the regulatory body of the Medicare and Medicaid programs.

2. The Medicare fiscal intermediary is the organization under contract with HCFA to provide fiscal management of Medicare funds, field and desk audits of hospitals, and other Medicare providers and administrative assistance in the provision of a utilization program. Blue Cross of Montana is a fiscal intermediary in Montana.

3. The Medicare provider reimbursement manual (HIM-15) provides guidelines which set forth principles for determining the reasonable cost of furnishing services under the Medicare program.

4. The Medicare cost report is a standard financial presentation of the hospital's claim of reimbursable expenses. The report is intended to measure allowable costs, which are those expenses that are reasonable in amount and necessary for the efficient provision of medical care. Costs are reported according to the Medicare provider reimbursement manual.

Montana's program relies on Federal regulation as to program requirements and determination of allowable costs. Blue Cross of Montana, the Medicare fiscal intermediary, is under contract with SRS to provide desk and field audits in an effort to reduce administrative duplication with Medicare.

The Montana Medicaid program is currently utilizing a retrospective hospital reimbursement system. Under this system hospitals are paid on an interim basis during the fiscal year. The rate of payment for services is based on a percentage of the hospital's customary charges which approximates cost. At the end of the hospital's fiscal year, costs attributed to providing care to Medicaid recipients are compared to the interim payment amount. A settlement is then established to adjust any overpayment due from or underpayment due to the facility.

The settlement findings are sent to SRS and a copy of the findings are sent to the facility.

SRS then notifies the facility to confirm the amount due to the facility or receivable from the facility. Procedures are then initiated to assure timely collection or disbursal of settlement payments.

Cost-based reimbursement is, therefore, a relatively simple system to operate. Because of the reliance placed on federal administrative services the Medicaid program required relatively few administrative resources and places little risk on providers. Conversely, this system provides few incentives for efficient management and cost containment. In fact, cost-based reimbursement provides an incentive to increase spending. The higher the costs incurred by a provider the higher the reimbursement received.

To overcome the changes of the Medicare program, the criticisms of cost based reimbursement and provide for cost containment incentives the State must make additional administrative effort.

The first step in addressing the current problems is choosing a reimbursement system. The system not only must meet the cost containment criteria, but must also be accompanied by the necessary administrative effort in-order to be successful.

The SRS Task Force identified the following reimbursement system alternatives:

1. Remain on a retrospective system with modifications to recognize regulatory changes and include those functions no longer performed by the Medicare fiscal intermediary.

2. Use a system of preapproved budgets.

3. Use indexed costs to limit increases of hospital expenditures.

4. Use competitive bids to establish contracts with hospitals for reimbursement of Medicaid health care.

5. To adopt some form of DRG system compatible with the Medicare system.

Only the option to formulate a DRG approach met all of the evaluation criteria. Most of the other options would require substantial new administrative resources, fail to achieve cost containment objectives or did not meet the needs of the Montana Provider Community.

Prospective Payment with Diagnostically Related Groups

Prospective payment is a system in which rates of payment are established in advance of the coming year. These rates are paid regardless of actual cost. This type of system promotes efficiency in a simple, effective way. Hospitals will be allowed to retain any surplus they can earn by operating efficiently. Likewise, they must absorb any losses for their inefficiencies.

Medicare devised a prospective payment plan which reimburses hospitals on a modified flat rate according to the patients diagnosis and treatment. This system is commonly referred to as Diagnostically Related Groups or DRG's.

Under this plan, which commenced October 1, 1983, hospital payment will be related to the treatment provided to each patient. Since patients have different diagnoses, require different treatments, are of different ages, and differ in other ways, each patient will be classified into one of 467 separate DRG's and each DRG will reflect the total payment for providing inpatient hospital services.

The rates will be payment in full to the hospital with no beneficiary cost-sharing except for any deductibles and co-insurance mandated by law. Hospitals are precluded from charging beneficiaries any amount which exceeds the deductible and co-insurance amounts specified by Congress.

This prospective payment system should improve quality of care in hospitals as it will encourage hospitals to specialize in providing the services which they do best. In addition, a national evaluation of state rate setting programs performed by Medicare has shown no adverse impact of prospective payment on hospital accreditation status, fatality rates, readmission rates, or other measures of quality of care.

The U.S. Department of Health and Human Services has reported to Congress that this approach to prospective payment has the following advantages:

1. Although complex to design, DRGs are easy to understand and simple to administer.

2. It can be implemented within a reasonable time frame, given the appropriate resources.

3. It ensures both hospitals and the federal government a predictable payment for services.

4. It establishes the federal government as the prudent buyer of services. A reasonable price is paid for services.

5. It may reduce the administrative burden on hospitals and provides rewards to hospitals to operate efficiently.

6. It will result in improved quality of care as hospitals begin to specialize in what they do best.

7. Beneficiary liability will be limited to the co-insurance and deductible payments mandated by Congress.

Medicare's adoption of a new reimbursement system has several significant impacts on Montana's Medicaid program, which include the following:

1. The regulatory basis of the program Montana relies on has been dramatically altered.

2. The role of the fiscal intermediary has been redefined by HCFA.

3. The standardized reporting forms will be revised making them unusable to the current state program.

4. The federal government has allotted a limited time period in which States are advised to take action.

Diagnostically Related Groups (DRGs)

DRGs are simply a method for calculating payments based on a patients diagnosis. Each diagnosis is represented by a weight which compares resource utilization of that diagnosis relative to "average" resource utilization. For example, DRG 104 is a type of cardiac surgery with a weight of 6.85. This means this surgical procedure uses 6.8 times the amount of resources a an average hospital stay. The payment would also be 6.8 times the average payment. The average payment used in rate setting is a result of averaging historical costs of hospitals, indexed for differences in wage levels, difficulty of case load and inflation.

The Medicare DRG rate formula is as follows:

$$\left[\begin{array}{l}\text{(Average Wage)}\\ \text{(Costs indexed)}\\ \text{(for inflation)}\end{array}\right] \times \left[\begin{array}{l}\text{(Wage)}\\ \text{(Index for)}\\ \text{(geographic)}\\ \text{(differences)}\end{array}\right] + \left[\begin{array}{l}\text{(Non-Wage)}\\ \text{(costs)}\\ \text{(index for)}\\ \text{(inflation)}\end{array}\right] \times \text{DRG WEIGHT}$$

$$= \text{DRG PAYMENT}$$

Where:

- The average wage costs portion is determined through the Federal Department of Labor.

- The inflation index to be used by Medicare is a measure of hospital market basket inflation from the base year to the next rate year.

- The wages index is a weighting factor used to account for significant geographic differences in wages. There are three different areas in Montana, Billings with an index of .9648, Great Falls with 1.0307 and all other areas at .8701. (eff 9/1/83).

- Non-wage costs are all other operating costs other than wage and benefits and capital costs which are determined through an audit of the base year cost reports.

- The DRG weight is the specific weighting factor for any of the 467 DRG's.

An example showing how a DRG system works is as follows:

A 65 year old woman is admitted to the Hospital XYZ in rural Montana with an admitting diagnosis of appendicitis. Her appendix is removed and after several days she is discharged form the hospital. A bill is prepared and presented to Medicare for payment.

The Hospital stay data is analyzed and DRG 167 is assigned, which has a weight of 1.0818.

During this time, the fixed fee per service paid by Medicare is $2,244, of which the wage portion is $1,819, the non-wage portion is $425. This fee is the Mountain Region Price which includes Montana. The current wage index in rural Montana is 0.8701. (effective 9/1/83)

To calculate the payment amount for this diagnosis, the above formula is used as follows:

$$((1{,}819 \times .8701) + (425)) \times 1.0818 =$$
$$(1{,}582.71) + (425) \times 1.0818 =$$
$$2{,}007.71 \times 1.0818 = \underline{\$2{,}171.94}$$

The $2,171.94 would be paid to Hospital XYZ regardless of the charged amount. In addition to these payments for each case the hospital receives payments for capital costs and outpatient costs. The DRG system is flexible enough that additional payments can be made if there are complications or problems which would result in an unusally long hospital stay or any case is unusally expensive. Such cases are known as "outliers".

DRGs for Montana Medicaid

The DRG-based payment system being developed for Montana Medicaid will use the Medicare framework with Montana-specific data. Payments for inpatient hospital services will be based on a weighted average cost per discharge which may be adjusted by indices for geographic wage differences, case mix and inflation. Additional payments may be made for cases with unusually long lengths of stay or unusually expensive costs. These cases are known as outliers.

Property related costs, such as depreciation, insurance, interest and taxes, are paid in addition to per discharge payments and are known as "pass through" costs. These amounts are paid on a periodic interim basis and retrospectively settled to reasonable costs.

There are many technical issues which must be dealt with in developing a DRG system. These issues include choice of an inflation index, phase-in periods and methods used to set rates. The impact of a DRG system can be substantial.

DRG's reimbursement will impact more than providers and rate setters. DRG's require a much more aggressive and thorough administration than cost-based reimbursement. Other Medicaid functions which will be impacted include: The MMIS payment system Utilization Review and cost reporting.

In addition to the many technical changes necessary to implement DRG payments there will be a need to expand the State's administrative efforts. These efforts will be made to the greatest extent possible with the existing group of contractors such as Consultec, Blue Cross and the Montana Foundation for Medical Care. By doing this the Department anticipates minimal impact on internal operations.

At the request of the Legislative Finance Committee Compass Consulting Group was asked to review a series of potential reimbursement strategies which would be within the State's fiscal capabilities, would ensure continuity of service, accessibility and quality of care without resulting in cost shifting from Medicaid to other payors.

Compass Consulting Group concurred with the recommendation of the SRS Task Force to pursue a DRG based system. They further recommended that the state acquire the necessary resources to accomplish the task of implementing the recommendation.

RWO/a

Exhibit 7
2-19-85

Acute Care PFP Initiative

EN-8

Initiative is located in tier 2 of the PFP proposal.

Current Level:

Hospital services are paid on a cost basis. Detailed annual cost reports are received from the facility and amounts payable between the Department and the hospital are computed.

Medicare payment system was formerly identical to Medicaid. The Department was able to utilize a significant amount of Medicare resources.

Problem:

Medicare reimbursement system has changed (DRG's). Medicaid will soon be unable to use Medicare resources. If Medicaid stays with current payment system a significant amount of additional resources will be required to administer the program.

The Department is currently proposing to change to a payment system similar to that used by Medicare.

Resources Needed:

Currently the Medicare intermediary uses 15 FTE's to provide the services needed under the cost based system. With the implementation of the Departments proposed system an additional 4 FTE's is required; 2 financial analyst 1 clerical and 1 accounting technician at a cost of $110,029 for 86 and $115,391 FY87.

Initiative Implications:

Without these additional resources the proposed hospital payment program would not be possible. Although our programs would be similar to Medicare's many changes made were to make the program cost effective. If the current reimbursement system is maintained costs would continue to escalate at their current rate and personal resources would have to be increased dramatically to administer the program. It is therefore important that the hospital reimbursement system be modified and staff be made available for its operation.

Exhibit 8
2-19-85

EN - 10

PRIORITIES FOR PEOPLE

SOCIAL & REHABILITATION SERVICES

INITIATIVE SUMMARY SHEET

Date: June 1, 1984

X SRS program change

__ SRS policy change

__ recommendation to SRS on regulation or law change

Initiative Title: Medicaid Cost Containment Pilots/Capitation and Recipient Education/Benefits Package

Contact Person(s): Marna Jones/Lowell Uda

Constituent/Budget Building Team: Economically Disadvantaged

STATEMENT OF NEED:

Population to be Served: AFDC-related eligibles, SSI-related eligibles, and the Medically Needy.

Current Level of Service: Montana Medicaid covers all mandatory services and most optional services.

Description of Problem: There is increasing recognition that public and private health financing programs have been unable to provide the full range of medical services or to control health care costs. Medicaid costs are projected to be $4.9 million over budget in FY1984. Health care costs in Montana rose 20.3% between 1981 and 1982. As a result, the purchasers of health care (private insurers, private individuals, and public programs) have faced significant cost escalation and a commensurate decline in the purchasing power of their dollar.

In our current fee-for-service system, when a third party payment is available, neither providers nor patients have an incentive to utilize services only when necessary nor in the most cost effective manner or setting. Third party programs have historically displayed a bias toward costly institutional care. Patients must frequently obtain ambulatory care in expensive outpatient hospital departments or emergency rooms because low payment rates and paperwork discourage physician participation, especially in public third party programs. The worsening fiscal situation at the state and local level has compounded the financial impact of these programs.

Unfortunately, most health care cost containment measures have attempted to control costs without altering the basic incentives which affect provider/consumer decision-making. Also, most health cost measures have tinkered with the fee-for-service system. More might be done to fee-for-service system or constructive alternatives proposed.

Approaches to containing costs are being worked on by SRS to the extent possible with current limited staff and resources. SRS efforts to control costs through checks for abuse/fraud, the new community case management system for long-term care and ongoing data analysis are making significant progress in

this regard but still fall short of being a comprehensive, coordinated approach to controlling health care costs in Medicaid. Because of limited staff and resources, efforts tend to be fragmented and many factors that affect Medicaid expenditures must go unattended.

Four primary problems have been identified. First, there is a lack of resources to take action on the existing knowledge that indicate ways to control costs. Second, the existing data and knowledge needs supplementation through further research and analysis. Third, once data have been gathered and analyzed to pinpoint problem areas or to allow for decision-making in known problem areas, resources are needed to develop and pilot test expanded or new approaches to controlling costs and yet preserve access to and quality of care to the medically indigent. Fourth, there is a need for a long term action plan for health care cost containment: It is clear that the current trends in cost escalation appear unending and that an active, comprehensive effort is required in order for the Medicaid Program to continue fulfilling its statutory obligations.

The final consideration that lends credence to expanding SRS efforts in this area is the existence of known, successful approaches in health care cost containment that have been experienced by a variety of other states and public and private organizations. With additional resources, SRS can more readily capitalize on such experiences.

INITIATIVE STATEMENT:

(Summary: interest, action & timeframe, involvement) It is proposed that: 1) a careful examination of what other state medical assistance programs and private sector initiatives have been able to produce in health care cost containment; 2) as a result of this study, one or two pilot programs to control health care expenditures be developed and tested; 3) a study be done of the medicaid program through the means of these pilots to determine and pinpoint factors that contribute to increased/unnecessary/inappropriate health care expenditures; and 4) a long-range, system-wide proposal be constructed for controlling health care expenditures while assuring access to and quality of care in the Medicaid program for the entire State.

These pilot programs, the study and the proposal should be accomplished with the support of an independent, expert contractor or contractors. A working advisory committee appointed by the Director of SRS should be used to provide input to pilot development, study, and long-range proposals. The advisory committee should be made up of a group of no more than 10 (ten) appointees representing Medicaid recipients, health professionals, hospitals, extended care facilities, home health agencies and SRS staff.

The study that issues from the pilots should include a thorough examination of the factors that affect Medicaid health care expenditures. These factors include, but are not limited to:

1. Utilization patterns, by procedure, diagnosis, provider, facility, beneficiary, cost per unit of service, outpatient vs. inpatient care to determine problem areas in the program;

2. Benefits design, i.e. pinpointing inappropriate incentives or the lack of appropriate incentives that encourage the provision of

unnecessary/inappropriate care by providers or the seeking of unnecessary/inappropriate care by beneficiaries;

3. Provider knowledge/attitudes/beliefs/behaviors that contribute to increased utilization and costs.

4. Beneficiary knowledge/attitudes/beliefs/behaviors/health history that contribute to increased utilization and costs;

5. Financing/reimbursement policies that contribute to increased utilization and costs;

6. Social/geographical/community factors that contribute to increased utilization and costs;

7. Federal and State statutes and regulations that limit or affect what can be done to control costs.

These data will be gathered through a variety of methods, including examining claims records, documents, surveys and interviews. What other states and private initiatives have done in the cost containment area will be researched through correspondence, telephone, literature reviews and a few carefully selected site visits.

Some of the data will form a baseline against which to compare and evaluate the pilot programs.

The pilot programs will be developed based upon study findings on the experiences of other states and input from the advisory committee. One pilot to be considered would be a fee-for-service model with targeted limits on amount, scope and duration of services and a strong recipient education component. The elements of such a program can be expected to contain, but not be limited to, some of the following components:

1. Benefits design changes with specific limitations on coverage or specific parameters of utilization which trigger prepayment medical review of claims.

2. Prior authorization of certain elective medical procedures;

3. Mandatory outpatient surgeries/procedures (except where there is a compelling medical reason for inpatient care or in emergencies);

4. Increased use of allied health professionals;

5. A case management system for high risk beneficiaries only;

6. Beneficiary education in wise buying of health care, staying well and medical self-care;

7. Financial and other incentives for providers and beneficiaries within the fee-for-service framework to reduce utilization:

A second pilot to be considered would be a prepaid, capitation approach with case management for all enrolled clients. One of the key components to the formulation of this pilot is the development of a model that would be viable

in Montana. To date, virtually all prepaid arrangements have been conducted in heavily populated areas where there is already significant competition in health care provider systems. Southern California, Denver, and Minneapolis are a few of the areas where several types of prepaid systems are in current operation. Because of the demographics of Montana's population and health care system, a rural model needs to be developed and tested. Preliminary discussions with both federal and private funding sources have elicited a significant degree of interest in the development of rural prepaid models for alternative health care delivery.

1. Based on the information available, structure the type of capitated mechanism that is most viable given the rural demographics of the pilot site. (HMO, PPO, IPA and other alternative models.)

2. The establishment of a strong administrative and marketing component for the project.

3. Determination of enrollment policies for subscribers -- lock-in, open enrollment, employee or beneficiary groups to be included.

4. Contracted medical groups and/or preferred providers for the full range of health care services.

5. The establishment of contracted reimbursement rates and/or negotiated fee schedule with preferred providers.

6. The establishment of a provider panel or other mechanisms for quality control assurance as well as utilization control.

Both pilots would also have the following components:

1. Safeguards to assure the maintenance of access to and quality of care in any chosen methods to contain costs.

2. The design, construction, and formulation of a research pilot program.

3. The preparation of grant proposals seeking funding from federal and private research and development sources.

4. If funding is obtained, the development of a budget amendment for the funding received and the implementation of the research component around the pilot program as a vehicle for the research and the testing of the research hypotheses.

It is estimated that these functions and activities would require approximately two years to complete.

Estimated maximum costs for the accomplishment of those activities appropriate under contract would be approximately $65,000. Monies to operate the pilots would come through successful grant proposals.

Initiative impact on other programs would be negligible until such time as the pilots were up and operating. Other programs would then only be impacted in the communities in which the pilots were implemented.

Several federal waivers of Medicaid rules and regulations would need to be obtained. Among these would be state-wideness, availability of Medicaid

services to all clients, and possibly some of the client freedom of choice regulations.

If the pilot program and the resulting data from the attached study demonstrated significant financial and utilization changes, and if the documented changes were to be adopted by the Medicaid program on a state-wide basis, the fiscal ramifications could be highly significant. Some very preliminary information from other areas of the county have indicated up to a 15% reduction on overall Medicaid expenditures if the capitation approach is used statewide. Whether this would be possible in Montana given the accessibility problems for health care services is unknown at this time. The potential, however, is very real.

The development of the pilot program will occur over the first six months of the biennium. The implementation and evaluation of the one-year pilot program including the utilization study will occur during the latter 18 months of the biennium. The long-range proposal will be developed during the last six months of the biennium.

INITIATIVE IMPLICATIONS: All Medicaid eligible clients will be assisted if effective cost and utilization control systems can be implemented. This is a benefit for both the client groups and for the Department. Optional services under the Medicaid program can be maintained within legislative financial constraints; other cost containment measures, such as co-payment, might be eliminated.

Number to be Served A pilot might serve approximately 1,000 Medicaid recipients.

How it Meets the Needs of Constituency: A provider-centered cost-containment system, such as capitation is, might remove the need for cost-sharing by the Medicaid recipient. Aggressive changes to the fee-for-service system with a strong effort to foster wise consumers of services may make the kind of changes to the service delivery system as would be initiated by a capitation approach, unnecessary.

Short and Long-term Effects: The effect would be long-term. If, say, the capitation pilot proves successful and capitation is extended to other areas of the state, the impact on health costs and the health delivery system would be significant. The fee-for-service pilot might reveal that broader use of allied professionals as independent providers is cost effective.

Initiative Impact on Other Programs: The capitation approach can result in a 15% savings to Medicaid. Any reduction in Medicaid outlays would benefit the appropriations of other programs. Savings under the fee-for-service pilot is not known.

IMPACT ON BIENNIUM BUDGET:

_X_ increase ___ decrease ___ adjustment General Fund & Federal source

Total amount: $125,000 FY 86: $75,000 FY 87: $50,000

one time cost: _____ for FY _____

Affect on Budget of Other Programs Directly Impacted by Initiative: None

Definition of Unit: NA

Cost per Unit: NA

Impact on SRS: Existing staff assignments and priorities would need to be reviewed and adjusted where necessary.

One FTE at grade 15 (approximately $30,000 annually) would specifically need to be assigned responsibility for:

- preparation of RFPs
- bidder's conferences
- awarding of contracts
- contract administration
- assist in development of criteria and program components
- gathering and analysis of existing Montana Medicaid data and data and information from other states in conjunction with the contractor
- public relations with the community at large and the medical community within the site to be selected
- liaison with existing client and provider groups who would be affected
- liaison with existing agencies and departments where the pilot would have implications for other programs

ASSURANCES:

This initiative is not meant to be duplicative with any similar efforts of the Legislative Fiscal Analyst Office, the Legislative Council, or the Legislature itself. The activities pursued under this initiative are to be fully coordinated with these parties as well as SRS. If any of these conditions cannot be assured, support of this initiative by Priorities for People is to be withdrawn.

PFP/010

EN-3
Exhibit 9
2-19-85

PRIORITIES FOR PEOPLE/INITIATIVE SUMMARY SHEET

Date: May 2, 1984

(X) Program Change
( ) Policy Change
( ) Law Change

INITIATIVE TITLE: Volume Purchasing of Eyeglasses
CONTACT PERSON(S): Lowell Uda (444-4540 or 4067)
BUDGET BUILDING TEAM: Economically Needy
PROGRAM/SERVICE AFFECTED: Medicaid

STATEMENT OF NEED

POPULATION SERVED: AFDC-related eligibles, SSI-related eligibles, and the Medically Needy (AFDC-related and SSI-related individuals and families with excess income which must be applied to the cost of care).

CURRENT LEVEL OF SERVICE: Currently, Medicaid recipients who are 21 years of age or older are eligible for a new pair of eyeglasses every two state fiscal years. Glasses may be obtained more frequently only if there is a significant change in prescription. In addition, eyeglass repairs up to the cost of a second pair of glasses is available each fiscal year. Individuals under 21 years of age are eligible for a new pair of eyeglasses every state fiscal year. Glasses may be provided more frequently only if there is a significant change in prescription. In addition, eyeglass repairs up to the cost of a second pair of glasses is available each fiscal year.

Under the Federal Freedom of Choice provision (Section 1902(a)(23) of the Social Security Act), Medicaid recipients must have the opportunity to obtain eyeglasses from any eligible Medicaid provider. Under current Montana Medicaid coverage, eligible providers of eyeglasses include Ophthalmologists (physicians skilled in diseases of the eye), Optometrists, and Opticians who elect to participate in the program.

DESCRIPTION OF PROBLEM: The cost of materials to buy glasses is continually rising. In order to stay within current fees and budgetary limits, the frames available to recipients are of necessity limited by providers themselves. In addition, some providers indicate that current fees do not cover the cost of materials in severe, exceptional cases and find themselves disadvantaged when taking on such cases. Therefore, there is some impetus on both the part of providers and on the part of the recipients to pursue another method of acquiring eyeglasses for Medicaid recipients.

At the federal level, there has been some movement in the direction of opening opportunities for states to use volume purchasing. Initially, Section 1902(a)(23) of the Social Security Act, the Freedom of Choice provision, limited states in their efforts to use volume purchasing as a means of containing cost in Medicaid. However, since 1981, federal policy interpretations of the law have been modified to exclude the supplying of materials from the freedom of choice provision. HHS has interpreted Section 1902(a)(23) to apply to providers who dispense eyeglasses only. It does not prevent a state from requiring that eyeglass dispensers obtain materials from specified suppliers. In addition, section 2175 of the Omnibus Budget Reconciliation Act of 1981 added section 1915(a) to the Social Security Act. This change to the Act excludes competitive bidding arrangements from the free choice of providers requirement. The exclusion is applicable to certain medical items and services. Eyeglasses are clearly identified as an item that may be volume purchased.

INITIATIVE STATEMENT

The objectives of the proposed program change are:

1. To contain costs in Medicaid through the use of volume purchasing, in particular through volume purchasing of eyeglasses.
2. To eliminate problems with high cost glasses encountered by providers who serve recipients with severe eye problems. Since the supplier would be assured of a certain level of funding and volume of business from the Medicaid program, the supplier would be in a better position to deal with unusual circumstances without an overall loss in profits than would be an ophthalmologist, optometrist or optician.

3. To promote the use of quality materials in eyeglasses provided to Medicaid recipients. The experience of states which have engaged in volume purchasing of eyeglasses shows that the quality of the materials provided has improved.
4. To provide a range of eyeglass frames that do not conspicuously stand out as "welfare glasses". Some states allow a choice of as many as 60 frames. An acceptable range of choice is from 12 to 18 frame types per client group. Client groups would include men, women, and children.

The major features of the program change would include:

1. Opthalmologists, Optometrists and Opticians would all be paid a standard dispensing fee for eyeglasses.
2. A contract through a competitive bidding process would be issued to a single supplier of materials. Payments would be made directly to the supplier for glasses provided; therefore, no exchange of funds between the suppliers and dispensers would be necessary.

   Since most labs in the state may not be in a position to bid successfully, the bidding process would allow for the development of consortiums of laboratories in the state in order to reasonably compete for the contract. This has been successful in at least one other state. The consortium in that state consisted of small laboratories within the state. They were able to successfully acquire the bid and benefit from the Medicaid payments.
3. The co-payment for eyeglasses themselves could be eliminated since there would be no direct contact between the supplier and the recipient. Co-payments would remain on dispensing and other professional components of service.

TIME FRAME FOR IMPLEMENTATION

The program would be implemented beginning in SFY86.

RESOURCES NEEDED

The program can be implemented without additional FTE's.

INITIATIVE IMPLICATIONS

NUMBER OF VOLUME PURCHASED EYEGLASSES: Currently, approximately 10,000 recipients receive eyeglasses through Medicaid annually. This would be the number of eyeglasses that the Department would expect to volume purchase in a year.

IMPACT ON CONSTITUENCY: The effect on interest groups would be generally favorable. Providers would be favorably affected because the cost of materials are somewhat beyond the providers' control. Under the new program, providers who are dispensers would have a fixed dispensing fee. Providers who are suppliers of the materials would have an anticipated income from Medicaid designed to cover the cost of materials, a laboratory operation and a reasonable profit. Providers who have their own laboratories for producing lenses, however, will be adversely affected. The income these providers currently receive for materials would no longer be available to them.

Recipient choice of frames and glasses will be limited to those purchased under contract.

BUDGET IMPACT

The savings effected through volume purchasing of eyeglasses would more than offset the savings lost from elimination of copayments on frames/glasses. The savings from a volume purchasing effort could be as high as over fifty percent of the current expenditures, based on comparisons between states with volume purchasing programs and those without such programs (see page 7 of the Governor's Association Report on Volume Purchasing of Goods and Services). The initial savings could be as high as $285,000. This is based on an estimate of $570,400 per state fiscal year for purchase of eyeglasses.

____ increase __X__ decrease ____ adjustment

Total Amount $570,000 FY86 $285,000 FY87 $285,000

One Time Cost: N/A for FY ____

Definition of Unit: Volume purchased eyeglass

Savings per Unit: $28.50

Exhibit 10
2-19-85
EN-2

PRIORITIES FOR PEOPLE

SOCIAL & REHABILITATION SERVICES

INITIATIVE SUMMARY SHEET

Date: April 16, 1984

X SRS program change

___ SRS policy change

___ recommendation to SRS on regulation or law change

Initiative Title: Mandatory Second Surgical Opinion Program for Specified Elective Surgeries

Contact Person(s): Lowell Uda - 444-4540 or 444-4067

Constituent/Budget Building Team: Economically Needy

Program/Service Affected: Medicaid

STATEMENT OF NEED:

Population to be Served: AFDC-related eligibles, SSI-related eligibles, and the Medically Needy (AFDC-related and SSI-related individuals and families with excess income which must be applied to the cost of care).

Current Level of Service: Currently, second opinions may be requested by the client, and Medicaid will pay for such opinions. However, the program is voluntary, as opposed to mandatory.

Description of Problem: This program change is predicated upon several factors, including research done nationally in the early 1970's which indicates that "surgical admissions expand to fill available hospital beds, operating units and surgeons' time". The conclusions of this research provided an impetus for health care managers to look at ways of monitoring client use of surgical services as a means of cost-containment. One means of monitoring client use of surgical services is a mandatory second surgical opinion program.

Two states, Massachusetts and Wisconsin, have established second surgical opinion programs. The Massachusetts program has been in effect since 1978. The Wisconsin program has been in effect since 1981. Evaluations of both programs have demonstrated cost savings to Medicaid.

The Montana Foundation for Medical Care has expressed interest in having a second surgical opinion program established. The Department itself is currently evaluating its Medicaid utilization control program in light of:

1. Medicaid coverage of ambulatory surgical centers. Current Medicaid utilization control activities under contract with the Montana Foundation for Medical Care does not clearly address surgeries performed in such outpatient settings.

2. The impact of the new Medicare prospective reimbursement system for hospitals on Medicaid. If the Department adopts the Medicare system, or some adjustment to that system, the Department will have to consider approaches to utilization control which will prevent manipulation of the system. One way to manipulate the Medicare system is to increase

admissions. A second surgical opinion program would prevent such manipulation. A second surgical opinion program will also work in controlling utilization under the current Medicaid retrospective system for hospital reimbursement.

INITIATIVE STATEMENT:

The objectives of the proposed program change are:

1. Give further assurance that elective surgical procedures when provided to Medicaid recipients are medically necessary;
2. Promote appropriate use of Medicaid coverage by Medicaid providers and recipients; and
3. Conserve Medicaid funds.

Second surgical opinions would be required for the following 11 procedures initially:

1. Cataract extraction, Procedure Codes 66830-66945
2. Cholecystectomy, Procedure Codes 47600-47620
3. Dilation and Curettage (D & C)
4. Hemorrhoidectomy
5. Hernia, Inguinal
6. Hysterectomy
7. Joint Replacement (hip, knee)
8. Tonsillectomy and/or Adeniodectomy (T & A)
9. Transurethral Resection, Prostate (TUR)
10. Ligation, Varicose Veins
11. Rhinoplasty

When certain diagnoses are documented by specified tests, the second opinion may be waived. The designated review organization, under contract with the Department, will review the test results and inform the physician proposing the service that a second opinion is not necessary.

Provisions for emergencies and exceptional circumstances such as excessive recipient travel would be included in the shaping of the program. The Department will evaluate the circumstances that may warrant waiving the second opinion requirement.

Second opinions are mandatory in this sense: the procedure may not be performed until a second opinion (i.e., unless the Department waives the second opinion requirement). However, if the second opinion conflicts with the originating physician's opinion, the Department may not deny the service; the choice as to whether or not the procedure will be performed remains with the Medicaid recipient.

INITIATIVE IMPLICATIONS:

Time Frame for Implementation: The program would be implemented in SFY 86 and evaluated through the biennium.

Resources Needed: The program can be implemented without additional FTE's. Start-up funds are not required if the current utilization control contract for hospital services is used for this purpose. This contract is with the Montana Foundation for Medical Care and, for Federal FY 84, amounts to $122,610. The program would fall within the scope of the contract.

The cost of the second surgical opinion would be paid for by Medicaid as a client benefit.

Number of Avoided Procedures: Based on the experiences of the Massachusetts and Wisconsin programs, the number of avoided procedures per year for each of the 11 procedures for which a second opinion would be required is as provided in Attachment A.

Impact of Constituents: Providers will be more thorough when diagnosing the need for the 11 procedures of which second opinions are required, and may recommend fewer such elective procedures because their recommendation are being reviewed by their peers. Recipients will have further assurance that recommended surgeries are necessary, or, at a minimum, will have additional information with which to decide whether they should consent to an elective procedure. This additional information puts more decision making power in the hands of the client.

Both providers and clients may object to the additional time and effort involved in obtaining a second opinion.

IMPACT ON BIENNIUM BUDGET:

The program would yield a net savings in dollars available for client benefits. This dollar savings would be available for paying client benefits in other areas of the Medicaid program.

If all avoided procedures were those which would have been performed in a hospital, the dollar savings would be as indicated on Attachment A.

_____ increase __X__ decrease _____ adjustment _____ source

Total amount: $133,020 FY 86: $66,510 FY 87: $66,510

one time cost: N/A for FY N/A

Affect on Budget of Other Programs Directly Impacted by Initiative: None ?

Definition of Unit: Avoided Surgical Procedure

Cost per Unit: $1,789

Impact on SRS: None ?

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ATTACHMENT A

	MT Avoided Procedures/yr.	Surgeon Cost	Anesthesia Cost	(Avg) Inpat Hosp. Cost	Total Cost Per Procedure	Avoided Proc. Svg. W/MSO	Cost of MSO, $/year	Net Savings $/year
Cataract	1.04	432	144	1,439	2,015	2,096	$ 229	$ 1,867
Cholecystectomy	3.42	523	174	1,439	2,136	7,305	376	6,929
D & C	11.63	180	54	1,429	1,673	19,456	576	18,880
Hemorrhoidectomy	0.56	173	57	1,439	1,669	934	54	880
Hernia	2.51	324	108	1,439	1,871	4,696	328	4,368
Hysterectomy	3.40	577	192	1,439	2,208	7,507	333	7,174
Joint Replacement	1.02	721	240	1,439	2,400	2,448	93	2,355
T & A	6.99	144	48	1,439	1,631	11,401	577	10,824
TUR	3.57	613	204	1,439	2,256	8,054	380	7,674
Varicose Vein	0.36	42	30	1,439	1,511	544	30	514
Rhinoplasty	2.67	405	135	1,439	1,979	5,284	239	5,045
							Annual Net Savings	$ 66,510

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VISITORS' REGISTER

Human Services Sub COMMITTEE

BILL NO. Domestic Violence Funding DATE 2-19-85

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Lenore F. Taliaferro	Helena	✓	
Noreen Dever	Great Falls	✓	
Caryl Wickes Borchus	Montana Coalition Against Domestic Relations	✓	
Sue Bennett, MSW		✓	
Lucia Oakland	Gt. Falls	✓	
Kelly Chandler WLF	Missoula Leading for Women's Place	✓	
Gail Kline (WLF)	Great Falls	✓	
JUDITH CARLSON	NASW - HELENA		
Noely Mecure	MONTANA - Helena	✓	

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.