MEETING MINUTES
HUMAN SERVICES SUBCOMMITTEE
FEBRUARY 18, 1987

The meeting of the human services subcommittee was called to order at 8:00 a.m. on February 18, 1987 in room 108 of the state capitol building by Chairman Cal Winslow.

ROLL CALL: All members were present.

(44a:150) Janice Connors, director of the Montana/Wyoming Foundation for Medical Care, in response to inquiries from Chairman Winslow on the prescreening process for nursing homes, stated the nurses perform the medical screening only, which is only one part of the geriatric evaluation. Long term care workers complete the geriatric rating scale and follow through with contacts and setting up alternatives. Where there is not a long term care social worker, the nurses fill out the medical screening form and the geriatric rating scale form, but don't follow through and set up alternative services. Nurse coordinators are trained to do the geriatric rating scale, one portion of the long term care workers job. She added what they don't do and never have done is all the administrative work that goes along with the program, i.e. the paperwork, contacts with individual family members, finding and setting up alternatives. Ms Connors stated she was not aware of all the services provided by the long term care workers. She stated a contractual agreement with the state to provide long term care services through the foundation would have to be reviewed and assessed as to what the job requires and what the expectations are. She added she was not sure if nurse coordinators would be used to provide those services, or if they would employ social workers to provide outreach services.

(44a:221) Lee Tickell, administrator of Economic Assistance (EA), SRS, stated long term care workers are in areas where the Medicaid waiver is being implemented. These individuals screen for inappropriate placements for nursing home services, and coordinate appropriate social services for elderly individuals living in their own homes. He stated he did not feel there was a duplication of services being provided.

In response to a question from Sen Himsl, Mr Tickell noted the program was audited and evaluated, including an audit for duplication of services.

MEDICAID PRIMARY CARE

(44a:310) Peter Blouke, LFA, provided a comparison of FY 86 and FY 87 costs for AFDC and SSI Medicaid costs (exhibit 1) by category of service. He stated questions that need to be addressed are: "If the caseload is going up, does the committee have any options to slow the caseload growth?" - "If the price is going up, are there options available to the committee to slow down price increases in the program".

(44a:380) Lee Tickell, stated the number of eligible recipients, the number of services used, and the dollars per services are driving up the cost of the Medicaid program. He added any time cuts are made either someone will not get services, or someone is not going to get paid, resulting in cost shifting, or reduced funding for one program may cause shifting of the eliminated services to another category of expenses. Mr Tickell then provided information clarifying the figures and percentages reflected in exhibit 1.

(44a:588) Bob Olson, Medicaid Bureau, SRS, presented a list of potential cuts compiled by the department at the committee's request (exhibit 2). He stated inpatient hospital expenditures have increased by 44%. The department generated reports on four (4) of Montana's large hospitals for 1985-1986 and the resulting facts showed a rise in the number of people being served, increased costs for the services provided, and the amount of services provided and not covered by Medicaid quadrupled in one year. The department then contacted one of the hospitals to clarify the findings and found the figures did correlate with those of the hospital. He further stated the hospital explained that the quadrupling of costs above Medicaid was due to the fact that those eligible for SSI Medicaid services were dropping supplemental policies. He explained this was confirmed by the declining amount of third party reimbursement the department had been receiving. He stated the indigent hospital care is on the rise, and hospitals are encouraging these individuals to apply for Medicaid.

(44b:100) In response to a question from Sen Himsl, Mr Olson clarified the criterion and system for determining the amount of Medicaid coverage and deductible for services provided.

Mr Olson discribed DRG's (Diagnostic Related Groupings), as a perspective payment system; i.e., a rate set for a service based on the type of service received. He stated it is the same system the Medicare insurance uses for reimbursement.

(44a:246) Discussion continued on the proposed areas under consideration for elimination. Specific points were: heart

transplants are no longer considered an experimental surgery under the Medicaid program, and nine (9) hospitals will be designated in the nation to perform this procedure. Kidney dialysis services will be cut back due to the costs involved in providing this service. Liver transplants are covered by Medicaid for children under the age of 18 years.
The problem of providers collecting co-payments.

(44b:566) Dave Lewis, DSRS, stated that if there were cuts made in the Medicaid program he would need another FTE position for an attorney to deal with litigation.

EXECUTIVE ACTION

Preadmission Screening

(44b:641) Rep Switzer made a motion to eliminate payment of any inpatient claim unless preadmission screening had been obtained.

A voice vote was taken and the motion PASSED, with Sen Manning voting no.

Limitation of Rates

Rep Bradley made a motion to limit the room and board rate to a set reasonable fee.

(45a:007) Peter Blouke, speaking as a board member at St Peter's Hospital in Helena, noted that most hospital boards are made up of community citizens who have no personal investment in the profit of the hospital and who are concerned about costs. He stated his own impression was, in talking to other board members, that they would be receptive to this action and willing to work with the state.

A voice vote was taken and the motion PASSED, with Rep Connelly voting no.

Limitation for Inpatient Services

Mr Tickell stated the average hospital stay is four (4) days, with the most common service provided being maternity care for births in the AFDC program. There was discussion of how a day limit could be established, alternative choices, problems with limitations, and the details of services provided to AFDC and SSI individuals.

Dave Lewis noted in his discussion with physicians on this issue that their feeling was a 30 day limit subject to review by a hospital ethics or peer review committee for recertification of services would be acceptable. The 30 day

limit only was unreasonable because there would always have to be exceptions made to the rule.

(45a:132) Sen Harding made a motion to establish a limit of 30 days for inpatient services for which Medicaid would pay per recipient in any given year, subject to review by the hospital ethics committee.

A voice vote was taken and the motion PASSED unanimously.

Limitation of Outpatient Services

(45a:206) Sen Manning made a motion to limit non emergent, out patient room visits to five (5) per year where there is not an inpatient stay.

A voice vote was taken and the motion PASSED unanimously.

Discussion followed on preauthorization of select optional services, second opinions on surgical procedures, and physical therapy services.

Physician

(45a:301) Mr Tickell described the reimbursement process for physician services, which is by either a fee for service or on a "by report" basis.

Bob Olson, SRS, stated fees for services have been set for as many "by report" services as possible to tie down costs on a per service basis. He stated areas he felt needed to be addressed was the inequity in the reimbursement process among the physicians by speciality. He said the latest data shows a ten (10) percentage point slip in reimbursement for OB/Gyn routine services while other types of physicians not facing large malpractice insurance or cost of doing business are enjoying the same level of reimbursement to their charges that they have customarily enjoyed in the past. The regular charge for ob/gyn services is $1,500, while the reimbursement fee is $570. Mr Olson stated there has been an increase in the amount of component billings in which the physician, rather than doing an x-ray in his office and looking at that x-ray, will utilize a radiology department and he then bill for a professional component of that service. There is then a bill for the full cost for the use of the radiology department, normally situated in a hospital or clinic, and the physician fee for interpretation of that service.

(45a:474) Sen Manning made a motion to provide a 1.5% rate increase per year from the base, 3.0% over the biennium, and give the department discretion on how to distribute the increase based on the physician specialties and their increase in costs.

A voice vote was taken and the motion PASSED unanimously.

(45a:500) Discussion continued on the concept of HMO's and its application to Medicaid individuals, and the issue of pharmacy services to Medicaid individuals.

The meeting was adjourned at 10:02 a.m. (45a:672)

Cal Winslow, Chairman

cw/gmc/2.18

DAILY ROLL CALL

HUMAN SERVICES SUB COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date Feb 18, 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 B 2-18-87

02/16/87 MED_01H6

Medicaid Primary Care
Comparsion of FY86 and FY87

TYPE of SERVICE	AFDC FY86 as of 1/86	AFDC FY87 as of 1/87	AFDC Actual Change: Increase (Decrease)	AFDC Percent Change: Increase (Decrease)	SSI FY86 as of 1/86	SSI FY87 as of 1/87	SSI Actual Change: Increase (Decrease)	SSI Percent Change: Increase (Decrease)	Total AFDC & SSI FY86 as of 1/86	Total AFDC & SSI FY87 as of 1/87	Total AFDC & SSI Actual Change: Increase (Decrease)	Total AFDC & SSI Percent Change: Increase (Decrease)
Inpatient Hospital												
Eligibles	177,477	198,532	21,055	11.86%	67,859	71,679	3,820	5.63%	245,336	270,211	24,875	10.14%
Recipients	2,867	3,069	202	7.05%	1,315	1,619	304	23.12%	4,182	4,688	506	12.10%
Recipients/Eligibles	0.0162	0.0155	(0.0007)	-4.31%	0.0194	0.0226	0.0032	16.56%	0.0170	0.0173	0.0003	1.78%
Services	198,613	222,750	24,137	12.15%	247,921	293,597	45,676	18.42%	446,534	516,347	69,813	15.63%
Services per Recipient	69.28	72.58	3.31	4.77%	188.53	181.34	(7.19)	-3.81%	106.78	110.14	3.37	3.15%
Expenditures	$3,781,053	$4,399,644	$618,591	16.36%	$2,483,597	$3,470,700	$987,103	39.74%	6,264,650	7,870,344	$1,605,694	25.63%
$ per Recipient	$1,318.82	$1,433.58	$114.76	8.70%	$1,888.67	$2,143.73	$255.06	13.50%	$1,498.00	$1,678.83	$180.82	12.07%
$ per Service	$19.04	$19.75	$0.71	3.75%	$10.02	$11.82	$1.80	18.00%	$14.03	$15.24	$1.21	8.65%
Outpatient Hospital												
Eligibles	177,477	198,532	21,055	11.86%	67,859	71,679	3,820	5.63%	245,336	270,211	24,875	10.14%
Recipients	11,350	12,970	1,620	14.27%	4,236	5,181	945	22.31%	15,586	18,151	2,565	16.46%
Recipients/Eligibles	0.0640	0.0653	0.0014	2.15%	0.0624	0.0723	0.0099	15.79%	0.0635	0.0672	0.0036	5.74%
Services	50,016	58,493	8,477	16.95%	34,761	69,784	35,023	100.75%	84,777	128,277	43,500	51.31%
Services per Recipient	4.41	4.51	0.10	2.34%	8.21	13.47	5.26	64.14%	5.44	7.07	1.63	29.93%
Expenditures	$954,208	$1,037,973	$83,765	8.78%	$414,076	$518,587	$104,511	25.24%	1,368,284	1,556,560	$188,276	13.76%
$ per Recipient	$84.07	$80.03	($4.04)	-4.81%	$97.75	$100.09	$2.34	2.40%	$87.79	$85.76	($2.03)	-2.32%
$ per Service	$19.08	$17.75	($1.33)	-6.99%	$11.91	$7.43	($4.48)	-37.62%	$16.14	$12.13	($4.01)	-24.82%
Physicians												
Eligibles	177,477	198,532	21,055	11.86%	67,859	71,679	3,820	5.63%	245,336	270,211	24,875	10.14%
Recipients	42,327	48,513	6,186	14.61%	14,292	16,829	2,537	17.75%	56,619	65,342	8,723	15.41%
Recipients/Eligibles	0.2385	0.2444	0.0059	2.46%	0.2106	0.2348	0.0242	11.48%	0.2308	0.2418	0.0110	4.78%
Services	99,352	110,117	10,765	10.84%	40,096	45,492	5,396	13.46%	139,448	155,609	16,161	11.59%
Services per Recipient	2.35	2.27	(0.08)	-3.30%	2.81	2.70	(0.10)	-3.65%	2.46	2.38	(0.08)	-3.31%
Expenditures	$2,440,499	$2,728,783	$288,284	11.81%	$702,471	$829,485	$127,014	18.08%	3,142,970	3,558,268	$415,298	13.21%
$ per Recipient	$57.66	$56.25	($1.41)	-2.44%	$49.15	$49.29	$0.14	0.28%	$55.51	$54.46	($1.05)	-1.90%
$ per Service	$24.56	$24.78	$0.22	0.88%	$17.52	$18.23	$0.71	4.07%	$22.54	$22.87	$0.33	1.46%
Other Practitioners												
Eligibles	177,477	198,532	21,055	11.86%	67,859	71,679	3,820	5.63%	245,336	270,211	24,875	10.14%
Recipients	6,164	7,501	1,337	21.69%	2,901	3,541	640	22.06%	9,065	11,042	1,977	21.81%
Recipients/Eligibles	0.0347	0.0378	0.0031	8.78%	0.0428	0.0494	0.0067	15.56%	0.0369	0.0409	0.0039	10.60%
Services	43,606	54,691	11,085	25.42%	20,291	24,863	4,572	22.53%	63,897	79,554	15,657	24.50%
Services per Recipient	7.07	7.29	0.22	3.07%	6.99	7.02	0.03	0.39%	7.05	7.20	0.16	2.21%
Expenditures	$552,246	$664,676	$112,430	20.36%	$254,889	$325,709	$70,820	27.78%	807,135	990,385	$183,250	22.70%
$ per Recipient	$89.59	$88.61	($0.98)	-1.09%	$87.86	$91.98	$4.12	4.69%	$89.04	$89.69	$0.65	0.73%
$ per Service	$12.66	$12.15	($0.51)	-4.04%	$12.56	$13.10	$0.54	4.29%	$12.63	$12.45	($0.18)	-1.45%
Drugs												
Eligibles	177,477	198,532	21,055	11.86%	67,859	71,679	3,820	5.63%	245,336	270,211	24,875	10.14%
Recipients	32,614	38,030	5,416	16.61%	50,658	53,791	3,133	6.18%	83,272	91,821	8,549	10.27%
Recipients/Eligibles	0.1838	0.1916	0.0078	4.24%	0.7465	0.7504	0.0039	0.53%	0.3394	0.3398	0.0004	0.12%
Services	56,296	66,061	9,765	17.35%	170,335	186,592	16,257	9.54%	226,631	252,653	26,022	11.48%
Services per Recipient	1.73	1.74	0.01	0.63%	3.36	3.47	0.11	3.16%	2.72	2.75	0.03	1.10%
Expenditures	$607,158	$777,027	$169,869	27.98%	$2,230,720	$2,729,947	$499,227	22.38%	2,837,878	3,506,974	$669,096	23.58%
$ per Recipient	$18.62	$20.43	$1.82	9.75%	$44.03	$50.75	$6.72	15.25%	$34.08	$38.19	$4.11	12.07%
$ per Service	$10.79	$11.76	$0.98	9.06%	$13.10	$14.63	$1.53	11.72%	$12.52	$13.88	$1.36	10.85%
Dental												
Eligibles	177,477	198,532	21,055	11.86%	67,859	71,679	3,820	5.63%	245,336	270,211	24,875	10.14%
Recipients	11,942	13,222	1,280	10.72%	3,223	3,481	258	8.00%	15,165	16,703	1,538	10.14%
Recipients/Eligibles	0.0673	0.0666	(0.0007)	-1.02%	0.0475	0.0486	0.0011	2.25%	0.0618	0.0618	0.0000	0.00%
Services	48,204	51,875	3,671	7.62%	10,431	11,190	759	7.28%	58,635	63,065	4,430	7.56%
Services per Recipient	4.04	3.92	(0.11)	-2.80%	3.24	3.21	(0.02)	-0.67%	3.87	3.78	(0.09)	-2.35%
Expenditures	$1,032,425	$1,142,773	$110,348	10.69%	$298,594	$352,843	$54,249	18.17%	1,331,019	1,495,616	$164,597	12.37%
$ per Recipient	$86.45	$86.43	($0.02)	-0.03%	$92.64	$101.36	$8.72	9.41%	$87.77	$89.54	$1.77	2.02%
$ per Service	$21.42	$22.03	$0.61	2.86%	$28.63	$31.53	$2.91	10.15%	$22.70	$23.72	$1.02	4.47%
Other												
Eligibles	177,477	198,532	21,055	11.86%	67,859	71,679	3,820	5.63%	245,336	270,211	24,875	10.14%
Recipients	6,107	6,480	373	6.11%	9,855	12,383	2,528	25.65%	15,962	18,863	2,901	18.17%
Recipients/Eligibles	0.0344	0.0326	(0.0018)	-5.15%	0.1452	0.1728	0.0275	18.96%	0.0651	0.0698	0.0047	7.30%
Services	80,406	103,810	23,404	29.11%	508,181	616,763	108,582	21.37%	588,587	720,573	131,986	22.42%
Services per Recipient	13.17	16.02	2.85	21.68%	51.57	49.81	(1.76)	-3.41%	36.87	38.20	1.33	3.60%
Expenditures	$345,947	$502,647	$156,700	45.30%	$1,734,242	$2,527,438	$793,196	45.74%	2,080,189	3,030,085	$949,896	45.66%
$ per Recipient	$56.65	$77.57	$20.92	36.93%	$175.98	$204.11	$28.13	15.98%	$130.32	$160.64	$30.32	23.26%
$ per Service	$4.30	$4.84	$0.54	12.54%	$3.41	$4.10	$0.69	20.08%	$3.53	$4.21	$0.67	18.98%
Totals												
Eligibles	177,477	198,532	21,055	11.86%	67,859	71,679	3,820	5.63%	245,336	270,211	24,875	10.14%
Recipients	113,371	129,785	16,414	14.48%	86,480	96,825	10,345	11.96%	199,851	226,610	26,759	13.39%
Recipients/Eligibles	0.6388	0.6537	0.0149	2.34%	1.2744	1.3508	0.0764	6.00%	0.8146	0.8386	0.0240	2.95%
Services	576,493	667,797	91,304	15.84%	1,032,016	1,248,281	216,265	20.96%	1,608,509	1,916,078	307,569	19.12%
Services per Recipient	5.09	5.15	0.06	1.19%	11.93	12.89	0.96	8.03%	8.05	8.46	0.41	5.06%
Expenditures	$9,713,536	$11,253,523	$1,539,987	15.85%	$8,118,589	$10,755,709	$2,636,120	32.47%	17,832,125	22,008,232	$4,176,107	23.42%
$ per Recipient	$85.68	$86.71	$1.03	1.20%	$93.88	$111.07	$17.20	18.32%	$89.23	$97.12	$7.89	8.85%
[illegible]	$16.85	$16.85	$0.00	0.00%	[illegible]	[illegible]	[illegible]	[illegible]	$11[illegible]	$[illegible]	[illegible]	[illegible]

EXHIBIT 2
DATE 2-18-87
HB

The Department has identified some areas of possible savings in acute care services provided in the hospital for Medicaid recipients. We can decrease the amount and scope of the services we provide as long as we do it across the board, i.e. we cannot discriminate on the basis of age, sex, or diagnosis.

The following list is comprised of suggestions which would alter the scope of the Medicaid program drastically. The full monetary impact of these suggestions for the most part is unknown.

1. Establish a dollar amount as a top limit for inpatient services for which Medicaid would pay per recipient in any given year.

2. Establish a day limit i.e. 30 days as a top limit for inpatient services for which Medicaid would pay per recipient in any given year.

3. Reimburse the lesser of allowed costs or the 50% for the primary diagnosis for each hospital admission.

4. Limit the room and board rate to a set reasonable fee.

5. Pay for only emergent care. This would eliminate all payments except for those conditions determined to be life threatening.

6. Eliminate payment of any inpatient claim unless preadmission screenin has been obtained. The only allowable exception to this rule would be cases where eligibility is determined retrospectively.

7. Limit eligibility for Medicaid by eliminating the medically needy.

The two following suggestions would limit the scope of Medicaid in outpatient hospital services:

1. Limit emergency room visists to a set amount per year.

2. Require pre-authorization of select optional services such as physical therapy.

VISITORS' REGISTER

HUMAN SERVICES SUBCOMMITTEE

BILL NO. _____ DATE February 18, 1987

SPONSOR _____ DEPT _____

NAME (please print)	Representing	SUPPORT	OPPOSE
Janice Connors	MWFMC		
Ellen Vogelsang-Tanner	Speech Pathology		x
Mary Anne Molineux	Speech Pathology		X
Steve Waldron	Mental Health Centers		
[illegible]			
Roger Tippy	Mont Dental Assn.		
Jean Kanac	IHH		
[illegible]	NASW		

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.