MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

SUBCOMMITTEE ON HEALTH & HUMAN SERVICES

Call to Order: By Chairman Bradley, on January 19, 1989, at 8 a.m.

ROLL CALL

Members Present: All members were present with the exception of Sen. Van Valkenburg and Sen. Keating.

Members Excused: None

Members Absent: Sen. Van Valkenburg and Sen. Keating

Staff Present: Peter Blouke, LFA
Lois Steinbeck, OBPP

Announcements/Discussion: Medical Assistance, Department of Social & Rehabilitation Services (SRS), Tour of facilities.

HEARING ON DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES

Chairman Bradley asked Dr. Blouke to discuss agenda for the day, Medical Assistance Contracted Services. (See attachments).

Discussion followed on the Medicaid Waiver program and its effectiveness as a means of health care and cost containment. Rep. Cody asked if there were any statistics to show we are saving by keeping them in their own home. Dr. Blouke stated the program was set up as an alternative to nursing home care and medicaid regulations allow reimbursement for a variety of home and community based services. Also to be eligible for these services, the individual must be certified as requiring the same level of care as would be provided in a nursing home. Services provided under the waiver include case management, homemaker services, respite care, personal care attendant services, adult day care, medical alert, and transportation services. Also when first authorized by the legislature during the 1985 biennium, the program was specifically targeted at the

elderly population. As the program expanded during FY1986, there was an increasing number of disabled individuals served by the program. Because the cost of providing services to the disabled is significantly higher than the cost of services to the elderly, the total number of persons who can be served by the program within the budget established by the legislature is determined by the mix of disabled and elderly clients.

A comparison of waiver services for elderly and disabled:

Monthly caseload, elderly, 205, cost/case $7,791;
Monthly caseload, disabled 116, cost/case $10,522;
Total cost, elderly $1,597,367;
Total cost, disabled $1,220,592.

During FY 1988 the average cost to provide services to a disabled client was $2,730 more than the cost to provide services to an elderly client. During FY 1988, a total of 465 elderly and 206 disabled clients were served by the program.

The comparison to nursing home costs of an average $18,000 to $22,000 per year to in home/community care cost for elderly of $7,791 and for disabled of $10,522 reflects a saving of approximately one-third to one-half. Mr. Tickell of SRS stated that in home care tends to maintain the individual in an independent, autonomous position which is beneficial to their well being.

There are eight/nine teams that supervise case management of those who are determined eligible under the Medicaid Waiver program. The state specifically requested a waiver of "statewideness" and does not have to provide home and community based services to all individuals who might be eligible, so the program is not comparable to other medicaid programs in the sense of "entitlement."

Rep. Cody had an inquiry about administration of the Indian Health Service under the Medicaid program and asked if SRS received any reimbursement. SRS does not but this is a service handled voluntarily that keeps state informed of Medicaid funds appropriated to state.

Mr. Tickell of SRS described the Medicaid program as the largest health insurance program in the state which impacts on all providers, e.g., hospitals, nursing homes, physicians, and other health practitioners, dentists, denturists, therapists, laboratories, chiropractors, pharmacists, optometrists, etc.

Mr. Tickell further stated that much of costs relate to services targeted at cost containment. Sen. Hofman requested information on the Medicaid Management Information System (MMIS) and the MMIS Enhancements budgets. Mr. Tickell stated that the MMIS processes medicaid claims at reasonable rates in comparison to other states. SRS' contract with Consultec, Inc. for computer programming, is set at a fixed five year, four month period (to coincide with our fiscal); the Diagnostically Related Groups (DRG's) is another cost containment program, which puts the ever changing DRG pricing on SRS computer so that the 66 hospitals in Montana do not have to maintain two computer programs, each hospital, for Medicaid and Medicare billing; contracted utilization of hospital services, which are mandated by the federal, with the Montana/Wyoming Foundation for Medical Care so that hospital services and nursing home care are neither underused or overused; auditing of nursing homes to ensure monetary compliance with state and federal regulations; audits of hospital costs by Blue Cross/Blue Shield; licensure/certification requirements mandated by federal and state regulations of nursing homes for medicaid reimbursement; and professional consultants who provide expertise in the development of regulations for medicaid and to assist in monitoring utilization.

Rep. Grinde requested that copies of contracts SRS has with various organizations be furnished to the subcommittee for their information. Mr. Tickell will present these contracts within the next few days.

Tony Wellever of the Montana Hospital Association and Janice Connors of the Montana/Wyoming Foundation for Medical Care addressed the need and the reason why DRG's were implemented.

Rep. Fritz Daily of Butte introduced the Butte-Silver Bow group who are interested in obtaining a Medicare Waiver case management team funding for this area. Statistics demonstrate that 17.2% of Montana's seniors reside in Silver Bow County but do not have this team. Statewide statistics show that 10% of the population are composed of the elderly and nationally that percentage is 12%.

Testimony of the Butte-Silver Bow contingent requesting Medicaid Waiver status for their area followed (see attachments). Rep. Cody requested cost figures for start up and Mr. Tickell stated that this would be 100% general fund initially but would become 75%/25% federal and state respectively.

Rep. Daily testified there are three nursing homes in Butte which are full with waiting lists. For cost effectiveness, 40 slots in Medicaid Waiver program would have to be used to make the program viable. Testimony confirms that there are 40 individuals to fill these slots which would be a cost containment service in comparison to nursing home care.

ADJOURNMENT

Adjournment At: 10:45 a.m.

Dorothy Bradley
REP. DOROTHY BRADLEY, Chairman

DB/dib

1623.min

DAILY ROLL CALL

HEALTH & HUMAN SERVICES SUBCOMMITTEE

DATE 1-18-89

NAME	PRESENT	ABSENT	EXCUSED
Rep. Bradley, Chairman	✓		
Sen. Keating, Vice Chairman	✓		
Sen. Van Valkenberg	✓		
Sen. Hofman	✓		
Rep. Cobb	✓		
Rep. Cody	✓		
Rep. Grinde	✓		

Form CS-30A
Rev. 1985

DAILY ROLL CALL

HEALTH & HUMAN SERVICES SUBCOMMITTEE

DATE 1-19-89

NAME	PRESENT	ABSENT	EXCUSED
Rep. Bradley, Chairman	✓		
Sen. Keating, Vice Chairman	✓		
Sen. Van Valkenberg	✓		
Sen. Hofman	✓		
Rep. Cobb	✓		
Rep. Cody	✓		
Rep. Grinde	✓		

Form CS-30A
Rev. 1985

EXHIBIT 1
DATE 1-19-89
HB

Home and Community Services Waiver
Silver Bow County

Issue - To implement a case management team (CMT) in Butte to serve forty elderly and physically disabled individuals under the Home and Community Services (HCS) Waiver Program.

Background - The HCS Program is in its fifth year of operation and has served more than 1,670 elderly and physically disabled individuals in twenty-four counties. Silver Bow County is the only large population center left in the state that does not have a waiver program. In 1987, 17.5% of the Butte-Silver Bow population was over 65 compared to 12.5% for the state and 12.3% for the county. There are approximately 400 Medicaid nursing home beds in Butte. It is estimated that some of these individuals could be served under the waiver program at approximately one-half the cost of nursing home care. There are also many individuals in the community who could delay institutionalization if waiver services were available in the area. The Department would be required to issue a competitive request for proposal for a case management team to provide case management services. The case management team would then contract with existing individuals or agencies in the community to provide the direct services available under the program.

Budget Requirements - Implementation of a case management team requires start-up funds to initiate work activities prior to Medicaid reimbursement for services. Start-up funds would be used to hire and train staff, secure office space and provide for other administrative costs that are incurred before clients are enrolled. A Long Term Care Specialist (LTCS) is needed to screen waiver applicants to determine if applicants meet nursing home level of care eligibility requirements and monitor ongoing delivery of services. The average cost of a waiver slot in FY88 was $5,023 for the elderly and $9,389 for the disabled. The projected cost of a slot in FY90 is $7,013 for elderly and $9,390 for disabled. The projected cost in FY91 is $7,236 for elderly and $9,689 for disabled. It is anticipated that the case management team would serve a total of 30 elderly and 10 disabled individuals. Only half of the slots were budgeted in FY90 since it is anticipated that the CMT could not start enrolling clients until January 1990.

	FY90			FY91		
	GF	FFP	Total	GF	FFP	Total
LTCS	$15,000	$15,000	$30,000	$15,000	$15,000	$30,000
Start-up	$25,000	---	$25,000	$10,000	---	$10,000
Client Services						
Elderly	$31,558	$73,637	$105,195	$65,124	$151,956	$217,080
Disabled	$14,085	$32,865	$46,950	$29,067	$67,823	$96,890
TOTAL	$85,643	$121,502	$207,145	$119,191	$234,779	$353,970

NSE2/006

MARK LIPONIS, M.D.
505 WEST PARK
BUTTE, MONTANA 59701

January 3, 1989

Sen. Larry Stimatz
1615 C Street
Butte, Montana 59701

Dear Sen. Stimatz:

As a physician involved in primary health care for a large group of patients here in Butte, I have often times been reminded of the need for a coordinated and unified health care need assessment and delivery system here in Butte-Silver Bow area for patients of limited means who are functioning in a marginal or borderline capacity due to health care needs that are not being adequately served by our present system of in-hospital, institutional, or extended health care services. Unfortunately there is a large number of patients who fall in the gap between a patient who is self-sufficient regarding their personal health care needs and the patient who requires in-hospital or institutionalized heath care. This is perhaps one of the saddest and most unfortunate situations where an individual may not be able to function fully self-sufficiently in an outpatient setting and may be forced to consider permanent institutionalized health care simply because of lack of resources and the absence of a cohesive outpatient health care delivery system. Oftentimes nursing home placement for these marginally functioning individuals is not only a psychological but also a considerable financial burden not only for the individual themselves but also for the remainder of our society.

I believe Case Management Services would be an appropriate excellent step in beginning to close the gap and provide much needed assistance for this large group of individuals functioning only marginally within our present health care delivery system. I would guess that almost everyone knows of at least one such individual who would benefit from Case Management Services. Especially now as the new year begins and we are all reminded of our own personal blessings, it is especially important to extend a helping hand to those less fortunate individuals in our community. I truly believe Case Management Services could be an extremely effective method of assessing and supplying these needs. As a local physician involved in the care of many of these patients, I personally urge your support for Case Management Services in Butte-Silver Bow County. Thanks for your consideration in this matter and happy New Year.

Sincerely,

Mark Liponis, M.D.

ML/teo

Hannibal Street Baptist Church

3215 HANNIBAL
BUTTE, MONTANA 59701

Mailing Address
P.O. Box 4188
Butte MT 59702

Rev. Jim Amaral, Pastor
Church Phone 494-9958
Home Phone 494-4067

January 12, 1989

Ms. Colleen Broderick, Chairperson
Crest Nursing Home
3131 Amherst Ave.
Butte, MT 59701

Dear Ms. Broderick,

The Butte Ministerial Association has a great interest in the general well being of the needy and elderly of our community. In an ongoing search for improving services to these groups we discovered that a special need in the area of medical care is being addressed by a committee of which you are the chairperson. The specific pgrogram to which I refer is "Case Management Services under Medicaid Waiver."

We were informed that there are nine such programs in the State. Realizing our heavy concentration of elderly, highest in the State we understand; we believe that this program would be of great assistance in filling a gap in our current medical services. The Ministerial Association has authorized me to forward this letter of our support and assurance of individual action relevant to this matter.

We would like to thank you for your interest in our community and for your continued desire to better the current level of medical services. If we can be of assistance in the future, please do not hesitate to contact us.

Sincerely Yours,

Rev. Jim Amaral, President
Butte Ministerial Association

CORINNE SHEA, Executive Director

TIM J. SHEA, CHAIRMAN

H R C

Human Resources Council, District XII

700 CASEY P. O. BOX 3486 BUTTE MONTANA 59702
TELEPHONE 782-7200

HUMAN RESOURCES COUNCIL, DISTRICT XII

BEAVERHEAD
DEER LODGE
GRANITE
MADISON
POWELL
SILVER BOW

January 13, 1989

Coleen R. Broderick
Administrator
Crest Nursing Home
3131 Amherst
Butte, MT 59701

Dear Colleen:

Human Resources Council, XII has many elderly participants of the programs we sponsor, and are well aware of their problems. Among these is the need for in-home care for the increasing number of frail and sick senior citizens. Our agency supports the idea of a community-based waiver program to provide long-term care for the Medicaid client in the home.

This letter is to confirm our position that the SRS community-based waiver to provide case management services to senior citizens needing long-term care, is greatly needed in Butte-Silver Bow. We stand ready to help in your endeavor to get this program for our community.

Sincerely,

Corinne Shea

Corinne Shea,
EXECUTIVE DIRECTOR

GD

BUTTE–SILVER BOW COUNTY
SENIOR CITIZENS' ACTIVITY CENTER
25 WEST FRONT STREET RK
PHONE 792-4108 (AREA CODE 406)
BUTTE, MONTANA 59701

January 9, 1984

Colleen Broderick
3131 Amherst Avenue
Butte Montana 59701

Dear Colleen,

I am writing this letter in support from our Butte Silver Bow Senior Citizens Center for the establishment of the Case Management Services.

The Butte Silver Bow Senior Citizens Council is on record for supporting the Medicaid Waiver - Case Management Concept.

Very truly yours,
Eileen Shea Director
Butte Silver Bow Senior Citizens Center

E.S.

NORTH AMERICAN INDIAN ALLIANCE

Butte Indian Health & Chemical Dependency Program

723-4361 782-0461

303 West Silver • Butte, Montana 59701

December 14 1988

Connie Brodrick, Chairman
25 West Front Street
Butte, Mt. 59701

Dear Connie:

The North American Indian Alliance is in full support of the Medicaid Waiver.

I feel as the Health Coordinator at the Indian Alliance it is a highly needed resource that we should have had many years ago in the Community.

In working with the elderly, I have found that most do not have transportation or even family members who they can rely on for their needs, so what generally happens is that they go without either quality health care or food, which are very vital to their survival.

It is always a great accomplishment when all the different organizations pull together and work to bring about positive changes in the Community.

Sincerely,

Patty Boggs

Patty Boggs, Health Coordinator
North American Indian Alliance
303 West Silver
Butte, Mt. 59701

Butte Community Union
P.O. Box 724
Butte, Montana 59703
December 18, 1988

Dear Colleen,

December 13, 1988 our BCU Board met. Karen Henick presented the proposal for Case Management Services Under the Comminity Based Waiver Program for SRS. After discussing the program with her, the Board voted to send you a letter of endorsement.

We fully support you in this effort. The fact that this program could close gaps in health care accessability is exciting. We will welcome any requests, you might have of us, to help you realize the goals. Please feel free to call the office, 782-0670 or 782-3947, and ask to talk to Karen Andersen, our Director/Organizer. She will bring any of your concerns or requests to the Board for our approval and/or action.

The BCU Board would also be interested in any training or presentations you might facilitate for accessing health services, co-dependency issues, group management, or ANY other topics that you consider even remotely related to low-income organizing. And of course, we are always interested in any job opportunities.

Please, keep us in touch. We are very interested in your development.

Sincerely,

Bonnie Stefanac
Secretary/Treasurer

UNITED WAY OF SILVER BOW COUNTY

Symbol of Community Service

P.O. Box 369
226 West Broadway
BUTTE, MONTANA 59703
Telephone 782-3076 ======782-1255

December 19, 1988

Colleen Broderick
3131 Amherst Ave.
Butte, MT. 59701

Dear Colleen:

I wish to take this opportunity to thank you for including United Way for input on the newly formed Steering Committee for the establishment of Case Management services in our area.

United Way is Committed to involvement in the field of human services. Health care is a priority and we feel thereis a need for Case Management services in our community.

The officers and members asked that I offer my services to you by serving on the Steering Committee.

With best wishes for the success of this program, I remain,

Sincerely,

(Mrs.) Edythe Skewes
Executive Director

EXHIBIT 2
DATE 1-19-89
HB

Formal Testimony

Butte-Silver Bow Case Management Program Task Force

Supporting the Establishment of Case Management Services in Butte-Silver Bow

Agencies on Task Force:

Area V Agency on Aging
Butte-Silver Bow Council of Commissioners
Butte-Silver Bow Health Department
St. James Community Hospital
City-County Home Health Service
United Way
Human Resource & Development Council
Butte-Silver Bow Senior Citizens Center
Crest Nursing Home
Department of Family Services

The Case Management Task Force has developed in our community due to the identified gaps in long term care services. You will find the needs assessment that was completed by our group that assisted us in validating our perception of the need. We have met with many service and support agencies to establish the broad base community support that is needed to make a successful case management program.

The fact that Butte-Silver Bow has 17.2% of its population 65 years and older, as compared to 12.3% in the United States, and 12.5% in Montana, confirms the increase demand for long term care services in our community. We see the need to prepare alternatives and future planning to meet this challenge of providing cost effective long term care.

Challenges have been made in the past that the Case Management Services are only an additional service to a new group of individuals. On the contrary, case management provides services only to those who choose to receive community based services in lieu of nursing home care, which is more expensive.

Case Management Services also provide a mechanism for the targeting of the vast array of aging and handicapped services to those at the highest risk of institutionalization. Due to the fact that there are many services that are contracted for that don't have well developed screening methods, case management helps target other state and federal programs to those in greatest need.

The fact that the Medicaid nursing home budget has not been reduced during the existance of case management in other areas of the state, is a positive statement for case management. With the increase demand for Long Term Care Services, no increase would indicate a gain.

Also, under the Medicare Catastrophic Legislation the Medicare Skilled Nursing Home Benefit has been greatly expanded. This fact will result in fewer intermediate care beds and a greater demand for either building more nursing homes and/or expanding long term care services in the community. The nursing homes of today are caring for sicker and sicker individuals and the demand for beds will continue to increase.

The length of stay on the case management program is shorter for the elderly than the disabled. This validates that the services are being provided to those at risk for death or institutionalization. Reasons for discharge in the November '88 statistics from Medicaid indicate that 19.2% died and 42.3% were admitted to nursing homes.

In conclusion, we are trying now to lay the foundation in our community where there are options to nursing home care and establishment of a cost effective delivery of long term care services.

EXHIBIT 3
DATE 1-19-89
HB

THE NEED FOR A HOME AND COMMUNITY BASED SERVICE PROGRAM IN BUTTE-SILVER BOW

Prepared by:

Butte-Silver Bow
Case Management Program Task Force

December, 1988

INTRODUCTION

The Home and Community Services (HCS) Program is designed to help frail elderly and physically disabled persons remain independent in their own homes. The HCS Program is also known as the Medicaid Waiver Program because the Federal Government has granted the Montana Department of Social and Rehabilitative Services (SRS) a waiver to provide Medicaid home and community services to persons who would otherwise have to reside in and receive Medicaid reimbursed care in a hospital or institutional setting.

The HCS Program was created in response to the Federal Omnibus Budget Reconciliation Act of 1981, which encouraged the development of home and community based services in lieu of institutional care. Statutory authority for the HCS Program can be found in Sections 53-6-401 and 53-6-402 of the Montana Codes Annotated.

The HCS Program is in its fifth year of operation. State-wide it has served more than 1,670 elderly and physically disabled persons since 1983. Butte-Silver Bow is one of the last major population centers in Montana to have not implemented the HCS Program.

SERVICE DELIVERY

The Butte-Silver Bow HCS Program would be operated cooperatively by the Montana Department of SRS, and a local Case Management Team.

Persons needing HCS services would first apply for Medicaid assistance at the Butte-Silver Bow Office of Human Services. After the applicant has been determined financially eligible for Medicaid assistance, a screening team made up of a Department of Social and Rehabilitation Services (SRS) Long Term Care Specialist and a Registered Nurse would visit the applicant to assess the level of care required and evaluate the option of Home Care Services and discuss the individual's choice of home or institutional care. If the individual meets skilled or intermediate level of care criteria, a referral would be made to the Butte-Silver Bow Case Management Team.

Upon receipt of the referral, the Case Management Team would visit the individual and, with input from the client, the client's family, and the attending physician, prepare a plan of care to meet the individual's needs.

The Case Management Team would help arrange the required services and continuously monitor the individual's condition and quality of delivered services.

SERVICES PROVIDED

Federal regulations require that person served under the HCS Program must need a similar level of care provided in a nursing home even though the individual chooses to remain at home.

Generally, the following home and community services are provided under a Case Management Program:

1. Homemaker Services.
2. Personal Care Attendant Services.
3. Habilitation Services.
4. Adult Day Services.
5. Respite Care Services.
6. Medical Alert and Monitoring Systems.
7. Nutrition Services.
8. Environmental Modification/Adaptive Equipment.
9. Outpatient Physical Therapy.
10. Outpatient Occupational Therapy.
11. Speech Pathology and Audiology.
12. Natural helping networks such as volunteer assistance, family, and friends.

All services provided under the Case Management Program would be prescribed by a physician and directly relate to the plan of care developed and monitored by the Case Management Team. The Case Management Team would consist of a registered nurse, a social worker, and clerical staff.

NEED FOR SERVICES

The Butte-Silver Bow HCS Program would address the health needs of Medicaid eligible individuals who are elderly or physically

disabled. To qualify for the program, individuals would be required to meet the following criteria:

1. Be financially eligible for Medicaid.

2. Be age 65 or over or certified as disabled by the Social Security Administration.

3. Meet Medicaid skilled or intermediate nursing home level of care requirements.

4. Reside in Butte-Silver Bow.

5. Need a level of care that can be provided in a community or home setting at a cost less than that of institutional care.

Currently Montana has nine Case Management Teams serving 24 of the State's 56 counties. During State Fiscal Year 1988, a total of 671 unduplicated recipients were served. Of this total 69 percent were elderly (over age 65) and 31 percent were physically disabled.

Montana Department of SRS records indicate that approximately 8.7 percent of Butte-Silver Bow's population are Medicaid eligible. In contrast, 3.3 percent of the total State population is eligible.

The service area of the Butte-Silver Bow HCS Program would include the boundaries of the consolidated government of Butte-Silver Bow. In 1987, the population of this area was estimated at 33,700. Table 1 below provides a comparison of the population over age 65 in Butte-Silver Bow, the State of Montana, and the United States between 1975 and 1987.

Table 1
Estimated over Age 65 Population
as a Percent of Total Population

	1975	1980	1985	1987
United States	10.5%	11.3%	12.0%	12.3%
Montana	10.0%	10.7%	11.7%	12.5%
Butte-Silver Bow	12.1%	14.9%	17.4%	17.5%

Source: National Planning Association

Considering the high level of Medicaid eligible and elderly residents, there appears to be considerable need for home and community based services in Butte-Silver Bow.

COST-EFFECTIVENESS

The Butte-Silver Bow HCS Program would not increase the level of Medicaid expenditures in Butte-Silver Bow. Rather, it would redirect current resources to best meet the needs of local Medicaid recipients.

As directed by the Montana Department of SRS, all services provided under a case management program must cost less than the cost of nursing home care. Additionally, programs may pay for services only if no other system of care is available such as volunteer or family support.

Current Montana HCS per capita expenditures indicate that the cost of HCS services are generally less than half that of nursing home expense. Table 2 provides a summary of the average per capita cost of HCS programs verses nursing home expenses.

Table 2
Average per Capita Cost
Home and Community Services Program Compared to
Nursing Home Expense

	---1986---	---1987---	---1988---
HCS Clients	336	405	671
Average HCS Cost *	$ 4,341	$ 4,663	$ 4,203
Nursing Home Clients	4,817	4,898	5,024
Ave. Nurs. Home Cost	$ 9,171	$ 9,803	$10,002
HCS as % of Nurs. Home	47%	48%	42%

* Includes the following services: Case Management; Group Home; Homemaker; Transportation; Nursing; Habilitation; Respite; and Personal Care.

Source: Montana Department of Social and Rehabilitative Services, Economic Assistance Division, Medicaid Bureau.

To maximize cost effectiveness, the Butte-Silver Bow HCS Program proposes to provide Case Management services to 40 clients per year. Based on the 1988 average per capita costs identified in Table 2, the program could save the State of Montana as much as

$232,000 per year if home and community services were provided to Butte-Silver Bow residents in lieu of traditional nursing home care. Not included in the potential cost savings are the quality of life improvements Butte-Silver Bow residents would enjoy as a result of being able to live at home rather than in an institutional setting.

PROGRAM ADMINISTRATION

The Butte-Silver Bow HCS Program would contract with the Department of SRS to arrange and monitor the home and community services required by local recipients. The HCS Program would be administered by a local Case Management Team consisting of a registered nurse, social worker, and clerical assistant. The Team would be administratively attached to the Butte-Silver Bow Health Department.

The Case Management Team would not directly provide any home and community services. Rather, it would subcontract for all services to be provided.

To facilitate program administration, an administrative and policy making board comprised of representatives of local health providers and public agencies would be appointed. The groups providing input to the proposed board would include:

- Butte-Silver Bow Health Department.
- Butte-Silver Bow Home Health Agency.
- Butte-Silver Bow Council of Commissioners.
- Butte-Silver Bow Chief Executive.
- Butte-Silver Bow County Attorney.
- Butte-Silver Bow Vo-Tech.
- Montana Department of Family Services.
- St. James Community Hospital, Inc.
- Region V Agency on Aging.
- United Way.
- Human Resource and Development Center.
- Senior Nutrition Program/Activity Center.
- Local Physicians.
- Butte Community Union.
- Butte Indian Alliance.

Copies of letters of support from the above groups are attached.

CONCLUSION

The implementation of a Butte-Silver Bow HCS Program would provide a cost-effective method to improve the quality of life of Butte-Silver Bow's elderly and physically disabled adults. At the same time, it would provide a means for local input into the delivery of Medicaid services to local residents.

EXHIBIT 4
DATE 1-19-89
HB

September 29, 1987

Lee J. Tickell, Administrator
Economic Assistance Division
Social and Rehabilitation Services
Room 205, SRS Building
111 Sanders
Helena, Montana 59620

Dear Mr. Tickell:

In the September 1, 1987 Federal Register, the Health Care Financing Administration published its final ruels on FY 1988 changes to Medicare DRG classifications. The rules restructure alcohol and drug abuse DRGs and reorder the surgical hierarchy in several Major Diagnostic Categories (MDCs). These changes will be implemented on October 1, 1987.

The new Medicare rules will require a modification of the DRG grouper, because of changes in the definition of some DRGs and and changes in grouper logic. Some hospitals have already purchased the new grouper and are ready to process discharges with it on October 1. For Medicare purposes, all hospitals will be required to use the new grouper for discharges occurring after October 1. (The freeze on implementation of 1988 Medicare policies contained in the Debt Ceiling Limitation Bill will not apply to the new grouper.)

The new Medicaid DRG system scheduled for implementation on October 1, 1987 will use the old (i.e., 1987 or version 4.0) grouper. It is important for hospitals that both Medicare and Medicaid use the same grouper. If they do not, hospitals will be required to maintain two billing systems. The maintenance of dual systems increases the complexity of the new Medicaid DRG system, which will result in an increase in both errors and cost.

The Montana Hospital Association requests that an amendment to the Medicaid DRG rules which incorporates the latest version of the grouper be made immediately. MHA will firmly support the rule change. Because the rule-making process takes time, MHA requests that the Department inform providers of the need for the amendment, and issue policy instructions stating that the submission of claims grouped by the latest version of the Medicaire grouper will be acceptable for Medicaid billings. In other words, while the new rules are being finalized, the Department will allow liberal execution of the existing rules.

30 NINTH AVE
P.O. BOX 5119
HELENA, MT
59604
(406) 442-1911

I believe that the reason SRS did not include the new grouper in its final rule is because HCFA finalized the grouper less than two weeks prior to the Medicaid final rule publication. From my understanding of the Department's intent, were it common knowledge that the new grouper were available, it would have been incorporated in SRS's final rule. MHA is merely requesting that SRS do what it would have done if it had "perfect knowledge" on September 14, 1987.

I appreciate your attention in this matter, and look forward to a response from you or your staff.

Sincerely,

Tony

Anthony L. Wellever
Senior Vice President

ALW:mhu

Report to the Legislative Finance Committee

On

Montana Medicaid Prospective Reimbursement

For Inpatient Hospital Services

September 18, 1987

Time Line For The Project Implementation

The inception of work on this project began with the 1985 session. Work on preparing and Advanced Planning Document (APD) and obtaining 90% federal participation in the project was begun immediately. The approval of the APD led the way to award a contract in September of 1985 to Compass Consulting Group to assist in the design and implementation of the project. Initially the project was planned for implementation in March of 1986. This was moved to July 1986 to allow adequate time to build the necessary databases and to allow the implementation date to coincide with a majority of hospital providers fiscal year ends.

In March of 1986 it became apparent that a conflict in the Consultec MMIS contract would require changes to the DRG proposed system or dispute over the scope of work to be performed. Because the nature of changes to the proposed system would shed doubt on the success of the DRG project, alternatives were explored to implement the system as it was designed by the Department and Compass. Early estimates were that additional funding of $118,000 would be required to implement the system as designed. The implementation was delayed while funding was sought.

During the fall of 1986 additional funding was obtained and modification to the APD were submitted for HCFA approval. Upon approval of the APD modifications, a new contract was written to start work on March 24, 1987 to modify the MMIS. Since that time work has been proceeding as scheduled towards an implementation date of October 1, 1987.

Budget Neutrality

One of the initial policy decisions in this project was to introduce a reimbursement system that, in the aggregate, paid no more or no less than the current cost based system in the initial year of implementation. This is how the term budget neutrality is defined.

In order to integrate this policy into the calculation of the base price, the most current data available for cost reports and claims was used (1983). Basically this entailed calculating the base price at the 1983 level and comparing it to cost based payments for that year. An adjustment was then calculated to set the base price at a level that would pay the same as the cost based system did. The adjustment for budget neutrality resulted in a decrease in the base price of 7.6035 percent.

Once the base price for 1983 was calculated, the price was inflated to reflect an implementation date of October 1, 1987. The inflation factors used for this calculation were the Data Resources Inc. (DRI) hospital market basket inflation factors. Use of the DRI index was selected because it is consistent with the Medicare Prospective Payment System (PPS), hospitals are familiar with it, it is a recognized hospital index and requires no additional administrative resources to calculate.

The current cost based system limits hospital cost increases through the use of the Tax Equity and Fiscal Responsibility Act (TEFRA) indices. These limits are important in the development of a prospective system in that State

Medicaid Programs must provide assurances to HCFA that the prospective system is not expected to pay more than the cost based (TEFRA) systems.

The TEFRA limits are target rate-of-increase limits on the average cost per discharge of each hospital. Each facility has a base year average cost per case which is inflated by the TEFRA indices. If a hospital's costs increase at a rate less that the index, the facility will receive an incentive for controlling cost increases. When a hospitals costs increase faster that the TEFRA index, the hospitals are penalized.

The TEFRA indices were not used in the inflation of the project for several reasons. First, these limits are published by HCFA and are not available for the most current periods on a timely basis. Second, the limits are calculated for each specific facility. These calculations are subject to settlement of cost reports which have not been completed in recent years because of a malpractice legal action. The limits are also subject to appeal and administratively burdensome to compute. Third, these limits are assimilated by the DRI market basket. (For cost reporting periods beginning in FFY 1983 and 1984 the TEFRA limits were calculated as the market basket index plus one percent. Since then the target rates have been reduced to the market basket plus 1/4 of one percent of FFY 1985, and below the market basket in FFY 1986 and 1987 to an increase of just 5/24ths of one percent of 1/2 of one percent, respectively.)

Language has been inserted into the Administrative Rules of Montana pertaining to the Prospective Payment System to insure that during the initial year of PPS the system will pay no more or no less than the cost based (TEFRA) system would. Should the system pay more or less than the cost-based system would the base price would be adjusted and claims would be retroactively adjusted.

Since the current appropriation is based on the cost-based system and HCFA mandates paying no more than TEFRA costs, no increases in the budget is expected for the current biennium.

Administrative Costs

The Medicaid DRG system was designed to utilize existing administrative structures and staff whenever possible. This not only included Department administrative structures, but also structures in place at the facilities, Department agents and contractors.

When feasible, the Department implemented policies that would reduce administrative burden on all parties by proposing a system similar to Medicare that the hospitals are familiar with and deleting policies that were no longer required because of the new system. This includes utilization review for continued stay. Staff time utilized for this function in the past will be reassigned to DRG validation and quality of care issues.

The PPS system enhance will cost an additional $600 per month in fiscal agent operational costs from October to March. This is subject to 75% federal financial participation. The next contract for operating the MMIS includes these costs. The Department is committed to reviewing updates to the grouper and code editor software packages. Major changes to these programs could result in additional costs to install and operate in the MMIS.

The Department plans to utilize existing staff and does not project any other additional administrative costs for the project.

The DRG system was designed so that additional administrative functions would not be required of providers. The changes affecting provider billing and payment are minimal.

Ability of the Fiscal Agent to Transfer to a New System Without A Loss of Continuity with Historical Medicaid Statistical Data

The modifications to the MMIS system does not diminish any existing reporting capabilities. It does produce reports in addition to those already required. These reports will provide necessary information to administer the change.

The institutional claim record was expanded to included fields necessary for DRG pricing. No fields were removed or changed.

The Department does not believe that this modification will have any effect on the continuity of the historical Medicaid statistical data.

Some concerns have also been raised as to the ability of the fiscal agent to implement the change as scheduled. Consultec is under contract to provide this capability and has assured us that implementation is on schedule.

Rational and Impact of DRG for Inpatient Psychiatric Care

The policy adopted by the Medicaid program is to include psychiatric units of acute care hospitals in the prospective reimbursement system. Freestanding psychiatric facilities will be subject to the existing cost bases (TEFRA) reimbursement system.

The Department has proposed to include psychiatric units of acute care hospitals for the following reasons:

1.) Historically, Montana Medicaid has reimbursed for inpatient care without distinction between units in which care is provided. Given this historical cost reporting and billing mechanism, it would be extremely difficult and costly to isolate and identify costs in these units in order to exclude them from the calculation of the weights and prices.

2.) The Department has not seen any indication of budgetary impact from the policy of including these units that would warrant exclusion.

3.) The policy of inclusion is consistent with prospective payment for acute care. The Medicaid program in Montana has no benefit for chronic care and the provision of this type of care for Medicaid client in a unit would be inappropriate.

4.) Inclusion of a unit provides incentives to use that unit efficiently in relation to all other included costs.

[1] Evidence from state Medicaid agencies suggests that payment for psychiatric care and treatment of substance abuse in special facilities or distinct part units excluded under the DRG-based system are increasing more rapidly than overall Medicaid costs.

The Department has proposed to exclude freestanding psychiatric facilities for the following reasons:

1.) The DRG system was created using acute care data from a nation wide sample of short term acute care general hospitals. There are concerns that these groups are not clinically appropriate for psychiatric facilities. This type of treatment is longer term and distinct from treatment of the same diagnosis at an acute care hospital.

2.) Costs for these facilities is not included in the data used to compute the weights and prices. Until 1987 there were no psychiatric facilities enrolled in Medicaid in Montana. Limited data is available regarding the cost of this type of care.

Attached to this report is an addendum that is made up of the comments and responses to the Administrative Rule. This addendum covers many issues that are of importance in the area of psychiatric distinct part unit reimbursement that are not covered in this document.

The Department does not feel that this policy has a major impact financially on reimbursement or results in inadequate reimbursement for this type of care. The Department also feels that the weights, average lengths of stays, and prices are reasonable and adequate and reflect levels of care currently provided.

REFERENCES

1. Health Care Financial Review/Winter 1986/Volume 8, Number 2: Reimbursement under diagnosis-related groups: The Medicaid Experience by Fred J. Hellinger

THB/025

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59604

October 5, 1987

Anthony L. Wellever
Senior Vice President
Montana Hospital Association
P.O. Box 5119
Helena, MT 59604

Dear Tony:

I have received your September 29, 1987 request to amend the Administrative Rules of Montana to incorporate the 1988 (version 5.0) Medicare grouper and to allow liberal execution of the existing rules.

Montana Medicaid contracted with Consultec Inc. in March of 1987 to develop and install the capability to process inpatient hospital claims using the DRG methodology. When this work was begun, the most current grouper available was the 1987 (version 4.0) version. This was used in the development of the project because the contract was specific in defining the use of the most current version of the grouper that was available at the inception of the project.

Installing a new version results in a major effort to determine if changes cause variations in relative values that would require rebasing to determine new values or if leaving existing values in place result in acceptable payment variations.

The Department disagrees that hospitals will be required to maintain two billing systems. The Medicaid prospective system does not require providers to group claims. It is the departments understanding that many providers already have the capability to use two versions of the grouper to group claims for different time periods (i.e. before October 1, 1987 and after October 1, 1987 for Medicare.

While it may be beneficial to the hospitals and the department to use the same version of the grouper, the method of implementation by Medicare made it impossible for Medicaid to incorporate the new version on October 1, 1987. The department will study the feasibility of implementing version 5.0 and obtain estimates for the cost and scheduling of incorporating this change. The department will use version 4.0 to group claims and will not allow liberal execution of the existing rules.

If you have any questions regarding this issue please contact me or Terry Krantz at 444-4540.

Sincerely,

Lee J. Tickell, Administrator
Economic Assistance Division

TK/FA/u

c: Terry Krantz
Bob Olsen
Jack Nielson

EXHIBIT 5
DATE 1-19-89
HB

Easter Seal Society
of Idaho, Montana and Wyoming

Goodwill Industries
of Montana and Southern Idaho

January 17, 1989

Human Services Subcommittee
Capital Station
Helena, MT 59620

Dear Dorothy and Committee:

The Case Management Team in Great Falls hopes that your committee would consider our recommendations for the continuation of the Home and Community Services within the Medicaid Waiver Program.

Here in Great Falls, the team of the registered nurse and the social worker monitor and manage clients in 3 of the 24 counties - Cascade, Fergus and Teton - in which the Medicaid Waiver program is available. The number of clients who may be served is restricted to 45 elderly (over 65) and 17 physically disabled (under 65). Presently, 42 of the 45 elderly positions are filled although within the last month all the positions were filled and we unfortunately had a waiting list. Sixteen of the 17 physically disabled slots are filled.

The Medicaid Waiver program is a cost effective, sensible program which provides monies (2/3 Federal and 1/3 State) for services within the home for recipients whose medical condition warrants the same level of care as would be received at a nursing home. For the many elderly in the State of Montana who have contributed to the growth of our communities, it is an opportunity to remain independently at home with dignity among friends and family.

In Great Falls the profile of the recipient served is consistent with sociodemographic characteristics statewide. Clients are generally women, widowed or single, living alone, dependent or semi-dependent in activities of daily living and 75 years or older. Because so many women who have been the traditional caregivers are now working or may have moved to new communities, a significant number of elderly and physically disabled persons are unable to manage independently and safely without our Home and Community Services.

As of this date, the cost of a year of Home and Community Service for the physically disabled is $12,334. The cost of the same service for the elderly recipient is $10,332. These costs are well below the average cost per year of nursing home care which is conservatively set at $18,125 at this time.

It is our opinion that the Medicaid Waiver program provides a fiscally responsible plan for necessary home services.

Sincerely,

Case Management Team
Great Falls, Montana

Melanie Walsh, RN
Paula Merrier, RN
Janel Jackson, SW

mb

January 17, 1989

Dorothy Bradley, Chairperson
Human Services Subcommittee
Capital Station
Helena, MT 59620

Dear Dorothy:

Because it is so difficult for me to write with my shaky hands, I have asked Melanie to correspond with you about Medicaid Waiver Home Services.

At this time I am 88 years old. Recently I was hospitalized here in Great Falls for treatment of orthostatic hypertension. I have a history of hypertension and degenerative joint disease. Dr. Krezowski was reluctant to allow me to go home unless I could have regular help at home. Otherwise, the doctor would have insisted that I go to the nursing home.

Happily, I do live alone in my own apartment and have a home attendant help me with house cleaning and shopping. I do not have the stamina to do these things myself. I also have lifeline medical alert on at all times. I do appreciate these Waiver services because with them I can continue to live independently in this community.

Sincerely,

Emma Killinger

Emma (Nel) Killinger

To whom it may Concern:

I am writing this letter to reinforce the need for PCAs and Homemakers in the home for the elderly.

My PCA does my cleaning of the house - vacuums, mops, dusts, does dishes, waters plants changes beds, washes all the laundry. Cooks - She also does all my shopping and pays bills takes me to the Doctor gets my prescriptions. I am unable to go outside and do not have an automobile so if she wasn't here I would have to go to a Nursing home, as I have no one to take care of me on a daily bases.

I hope you will continue this service, as I can't imagine what I would do without it.

Vera V. Foster

January 16, 1989

Easter Seals
Great Falls, MT

It would be impossible for me to get along without the services furnished to me.

It has been two years since I have been out of my home, except by wheelchair transport, and then only to a doctor's office, or hospital.

I am 78 years old, and had my right leg amputated due to an auto accident in 1955, and got along well with an artificial limb, and being able to drive, until two years ago, when I started to lose my strength, and at present, do not have too much control over things.

Respectfully yours,

Ralph K. Hill

Ralph K. Hill
421 Fourth Ave. South
Great Falls, MT 59405

Jan. 17, 1989

Dear Sirs:

I am writing this letter for Isabell Bickerstaff. If it wasn't for this program I wouldn't be able to stay in my home. I need the help I am receiving. The shower head and the hand rails for the toilet. Please keep the program active. Thank you.

Sincerely yours
Isabell Bickerstaff
by Ina Stafford, P.C.

Jan. 16, 1988

To whom it may concern,

I am a recipient of Easter Seal Care. Home care includes bathing, hair care, light house work fixing of meals and washing clothes, also shopping for groceries and transportation to and from doctor.

Without the help of the home care person which is greatly needed in my case, I would have to be put in a nursing home.

I am now receiving help five days per week, four hours per day.

I really appreciate this care.

Sincerely,

Maude Johnson

Dear Easter Seal Society;

I'm writing to say thank-you for all of the services I receive from you. Like PCA, meals-on-wheels, homecare, and Medicalert. I just don't know what I would do without them! Thank-you!

Mrs Martha Himebaugh

Dorothy Bradley

We are writing in support of the Easter Seals Waiver Program.

Gladys has acute Bronchitis, asthma and Emphasema and requires oxygen 24 hours a day. She takes her oxygen through a transtracial opening in her throat. This tube requires changing twice a day. Delbert has to take frequent trips to the Veterans hospital for his rumatoid arthritis. When he goes for any length of time they have a nurse from Columbus Home Care, come to change it. otherwise she would have to go to the hospital to have it changed. Gladys is on Medicade. They send help twice a week to help with house hold duties, since Delbert is unable to do them

Delbert & Gladys Kinsey
1007. 12th St. N.W.
Great Falls, Mt. 59404

Jan 16 - 89

To Whom this may Concern.

My Name is Dorothy E Sanderson
I had a Stroke and two very bad
Heart attacks. I live alone, but
Easter Seal has helped me in every
way I couldnt take a bath. so they
put handle bars so I can hang on to
for a Shower. they also have a
Lady come each week to do the
house work or what ever needs to be
done. if I wasnt getting help
I would be in a rest home and
that is one place I do not want to
be in, I am doing alright with
the help I get.

Thank you Very Kindly
Dorothy E Sanderson
1208 9th St So #2
Great Falls
Montana
59405.

Human Services Sub. Comm:

Im, Writing you how blessed I Am With My home care

Im, in a Wheel Chair have been for nearly six years

With all My great help Im, able to live at home and have a Normal life

I have Medicade Albert on my Chair One Meal a day on Wheels. a Hospital bed since September to raise my legs up high and My top of body for Hernia. I find My self Weak since I was sick this summer With Liver problem. for Many Weeks.

I have a home care helper. and I do a lot of Cleaning myself also Im used to keping a Clean home (She. is great)

We have a lot of activitys in the Rec-Room. Its Ninty two apts here. Its a great place to live

Easter Seal staff, are all so Wonderful I look forward to there visits so much. It Means so Much to have People that

Care about one's well being. I'm speaking from experience. I took care of my bedridden husband for eight years. And they have made my life so livable

This letter is from a very thankful lady. praying the Almighty God will bless each one in return with great rewards. for there understanding in my behalf.

Sincerely
Mildred B. Steele

To whom it may Concern.
We would like to thank the Medicade program for the things we badly needed that we are receiving, that make our daily lives so much better, such as the meals from the Hospital for Lillian, the Medicine that it helps pay for, the chair that helps her get on her feet helps us both I dont have to lift her out of the chair any more, and other things we would not have if it were not for this program.

Thanks Again
Hoyt and Lillian Brackney

EXHIBIT 12
DATE 1-19-89
HB

Like it or not, Jan. 1 brought tax increases

ANTHONY LEWIS

Don't bother to read George Bush's lips. No matter what he said in the campaign, federal taxes went up on Jan. 1 for a lot of Americans — most brutally for those who are elderly and reasonably well off financially.

You've run up balances on your credit cards? You're buying your automobile on time?

No matter what they call it, your taxes went up because in 1989 you can only deduct 20 percent of your credit-card and auto-loan interest charges, rather than the 40 percent you were allowed last year.

Social Security payroll taxes, for another unhappy example, will be levied this year on the first $48,000 of your income, compared with the first $45,000 in good old 1988. If you're doing that well, your payroll tax will go up from the maximum of $3,380 the feds hit you for last year to a maximum of $3,605 in 1989. So will the matching Social Security taxes your employer pays.

But by far the biggest increases in tax liabilities will be those of older people eligible for Medicare benefits who also pay federal income taxes of $150 a year or more.

They'll get a lot for their money — insurance coverage for catastrophic illness — but their tax costs could keep going up.

Last summer, Congress approved and President Reagan signed the greatest expansion of Medicare since its inception in 1965, affecting 32 million Americans immediately, and practically everyone who reaches retirement age in the future.

From now on, expanded Medicare will pay for unlimited hospital stays for retired people, for much of any unusually large doctors' bills they incur, and — beginning in 1991 — for a major proportion of onerous drug charges.

In the past, Medicare paid for only 60 hospital days, and only after the patient paid a deductible of $540.

As of Jan. 1, 1989, the deductible rises by a modest $24, but Medicare will pay total remaining hospital bills, for any length of stay. The $564 deductible will have to be paid only once a year, no matter how many times or for how long a patient may be hospitalized.

After a patient has paid an initial $1,370 in doctors' fees in any one year, all remaining doctors' bills will be paid by Medicare.

Fifty percent of drug costs, after a deductible of $600, will be paid starting in 1991, with the percentage to be picked up by Medicare rising in stages to 80 percent in 1993.

Thus, the most any Medicare patient will have to pay in any one year, starting in 1991, in hospital, doctor and drug bills — no matter the duration of the illness, or how many times hospitalized — is $2,534, the sum of the deductibles, plus half at first, later only 20 percent of remaining drug costs.

That's not a negligible total, but it should remove the fears of many retired people that even one catastrophic illness could wipe out their life savings, or force them to sell their homes.

As Adlai Stevenson once remarked, however, there are no gains without pains.

The estimated $30 billion cost of these new benefits in the first five years will not be paid by the general society, or by future recipients (as in Old Age and Survivors' Insurance, the program generally called "Social Security"). Only those immediately eligible for the benefits will pay for them.

For some, these costs will be steep — maybe more so than anyone now foresees.

Participants in Medicare's Part B (which covers doctors' fees) have been paying a premium of $297 a year. The expanded coverage of doctors' and drug bills will cause this premium to rise to $373 this year, and in yearly stages to $571 in 1993 — almost twice the 1988 premium.

Most retirees may consider that cheap at the price, but the more affluent among them will suffer additional new charges.

Whether or not they ever receive any of the new benefits, they will pay a surcharge of 15 percent on their federal income tax if it is as much as $150.

That's $22.50 at that level for an individual, $45 for a couple filing jointly.

For each additional $150 of income-tax liability, retirees will pay another 15 percent surcharge, up to a cap of $800 per person, $1,600 for a couple.

That's stiff enough; the cap will rise, however, to $1,050 per person ($2,100 per couple) in 1993. If, as would not be unexpected, benefit costs exceed estimates, the cap or the surcharge or both probably would be increased.

But even as it stands, that new surcharge will sufficiently burden affluent retirees to cast cold water on the easy assumption that Social Security benefits should be taxed even further.

ANTHONY LEWIS *is syndicated nationally by The New York Times.*

EXHIBIT 7
DATE 1-19-89
HB

OBSTETRICAL SERVICES AVAILABILITY ADVISORY COUNCIL

REPORT OF RECOMMENDATIONS
Submitted to the Honorable Ted Schwinden
Governor of Montana

October 1988

DEPARTMENT OF COMMERCE

TED SCHWINDEN, GOVERNOR

1424 9TH AVENUE

STATE OF MONTANA

(406) 444-3494

HELENA, MONTANA 59620-0401

November 2, 1988

The Honorable Ted Schwinden
Governor of Montana
State Capitol
Helena, MT 59620

Dear Governor Schwinden:

On behalf of the Obstetrical Services Availability Advisory Council, which was created by Executive Order No. 6-88, I am pleased to present to you the council's "Report of Recommendations" regarding the loss of obstetrical care in Montana.

Many groups and individuals presented information and viewpoints to the council. The council is appreciative of their contributions, which were essential to the recommendation process.

The council hopes that you and other policymakers will find these recommendations helpful.

Sincerely,

Kay Foster

Kay Foster
Chairperson

cp

OBSTETRICAL SERVICES AVAILABILITY ADVISORY COUNCIL

Medical Profession:

Dr. John T. Molloy
Great Falls, MT

Dr. Van Kirke Nelson
Kalispell, MT

Dr. Jimmie L. Ashcraft
Sidney, MT

Kyle N. Hopstad
Hospital Administrator
Glasgow, MT

Legal Profession:

Leo Berry
Helena, MT

Karl J. Englund
Missoula, MT

Insurance Industry:

Leonard Kaufman
Billings, MT

Charles Butler, Jr.
Helena, MT

Legislature:

Sen. Joseph P. Mazurek (D)
Helena, MT

Sen. H.W. Hammond (R)
Malta, MT

Rep. John R. Mercer (R)
Polson, MT

Rep. Ted Schye (D)
Glasgow, MT

Public Members:

Kay Foster (Chairperson)
Billings, MT

Marietta Cross, RN
Missoula, MT

Jean Bowman
Helena, MT

Staff:

Office of Research & Information Services
Montana Department of Commerce

OBSTETRICAL SERVICES AVAILABILITY ADVISORY COUNCIL
Report of Recommendations

Background

The Obstetrical Services Availability Advisory Council was appointed on March 11, 1988, by Governor Schwinden. The appointment of the Council was the result of a recommendation by the Insurance Subcommittee of the Governor's Council on Economic Development, which had been studying the obstetrical malpractice insurance crisis in Montana at the request of the Governor and the Montana Medical Association in anticipation of the possible convening of a special session of the Legislature. Finding that the complexity of factors involved in the obstetrical care crisis were beyond the scope of a brief special session, the subcommittee recommended the formation of a broader based council whose charge would be to study in depth the factors contributing to the crisis.

The Obstetrical Services Availability Advisory Council has 15 members, representing the medical and legal professions, the insurance industry, the legislature, and the public.

The PURPOSE of the Council is to:

(a) Examine the extent, causes and effects of the loss of obstetrical care in Montana;

(b) Analyze possible short-term solutions, including but not limited to increased medicaid reimbursement and direct payments for a portion of malpractice premiums related to obstetrical care;

(c) Analyze potential long-term solutions, including but not limited to those proposed by the Montana Medical Association and the State Auditor; and

(d) Recommend, on or before September 30, 1988, preferred short-term and long-term solutions for submission to the 51st Legislature.

^^^^^^

The Council considers the loss of adequate obstetrical services from competent providers and the loss of access to such services in Montana a crisis.

The extent of the crisis is widespread and worsening, especially in rural areas; but urban areas are impacted as well.

The causes of the crisis include the well-publicized problem of skyrocketing malpractice insurance rates, a variety of tort-related issues, and inadequate medicaid reimbursement rates.

The effects of the crisis are many, but combined, can be described as the loss of adequate obstetrical services from competent providers and loss of access to such services in Montana, especially in rural areas.

Among the worst effects are a possible increase in the number of low birthweight babies, the factor most closely associated with infant mortality, and an increase in the human costs and economic costs of babies born at risk.

BACKGROUND DATA AND RECOMMENDATIONS

BACKGROUND DATA

The Obstetrical Services Availability Advisory Council met five times between April 1988, and September 1988. In addition to contributing information from their own areas of professional expertise, Council members solicited viewpoints and information regarding access to obstetrical services in Montana and in the nation from concerned individuals and interest groups.

In the interest of the conciseness of its report of recommendations, the Council has declined to reiterate comprehensively in this document the information, data, and arguments and critiques regarding each of the components of the issue of access to obstetrical services. Readers seeking such information are directed to the bibliography of documents and resources. It is sufficient to present selected information and data to illustrate briefly some of the factors that drive the crisis in loss of obstetrical services in Montana.

The number of doctors delivering babies in Montana is declining.

1986	Family Practitioners	160
1987	" "	120
1988	" "	87
1986	Obstetricians	(na)
1987	"	42
1988	"	37

(Source: Montana Academy of Family Physicians; Montana Medical Association)

In January 1988, eighteen of Montana's fifty-six counties were without obstetrical services. Another nineteen counties were anticipating losing obstetrical services "soon."

(Source: Montana Academy of Family Physicians)

In 1982, there were 14,538 births in Montana; in 1987, 12,239 births. Twenty-eight percent of Montana babies are Medicaid babies. By 1990, the national Catastrophic Coverage health plan will raise Medicaid eligibility to 100 percent of poverty level, and the percentage of

Medicaid babies will increase in Montana.

(Source: Montana Dept. of Health & Environmental Sciences; Montana Dept. of Social & Rehabilitation Services)

Physicians' average global charges in Montana:

Normal deliveries -

1986	$ 778.00
1987	932.00
1988	1,150.00

Caesarean Section -

1986	$1,098.00
1987	1,296.00
1988	1,542.00

Nationwide, the physicians' average global charge is $1,436.00 in 1988.

Blue Cross and Blue Shield of Montana's maximum reimbursement to physicians in 1988 for a normal delivery is $1,175.00. This represents the 90th percentile of all charges submitted in calendar year 1987 by Montana physicians who deliver babies.

Medicaid reimbursement to physicians in FY88 was $619.00, and in FY89 is $662.00 for a normal delivery.

(Source: Montana Blue Cross/Blue Shield; Montana Department of Social & Rehabilitation Services)

Companies providing malpractice insurance to Montana family practitioners who deliver babies in 1988:

St. Paul	26 doctors	.....	29.0% of total
ICA	10 "	.....	11.5% " "
UMIA	26 "	.....	29.8% " "
Doctors' Co.	17 "	.....	19.5% " "
Truck Ins.	8 "	.....	9.2% " "
Total:	87 "		

Companies providing malpractice insurance to Montana obstetricians in 1988:

St. Paul	0 doctors		
ICA	0 "		
UMIA	5 "	.....	13.5% of total
Doctors' Co.	32 "	.....	86.5% " "
Total:	37 "		

"The lifetime costs of caring for a low birthweight baby can reach $400,000. The costs of prenatal care -- care that might prevent the low birthweight condition in the first place -- can be as little as $400."

(Source: National Commission to Prevent Infant Mortality, "Death Before Life: the Tragedy of Infant Mortality," p.9)

RECOMMENDATIONS

Having carefully considered the broad spectrum of information, data, and viewpoints, the members of the Council determined that the loss of adequate obstetrical services from competent providers and the loss of access to such services in Montana is a complex crisis having no single perfect solution. Efforts to ameliorate the crisis must be broadbased and sustained, and responsibilities for those efforts must be assumed immediately by state and local government, professional organizations, and the private sector.

Therefore, the Council recommends to the Governor of Montana, the following short-term measures that can be taken to encourage physicians to maintain their obstetrical practices, and long-term measures to address problems of insurance availability and affordability and to improve Montana's medical/legal climate.

Short-term Measures

Regarding Increasing Medicaid Reimbursements -

- Raise the level of Medicaid reimbursement to doctors who deliver babies to $1,000, which is a "break even" amount for doctors delivering babies, and which is approximately 80 percent of the insurance industry's allowance for a normal delivery. It is expected that this increase will encourage doctors considering leaving the practice not to do so, although it is not anticipated that doctors who have stopped delivering babies will begin delivering them again.

- Adopt presumptive eligibility for pregnant women and expedite applications for Medicaid assistance so that early, effective prenatal care is available to Medicaid clients. Further, reimbursement by Medicaid to providers for any services rendered must be guaranteed.

- Extend Medicaid eligibility coverage for pregnant women to 150 percent of the poverty level. (In 1990, by Federal mandate, Medicaid programs will include the population at 100 percent of poverty level.)

- Expand Medicaid's outreach/education/application programs for prenatal and infant care to sites where health providers deliver care, such as state and local health department clinics, hospital clinics, etc.

Regarding Funding Medicaid -

In seeking a source of funding for increased Medicaid reimbursements for obstetrical services, the Council recognizes the strains on the state budget.

There is considerable evidence that a significant number of Medicaid mothers with complicated pregnancies, which often result in the birth of babies whose health and development are at risk, use tobacco products.

- Because of the correlation between problem pregnancies, tobacco use, and infants born at risk, the Council recommends that the best potential source of increased funding for Medicaid reimbursements for obstetrical services is a tax increase on tobacco products to be matched 70/30 by federal funds.

Long-term Measures

Regarding Reducing Medical Malpractice Insurance Costs -

The Council recognizes the 50th Legislature's tort reform efforts, and believes that those efforts will have a long-term beneficial impact on medical liability insurance premiums. The Council makes these further recommendations.

- Consider legislation that reduces medical liability insurance premiums for doctors who deliver babies. Of the proposals before the Council, the Montana Medical Association proposal published/dated June 1988, warrants careful consideration by the Legislature. The Montana Medical Association proposal seeks: (1) actuarial soundness; (2) provisions for injury prevention in birth-related cases; and (3) provisions for eliminating the uncertainties of the current tort and insurance system. The Infant Compensation Plan, proposed by the Office of the State Auditor, is too narrow in scope, does not adequately address the variety of needs, does not solve the problem on a short-term or long-term basis, and is not viable in the form presented to the Council.

- Consider alternative methods of medical malpractice liability insurance rate-setting.

- Amend current law relating to discretionary periodic payment of future damages of $100,000 or more and make such periodic payments mandatory in obstetrical cases.

Other

- The Council recognizes that some small communities have devised creative, short-term solutions to encourage physicians who deliver babies to remain in those small communities, including paying a portion of the doctors' liability insurance premiums and making the doctors employees of the community hospitals. The Council applauds those efforts and urges other small communities to do the same. The Council recommends cooperation

and financial assistance in the form of matching grants or loans from the Legislature, private insurance carriers and others, in the short term, to keep physicians delivering babies in small communities.

- The Council supports and commends existing maternal/child health programs whose goals are the prevention of low birthweight babies and early access to medical care.

- The Council supports and commends the reform recommended by the Montana Medical Association limiting the liability of doctors who participate in peer review.

- The Council supports and commends the intentions of the Montana Medical Association to study the topic of state examination and certification of physicians practicing in Montana.

- The Council recommends that there be full disclosure to patients of the risks, particularly in rural areas, regarding the availability of and access to obstetrical services.

The Council extends its appreciation to all the organizations and individuals who contributed to the considerations of the Council, and especially to the Montana Medical Association and to Gerald (Gary) Neely.

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TESTIMONY / COMMENTARY / DATA

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Blue Shield/Blue Cross of Montana
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Montana Academy of Family Physicians
Montana Department of Social and Rehabilitation Services
Montana Hospital Association
Montana Legislative Council
Montana Medical Association
Montana Midwifery Association
Montana State University, College of Nursing
Neely, Gerald (Gary), Esq.
Office of the State Auditor and Commissioner of Insurance
Saint Paul Fire and Marine Insurance Company
State Bar of Montana
Trieweiler, Terry N., Esq.

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