VISITORS' REGISTER

HUMAN SERVICES SUBCOMMITTEE

BILL NO. ______ DATE February 10, 1987

SPONSOR ______ DEPT Medicaid

A.M. meeting

NAME (please print)	Representing	SUPPORT	OPPOSE
Judith H Carlson	NASW	X	
Karen E Black	Brendan House	X	X
Barbara Larsen	Summit		
Johnnie Phillips	PCA - Livingston		X
Lois Steinbeck	OBPP		
Charles Briggs	Governor's Office		
Chris Volinkaty	DD Lobbyist	X	
Donna Hale	Mental Health Services	X	
Steve Waldron	Mental Health Centers		
Bill McLain	Valle Vista Manor		X
Mike Halligan	Senate Dist 29	X	
Bob Frazier	MSU	X	
Lowell Luke	NASW	X	
Nancy Adams	Mental Health	X	
Kenny Betts	Montana House	X	
Tom Senger	Montana house	X	
Tim Cherry	MT Mental Health Assn	X	
Joyce Renfroe	Myself	X	
Jeanne Hatfield Artman	myself		

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

CS-33

VISITORS' REGISTER

HUMAN SERVICES SUBCOMMITTEE

BILL NO. ____________ DATE February 10, 1987

SPONSOR ____________ DEPT Medicaid am Mtg

NAME (please print)	Representing	SUPPORT	OPPOSE
Robert H Johnson	Mont State Hosp Assn	✓	
Emily Johnson	PCA	✓	

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

CS-33

MEETING MINUTES
HUMAN SERVICES SUBCOMMITTEE
FEBRUARY 10, 1987

The meeting of the human services subcommittee was called to order on February 10, 1987 at 8:05 a.m. in room 325 of the state capitol building by Chairman Cal Winslow.

ROLL CALL: All members were present.

DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES (SRS)

Primary Care - Public Testimony

Personal Care Attendants (PCA's) - Westmont Contract

(35b:000) Sen Mike Halligan, Missoula, spoke in support of the SRS budget and an increase in the appropriation to increase the wages of Personal Care Attendants (PCA's) above $3.35 an hour to provide a continuity of services and eliminate employee turnover. He presented exhibit 1 which contains signatures in support of an increase in PCA wages.

(35b:047) Johnnie Phillips, Livingston, expressed her strong objections to the current contract with Westmont and the pay decrease from $3.85 an hour to $3.35 an hour. She stated industrial accident and liability insurance, offered as benefits, are not benefits but must be provided by law. She said the health insurance program offered to PCA's requires a $75.00 participation from the employees, and is offered for those who work 40 hours a week. She stated most PCA's work on a part time basis, and the contract with Westmont does not guarantee 40 hours a week. She added the employees are not eligible for health insurance until they have worked three (3) months. Ms Phillips stated that $6,000 was set aside for reimbursement of mileage expenses, but none of the PCA's in her area have been reimbursed.

Ms Phillips said the contract states the PCA's nurse supervisor could take care of and call upon 30 to 35 patients a week during a 40 hour work week, which she felt was not feasible. She said the Livingston number is almost always busy, and if you ask a question the caller is directed to contact Westmont in Helena. Also under the current contract an individual has no choice in selecting a PCA, they take who is sent to them. She further added that the PCA's have to get permission before transporting a client to the hospital and that products sent out by Westmont are vastly overcharged, i.e. incontinent diapers were $128 a case, whereas they could be purchased locally for $56 a case. She added the contract contains no firm statements of intent by

Westmont but implies intent, and that Westmont is hard to deal with. She closed by asking the committee to consider the aged and elderly population in the state - that they are easily intimidated, afraid of official looking letters, and those who are sick and on medicaid do not have a chance to set aside savings to live on, having had worked for .50 or $1.00 a day to provide the necessities for their families.

(35b:193) Joyce Renfroe, who has worked as a PCA and homemaker providing home health care services, expressed her concern for the clients in the state affected by the Westmont contract. She presented her written testimony (exhibit 5) in support of an hourly wage of $5.00 an hour plus real fringe benefits for PCA's.

(35b:228) Jeanne Hartfield Artman, PCA from Missoula, expressed her concerns about the PCA's wage reductions, the lack of training for PCA's, client's not having a choice in PCA's, and the frustration of calling Westmont and getting a recording when decisions were needed for client care. She presented her written testimony (exhibit 4) in opposition to the SRS/Westmont contract.

(35b:291) William Boharski then testified and urged wages of $5.00 to $5.50 for PCA's to retain quality attendants. He noted the cost savings to the state to have disabled individuals in home based environments versus institutionalization. He urged support of this program which he considers cost effective to the state.

(35b:378) Bob Frazier, MSU Disabled Student Services, Bozeman, stated several years ago at a hearing in Bozeman, the claim was made that $3.35 was not comparable to the tasks that PCA's were performing. He said at that time SRS reassessed the program and agreed on an increase to $3.85 an hour. Mr Frazier stated that prior to that increase there was a great deal of turnover at the $3.35 an hour rate, which decreased dramatically when the wage was increased. He asked for strong consideration to Sen Halligan's bill.

(35b:438) In response to several questions from Chairman Winslow, Lee Tickell, administrator of Economic Assistance (EA), SRS, presented a brief history of the PCA issue and how it evolved to where it is today. He explained the department came under scrutiny by the Department of Labor as to whether SRS should be paying WCD and unemployment insurance on individuals considered under a contracted relationship and not employees, affecting 400 to 500 individuals. Also, he stated, the IRS questioned as to whether there existed an employer/employee relationship or a contracted relationship. These programmatic concerns, as well as the liability of the department and the state as a result of this contracted relationship, led the department to go out

for Request for Proposals (RFP's) to get bids from any agency or group that felt they wanted to take on the PCA program and hire them as employees of that organization. Mr Tickell stated six (6) statewide responses were received and six (6) received stating they would operate the program on a regional basis. He said that under state laws, the department was obligated to accept the lowest responsible bid. Westmont was the lowest in cost and also the most responsive in terms of the evaluation done by a committee of four (4) SRS people.

He stated the department would not argue the equity issue, i.e. $3.35 or $3.85 an hour compensation. Under the contracted agreement with SRS, individuals were reimbursed $3.85 based on an hourly rate of $3.35 plus 15% benefits which translates into a $ .50 per hour reimbursement for WCD and unemployment insurance. The comparable benefit package of reimbursement computed by Westmont is $3.89 per hour in consideration of employer contributions plus a base salary. He added that SRS has accepted and signed a contract with Westmont.

Mr Tickell stated testimony indicating that PCA's were administering medication and performing catheterizations caused him some concern because those services are not within the scope of the duties of the position. By state rules, he said PCA services are intended to prevent or delay institutionalization by providing medically necessary, long term maintenance or support services in the home. This includes assisting with personal care functions such as bathing, grooming, self administered medications, meal preparation, escort services and home management. He stated under the waiver more extensive services can be provided, one of which may be PCA services.

Dave Lewis, director of SRS, clarified that homemaker services provided through the Community Services Division (CSD) for the elderly were basically tied to housekeeping, shopping, less medical type of assistance, and these individuals were state employees. In-home services were provided by area agencies on aging under contract with the department, which is basically the same service, with the only difference being in terminology. He added that in-home services are not a means tested service, so the individual does not have to be medicaid eligible, only over 60 years of age. He stated that PCA's perform bathing, feeding, and more intensive personal and medical care.

(36a:000) Charles Briggs, state aging coordinator, Governor's Office, stated the in-home services program has been the number one request of senior citizen organizations since 1980. These services follow the guidelines of eligibility under the Older Americans Act. He said the programs under

in-home services can contract with whomever to provide those services - so they may contract with a home health agency for a visiting nurse or other kinds of medically related health services as well as in-home homemaker type of services. Mr Briggs stated there was a requirement stating in home services must be coordinated with medicaid waiver services to avoid duplication of effort.

(36a:042) Chairman Winslow asked for a breakdown of the three (3) categories of services provided by the PCA's homemakers, and individuals under the medicaid waiver, including the administrative breakdown for clarification for the committee.

In response to a question from Rep Bradley, Mr Lewis stated the department has no specific reference of noncompliance on the part of Westmont. There is a weekly review of clients being served by the PCA's and spot checks have been done in the Missoula area. He stated the department cannot come up with a specific instance where Westmont has failed to perform. Mr Lewis urged any of the people testifying that if they have specific instances of noncompliance to come forward and tell the department, that the department can't take action based on rumors.

(36a:148) Mary Martin, case manager/social worker, Bozeman, stated no documentation for noncompliance had been submitted partly due to vested interest case management has in protecting their patients and seeing that they were covered. She stated what happened in Bozeman was that Westmont was unable to completely take over on January 1 and asked for help to cover until they were ready - which happened in five (5) instances. She stated some individuals felt that had been noncompliance with the contract. She added there are some major problems with getting the whole organization to work, partly due to attitude adjustments needed on both the recipient and the administration end.

(36a:169) Chairman Winslow noted this was an optional services in the state, with 30 other states not providing this program.

In response to an inquiry from Chairman Winslow, Mr Lewis stated 298 people were receiving services for a total budget of $4 million per biennium.

(36a:218) Jeanne Hartfield Artman, PCA, stated she quit because of the wage cut but ended up going back when her replacement, Shirley Ruff, was not trained to perform the necessary services for the client. She stated her replacement had never worked with a quadraplegic, never performed transfers, and had never done a catheterization, which at that time was one of the responsibilities. She stated Ms

Ruff had injured her back doing transfers and was unable to continue the job. She added Ms Ruff tried to get more clients, and was given the name of an individual and told to go and take care of them, no interview was given or consideration of compatibility with the client. Ms Artman related a time when she was unable to get to Missoula to take care of her client, and called Westmont who stated they were unable to provide a replacement for her. She said she called other agencies in Missoula until she found someone who could help her client.

She further stated she had a letter from Raylin Bell, who was involved in an auto accident January 26th and tried to call Westmont to let them know they would have to provide another PCA for her client. She said she couldn't reach them and only got the recording. Ms Bell then contacted Five Valleys, another agency, and they found a replacement for her.

(36a:260) Chairman Winslow stated he personally could not see spending $4 million a biennium on a program that is evidently not doing the work or, from what the committee is hearing, spending that money on a program that seems to have all kinds of holes in it. He stated unless there were assurances that these problems would be rectified that this service, as an option, should be scrutinized and a realistic look taken at the priorities and services presently provided.

(36a:271) Johnnie Phillips injected that PCA's do give medicine to clients and provide services usually performed by registered nurses.

(36a:287) William Boharski suggested setting up a board to oversee this issue composed of individuals from Westmont, PCA's, SRS, and clients.

Mental Health Services

(36a:335) Judy Carlson, speaking for the Montana Chapter of the National Association of Social Workers, read her prepared text (exhibit 2) in support of the provision of mental health services to medicaid patients.

(36a:370) Lowell Luke, clinical social worker in private practice, spoke in behalf of the Montana Association of Social Workers. He noted that half of his caseload consisted of youth receiving services from SRS through medicaid. He stated mental health centers are understaffed with long waiting lists and an overload of emergency cases. He added that social workers in private practice provide hospital workers and SRS human services with another option for treatment. He stated some of the most experienced

therapists are social workers in private practice where there is no administrative costs to the state. He stated social worker's fees were the lowest for mental health services, and urged continuation of mental health services as an optional medicaid service.

(36a:398) Steve Waldron, representing the Community Mental Health Centers, stated the majority of funds that go to the centers provide services to clients who would otherwise be in the Montana State Hospital, and a number of the clients were patients at one time. He added the centers also provide out patient services to other clients other than the chronically mentally ill. He said the majority of medicaid money going into the centers does go to that category of clientele. He urged continued funding of this program.

(36a:417) Nancy Adams, Montana House detreatment center, stated the center serves 90 to 120 long term seriously mentally ill clients who would otherwise, without a comprehensive community program, might be back in the state hospital or on the adult protective services list. She urged funding for mental health services, noting 50% of their clients are on medicaid and all, except for a small minority, are on some type of disability. Ms Adams stated that without ongoing care and the support of medicaid, the services they provide would be drastically cut and she would be concerned about the quality of services they would then be able to deliver.

(36a:460) Donna Hale, Westside Adolescent Day Treatment, Helena, spoke in support of mental health services for adolescents. She stated that in the past if an adolescent became seriously mentally ill, the only option was institutionalization. She said Westside is an effort to keep youth in the community or in a shorter residential stay. She stated treating them in the community is more effective, less expensive, and work can be done with the families. She explained that the children being served are 13 to 18 years of age, many have failed in school, are abused physically and sexually, and almost always emotionally abused. She stated some have committed minor crimes, many have serious drug and alcohol problems, and are the type of kids that cannot be ignored because they manage to get attention either by suicide, committing crimes, or by having children that they themselves cannot raise, requiring services later on. Ms Hale stated medicaid funds part of the program for those eligible for individual and group therapy. She urged continuation of this service.

Other Proponents:

Tom Cherry, Mental Health Association
Kenneth Betts, Montana House client

Tom Senger
Holly Kalazak, Montana Psychological Association

Pharmaceutical Services

(36a:515) Robert Likewise, Montana Pharmaceutical Association, read his prepared text, exhibit 3, in support of timely reimbursement for medicaid paid prescriptions and an increase in the reimbursement paid for filling and handling the medicaid prescriptions. He noted pharmacies are losing money by not being adequately reimbursed.

(36a:647) Dave Lewis, director of SRS, commented in closing the testimony on medicaid optional services. He stated in regard to state medical, the constitution requires the state legislature to provide for the aged, infirmed and those suffering from misfortune. He commented that all the services discussed in testimony could be considered under the infirmed category. He added the state medical program in the state assumed counties applies statewide and would provide services to those people who were not covered under medicaid; and those services are either 100% state or county funding. Mr Lewis voiced his concern on the rapid growth in the medicaid program which could exceed $300 million in total funds in the coming biennium. He stated that given our existing constitution, any changes in the program could very well push payments and claims over into the state medical program. He said to consider these services optional would be to ignore their interaction with the state medical program and the long term affect their elimination or cutbacks might have on the general fund.

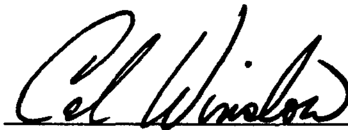
Nursing Homes

(36b:028) Rose Skoog, director, Montana Health Care Association, covered how the rates were developed, how providers are reimbursed, explained providers increased costs, and what a freeze of rates means to the providers. She stated medicaid patients in a nursing home are not only poor and elderly, but also have a variety of illnesses requiring them to be in the facility and cannot be maintained in their home with community based in-home support services. She stated in 1982 SRS revamped how nursing homes would be paid for providing services to medicaid patients. At that time, various analysis of the cost of providing care were done. She noted they are a cost based service but are not reimbursed on a cost related basis. Rates for reimbursement were based on the base rate equal to the average cost of providing a day of nursing home care in the state in 1980, which meant that based on this "average", half of the facilities in the state at that time were looking at rate cuts in order to be at the "average" while less than half were looking at rate increases to bring them to a level of reimbursement

that was appropriate to meet the care needs of their patients. She stated roughly one third of the providers stayed at the same rates, one third faced cuts, and the other third faced increases to comply with the way the system worked and the way costs were established. She added another two (2) year freeze would make a total of seven (7) years the facilities have operated without an increase to cover expenses. She then explained the patient assessment score that was developed and used for the reimbursement for the type of care provided to the patients in a facility during a given month. She stated the level of care required by patients being served is becoming more difficult, which is not accounted for in the scoring system. She added this difficult care was due in part by the community based services providing for lighter care patients so that they could remain in their homes and the hospital DRG's which encourage the hospitals to get the acute care patients into a lesser care setting as soon as possible. Therefore, she said, providers lose on the care of the patients, as when the average goes up, nothing happens to the base rate, resulting in a loss of buying power, including the fact that the patients are more difficult to care for. She added that the score pays for the heavier care patient after the fact, if the patient assessment score is up during the current year, an adjustment in the rate is not seen until July 1. She stated a freeze would be a major problem in the face of the rising cost of fixed expenses, i.e. wages, insurance, liability. Ms Skoog urged consideration in opposition of a freeze to the proposed medicaid reimbursement rate freeze.

(36b:206) Karen Black, Kalispell Brenden House, read her prepared text (exhibit 6) against the proposed medicaid reimbursement rate freeze. She stated their total medicaid reimbursement is $53.34 per patient day, which is a shortfall of $22.05 per day, and noted that medicaid patients are no less expensive to care for than any other patients.

The meeting was adjourned at 9:55 a.m. (36b:307)



Cal Winslow, Chairman

cw/gmc/2.10a

DAILY ROLL CALL

HUMAN SERVICES SUB COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date February 10, 1987

NAME	PRESENT	ABSENT	EXCUSED
Rep. Cal Winslow, Chairman	X		
Sen. Richard Manning, Vice Chair	X		
Sen. Ethel Harding	X		
Sen. Matt Himsl	X		
Rep. Dorothy Bradley	X		
Rep. Mary Ellen Connelly	X		
Rep. Dean Switzer	X		

EXHIBIT 1
DATE 2-10-87
HB ____

PETITION AGAINST WESTMONT

WE the undersigned respectively request you consider the impact on the P C A'S pay. When WestMont was given the medicaid contract they cut the hourly pay from 3.85 an hour to 335 an hour. They cut the Elderly's care from 70 hours per week to 55 hours.

This is forcing more elderly into nursing homes.

NAME	ADDRESS	OCC.
Gerald Stephens	109 N. L St. Livingston	Bartender
[illegible]	109 W Lewis	
Henry Reynolds Mills		[illegible]
Rich Ayers	Livingston -	Labor
		Retired
Lee Ramey	Livingston	
[illegible]		- 210 MILLESAPRS
Herbert Stallman	109 - W. Lewis 3-9 Livingston Mt	
Harry Rosaul	107 S 2d	Livingston Mt Sta. 205
[illegible]	P.O. Box 66	Livingston Mt, 59047
archie Mann	Rt 62, Box 3134	Livingston Mt, 59047
Stanley Phillips	retired	- 1001 E. Geyser - Livingston 59047

(see attached)

EXHIBIT 1
DATE 2.10.87
HB

Darlene Stephens 109 N L Livingston PCAs
Quinsana Sarrazin Rt 85 Box 4236 Livingston, MT. (PCA)
LaJune Frisk 322 So. Main Livingston, MT.
Gerald D. Frisk 322 So. Main "
Kenneth W. Foy 322½ So. Main "
JoAnn Smith (PCA) 222 South 8th Livingston Mt
[illegible] Greenwood (PCA) P.O. Box 282 Livingston
Michael Greenwood (Rancher) 115 S. P. Livingston
Mrs Stanley C Phillips housewife & volunteer 1001 E Geyser Livingston Montana 59047

EXHIBIT 1
DATE 2-10-
HB

Kelley M Stephens P.C.A
Beula Biederman
Hilma Zetterwall
Vilma Wasdell
Gladys Nelson - 401
~~Nathey I Stephens~~
Laura V. Stelcher

Abbie Mathis
Fabian Stephens
Harold W Lewis
Linda Lewis
DeMaé Kramer
Daisy Tophanen
Frances Richardson
Amelle Moss
Ernestine Gesling
Ruth E. Hock
Helen Polak
Evelyn Hiller
Ruth Randall
A. M. O'Rim Jr.

John Valentine Gardiner

Anna Belle Jones - Box 911 Liv.
Ral [illegible]
Al & Etha Meyer
Ada Sherwood
Homer Terwilliger
~~Gladys Steinmetz~~ — 311 E. Callender Liv. Mt
Edna Merchington } Box 846 Liv. 59047
Ed Merchington
Annie B Carpenter Box 172, Livingston 59047
H L Carpenter
R & MRS. Raymond Bishop — 415 N. 6th Livingston
Altha Van Aken, — 220 W. Montana Livingston
Vincent Van Aken — 220 W. Montana Livingston Mt.
Mark Teeters } 304 No 5 City
Jessie Teeters
Hazel Ellison — 516 N 11, Livingston
Bert Kh lick — Box 46 " "
Floyd Woodhull — 302 Lo[illegible] St " "
Ann Woodhull — " " " " "
Dorothy Garmer — P.O. Box 454
Hallard Johnson — 527 No N. St. Livingston Mont
Essie Johnson — 527 No. N. St Livingston Mont.
Joe Malaguelli

Orren N Doty — 314 No 3 [illegible]
Palmer E Boyle — 422.50 N [illegible]
Margaret Boyd — " " "
Leonore Holmen — Rt 38 - Box 2[illegible]
Ray Holmen — Rt 38 Box [illegible]
Neoma Shepherd — 212 W Fr[illegible]
Mena Amundson — 1124 E [illegible]
Mae Bowen — 129 So 2 [illegible]
J. Erickson — 317 N [illegible]
Goldie Hash — 702 West [illegible]
Clio Case — 109 W. Lewis
Velma Lacy — 109 W. Lewis
Harold King — Box 70 S - Small
~~John Black~~ — [illegible]
H. A. Reid — 11 West Geyser
Annetta Roy — 320 S 13
(Effie) Della Van Orden — 524 East Lew[is]
~~Mildred Doyle~~
Minnie Wallace - 1601 Acres [illegible] Sheri[dan]
Mildred J Doyle — 325 S. Main S[t]
Earl & Ruth Ingersoll — 2375 [illegible]
Floyd Smith — 107 No. 9th St.
Carl Meldrum — 109 W Lewis [illegible]

Miysko Batten

Virginia Tecca

Lemuel Batten

Anne Colby

Mary Bailor 315 So B. Livingston Mt.

Harriette Conklin 314 So Livingston Mont

Lorene Nickerson 415 W. Gallatin

Carolyn Kaya Aberna 603 E Mont.

~~Myr~~ Myrtle Scharf 417 E. Gallatin

Melvin L. Hoglund - Sr. Citi Center

Al Meyer - Sr. Citizens Edgewater Apt 105

Ethea Meyer. Sr. Citizens Livingston Mont

Herbert Skattum Sr Cit 109 - S. Livingston

Margaret Reeb - Sr. Citizen Box 301 "

Bernice McGee - 427 So 8th Livingston

Sylvia Anderson P.O 783 - City

Ethel Alt P.O Box 250 - Livingston, Mt.

Esther Skillman P.O. Box 13 - Livingston Mt.

Martha Lambert Rt 38 Box 2039 Livingston Mt

William Lambert Rt 38 Bx 2079 Livingston Mt.

Robert R Cumba 109 W. Lewis Livingston Mt.

George Eden Box 203 " "

Jesse McAee
P.O Box 185 - Livingston Mt.

Anne McAee - P.O Box 185

G. M. Hickey 159 ...

Virginia Colby

...

...

Becky Flicko - 109 West Lewis

Mildred Crary - 109 West Lewis

Opal Hinman 109 West Lewis

Lyle Hinman 109 W. Lewis

Cathy Kirk 107 S 2nd # 228 Livingston

Bus Lahren 425 No. Sixth "

Mike Romajko 1862 Box 3002 Livingston

Glen Cool 432 So. 16th

Edna L. Lanning 216 W. Clark Liv

Joyce Herauf P.O. Box 1277 L...

Leonard C. Green 122 - W. Gallatin

Marge Ziegeldorf } 512 No. 11th

Albert Ziegeldorf }

Elwood ...

Louie & Aldie Schultz

Eugene J Kmoreк
107 So 2nd Milesapt 331
Livingston
59047 Mont

Carl D Olmstead
325 So. main apt 304 Livingston, Mt

Hazel B. Case
109 W. Lewis 3-6 Livingston

Val Jansen
119 So. Yellowstone
Livingston, Mont. 59047

Mildred H. Webb Livingston, Mt.
322 N. 7th St.

Mary Broadland
107 S 2 ap 224
Livingstone mt

Marcella R. Mills
107 So 2nd # 332
Livingston, Mt.

Tom Shellman
Livingstone
[illegible] Livingston.

Pamel [illegible] P.O. Box [illegible] [illegible]

Betty L. Clark Box 244, Livingston, Mont.
Linda Sigler 603 Robin #48 Li[illegible]
Marylou Huffman 122 HighGround Living[illegible]
Minnie Hecht 321 So 13 St Living[illegible]
Leo L Hecht 321 So. 13th St. Living[illegible]
Janice A Ewan 410 S. Yellowstone Living[illegible]
Mary Wengrae Sherwood Inn
Jackie Little - 309 South 2nd Liv[illegible]
Amy R Towsend 420 N. Yellowstone, [illegible]
Cindie Phillips 117½ N. 7th Livingston
Jo Ann Sluss 214 ELM - P.O BOX 750 [illegible]
Vera Horsley 325 S main apt. 407 [illegible]
Patsy H. Brandon P.O. Box 730 Livingston, [illegible]
Nancy Baker 507 N. 8 Livingston, Mt
Deanne L. Williams 603 N. 10th Livingston
Helen Harper 520 So 9th Li[illegible]
Toots Mimesa 630 N. 2nd
Virginia M. O'Hara 630 No D St.
Millie Stern 104 Elm[illegible]
Cheryl D Merrell Clyde Park Mt

DATE 2.10.87

1. Susan B. Bragg
PCA, Livingston

2. Thomas K. Bragg

3. John R. [illegible] - Montanan

4. Dean R. Carter - Retired

5. Donald W. Fraser - Retired

6. John P. Davis, Chairman - Gateway Hospice Bd. of Directors Livingston, Montana

7. Judy Davis - homemaker

8. June E. Brown retired

9. Wayne T. Brown retired

10. Roberta Davis homemaker

National Association of Social Workers

EXHIBIT 7
2-10-87

MONTANA CHAPTER

TESTIMONY BEFORE THE JOINT SUBCOMMITTEE ON HUMAN SERVICES OF THE SENATE FINANCE AND CLAIMS COMMITTEE AND THE HOUSE APPROPRIATIONS COMMITTEE

February 10, 1987

My name is Judith H. Carlson and I am speaking for the Montana Chapter, National Association of Social Workers. We've talked about social workers before in front of this committee in asking for more social workers in the field of child protection.

But there are about 1/3 of licensed social workers who do a different kind of social work - these are ones who are highly trained and skilled in the psychotherapy part of social work. They maintain private practices, either singly or as a member of a group of therapists. They are members of the private sector of mental health practitioners.

These social workers are licensed by the state of MOntana, hold graduate degrees from accredited universities, and have experience as clinical social workers.

Who goes to see privatepractice social workers? Persons with emotional problems, persons with family problems, marital problems, parent-child problems, whatever. The county social workers may refer families, children or parents or both, for counselling or therapy. When that is the case, medicaid may be called upon to pay the bill. This is when it becomes an optional medical service.

Provision of mental health services to medicaid patients early will ward off more serious problems later and avoid higher costs. We urge you to maintain the medicaid program at its present level of services.

Judith H Carlson

EXHIBIT 3
DATE 2.10.87
HB

Mr. Chairman, Members of the Committee. For the record, I am Robert H. Likewise, the Executive Director for the Montana State Pharmaceutical Association. Some time back I testified before this committee regarding the problem of timely reimbursement. This is still a problem. I realize that it is not something that can be corrected overnight, but as the problem continues, pharmaices will continue to discontinue to provide some of the services. It is my understanding that since I last testified at least one more pharmacy in Missoula has discontinued to accept State Medical. I have also learned that since that time one store in Eastern Montana has written off $2600 in medicaid claims that they have given up on billing and rebilling.

In response to the last request for a cut in the SRS budget, the pharmacists of Montana have had their dispensing fee frozen at the level they were at on November 31, 1986 and also have had their ingredient cost frozen until such time as this cost increases above 10% of cost on November 31, 1986. The dispensing fee range for pharmacies in Montana has remained the same since October 1, 1980 with no increases in the maximum level.

These freezes make it difficult for pharmacies to provide this valuable service to the community as they desire to do. An example would be a small store that only receives a discount of say 6% from the wholesaler. If this pharmacy dispenses a well known product such as Naprosyn in quantities of 120 (for a months supply at 4/day) the average wholesale price would be approximately $91.00. For this sale, the pharmacy would be reimbursed at AWP minus 10% plus the fee or $81.90 plus the dispensing fee. If the fee was at the maximum of

$3.75, the reimbursement would be $85.65. Once again with a discount of 6%, the store would have paid $85.54 for the above. Another common product would be Zantac with an AWP of $60.94.

Example: AWP 60.94
Cost after discount: 57.28
Reimbursement by SRS: 58.60 (AWP minus 10% plus fee of 3.75)

These are just a couple of examples. What this adds up to is that pharmacy isnot only losing money on each medicaid prescription filled in Montana on an average basis, but also you can see that they are just barely recouping the cost of th product. They must pay the wholesaler for the product in 2 weeks and are waiting for 4 weeks or longer for reimbursement by medicaid.

A cost to dispense survey was conducted in 1984 from figures of 1983. I again conducted a survey at the expense of MSPA of the stores that sent in questionnaires for the purpose of updating their fees before the freeze went into effect. Both sets of figures were compared.

(The following results were obtained by comparing data of the stores that responded in 1986 to the figures from the same stores from the 1984 survey)

	1984 Survey	1986 Average
Average # of Rx filled	28,289	28,753
Average Selling Price	9.98	12.89
Ave. Cost to Dispense	3.84	4.35
Ave. Gross Margin	3.80	4.64

The average increase in the ingredient is calculated by the following:

S/P - G/M = ingredient cost
1984 9.98 - 3.80 = 6.18
1986 12.89 - 4.64 = 8.25

The difference is $2.07 or approximately 10% per year.

Since the maximum fee is $3.75, these pharmacies are losing approximately $.60 on each prescription filled.

A summary of the above indicates that the selling price increased by 23%, the cost to dispense increased by 12% and the gross margin by 18%. This would indicate a cost shifting to the private pay sector for the above loss.

In closing, I would like to emphasize that the pharmacies of Montana are trying and want to provide this service and would gladly do so at a break even point. However, they are finding it difficult to continue providing a service that not only is done so at a loss but also places a strain on the cash flow. They would therefore ask that you give the medicaid budget every consideration.

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DATE 2-10-87
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Feb. 4, 1987

Dear Committee Member:

A crisis situation has arisen in the Home Health Care Program in the State of Montana. As a direct result of the recent wage reduction for Personal Care Attendants, the elderly, and the physically and mentally challenged citizens of this state are no longer receiving the quality and availability of care they deserve. Under the new program clients have been left without attendants, training for new attendants has failed to be provided, and calls to the locol West Mont office are usually met with a recording.

This is a sad state of affairs concerning a group of citizens that the people of Montana have deemed worthy of support and assistance. If the disabled and the elderly do not receive care in their own homes, they will be forced into hospitals, nursing homes and similar facilities. Not only would this move be devastating to the clients, but it would also create a quantum leap in the cost of care for these individuals.

While I, as a Personal Care Attendant, am appalled by the ramifications of a wage cut, I realize that the State of Montana has no legal obligation to Personal Care Attendants. But the State of Montana has an obligation to the elderly and disabled population. The people of Montana have set a precedent concerning the elderly and disabled. It is a precedent which says that these people have a right to be treated better than second class citizens. Now these home health consumers are having to deal with such things as having no one available at the West Mont office, having no choice as to who the Personal Care Attendants are that work with them, and

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having a new Personal Care Attendant that may not have been trained. Not only does this create a situation of tension and loss of control on the part of the elderly and disabled, but also a hazard for them as well. It is with no exaggeration that I say that the potential exists for serious injury or even death amongst elderly and disabled clients. These allegations of negligence are not merely inflammatory statements. Evidence can be provided supporting the veracity to the claims of negligence against West Mont opperations.

My fear is that what is currently a bad situation for the Health Care Consumers is only going to get worse. Quality of skill among Personal Care Attendants shall errode continuously as qualified people leave their clients for employment opportunities that pay a decent wage. But what of the clients?

It requires a good deal of physical, mental, and spiritual energy to be a responsible Personal Care Attendant. For a quadrapalegic unable to move any part of his body except the neck and head, who cannot urinate or have a bowel movement by himself, or dress or bathe himself, or brush his teeth, or even scratch his nose, the sensitivity of a responsible attendant is priceless. What are the elderly and disabled going to recieve for 3.35 an hour?

When you depend upon someone for virtually every bodily function and you've developed a good relationship with your Personal Care Attendant only to see that person leave for the necessity of a livable wage, how would you feel?

If you are not concerned with the health and dignity of the clients, then consider the astronomical rise in the cost of care if these people are forced out of the home environment. The

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statistics are readily available to prove the drastic increase that would result. But I would hope that there would be at least a measure of concern for the elderly and disabled, and their right to live with dignity.

I strongly urge you to take action immediately to stop the erosion of the Home Health Program. It is of the utmost urgency! Please do something before a client is injured or worse!

Concerned Citizen and Personal
Care Attendant -

Jeanne Hatfield Artman

Jeanne Hatfield Artman

P. O. Box 4642
Missoula, Mt. 59806

EXHIBIT 5
DATE 2-10-89
HB

To all committee members:

I implore each of you to act now to stop the suffering and loss of the elderly and the disabled who are cared for by Personal Care Attendents. These individuals have been since January 1, at an ever increasing risk of being forced into nursing homes or similar institutions.

The devasting cost to these special citizens cannot be measured, the cost to the state will be millions of dollars. This crisis is a direct effect of Social and Rehabilitation Services' contract with West Mont and the resulting 50 cents per hour wage reduction that Personal Care Attendents have been forced to accept.

I, myself, have been a Personal Care Attendent/Homemaker working directly or indirectly for Social and Rehabilitation Services for over a year. I am now solely a Homemaker for Missoula Community Hospital. Trained, experienced, dedicated Persoanl Care Attendents are being forced to leave the field.

We cannot live on minimum wage and provide the quality care our clients deserve and require. As a Homemaker, my wage will be reduced from $4.50 per hour to $3.85 in July. At that point I will be forced to quit.

I worry deeply for my 80 year old client who has short term memory loss, mental confusion, diabetes, and high blood pressure. For almost 15 years this woman has been virtually isolated, her health deteriorating.

After 3 months of daily assistence, she has finally come to recognize and trust me. Her diet is healthy and regular,

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she no longer misses or doubles up on her medication. It has taken slow careful steps, but she has reestablished the quality of her life at home and a life at all outside those 4 walls.

If I am forced to leave this client, who will take my place? The potential for abuse is tremendous here. I fear for my client's loss of freedom of choice, dignity, health, and the possible loss of her possesions. What kind of personal responsibility and dedication can be expected for $3.35 per hour?

Then there is my 6 year old client with severe brain damage. He has no speech and cannot control most of his muscles including his bowels and bladder. His caregiver must learn his specific physical therepy, ways of being transfered, diet, and ways to restrain muscle spasms, among many other things.

It has been difficult in the past to find people to work with these kinds of disabilities at $3.35 and $4.50 per hour; with the wage reduction this problem only gets worse.

There are hundreds of clients in Montana. They do not need or want to be institutionalized. All will suffer. Some will not survive.

This crisis will only worsen as the pool of Personal Care Attendents shrinks, reduced to only those who can and will work for $3.35 per hour. The caregivers will go on, often to higher wages for far less demanding work. The clients cannot escape the actions of Social and Rehabilitation Services and West Mont--already they have failed to provide the care available prior to this contract.

For the sake of these clients, Personal Care Attendents must be paid at least $5.00 per hour plus real fringe benefits. A commitment to the people of Montana has been made, I ask you each to do what you can to see that it is fulfilled.

EXHIBIT 6
DATE 2-10-87
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TESTIMONY OF: Karen E. Black, Administrator
Brendan House Skilled Nursing Care Facility

ADDRESS: 250 Conway Drive
Kalispell, Montana 59901

THIS TESTIMONY IS IN OPPOSITION TO THE PROPOSED MEDICAID REIMBURSEMENT RATE FREEZE.

Thank you for allowing me to speak to you today. I would like to tell you a little about Brendan House and then, talk with you about what a freeze in Medicaid rates would mean to the people we care for.

On April 15, 1985 Brendan House was opened. It is a Skilled Nursing Facility, built to accommodate 80 patients. Our current state license is for 69 beds. Brendan House is somewhat different than the traditional nursing home, in that the majority of our patients require rehabilitative services such as physical therapy, occupational therapy, respiratory therapy, cardiac rehabilitation therapy and speech therapy; or their care needs require the consultation of medical specialists; or they require a high level of skilled nursing intervention and frequent physician contact.

The Brendan House philosophy behind providing this level of care is based on our beliefs that elderly and disabled persons are entitled to skilled medical and nursing services which accept the potential for continued learning and growth; that they deserve excellence in rehabilitation services which provide a channel back into the community; that they deserve honor and respect in an environment which is adapted to maximize what is intact and support what is impaired. We stand as a patient advocate, respecting

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always the right of the elder or disabled person to choose the goals of their therapy and the substantial ways they will be realized. We know this philosophy and level of care pays off because it has resulted in an average discharge rate of 29 patients per month, and an average length of stay of 77 days. Traditionally, Extended Care Facilities are unable to measure length of stay in anything other than years. The majority (60%) of discharged patients return home with appropriate services in place. We have the largest number of discharges to the Medicaid Waiver program in the Flathead Valley. Patients that remain in the facility or go to other facilities are brought to their maximum functioning level. To get these kinds of results takes a lot of work by a highly motivated and well educated staff. This level of care costs money to provide, but in the long term it is most cost effective and preserves human dignity.

In order to discharge this number of patients each month a team of skilled professionals need to assess each resident's needs and coordinate services that will assure that all the patient's needs will be met when he or she returns home. A full time Social Worker, working with community agencies is necessary to complete this process.

To provide rehabilitative services you not only need qualified therapists but a place for them to work and some very expensive

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equipment.

Providing highly skilled care with patient and family teaching requires a greater number of staff with more training than would be required to simply keep a person clean and fed. However, it costs a lot less than keeping a patient in the hospital, and when the results are to return home, a lot less than long term custodial care.

I have come here today to tell you what a freeze in Medicaid rates would mean to Brendan House and to the patients we serve. It would most likely destroy our ability to provide this needed level of care. Paul Willging, Executive Vice President of the American Health Care Association recently stated that inadequate Medicaid reimbursement is likely to force facilities to discriminate against caring for Medicaid patients. We are here today because we do not want to see that happen.

Our current reimbursement rate at Brendan House is $50.08 per patient day. This rate is a penalty rate for not meeting SRS documentation requirements during our first year of operation. There is no way we can we tolerate this reduced rate for a few more months, let alone tolerate a two year freeze. It in no way reflects or compensates us for the actual care our Medicaid clients receive. Our actual current cost for care to our Medicaid patients is $75.39 per patient day. Our total Medicaid reimbursement is $53.34 per

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patient day. This is a short fall of $22.05 per patient day. Who will make up the difference? We cannot continue to accept this degree of financial shortfalls and at the same time continue to comply with the ever increasing quality assurance and patient rights regulations being imposed on long-term care facilities.

Medicaid patients are certainly no less expensive to care for than any of our other patients. They eat the same foods, require the same supplies occupy the same space and are cared for by the same skilled professional and support staff.

The Ombudsmans office has published a booklet titled, "Good Care Is Your Right." It tells residents they have the right to expect that a facility has enough staff, serves good food, provides laundry service, prevents bed sores and provides all appropriate therapies. I believe that residents have the right to expect that the care they receive will bring them to their maximum functioning level. The Legislature has a right to require this because it is less expensive for the people they represent because it is the most cost effective. Facilities who provide this level of care have the right to expect to be appropriately reimbursed.

Thank you

Feb. 3, 1987

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To Whom it may concern,

Please know that I am in favor of making the necessary changes in order to assure a fair wage of $3.85 or more to the P.C.A.s of Montana.

It is, indeed, disturbing to know that caregivers are making less wages than most teenagers do in the local ice cream shops. A variety of skills & experience are necessary in order to successfully care for the elderly (many of whom are not well) and disabled individuals on a regular basis.

Please support any legislation that will insure some monetary incentive for these good people to continue working with our weaker members of society. They need the best help available. Thank you.

Sincerly,

Beth Young L.P.N.
525 Rollins
Msla. Mt.
59801

2 10 87
Rae Lynn Bell
6125 Mullan Rd #1
Msla, Mont
59802

2/3/87

Senator Mike Halligan,

I am writting to you to voice my protest of the way West Mont is handling the PCA's (Personal Care Attendant's) problems. In my own case, I have called numerous times in early afternoon to the office here in Missoula and either I get there answering machine or no one at all.

One episode in particular was on January 26, 1987. I was in a car accident at 3:00 in the afternoon. I finally got home at 4:00. I tried to call West Mont to tell them I wasn't going to be able to be at work for the rest of the week, nor make it that afternoon. Instead of talking to a person, I got their machine. So I had to call Five Valley Health Care to tell them my problem. They apparently found a replacement for me. I had to get ahold of someone that day, because my client would need me at 6:30 AM the next day. I was suppose to be at my clients home at 3:30.

Another episode was at 3:00 in the afternoon. It wasn't life or death. But I felt they should answer their phones in the afternoon to answer questions or solve problems when its needed. I feel that communication is a big part of being a PCA, and you need to be able to communicate with your employer.

I feel that West Mont hasn't handled the takeover of the contract or what ever you care to call it well at all

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Personalley getting payed $3.35 an hour for the work I do is pretty bad. I started as a PCA in October. I had done this work before in a different situation. I enjoy being able to help people in this manner. I feel the more people that are able to stay at home are at a greater advantage than the people that are put into restHomes or other institutions. People are more comfortable in their own envirment where they have controll.

I am an SPN (Student of Practical Nursing) attending the Msla, Vo-Tech. for schooling. I enjoy of the health field and felt that Home-Health Care could be the future for my trait's. For the level of professionalism involved with this job, I feel that $3.35 an hour is a joke.

There's alot involved with caring for these clients. They are very dependant on us the PCA's. Thats the only reason that I signed with West Mont. I was concerned about my client. Over a period of time you become attached to your client. Their part of you life and family. West Mont played on these feelings.

Thank you for all you help and support.

Sincerly, Rae Lynn Bell
Msla Mont.

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PROPOSED FEDERAL MEDICAID CUTS THREATEN STATE PROGRAMS: The Reagan Administration's FY '88 budget proposal seeks to cap federal Medicaid payments for medical assistance at $25.4 billion (a $1.3 billion reduction from FY '87). Under the budget proposal, future federal spending increases would be limited to Consumer Price Index (CPI) inflation adjustments. Federal payments to states each year would continue to match state expenditures, but only up to each state's growth limit.

This proposal comes at a time when many states are facing tight budgets and are facing an increase in Medicaid recipients. Midwestern states are being hit by problems in the agriculture economy; Louisiana, Oklahoma and Texas are facing severe budget shortfalls and an increasing Medicaid burden due to the oil industry's economic problems. Northern California's Medi-Cal (California Medicaid) is anticipating an increase of 27,000 new recipients a month in 1988.

As a partial solution in California, the California Association of Catholic Hospitals (CACH) have announced plans to introduce legislation this month to fund indigent care by doubling the current 10 cents-per-carton cigarette tax. CACH estimates the tax would raise an additional $263 million in revenues which would be retained in a pool. Hospitals would be paid a percentage of the difference between Medi-Cal reimbursements and charity care bad debts from the funding pool. Last year California lost an estimated $600 million on charity care and is facing a Medi-Cal deficit.

CACH reports California's 10-cent cigarette tax is the sixth lowest in the nation. Taxes range from a high of 40 cents per carton in Hawaii to 2 cents per carton in North Carolina and Virginia. The average state per-carton-tax is 17.46 cents.

* * * * * *

CONGRESS URGED TO RAISE CIGARETTE PRICES AND BAN ADS: The Coalition on Smoking and Health has presented a proposal to the 100th Congress to increase the cost of a pack of cigarettes through higher taxes, to ban cigarette advertising and promotion, and to eliminate smoking aboard all domestic airliners. The coalition, which includes the American Cancer society, the American Lung Association and the American Heart Association, also asked Congress to restrict smoking in all public buildings, to reduce smoking in the military, to increase funding for the federal Office on Smoking and Health, and to end federal funding for the growth of tobacco. According to the Coalition, cigarette smoking kills an estimated 350,000 people and costs the economy $65 billion through health care expenditures and lost productivity.

* * * * * *

PROPOSED FY '88 MEDICARE AND MEDICAID BUDGET CUTS: Details of President Reagan's seventh federal budget proposal (FY '88), calling for total federal spending of $1.024 trillion and a deficit of $107.8 billion, just below the $108 billion ceiling set by the Gramm/Rudman/Hollings Balanced Budget Law, have become available. The combined legislative and regulatory budget package would reduce Medicare outlays by $4.7 billion in FY '88 while increasing Medicare revenues by some $2.3 billion. Highlights of budget proposals for Medicare include:

*A tentative rate increase of 1.5 percent in diagnosis related group (DRG) payments to hospitals (a projected savings of $510 million)
*By regulation, decrease current capital payments to hospitals by 7 percent in FY '88 and 10 percent thereafter, fold all capital costs into the prospective payment system (PPS) with movable equipment receiving a 2-year transition, and fixed equipment a 10-year transition (no projected savings in FY '88; a $2.4 billion savings in FY '88-92)
*Periodic Interim Payments (PIP) to disproportionate share hospitals would be eliminated (a projected savings of $1.2 billion in FY '88)
*Establishment of a permanent 30-day payment cycle schedule for Medicare claims payment (a projected savings of $890 million in FY '88)
*Return on equity payment to proprietary skilled nursing facilities and outpatient departments would be terminated (a projected savings of $30 million in FY '88)
*Payment for the services of radiologists, anesthesiologists, and pathologists would be folded into the DRG payment with Medicare paying the average for these services associated with a specific procedure code (a projected savings of $10 million in FY '88)
*Repeal of newly enacted benefits for optometric services, physician assistants, and occupational therapists, and the reduction in payments to kidney dialysis centers (a projected savings of $323 million in FY '88)
*Direct graduate medical education payments would be terminated as of July 1, 1987 (a projected savings of $310 million in FY '88)
*Indirect graduate medical education payments would be halved from 8.1 percent to 4.05 percent (a projected savings of $1.2 billion in FY '88)
*A four-part package of reductions in payments to physicians for certain "over-priced" procedures including cataract procedures (a projected savings of $190 million in FY '88)
*A proposed increase from 25 percent to 35 percent of program costs in the Part B premium for new enrollees and for states which buy Part B coverage for Medicaid recipients (a projected savings of $571 million in FY '88)
*The indexing of the current Part B deductible of $75 (projected savings of $25 million in FY '88)
*Delay in eligibility for benefits until the first day of the month following a person's 65th birthday (a projected savings of $295 million in FY '88)
*Establish Medicare as the secondary payor for the working disabled in mid-size firms (a projected savings of $120 million in FY '88)
*Extension of the payroll tax to all state and local government workers (revenue increases of $1.6 billion in FY '88)
*A multifaceted expansion of capitation with Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CPMs) (a projected savings of $4 million in FY '88)

Also, the Administration's budget proposal calls for a combination of legislative and regulatory initiatives that would reduce Medicaid outlays by $1.3 billion in FY '88. Highlights of the FY '88 proposals for Medicaid include:

*The establishment of a cap on federal payments to states (a projected savings of $1 billion in FY '88)
*Modification of matching rate formula for administrative costs for states with high administrative costs, and the reduction of special matching from 75 percent to 50 percent for information systems, survey and certification, peer review contracts, and fraud control (a projected savings of $360 million in FY '88)
*A requirement that states cut payments to physicians who provide non-emergency care to Medicaid recipients in an emergency room (a projected savings of $800 million in FY '88)
*The establishment of incentives for states to enroll Medicaid recipients in prepaid capitated plans
*Funding a new case management system for pregnant women through savings generated by reductions in the special matching rate for family planning
*Requiring states to look at any transfer of assets which occurred up to 2 years prior to an individual applying for Medicaid.

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