MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

Call to Order: By Dorothy Bradley, on January 31, 1989, at 8 a.m.

ROLL CALL

Members Present: All members were present.

Members Excused: None

Members Absent: None

Staff Present: Peter Blouke, LFA

Announcements/Discussion: Executive action: AFDC, General Assistance, OBRA, Catastrophic Coverage Act, Welfare Reform Act, Primary Care, Nursing Homes

HEARING ON VOCATIONAL REHABILITATION

Presentation and Opening Statement: Dr. Blouke presented issue sheets in the SRS budgetary process. He stated the calculation of maintenance of effort with the vocational rehabilitation program. (See Exhibit 1.) Maggie Bullock explained that the maintenance of effort is based on the three-year average of state funds that have been spent by Montana and our current maintenance of effort is approximately $1.4 million. That is a minimum. The law states that once a state has proclaimed its maintenance of effort level it has to stay at that level or increase. Ms. Bullock explained that the LFA vocational rehabilitation budget is short approximately $100,000 in general fund.

Ms. Bullock reported that the IARA is set; the $300,000 is the limit for administration and $365,000 for benefits.

Questions From Subcommittee Members: Sen. Keating asked Ms. Bullock if the $100,000 is a match and the chairman replied yes this was an 80/20 percent federal/state match.

Rep. Cody inquired what would happen if the caseload dropped. Ms. Bullock reported that the certified caseload had dropped but the total caseload is not decreasing. However, only the

certified can be paid out of the trust fund.

DISPOSITION OF FUNDING FOR VOCATIONAL REHABILITATION
Tape No. A093

Motion: Motion by Sen. Van Valkenburg to accept executive current level budget for funding vocational rehabilitation. See Exhibit 2.

Recommendation and Vote: Motion carried with Rep. Cobb and Grinde dissenting.

HEARING ON MCCA, OBRA, AND WELFARE REFORM ACT

Presentation and Opening Statement: Mr. Tickle presented the revised estimates of major program costs. See Exhibit 3. He said that the subcommittee had asked him to set down with the budget office and the Montana Health Care Association to try to arrive at some agreement or identify where there could not be agreement on the cost estimates we are using for implementation of OBRA provisions related to nursing homes.

Mr. Tickell discussed the costs of implementing the Medicare Comprehensive Catastrophic Act (MCCA), the Omnibus Budget Reconciliation Act (OBRA) and Welfare Reform Act. The type and total funding is detailed across the bottom of the revised estimates. See Exhibit 3.

Mr. Tickell made a report to the subcommittee on estimated OBRA costs as related to nursing homes. See page 10 of Exhibit 3. Discussion followed.

Testifying Proponents and Who They Represent: Lois Steinbeck and Dave Thorsen, Rose Hughes, Executive Director of the Montana Health Care Association (MHCA), Mona Jamison, Steve Waldron

Proponent Testimony: Lois Steinbeck remarked that the contingency fund of $2,043, 267 in 1990 just does not cover welfare reform. There are three pieces of major federal legislation from which we are only beginning to feel the impact. She stated that there is more concern right now about the impact of ICCA than the federal welfare reform in terms of accurately predicting the changes. Most of the people we are helping there aren't necessarily employed. We may have to cover them no matter what federal reform does.

Dave Thorsen referred subcommittee to AFDC caseload in Exhibit 3 which projects a 4% increase per year and in revising projections in 1989, the 4% increase is still the best estimate.

Rose Hughes presented testimony on the effect of implementation of OBRA provisions as related to nursing homes by SRS.

Testimony on medical necessity by Mona Jamison reflects that Medicaid regulations allow individual states the discretion to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. However, if a state chooses to provide an optional service (such as physical therapy), then the amount, scope and duration of those services must be sufficient to meet the general purposes of the state's Medicaid program, and services must be consistent with the state's definition of medical necessity to meet that purpose. Current Montana statutes do not provide a clear statement of legislative intent for the administration of the state's Medicaid program relative to the issue of medical necessity. Mrs. Jamison summarized by saying the final testing of medical necessity would require evaluation as to the constitutionality and legality of defining "medical necessity."

Chairman Bradley stated that instead of making a ruling on severity or need, in the past the policy has been first come, first served. Allocating money to a needed program such as kidney dialysis which runs out before the first year of the biennium is not a method procedure to create legislative intent or policy.

Testimony was provided by Steve Waldron on utilization review of services provided to the community mental health center.

Mr. Waldron reported that in the adult system, the state has not provided the services to the adult chronically mentally ill that we should have.

Sen. Van Valkenburg presented copies of a letter from Bev Reynolds, Clinic Coordinator, UM Speech, Hearing and Language Clinic to the subcommittee. See Exhibit 4.

Testifying Opponents and Who They Represent: Judith Carlson, Montana Association of Social Workers, Brenda Norlund, Montana Women's Lobby

Opponent Testimony: Testimony was presented by Judith Carlson. She opposed placing restrictions on the Medicaid program.

Testimony was presented by Brenda Nordlund. She opposed restrictions on medical services.

Questions From Subcommittee Members: Rep. Cobb asked why was the inflation increase factor of two percent per year added into the total estimate. Mr. Tickell stated that this is currently consistent with the Governor's budget. Cost on page 10 spread sheet are consistent with the revised estimates of major program costs per Governor's budget. See pages 1-2 of Exhibit 3.

Rep. Cobb asked if Medicare would be paying part of the cost that was picked up in the past by Medicaid. Mr. Tickell stated that under OBRA, 38% would be picked up by Medicare and Medicaid will represent only 62% of the cost.

In answer to Sen. Hofman's inquiry as to why GA caseload is dropping, Mr. Tickell stated they were not sure. Possibly people moving out of state, better employment, etc. The last page of Exhibit 3 reflects the general assistance caseload reduction.

In regard to AFDC caseload reduction, Rep. Cobb inquired as to how soon an impact will be felt from the project work program. Mr. Tickell said this is a factor his department is also trying to determine but it is hard to project. The chairman inquired if we can at least see a start in holding the caseload level. Mr. Tickell said that could be.

Sen. Keating asked how funding would be handled if we were wrong in our assumptions and caseload increased more than 4%. Mr. Tickell said that the department could fund through a supplemental.

Rep. Cody inquired about primary care. Mr. Tickell indicated there would be a decrease in cost of Medicaid through the biennium because increased costs are driven by the AFDC caseload, and so what we will be seeing is a moderation in that caseload so we will be seeing a moderation in primary care utilization.

In answer to questions form the subcommittee, Ms. Hughes reported that if OBRA estimated costs are not funded adequately, the cost becomes too excessive for the nursing homes. Sen. Van Valkenburg asked Ms. Hughes who should come up with money to balance the budget. Ms. Hughes replied if the general public demand more services, then the taxpayers should pay for them.

Chairman Bradley asked Mrs. Jamison if some contract money was set aside for some type of utilization review if that would be an appropriate mechanism to define the specifics medical necessity and a process to establish criteria. Ms. Jamison replied that this would indeed be a step forward and would let providers feel that positive steps are being taken. She

said that process would cost money but felt you would end up saving money and you end up building relationships between the legislature, the department and the providers and recipients. It would represent the cooperative benefits of working together and avoid confrontations.

Chairman Bradley asked if utilization of services has gone up. Mr. Waldron reported that utilization of community mental health services has gone up due to expansion of services to persons with chronic mental illness and services have also been expanded to two adolescent day treatment programs, one in Helena and one in Great Falls. Chairman Bradley stated that there has also been a dramatic increase/expansion of services for adolescents in Rivendell, Rivendell II and Shodair.

Chairman Bradley asked Dr. Blouke and the department to look at and refine the language of what constitutes "medically necessary."

Sen. Van Valkenburg inquired about the federal Medicaid matching rate and why it fluctuates. Mr. Tickell said the rate was based on personal income and Montana's standing relative to other states.

If Montana has an economic upturn during biennium, Sen. Van Valkenburg inquired, would this affect the rate. Mr. Tickell replied that if economics get better, the match gets worse.

ADJOURNMENT

Adjournment At: 10:30 a.m.

Dorothy Bradley
REP. DOROTHY BRADLEY, Chairman

DB/tcp

2623.MIN

DAILY ROLL CALL

HEALTH & HUMAN SERVICES SUBCOMMITTEE

DATE 1-31-89

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 1-31-89
HB

MAINTENANCE OF EFFORT
VOCATIONAL REHABILITATION

CALCULATION

The Maintenance of Effort level for VR is calculated by averaging the state match for Section 110 funds for the past three years. For 1990, the Maintenance of Effort is based on the years 1987, 1988, and 1989. SRS determined the Maintenance of Effort level for 1990 by averaging the state funds listed on the federal expenditure reports for 1987 and 1988 and the budgeted state funds for 1989. The Maintenance of Effort level for 1990 will be $1,418,842.

EXEC/LFA BUDGETS

The executive budget includes funds for Maintenance of Effort. The LFA budget only includes $1.3 million which can be used towards the Maintenance of Effort level. Approximately $96,000 general fund in 1990 and $~~15~~96,000 in 1991 needs to be added to the LFA budget to meet the Maintenance of Effort level.

PENALTY

If the Maintenance of Effort Level is not met, the VR program will be reduced six dollars for every dollar below the Maintenance of Effort level.

EXHIBIT 2
DATE 1-31-89
HB

31-Jan-89

FUNDING VOCATIONAL REHABILITATION: EXECUTIVE CURRENT LEVEL

	FISCAL 1990	FISCAL 1991
OPERATIONS AND SERVICE		
Fed Inservice	$17,950	$17,952
Fed Dis Determ	$27,000	$27,000
Fed Section 110	$1,639,822	$1,637,920
Fed Sup Employmnent	$215,224	$214,661
Fed Independ Living Part A	$34,310	$34,195
State IARA	$300,000	$300,000
Worker Comp Panels	$89,197	$86,845
Gen Fund Inservice	$1,994	$1,995
Gen Fund Match	$109,604	$109,141
Gen Independ Living Part A	$3,812	$3,799
	$2,438,913	$2,433,508
BENEFITS		
Fed SSI/SSDI	$102,378	$102,378
Fed Independ Living Part A	$220,000	$242,000
Fed Sup Employment	$436,023	$472,831
Fed JTPA	$333,000	$333,000
Fed Section 110	$3,290,381	$3,250,080
State IARA	$365,400	$321,000
GF Independ Living Part A	$29,019	$29,019
Gen Fund Extend Emp	$269,095	$269,095
Gen Fund SECTION 110	$457,546	$491,859
	$5,502,842	$5,511,262
Federal Funds	$6,316,088	$6,332,017
State IARA Funds	$754,597	$707,845
General Funds	$871,070	$904,908
Total Funds	$7,941,755	$7,944,770

31-Jan-89

FUNDING VOCATIONAL REHABILITATION: CURRENT LEVEL

	FISCAL 1990	FISCAL 1991
OPERATIONS AND SERVICE		
Fed Inservice	$17,950	$17,952
Fed Dis Determ	$27,000	$27,000
Fed Section 110	$1,640,533	$1,638,632
Fed Sup Employmnent	$215,224	$214,661
Fed Independ Living Part A	$34,310	$34,195
State IARA	$300,000	$300,000
Worker Comp Panels	$89,197	$86,845
Gen Fund Inservice	$1,994	$1,995
Gen Fund Match	$109,783	$109,319
Gen Independ Living Part A	$3,812	$3,799
	$2,439,803	$2,434,398
BENEFITS		
Fed SSI/SSDI	$102,378	$102,378
Fed Independ Living Part A	$220,000	$242,000
Fed Sup Employment	$436,023	$472,831
Fed JTPA	$333,000	$333,000
Fed Section 110	$2,906,381	$2,906,381
State IARA	$365,400	$321,000
GF Independ Living Part A	$29,019	$29,019
Gen Fund Extend Emp	$269,095	$269,095
Gen Fund SECTION 110	$361,546	$405,934
	$5,022,842	$5,081,638
Federal Funds	$5,932,799	$5,989,030
State IARA Funds	$754,597	$707,845
General Funds	$775,249	$819,161
Total Funds	$7,462,645	$7,516,036

EXHIBIT 3
DATE 1-31-89
HB

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES 89SESS

REVISED ESTIMATES OF MAJOR PROGRAM COSTS 01/30/89

Program	Per Governor's Budget FY90	Per Governor's Budget FY91	Revised Estimates FY90	Revised Estimates FY91	Difference FY90	Difference FY91
MCCA:						
Pregnant Women & Children	$2,970,646	$2,970,646	$591,906	$753,746	($2,378,740)	($2,216,900)
Buy-In (Current & Mod)	$3,956,721	$5,263,303	$5,464,009	$9,175,878	$1,507,288	$3,912,575
QMB Co-Ins. & Ded.	$0	$0	$1,715,971	$3,396,727	$1,715,971	$3,396,727
FTE's for QMB Impact	$0	$0	$61,362	$40,908	$61,362	$40,908
Spousal Impoverishment	$0	$0	$6,550,589	$9,041,031	$6,550,589	$9,041,031
NH 150 Day Coverage	$0	$0	($3,863,142)	($4,172,118)	($3,863,142)	($4,172,118)
OBRA:	$3,325,598	$1,231,791	$3,360,029	$2,994,284	$34,431	$1,762,493
Medicaid Waiver:						
Elderly Waiver	$1,893,569	$1,953,781	$2,364,469	$2,364,469	$470,900	$410,688
Disabled Waiver	$1,446,059	$1,492,090	$1,805,671	$1,805,671	$359,612	$313,581
Primary Care Reduction	$0	$0	($500,000)	($500,000)	($500,000)	($500,000)
Welfare Reform	$2,108,737	$5,238,218	$2,108,737	$5,238,218	$0	$0
DD Shortfall	$0	$0	$344,284	$344,284	$344,284	$344,284
Voc Rehab Funding Mix	$0	$0	($100,000)	($100,000)	($100,000)	($100,000)
SB 101	$0	$0	($778,947)	($1,076,585)	($778,947)	($1,076,585)
State Medical Reduction	$0	$0	($29,700)	($30,800)	($29,700)	($30,800)
GA Caseload Reduction	$0	$0	($202,872)	($210,576)	($202,872)	($210,576)
AFDC Caseload Reduction	$0	$0	($231,768)	($593,554)	($231,768)	($593,554)
Primary Care Adjustment	$97,724,031	$100,919,108	$93,100,776	$100,128,729	($4,623,255)	($790,379)
General Fund Contingency	$0	$0	$2,043,267	($649,718)	$2,043,267	($649,718)
Total Cost	$113,425,361	$119,068,937	$113,804,641	$127,950,594	$379,280	$8,881,657
Funding:						
General Fund	$26,646,398	$28,027,468	$26,646,398	$28,027,468	$0	$0
County Funds	$6,907,000	$7,030,000	$6,902,822	$7,025,822	($4,178)	($4,178)
Federal Funds	$79,871,963	$84,011,469	$80,255,421	$92,897,304	$383,458	$8,885,835
Total Funding	$113,425,361	$119,068,937	$113,804,641	$127,950,594	$379,280	$8,881,657

The primary care adjustment reflects Option #3 (proposed to subcommittee) agreed to by the LFA & OBPP.

General Fund:

MCCA:						
Pregnant Women & Children	$856,437	$853,170	$170,646	$216,476	($685,791)	($636,694)
Buy-In (Current & Mod)	$2,354,172	$3,035,359	$1,573,104	$2,636,243	($781,068)	($399,116)
QMB Co-Ins. & Ded.	$0	$0	$494,714	$975,540	$494,714	$975,540
FTE's for QMB Impact	$0	$0	$31,908	$21,272	$31,908	$21,272
Spousal Impoverishment	$0	$0	$1,888,535	$2,596,584	$1,888,535	$2,596,584
NH 150 Day Coverage	$0	$0	($1,113,744)	($1,198,232)	($1,113,744)	($1,198,232)
OBRA:	$922,970	$321,554	$868,503	$763,367	($54,467)	$441,813
					$0	$0
Medicaid Waiver:					$0	$0
Elderly Waiver	$545,916	$561,126	$681,677	$679,076	$135,761	$117,950
Disabled Waiver	$416,899	$428,528	$520,575	$518,589	$103,676	$90,061
					$0	$0
Welfare Reform	$283,166	$873,763	$378,957	$967,605	$95,791	$93,842
					$0	$0
DD shortfall	$0	$0	$344,284	$344,284	$344,284	$344,284
Voc Rehab	$0	$0	($100,000)	($100,000)	($100,000)	($100,000)
SB 101	$0	$0	($778,947)	($1,076,585)	($778,947)	($1,076,585)
State Medical Reduction	$0	$0	($29,700)	($30,800)	($29,700)	($30,800)
GA Caseload Reduction	$0	$0	($202,872)	($210,576)	($202,872)	($210,576)
AFDC Caseload Reduction	$0	$0	($62,641)	($159,809)	($62,641)	($159,809)
Primary Care Adjustment	$21,266,838	$21,953,968	$19,938,132	$21,734,153	($1,328,706)	($219,815)
					$0	$0
Contingency	$0	$0	$2,043,267	($649,718)	$2,043,267	($649,718)
Total General Fund	$26,646,398	$28,027,468	$26,646,398	$28,027,468	$0	$0

County Funds:

AFDC Caseload Reduction	$0	$0	($4,178)	($4,178)	($4,178)	($4,178)
Primary Care Adjustment	$6,907,000	$7,030,000	$6,907,000	$7,030,000	$0	$0
FTE's for QMB Impact	$0	$0	$0	$0	$0	$0
Total County Funds	$6,907,000	$7,030,000	$6,902,822	$7,025,822	($4,178)	($4,178)

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Economic Assistance Division

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988--PREGNANT WOMEN AND INFANTS

Effective July 1, 1989, states are mandated to provide Medicaid coverage to pregnant women whose household income is at or below 75% of the federal poverty level. Effective July 1, 1990, the requirement is applied to pregnant women whose household income is at or below 100% of the federal poverty level. States may choose whether or not to implement a resource test.

Eligibility

The income limits are on a sliding scale based on household size. The following have been projected for 1990 and 1991.

Household Size	SFY 1990 75% Poverty Level	SFY 1991 100% Poverty Level
2	518	725
3	655	908

All other eligibility requirements remain the same.

Cost Estimate: Benefits

Assumptions Used

Assumes 238 women will no longer have to meet the spenddown requirement, but will immediately become categorically needy. Medicaid will pay the entire cost of the pregancy and the infant.

Assumes that children will be covered for half year in FY1990. Medicaid reimbursement for prenatal care, delivery and post partum care is $670 (ARM). The average hospital obstetrical cost is $1,137 (MMIS reports). The total cost for delivery is $1,807.

The average cost per child for the first year is $1,360 (Paid claims tape). Assumes federal matching rate of 71.17% in FY 1990 and 71.28% in FY 1991.

Calculation		FY90	FY91
238 women X $1,807	=	430,066	430,066
For 1990, 238 children X $1,360 X ½ year	=	161,840	
For 1991, 238 children X $1,360 X 1 year	=		323,680
		591,906	753,746
General Fund		170,646	216,476
Federal Funds		421,260	537,270
		591,906	753,746

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Economic Assistance Division

Cost Estimate: Impact on Workload and Other Administrative Costs

Impact on Computer Systems

Assumptions Used

Assumes federal mathing rate is 50% (through the Department will apply for enhanced funding, the 90% rate).

Assumes eligibility system modification will require two months of programmer (Grade 15, Step 4) time, or $4,473.60 in salary and benefits.

Assumes need for 320 hours of computer time @ $15/hour, or $4,800.

Assumes claims payment system modification will require 53 hours of programmer time @ $95/hour, or $5,035.

Calculation

	SFY1990	SFY1991
Modification of Eligibility System (MIMS)	9,274	-0-
Modification of Claims Program System (MMIS)	5,035	-0-
	14,309	
General Fund	7,155	
Federal Funds	7,154	
	14,309	

CASES						EXPENDITURES						AVERAGE EXPENDITURES			Premium Rate In Effect
FY90 Month/Year	Cash Assistance	%	Non-Cash Assistance	%	Total	FY90 Month/Year	Cash Assistance	%	Non-Cash Assistance	%	Total	FY90 Month/Year	Cash Assistance	Non-Cash Assistance	Total	
July, 1989	10,500	100.00%	0	0.00%	10,500	July, 1989	$338,726.50	100.00%	$0.00	0.00%	$338,726.50	July, 1989	$32.26	$0.00	$32.26	$31.90
August	10,850	100.00%	0	0.00%	10,850	August	$350,017.38	100.00%	$0.00	0.00%	$350,017.38	August	$32.26	$0.00	$32.26	$31.90
September	11,200	100.00%	0	0.00%	11,200	September	$361,308.26	100.00%	$0.00	0.00%	$361,308.26	September	$32.26	$0.00	$32.26	$31.90
October	11,550	100.00%	0	0.00%	11,550	October	$372,599.15	100.00%	$0.00	0.00%	$372,599.15	October	$32.26	$0.00	$32.26	$31.90
November	11,900	100.00%	0	0.00%	11,900	November	$383,890.03	100.00%	$0.00	0.00%	$383,890.03	November	$32.26	$0.00	$32.26	$31.90
December	12,250	100.00%	0	0.00%	12,250	December	$395,180.91	100.00%	$0.00	0.00%	$395,180.91	December	$32.26	$0.00	$32.26	$31.90
January	12,600	100.00%	0	0.00%	12,600	January	$508,408.30	100.00%	$0.00	0.00%	$508,408.30	January	$40.35	$0.00	$40.35	$39.90
February	12,950	100.00%	0	0.00%	12,950	February	$522,530.75	100.00%	$0.00	0.00%	$522,530.75	February	$40.35	$0.00	$40.35	$39.90
March	13,300	100.00%	0	0.00%	13,300	March	$536,653.20	100.00%	$0.00	0.00%	$536,653.20	March	$40.35	$0.00	$40.35	$39.90
April	13,650	100.00%	0	0.00%	13,650	April	$550,775.66	100.00%	$0.00	0.00%	$550,775.66	April	$40.35	$0.00	$40.35	$39.90
May	14,000	100.00%	0	0.00%	14,000	May	$564,898.11	100.00%	$0.00	0.00%	$564,898.11	May	$40.35	$0.00	$40.35	$39.90
June, 1990	14,350	100.00%	0	0.00%	14,350	June, 1990	$579,020.56	100.00%	$0.00	0.00%	$579,020.56	June, 1990	$40.35	$0.00	$40.35	$39.90
Totals	149,100	100.00%	0	0.00%	149,100	Totals	$5,464,008.82	100.00%	$0.00	0.00%	$5,464,008.82	Totals	$435.66	$0.00	$435.66	$430.80
Average	12,425.00	100.00%	0.00	0.00%	12,425.00	Average	$455,334.07	100.00%	$0.00	0.00%	$455,334.07	Average	$36.30	$0.00	$36.30	$35.90

BUY_IN

CASES						EXPENDITURES						AVERAGE EXPENDITURES			Premium Rate In Effect
FY91 Month/Year	Cash Assistance	%	Non-Cash Assistance	%	Total	FY91 Month/Year	Cash Assistance	%	Non-Cash Assistance	%	Total	FY91 Month/Year	Cash Assistance	Non-Cash Assistance	Total	
July, 1990	14,700	100.00%	0	0.00%	14,700	July, 1990	$593,143.02	100.00%	$0.00	0.00%	$593,143.02	July, 1990	$40.35	$0.00	$40.35	$39.90
August	15,050	100.00%	0	0.00%	15,050	August	$607,265.47	100.00%	$0.00	0.00%	$607,265.47	August	$40.35	$0.00	$40.35	$39.90
September	15,400	100.00%	0	0.00%	15,400	September	$621,387.92	100.00%	$0.00	0.00%	$621,387.92	September	$40.35	$0.00	$40.35	$39.90
October	15,750	100.00%	0	0.00%	15,750	October	$635,510.37	100.00%	$0.00	0.00%	$635,510.37	October	$40.35	$0.00	$40.35	$39.90
November	16,100	100.00%	0	0.00%	16,100	November	$649,632.83	100.00%	$0.00	0.00%	$649,632.83	November	$40.35	$0.00	$40.35	$39.90
December	16,450	100.00%	0	0.00%	16,450	December	$663,755.28	100.00%	$0.00	0.00%	$663,755.28	December	$40.35	$0.00	$40.35	$39.90
January	16,800	100.00%	0	0.00%	16,800	January	$856,266.61	100.00%	$0.00	0.00%	$856,266.61	January	$50.97	$0.00	$50.97	$50.40
February	17,150	100.00%	0	0.00%	17,150	February	$874,105.50	100.00%	$0.00	0.00%	$874,105.50	February	$50.97	$0.00	$50.97	$50.40
March	17,500	100.00%	0	0.00%	17,500	March	$891,944.38	100.00%	$0.00	0.00%	$891,944.38	March	$50.97	$0.00	$50.97	$50.40
April	17,850	100.00%	0	0.00%	17,850	April	$909,783.27	100.00%	$0.00	0.00%	$909,783.27	April	$50.97	$0.00	$50.97	$50.40
May	18,200	100.00%	0	0.00%	18,200	May	$927,622.16	100.00%	$0.00	0.00%	$927,622.16	May	$50.97	$0.00	$50.97	$50.40
June, 1991	18,550	100.00%	0	0.00%	18,550	June, 1991	$945,461.05	100.00%	$0.00	0.00%	$945,461.05	June, 1991	$50.97	$0.00	$50.97	$50.40
Totals	199,500	100.00%	0	0.00%	199,500	Totals	$9,175,877.85	100.00%	$0.00	0.00%	$9,175,877.85	Totals	$547.91	$0.00	$547.91	$541.80
Average	16,625.00	100.00%	0.00	0.00%	16,625.00	Average	$764,656.49	100.00%	$0.00	0.00%	$764,656.49	Average	$45.66	$0.00	$45.66	$45.15

GENERAL FUND COSTS						TOTAL COSTS FY89				
	1	2	3 (1 X 2)	4	5 (3 + 4)					
FY90 Month/Year	Assistance Expenditures	State Share	General Fund Cost	Non-Assis. Expenditures	Total G.F. Cost	General Fund	%	Federal Fund	%	Total
July, 1989	$338,726.50	29.38%	$99,517.85	$0.00	$99,517.85	$99,517.85	29.38%	$239,208.65	70.62%	$338,726.50
August	$350,017.38	29.38%	$102,835.11	$0.00	$102,835.11	$102,835.11	29.38%	$247,182.27	70.62%	$350,017.38
September	$361,308.26	29.38%	$106,152.37	$0.00	$106,152.37	$106,152.37	29.38%	$255,155.90	70.62%	$361,308.26
October	$372,599.15	28.65%	$106,749.66	$0.00	$106,749.66	$106,749.66	28.65%	$265,849.49	71.35%	$372,599.15
November	$383,890.03	28.65%	$109,984.49	$0.00	$109,984.49	$109,984.49	28.65%	$273,905.54	71.35%	$383,890.03
December	$395,180.91	28.65%	$113,219.33	$0.00	$113,219.33	$113,219.33	28.65%	$281,961.58	71.35%	$395,180.91
January	$508,408.30	28.65%	$145,658.98	$0.00	$145,658.98	$145,658.98	28.65%	$362,749.32	71.35%	$508,408.30
February	$522,530.75	28.65%	$149,705.06	$0.00	$149,705.06	$149,705.06	28.65%	$372,825.69	71.35%	$522,530.75
March	$536,653.20	28.65%	$153,751.14	$0.00	$153,751.14	$153,751.14	28.65%	$382,902.06	71.35%	$536,653.20
April	$550,775.66	28.65%	$157,797.23	$0.00	$157,797.23	$157,797.23	28.65%	$392,978.43	71.35%	$550,775.66
May	$564,898.11	28.65%	$161,843.31	$0.00	$161,843.31	$161,843.31	28.65%	$403,054.80	71.35%	$564,898.11
June, 1990	$579,020.56	28.65%	$165,889.39	$0.00	$165,889.39	$165,889.39	28.65%	$413,131.17	71.35%	$579,020.56
Totals	$5,464,008.82	28.83%	$1,573,103.91	$0.00	$1,573,103.91	$1,573,103.91	28.79%	$3,890,904.92	71.21%	$5,464,008.82

GENERAL FUND COSTS						TOTAL COSTS FY89				
	1	2	3 (1 X 2)	4	5 (3 + 4)					
FY91 Month/Year	Assistance Expenditures	State Share	General Fund Cost	Non-Assis. Expenditures	Total G.F. Cost	General Fund	%	Federal Fund	%	Total
July, 1990	$593,143.02	28.65%	$169,935.47	$0.00	$169,935.47	$169,935.47	28.65%	$423,207.54	71.35%	$593,143.02
August	$607,265.47	28.65%	$173,981.56	$0.00	$173,981.56	$173,981.56	28.65%	$433,283.91	71.35%	$607,265.47
September	$621,387.92	28.65%	$178,027.64	$0.00	$178,027.64	$178,027.64	28.65%	$443,360.28	71.35%	$621,387.92
October	$635,510.37	28.75%	$182,709.23	$0.00	$182,709.23	$182,709.23	28.75%	$452,801.14	71.25%	$635,510.37
November	$649,632.83	28.75%	$186,769.44	$0.00	$186,769.44	$186,769.44	28.75%	$462,863.39	71.25%	$649,632.83
December	$663,755.28	28.75%	$190,829.64	$0.00	$190,829.64	$190,829.64	28.75%	$472,925.64	71.25%	$663,755.28
January	$856,266.61	28.75%	$246,176.65	$0.00	$246,176.65	$246,176.65	28.75%	$610,089.96	71.25%	$856,266.61
February	$874,105.50	28.75%	$251,305.33	$0.00	$251,305.33	$251,305.33	28.75%	$622,800.17	71.25%	$874,105.50
March	$891,944.38	28.75%	$256,434.01	$0.00	$256,434.01	$256,434.01	28.75%	$635,510.37	71.25%	$891,944.38
April	$909,783.27	28.75%	$261,562.69	$0.00	$261,562.69	$261,562.69	28.75%	$648,220.58	71.25%	$909,783.27
May	$927,622.16	28.75%	$266,691.37	$0.00	$266,691.37	$266,691.37	28.75%	$660,930.79	71.25%	$927,622.16
June, 1991	$945,461.05	28.75%	$271,820.05	$0.00	$271,820.05	$271,820.05	28.75%	$673,641.00	71.25%	$945,461.05
Totals	$9,175,877.85	28.73%	$2,636,243.09	$0.00	$2,636,243.09	$2,636,243.09	28.73%	$6,539,634.77	71.27%	$9,175,877.85

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Economic Assistance Division

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 -- MEDICARE PART B BUY-IN AND THE MEDICARE QUALIFIED BENEFICIARY PROGRAM

MEDICARE PART B BUY-IN

Definition

The Medicare Part B Buy-in Program pays the Part B premium for Medicaid eligible persons who are disabled or 65 years or older. The premium was $17.90 per recipient for calendar year 1987 and increased to $24.80 effective January 1988. By paying this premium, the state is able to require medical providers to bill Medicare for services first. After the deductible is met, Medicare will pay at least 80 percent of the Medicare fee, leaving no more than 20 percent for Medicaid to pay. Medicaid would pay the deductible up to the Medicaid for fee schedule.

The state buys in individuals receiving assistance payments (i.e., SSI) and individuals receiving no assistance payments (i.e., the aged and disabled who are Medically Needy) at different federal matching rates. Federal participation for individuals receiving assistance payments is approximately 70 percent for FY88. Federal participation for individuals receiving no assistance payment is zero -- in other words, the total premium is paid with State General Fund dollars.

Utilization and Costs for SFY 88

Yearly Cost	$ 2,213,278
Assistance Payment Cases	1,333,078
Non-Assistance Payment Cases	880,200
Average Number of Recipients per Month	8,900
Assistance Payments Cases	5,435
Non-Assistance Payment Cases	3,465

THE QUALIFIED MEDICARE BENEFICIARY PROGRAM

Eligibility and Coverage

The Medicare Catastrophic Care Act of 1988 has a major impact on the Medicare Buy-in Program. Under this Act, Medicaid is required to pay the premium, deductible and coinsurance of Medicare beneficiaries with incomes below the federal poverty level and resources less than twice the Supplemental Security Income (SSI) Program resource limit. This means that non-assistance payment buy-in recipients--i.e., the medically needy--will be bought in for months during which they are meeting their incurment requirement. This results in additional costs to Medicaid because there will be more premium months for non-assistance recipients. Also, Medicaid will now be paying the deductible and coinsurance which, during the incurment period, was previously the clients' responsibility. The trade-off is that the client will no longer be able to meet his incurment requirement with the Medicare deductible and coinsurance and thus may take longer to become eligible for services covered by Medicaid but not by Medicare. Also, under the Act, federal participation for non-assistance individuals is 70% rather than 0%. However, the premium will be higher, and the higher income level--up to the federal poverty level--will mean an increased buy-in caseload.

Medicaid will be paying the Part A and Part B deductibles and coinsurance on more individuals, as well as on services covered by Medicare but not now covered by Medicaid. Finally, under the Act, in 1991 Medicaid will have to pay the premium, deductible and coinsurance for the Medicare drug program.

Cost Estimate: Benefits

The following does not address the impact of the Medicare drug program.

Buying-in the Medically Needy

Assumptions Used

Assumes that 3,828 non-assistance buy-in recipients (2,963 aged and 865 disabled medically needy recipients) will be bought in a full twelve months. Recipient count is taken from FFY 87 HCFA-2082. Assumes 3,465 non-assistance recipients are currently bought in at a cost of $880,200 (from Management Operations Bureau 1988 report).

Assumes that of 3,465 non-assistance recipients, 2,668, or 77%, are aged and 797, or 33%, are disabled, based on distribution of medically needy recipients who are aged or disabled.

Assumes that average 1988 Part B premium for non-assistance buy-in recipient is $21 (from Management Operations Bureau 1988 report).

Assumes that the increase to the average 1988 Part B premium will be $8.00 in 1989, $12.90 in 1990, and $18.36 in 1991.

Assumes that Medicaid pays $338 in deductibles and coinsurance for an aged person and $424 in deductibles and coinsurance for a disabled person (from FFY87 HCFA-2082).

Assumes federal matching rate of 71.17% in FY1990 and 71.28% in FY1991.

Calculation of Increased Costs	SFY 1990	SFY 1991
Increased Premium Expense for Current Caseload		
1990: 3,465 X 12.90 X 12 =	536,382	
1991: 3,465 X 18.36 X 12 =		763,409
Increased Premium Expense for the Medically Needy		
1990: (3,828 - 3,465) X 33.50 X 12 =	150,109	
1991: (3,828 - 3,465) X 39.36 X 12 =		174,286
Increased Deductible and Coinsurance Expense for the Medically Needy		
(3,828 - 3,465) X .77 X 338 =	94,474	94,474
(3,828 - 3,465) X .33 X 424 =	50,790	50,790
	831,755	1,082,959
General Fund	239,795	311,026
Federal Funds	591,960	771,933
	831,755	1,082,959

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Economic Assistance Division

Buying in the Categorically Needy

Assumptions Used

Assumes that 5,435 assistance recipients are bought in currently at a cost of $1,333,078 (from Management Operations Bureau 1988 report).

Assumes that average 1988 Part B premium for assistance buy-in recipient is $20.58 per month (from Management Operations Bureau 1988 report).

Assumes that the increase to the average 1988 Part B premium will be $8.00 in 1989, $12.50 in 1990, and $18.36 in 1991.

Assumes federal matching rate of 71.17% in FY 1990 and 71.78% in FY 1991.

Calculation	SFY1990	SFY1991
Increased Premium Expense for Current Caseload		
1990: 5,435 X 12.90 X 12 =	841,338	
1991: 5,435 X 18.36 X 12 =		1,197,439
	841,338	1,197,439
General Fund	242,558	343,904
Federal Funds	598,780	853,535
	841,338	1,197,439

Buying in to the Poverty Level

Assumption Used

Assumes 10,050 Medicare Part A beneficiaries have income of $500/month or less (from LEADS tape) and will be enrolled over the next 24 months of the biennium at the following rate: 2,000 in the first month and 350 in every month thereafter. This will result in 3,925 fulltime equivalents in 1990 and 8,125 fulltime equivalents in 1991.

Assumes 77% of the above are aged and 33% are disabled (based on 1987 HCFA-2082 on medically needy aged and disabled recipients).

Assumes that average Part B premium for non-assistance buy-in recipient is $21 (from Management Operations Bureau 1988 report).

Assumes that the increase to the average 1988 Part B premium will be $8.00 in 1989, $12.90 in 1990, and $18.36 in 1991.

Assumes that Medicaid pays $338 in deductibles and coinsurance for an aged person and and $424 in deductibles and coinsurance for a disabled person.

Assumes federal matching rate of 71.17% in 1990 and 71.28% in FY 1991.

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Economic Assistance Division

Calculation	SFY1990	SFY1991
Premium Expense for new caseload		
1990: 3,925 X (21 + 12.90) X 12 =	1,596,690	
1991: 8,125 X (21 + 18.36) X 12 =		3,837,600
Deductible and Coinsurance Expense for new caseload		
Aged, 1990: (3,925 X .77) X $338 =	1,021,521	
Disabled, 1990: (3,925 X .33) X $424 =	549,186	
Aged, 1991: (8,125 X .77) X $338 =		2,114,613
Disabled, 1991: (8,125 X .33) X $424 =		1,136,850
	3,167,397	7,089,063
General Fund	913,161	2,035,979
Federal Funds	2,254,236	5,053,084
	3,167,397	7,089,063

Cost Estimate: Impact on workload and other administrative costs

The Department is working toward a July 1, 1989 implementation of the Qualified Medicare Beneficiary Program. There will be a need for additional eligibility staff to handle the increased caseload.

Assumptions Used

Assumes that there will be 5,850 cases opened in 1990 and 4,200 cases opened in 1991.

Assumes that 57% of cases will be in state-administered counties and 43% of cases will be in state-supervised counties. This means that in 1990, 3,335 cases will be in state-administered counties and 2,515 cases will be state-supervised counties; in 1991, 2,394 cases will be in state-administered counties and 1,806 cases will be in stata-supervised counties.

Assumes that the average caseload per eligibility worker is 285 cases. This means that in 1990, state-administered counties will require 12 additional FTEs and state-supervised counties will require 9 additional FTEs; in 1991, state-administered counties will require 8 further FTEs and state-supervised counties will require 6 further FTE.

Assumes salary, benefits, rent and equipment for each FTE will be $21,900.

Assumes that matching rates for state-administered counties are 50% federal and 50% state general fund and that matching rates for state-supervised counties are 50% federal, 42% county and 8% state general funds.

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Economic Assistance Division

Calculation	SFY1990	SFY1991
FTEs for State-administered Counties		
1990: 12 X $21,900 =	262,800	
1991: 20 X $21,900 =		438,000
	262,800	438,000
General Fund	131,400	219,000
Federal Funds	131,400	219,000
	262,800	438,000
FTEs for State-supervised Counties		
1990: 8 X $21,900 =	175,200	
1991: 14 X $21,900 =		306,600
	175,200	306,600
General Fund	14,016	24,528
County Funds	73,584	128,772
Federal Funds	87,600	153,300
	175,200	306,600
Total State-Administered and State-Supervised		
State-Administered	262,800	438,000
State-supervised	175,200	306,600
	438,000	744,600
General Fund	145,416	243,528
County Funds	73,584	128,772
Federal Funds	219,000	372,300
	438,000	744,600

Cost Estimate: Current Level Buy-In

Assumptions Used

Assumes that if federal government had not mandated the Qualified Medicare Beneficiary Program under the Catastrophic Care Act, the Department would continue to pay $2,212,278 each fiscal year for the Buy-in caseload of 8,900.

Assumes a federl matching rate of 71.17% in 1990 and 71.28% in 1991.

Calculation	SFY1990	SFY1991
Current Level Buy-in for 8,900 Recipients	2,213,278	2,213,278
	2,213,278	2,213,278
General Fund	638,088	635,653
Federal Funds	1,575,190	1,577,625
	2,213,278	2,213,278

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Economic Assistance Division

Overall Impact of Qualified Medicare Beneficiary Program on the General Fund

Calculation	SFY1990		SFY1991	
	Federal	GF	Federal	GF
Current Level Buy-in	1,575,190	638,088	1,577,625	635,653
General Fund Impact of Buying in the Medically Needy under QMB	591,960	239,795	771,933	311,026
General Fund Impact of Buying in the Categorically Needy under QMB	598,780	242,558	853,535	343,904
General Fund Impact of Buying in to the Poverty Level	2,254,236	913,161	5,053,084	2,035,979
General Fund Impact of Workload and Administration Costs Impact under QMB	219,000	145,416	372,300	243,528
	5,239,166	2,179,018	8,628,477	3,570,090

DT
1/30/89

OMB FTE's

5 ET's (3 in FY90, 2 in FY91)

G10/52 =	$ 15,623
Benefits @ 21%	3,281
TOTAL Personal Serv.	$ 18,904
Supplies	250
Communication	300
Equipment	1,000
	1,550
GRAND TOTAL	$ 20,454

FY90	FY91
61,362	40,908

DEPARTMENT OF SRS
Economic Assistance Division

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

SPOUSAL IMPOVERISHMENT

SUMMARY:

Effective September 30, 1989 Medicaid coverage is extended to more nursing home residents who have a spouse living at home. The amount of assets and income which may be retained by the spouse at home is increased allowing for Medicaid coverage for the institutionalized spouse to be determined earlier and less income required to be applied to the cost of care.

ESTIMATED INCREASE IN MEDICAID EXPENDITURES:

	FY90	FY91
General Fund	$1,876,744	$2,590,255
Federal Funds	$4,673,845	$6,450,776
Total	$6,550,589	$9,041,031

ASSUMPTIONS:

1. Ten percent private pay and Medicare-eligible residents of nursing facilities will become eligible for Medicaid as a result of the enactment of this legislation. The 10% estimate was determined by a group which studied the potential impacts.

2. There were approximately 2,400 private pay, Medicare and VA covered residents in Montana nursing facilities during December 1988 as calculated from monthly staffing reports. It is estimated that 3% of the total average occupancy of 6,165, or 185, were covered as skilled level by Medicare under the limited Medicare benefit during December 1988. It is also estimated that 16% of the remainder of the 2,400 may be eligible for the expanded Medicare skilled nursing coverage each year.

3. The institutionalized spouse determined eligible for Medicaid will be allowed to exclude more monthly income for the cost of care. This will also apply to previously eligible Medicaid residents. It is estimated from a sample of patient assessment abstracts that 22% of current Medicaid residents may have a spouse at home. The law allows at least $786 per month to be kept by the spouse at home as compared with the current limit of $368. This is estimated to increase the Medicaid payment by $13.74 per day. Estimated FY90 Medicaid payment rate is thus $54.75 per day for this group (41.01 + 13.74) and $58.03 (44.29 + 13.74) for FY91.

4. Estimated rate increases:

Current Medicaid payment in FY 89 = 37.35 per day

FY90 37.35 x 1.098 (7.8% OBRA + 2% rate increase) = 41.01
FY91 37.35 x 1.1859 (7.8% OBRA + 6.75% OBRA + 4.04% rate increase) = 44.29

5. Calculation Summary:

a. 2,400 non-Medicaid residents X 10% = 240

b. 19 (10% x 185) will be covered under the Medicare skilled nursing benefit each year for an average of 75 days.

c. (240 - 19) x 16% = 35 additional may be eligible for the Medicare skilled benefit for an average of 75 days each year.

FY 90

d. New Medicaid Eligible:

54 (19 + 35) x 200 days x $54.75	= $ 591,300
186 (240 - 54) x 275 days x $54.75	= $2,800,463

Current Medicaid Eligible:

3,800 x 22% x 275 days x $13.74	= $3,158,826
	$6,550,589

FY91

54 x 290 days x 58.03	= $ 908,750
186 x 365 days x 58.03	= $3,939,657
3,800 x 22% x 365 days x 13.74	= $4,192,624
	$9,041,031

NOTE: 275 days is used because the provision is effective 10/1/89 rather than 7/1/89.

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DEPARTMENT OF SRS

Economic Assistance Division

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

EXPANDED SKILLED NURSING FACILITY BENEFITS

SUMMARY:

Effective January 1, 1989 the Medicare Part A skilled nursing facility (SNF) benefit is extended from 100 to 150 days. The period of full Part A coverage is increased to the ninth through the 150th day, a significant increase over the previous limit of the first 20 days. The period for a daily coinsurance amount is reduced to the first 8 days in the SNF at a rate of $25.50 per day which is charged to the beneficiary or Medicaid. The three day prior hospitalization requirement is eliminated and eligible beneficiaries receive a fresh coverage period annually, beginning January 1 of each calendar year.

ESTIMATED MEDICAID SAVINGS (reduced expenditures):

	FY90	FY91
General Fund	(1,106,790)	(1,195,312)
Federal Funds	(2,756,352)	(2,976,806)
Total	(3,863,142)	(4,172,118)

ASSUMPTIONS:

1. Medicare skilled level determinations and subsequent billing to Medicare by nursing facilities will be consistent and complete. The Medicaid system shows Medicare as a payment source but does not require prior billing to Medicare before Medicaid payments are made to nursing facilities. Current Medicaid staff will be unable to closely monitor Medicaid payments for these residents coverable by Medicare.

2. Estimated reductions in Medicaid expenditures were based upon projected per diem payments for routine services only. No attempt was made to estimate the potential reduction in expenditures for ancillary and pharmacy services. Ancillary services include medical supplies, durable medical equipment, oxygen, physical, occupational and speech therapies.

3. Projected per diem rates were estimated to increase 9.8% in FY90 and 8.0% in FY91 to include the effect of OBRA costs and 2% provider rate increases. The FY89 rate of $37.35 x 1.098 = $41.01. $37.35 x 1.098 x 1.08 = $44.29.

4. All estimated Medicaid recipients eligible for the Medicare skilled nursing benefit, except for those estimated to be insulin dependent, were assumed to meet the skilled criteria for an average of 75 days each year. The insulin dependent were assumed to be eligible for the full 150 days

of coverage each year. 75 days is used because many residents will not meet the skilled criteria for the full period or will be discharged prior to using the maximum.

5. Estimated Medicaid recipients eligible for Medicare skilled benefits were based upon surveys conducted by the Medicaid Bureau staff and review of the patient assessment system data.

   Calculations Used:

   a. 3,800 average Medicaid recipients x 16% skilled (per patient assessment system) x 75% Medicare eligible (per Management Operations Bureau estimate) = 456 recipients eligible for Medicare coverage averaging 75 days.

      FY90 456 x 75 x $41.01/day = $ 1,402,542
      FY91 456 x 75 x $44.29/day = $ 1,514,718

   b. Four insulin dependent recipients per facility x 100 facilities = 400 recipients eligible for 150 days.

      FY90 400 x 150 x $41.01 = $ 2,460,600
      FY91 400 x 150 x $44.29 = $ 2,657,400

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OBRA Costs estimated	Per MHCA		Per Executive Budget		Currently Recommended	
Requirements	FY 1990	FY1991	FY 1990	FY1991	FY 1990	FY1991
1. Nurse Aide Training						
a. Train the Trainer	208500				208500	0
b. Train existing aides	1799721				1509874	0
c. Retrain existing aides who fail test	404754				339415	0
d. Train new aides	1542365	1619484			1152525	1152525
e.Retrain new aides who fail test	138293	158408			71229	71229
f. Ongoing education	885659	929943			885659	929943
g. Supplies and training	143251				143251	0
h. Nurse wage increases	1258738	2643349			0	0
Total training costs	6381281	5351184	0	0	4310453	2153697
2. Nurse Staffing						
a. RN's 8 hours a day/7 days a week		82952			0	82952
b. 24 hour licensed staff		145942			0	145942
Total Nurse Staffing	0	228894	0	0	0	228894
3. Quality Assurance Committee		392345			0	47083
4. Assessments, Reviews, and Plans of Care		947658			0	775000
5. Social Services/ Elimination of SNF/ICF Diff.						
a. Social Workers		258408			0	258408
b. Qualified Dieticians		16649			0	16649
c. Pharmacy Consultatants		40622			0	40622
d. Medical Records Consultants		24273			0	24273
Total	0	339952	0	0	0	339952
6. Physician Involvement		30548			0	30548
7. Miscellaneous						
a. Patient Trust Funds		22986			0	22986
b. Privacy Curtains		452092			0	90418
Total Miscellaneous	0	475078	0	0	0	113404
Grand Total					4310453	3688578
Inflation increase factor (2% each year)					86209	134460
Total with inflation included	6381281	7765659	2723976	640320	4396662	3823038
Percentage of Medicaid at 62%	3956394	4814709	1688865	396998	2725930	2370284
Federal Funds	2815766	3426628	1938654	455716	1940045	1686931
General Funds	1140628	1388080	785322	184604	785886	693353
Total	3956394	4814709	2723976	640320	2725930	2370284
Additional Federal funds					1391	1231215
Additional General funds					563	498748
Total additional funds					1954	1729964

FOOTNOTES - OBRA COSTS ESTIMATED

1.a. Under the assumption that the Vo.-Techs will not do the training for this program; the amount of $208500 appears valid.

1.b. The MHCA survey is a more valid accounting of the number of nurses aides than what was available to the department at the time that our initial estimate was compiled. However, it appears that the MHCA was somewhat high in their estmate of the cost for this training. In addition, please note that the MHCA used an overtime rate for this training. We agree that overtime should be used. In discussions with Rose Hughes of MHCA it was learned that the average salary for an experienced aide is $4.82 per hour, the overtime rate for this hourly wage would be $7.23. See the following analysis.

Total hours estimated by MHCA (2646 emp.x 43)	113778
Times per MHCA survey cost per hour overtime	$ 7.23
Total wages for training for existing aides	$ 822615
Rn training($15.03 x 38.5hrs x 519 sessions)	$ 300322
Add: Benefits ($1122937 x 20%)	$ 224587
Total training costs for existing aides fy 1990	$ 1347524
Add:12.048% to extend costs from sample to whole pop.	162350
Total	$ 1509874

1.c. According to Rose Hughes of MHCA the expected fail rate of for the nurses aide certifying exam is 20 percent. In order to be as fair as possible it was decided to use the MHCA estimate. In addition the MHCA has estimated that 48 additional hours would be needed to train the nurses aides who failed the certifying exam to the point where they could pass this exam. Please see the following calculation of estimated retraining costs.

Total hours estimated to retrain (2646 x 20% x 48)	25402
Times estimated hourly wage	$ 7.23
Total cost estimated for retraining	$ 183656
Add:Rn salary($15.03 x 44hrs x 104 sessions)	$ 68777
Add: Benefits at 20%	$ 50486
Total retraining costs fy 1990	$ 302919
Add: 12.048 % (See footnote 1 below)	$ 36496
Total	$ 339415

1.d. The MHCA survey states that 2036 new aides have to be hired every year. This is a turnover rate of 76% a year. This turnover rate appears to be somewhat high given the fact that these people will be undergoing extensive training to obtain this job in the first place. After discussions with the departments medicaid staff, it is our estimate that the actual turnover rate would be about 55%. Therefore, the actual number of new aides would be (2646 x 55%) or 1455. This is the number that is used in our analysis below.

Total hours estimated (2646 empl. x 55% x 83 hrs)	120790
Times the starting hourly wage	x $ 4.19
Total wages paid for new aide training	$ 506149
Rn Wages ($15.02 x 82hrs x 285 sessions)	$ 351017
Add:Benefits at 20%	$ 171433
Total to train new aides fy 1990	$ 1028599
Add: 12.048% (see footnote 1 below)	$ 123926
Total	$ 1152525
Total to train new aides in fy 1991	$ 1152525

1.e. See narrative in 1.c.above.The MHCA estimates that only 28 hours would be necessary to retrain new aides to enable them to take the certifying exam. See analysis below.

Total hours estimated to retrain (1455 x 20% x 28)	8148
Times estimated hourly wage	$ 4.19
Total new aide retraining salary	$ 34140
Rn ($15.02 x 22hrs x 57 sessions)	$ 18835
Add: Benefits at 20%	$ 10595
Total costs to retrain new aides for fy 1990	$ 63570
Add: 12.048% (see footnote 1 below)	$ 7659
	$ 71229
Total costs to retrain new aides for fy 1991	$ 71229

1.f. 42CFR, Part 405.1121h currently requires that on going training be acquired. However the department cannot accurately estimate the hours of additional training that will be required due to OBRA. Therefore the MHCA estimates are accepted.

1.g. The MHCA estimate appears reasonable.

1.h. The MHCA has estimated that a $ .41 per hour wage increase will be required as a result of this training and increased demand for trained aides. However, other cost increases included

in the MHCA analysis are to cover services directly mandated by OBRA. This is an estimate of what may or may not occur. Many factors such as labor supply and demand may effect the potential wage increase to the aides. The actual amount of the wage increase to the aides cannot be accurately estimated at this time. A $ .41 per hour increase if allowed in the rate at the onset of this biennium would have a significant impact on the setting of the actual rate per hour. To set the rate per hour increase at this time would be premature, it is impossible to make an accurate prediction. Therefore a rate per hour increase is not included herein.

2.a.& b. The department accepts the MHCA estimate.

3. 42CFR, part 405.1137 requires quality assurance to be performed for all skilled nursing facilities. MHCA states that this will be required in 60% of the facilities, according to the department's records only 7% of the facilities are not rated as skilled nursing facilities. These should already have quality assurance. Therefore our estimate of this cost is $47083. The MHCA has estimated that the cost for providing quality assurance to over 60% of the facilities would be $ 392345. This estimate is reasonable if the assumption of the 60% is accepted.

4. OBRA requires that plans of care and resident assessment be prepared upon the patient's admission and annually thereafter. The MHCA report does not explain their basis for this cost of $947658. Currently many facilities already provide this service. The department has prepared an estimate of this cost based on a cost of $ 62 for each assessment, which includes 2hours of Rn time at $15 per hour, 1 hour social worker time at $12 per hour, and one hour of therapy consultant time at $20 per hour. We estimate this cost to be $ 775000 ($ 62 x # patients x 2 visits per year).

5.a. thru d. The department did not take this additional requirement into account. The MHCA estimate appears valid.

6. Same as #5 above.

7.a. Same as #5 above.

7b. Privacy curtains would have to be depreciated over a 5 year period. The cost in the first year would be $90418.

Footnote 1. The MHCA estimate was extended over only 83 of the 93 facilities. For costs to be projected over the entire nursing home population 12.048% must be addedto certain costs.

DT
1/30/89

OBRA

Executive Recommendation

		FY90	FY91
TRAINING	(FMAP)	2,725,930	2,370,284
Personal Services	(62/38)	106,097	106,107
Contracted Services	(75/25)	169,200	169,200
Federal Pass Thru	(Dept, Health)	358,802	348,693
		3,360,029	2,994,284
FUNDING:			
General	785,886 + 40,317 + 42,300 630,746 + 40,321 + 42,300	868,503	763,367
Federal		2,491,526	2,230,917
TOTAL		3,360,029	2,994,284

HCS WAIVER EXPENDITURES
FY 89

FY 88 actual expenditures (per MOB report)	$2,526,007
FY 89 increases:	
1. PCA rate increase ($2.20 X 179,527 X 2)	789,918
2. Seven new heavy care clients	500,000
3. Caseload growth	354,215
FY 89 projected expenditures	$4,170,140

INCREASE IN WAIVER EXPENDITURES

1. Increase in Personal Care Unit Rate

Personal care expenditures account for over 40% of the total waiver expenditures. In April 1988, the unit rate for personal care services increased by $2.20. Since July 1, 1988, a total of 179,527 personal care units (176,640 attendant and 2,887 nurse supervision) have been billed for a net increase in expenditures of $394,959. Assuming utilization remains the same, waiver personal care expenditures will increase by $789,918 by the end of the fiscal year.

2. Heavy Care

There are a total of 6 heavy care cases. Two new heavy care cases were enrolled as of 7/1/88. Annual cost for these cases is projected to be $500,000. These individuals would have to be served in an inpatient hospital or rehabilitation setting without waiver services.

3. Waiver Occupancy

Occupancy in the waiver has increased by 15% over FY88. Currently, 370 (235 elderly - 135 disabled) out of 424 (270 elderly and 154 disabled) slots are filled for an occupancy rate of 87%. The average cost of a waiver slot in FY88 was $5,023 for the elderly and $9,390 for the disabled. It is anticipated that all slots will be filled by the end of FY89, which results in increased expenditures of $175,805 for the elderly (35 x $5,023) and $178,410 (19 x $9,390) for a total of $354,215.

THD/011

HOME AND COMMUNITY SERVICES WAIVER

	FY 89	FY 90		FY 91	
	SRS	Executive	SRS	Executive	SRS
FY 88 Actual expenditures (per MOB report)	$2,526,007				
FY 89 increases:					
1. PCA rate increase ($2.20 x 179,527 x 2)	789,918				
2. Seven new heavy care clients	500,000				
3. Utilization increase	354,215				
Projected expenditures	$4,170,000	3,339,628	(2%) 4,253,543	3,445,871	(2%) 4,338,614
General Fund	$1,237,698	956,803	1,218,640	987,242	1,243,013
Federal Funds	$2,932,442	2,382,825	3,034,903	2,458,629	3,095,601
Total	$4,170,140	3,339,628	4,253,543	3,445,871	4,338,614

1. PERSONAL CARE RATES - Personal care expenditures account for over 40% of total waiver costs. In April 1988, the hourly rate for personal care services increased by $2.20. Since July 1, 1988 a total of 179,527 personal care units (176,640 attendant and 2,887 nurse supervision) have been billed for a net increase in expenditures of $394,959. Assuming utilization remains the same, waiver personal care expenditures will increase by $789,918 by the end of FY 89.

2. HEAVY CARE - The waiver is currently serving six heavy care clients and expects to serve seven by the end of FY 89. Persons in the heavy care category include ventilator-dependents, quadriplegics, persons with muscular dystrophy, congenital heart defects and other severe impairments requiring 24 hour care and supervision. These individuals would have to be served in a inpatient hospital or rehabilitation setting without waiver services. Annual costs for heavy care cases are projected to be $500,000.

LEGIS2/301

January 30, 1989

UPDATE ON CASELOAD FORECASTS

AFDC Caseload: Using the Forecast Plus software package, the following are the estimated caseloads:

FY89: 9,432
FY90: 9,432
FY91: 9,349

Using a 95% confidence interval, the potential ranges for the caseload are as follows:

	Minimum	Maximum
FY89:	9,290	9,574
FY90	8,835	10,028
FY91:	8,270	10,427

Because of the unexpected decrease in the caseload in FY88 and FY89 YTD, the Forecast Plus model is predicting a decline in the caseload. I feel the decline is primarily due to the low unemployment rate, and decreased statewide population. This particular forecasting model only uses historical data and thus does not take into account economic factors. For this reason we decided not to use it for long range projections but rather use a linear regression model covering 6 and 1/2 years of historical data. The linear regression indicates an average caseload growth of approximately 4% per year. When preparing the caseload estimates for the Governor's budget we used FY89 as a base and at that time we were predicting the FY89 caseload would be 9,488. See the attached sheet for adjustments to the AFDC caseload projection.

Medicaid SSI Eligibles: Whereas this group has shown a fairly constant growth of 4% per year, no change in the estimate is needed.

GA Caseload: The most recent estimates for the GA caseload are:

FY89: 1,906
FY90: 1,982
FY91: 2,061

These estimates assume a 4% caseload growth in FY90 and FY91. These estimates are somewhat less than those used in the Governor's budget. See athe attached schedule for the impact of the revised GA caseload.

\wp\update

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES — 89SESS

AFDC Caseload — 01/29/89

Forecast 1/89	Forecast 10/88	Monthly Caseload	Per Governor's Budget FY90	Per Governor's Budget FY91	Revised Estimates FY90	Revised Estimates FY91	Difference FY90	Difference FY91
9392	9392	July	9,768	10,159	9,768	10,159	0	0
9290	9290	August	9,662	10,048	9,662	10,048	0	0
9154	9154	September	9,520	9,901	9,520	9,901	0	0
9015	9097	October	9,461	9,839	9,376	9,751	(85)	(88)
8987	9229	November	9,598	9,982	9,346	9,720	(252)	(262)
9286	9335	December	9,708	10,096	9,657	10,043	(51)	(53)
9430	9479	January	9,858	10,252	9,807	10,149	(51)	(103)
9672	9721	February	10,110	10,515	10,059	10,361	(51)	(154)
9849	9898	March	10,294	10,707	10,243	10,503	(51)	(204)
9926	9975	April	10,374	10,790	10,323	10,536	(51)	(254)
9670	9720	May	10,110	10,515	10,057	10,209	(53)	(306)
9513	9563	June	9,947	10,346	9,894	9,990	(53)	(356)
113,184	113,853	Total	118,410	123,150	117,712	121,370	(698)	(1,780)
9,432	9,488	Average	9,868	10,263	9,809	10,114	(58)	(148)

Original estimate was based on FY89 forecast from 10/88 - 9,488 and 4% per year increase.
Revised estimate is based on FY89 forecast from 1/89 - 9,432 and 4% per year increase.

Assumes caseload will be reduced by 50 cases per month beginning 1/91 due to effectiveness of JOBS.
FY91 savings equals 1,050 cases times $333.00 per case or $349,650

Savings due to revised caseload estimate:
FY90: 58 cases X $333 X 12 = $231,768
FY91: 61 cases X $333 X 12 = $243,756

Recap of total savings:
FY90: $231,768
FY91: $243,756 + $349,650 = $593,554

	FY90	FY91
General Fund	$62,641	$159,809
County Funds	$4,178	$10,659
Federal Funds	$164,949	$423,085
Total	$231,768	$593,554

	FY91 Caseload Reduction
1/91	50
2/91	100
3/91	150
4/91	200
5/91	250
6/91	300
Total	1,050
12 mo. avg	88

GENERAL ASSISTANCE 01/30/89
CASELOAD REDUCTION

	FY90	FY91
10/88 Estimate	2061	2143 cases
01/89 Estimate	1982	2061
Decrease	79	82
Estimated Savings	$202,872	$210,576

STATE MEDICAL SAVINGS

	FY90	FY91
79 Cases X .34 X $1,100	$29,700	
82 Cases X .34 X $1,100		$30,800
Estimated Savings	$29,700	$30,800

Assumptions: 1. 34% of GA cases also receive State Medical
2. Average State Medical cost for this group is $1,100 per year

EXHIBIT 4
DATE 1-31-89
HB

University of Montana

Department of Communication Sciences and Disorders • Speech, Hearing, and Language Clinic
Missoula, Montana 59812 • (406) 243-4131

January 26, 1989

Senator Fred VanValkenburg
Human Services Subcommittee
Capitol
Helena, Mt.

Dear Senator VanValkenburg,

This letter is a response to your question at the hearing on January 23, 1989 concerning the requirement that speech pathology services be based on medical necessity. At the hearing I stated that the majority of preschool children now receiving speech pathology under the Medicaid program do not have a medical diagnosis and would be denied service.

Most adults with neurological injuries are now served in hospitals and nursing homes. Since these adults have obvious medical problems they would meet any stringent criteria for medical necessity. If only hospitals and nursing homes could provide service, those who currently get help from private practitioners in rural areas would have to seek help in the major cities.

The preschool children are primarily served by private practitioners. In rural areas speech pathologists employed in the public schools may provide therapy after school hours because there is no other therapist available locally. I would guess that at least 20 of the 49 speech pathologists listed by Medicaid would fall into that category. Retention of their services would help rural children. In the cities where there are private practices, patients with medical problems could shift to hospitals to get outpatient service.

Over 60% of the preschool children enrolled for therapy at the University of Montana Speech Hearing and Language Clinic do not have a medical diagnosis. Many have a history of ear infections which are now resolved. Others come from high risk families where language stimulation is poor. Subtle neurological differences are usually not medically diagnosed. These children often have normal intelligence so they do not qualify for services funded for the developmentally disabled. Their inability to talk, if untreated during the preschool years, translates into later academic failure and a need for increased

special education services once they enter school. It is this group of children who have the most favorable prognosis for improvement. The research clearly shows these children will cost society less if intervention can begin before age 5.

A new federal law mandating special education through the public schools for all children over age three will take effect in 1991. At that time Medicaid should experience a drop in patients; special education budgets for the public schools will increase.

A different approach to the problem would be to use a severity index. I agree that Medicaid should not be paying for speech pathology services for mild problems that might be outgrown. The medical diagnosis, or the lack of one, does not always predict the severity of the speech delay. For example, a child with a cleft palate who has had a good surgical repair may learn to speak normally. A child, with no medical problems, from a poor functioning family may have a severe problem.

The public schools use a severity index to determine who is eligible for speech pathology. The determination rests on the extent of the speech problem, not on the medical diagnosis. Medicaid could take this approach by funding the initial testing for all children and require prior authoization before therapy was funded. That approach would allow Medicaid to deny service to those with mild problems or those whose cognitive levels were so severely delayed the prerequisites for language were not present.

To substantiate my opinion that the majority of preschool children do not have a medical diagnosis, I did a chart review of all children seen at this clinic since September, 1988. I have compared those results with the statistics from the Ninth Annual Report to Congress on the Implementation of the Education of the Handicapped Act (1987). That report is based on public school enrollments during the 1985-86 school year. 63% of the school children receiving speech pathology did not have a second handicapping condition. 37% of the children were also classified with other handicaps such as hearing loss, mental retardation and orthopedic problems.

In this clinic 41% of the sixteen preschool children judged to have speech disorders severe enough to warrant therapy had a clearly identified medical problem. 59% had either no previous medical problems or a history of ear infections which are now resolved. Some of these chilren come from abusive or poorly functioning homes; that etiology is more prevalent in the Medicaid funded children than in the general population. An additional 5 children were seen for whom no therapy was recommended because the disorder was judged to be mild and could possibly be outgrown with minimal advice for the parents on how to help their children. I have attached an appendix explaining the chart review.

I hope the committee will retain the optional services including speech pathology. Basing eligibility for service on the severity of the speech problem is more logical than using the assumption there is a direct correlation between speech disorders and medical problems. Talking is a complex skill neurologically. Unfortunately, neither the medical profession or speech pathologists can yet diagnose why many children fail to learn to talk.

Sincerely,

Beverly Reynolds

Beverly Reynolds
Assistant Professor, Clinic Coordinator
U. of M. Speech Hearing and Language Clinic

CHART REVIEW:

UNIVERSITY OF MONTANA SPEECH LANGUAGE AND HEARING CLINIC

Preschool Children enrolled in therapy since Sept, 15, 1988.

MEDICAL DIAGNOSIS	NUMBER	MEDICAID
Hearing loss	1	1
Hearing loss + motor problems	2	1
Cleft palate	1	1
Unspecified neurological injury	1	1
Seizure disorder	1	0
Chronic ear infections (now resolved)	5	2
Downs Syndrome	1	0
No medical problems	5	3

Children who would not qualify under a strict medical necessity definition are those with resolved ear infections and those who have no medical conditions.

A total of 17 children have been enrolled. 41% or 7 children would qualify for therapy with a medical necessity definition. 57% or 10 children would be denied.

A total of 9 children are funded by Medicaid. Of these 44% or 4 children could qualify with medical problems. 56% or 5 children would be denied service.

EXHIBIT 5
DATE 1-31-89
HB

W-Memo

AMERICAN PUBLIC WELFARE ASSOCIATION 1125 FIFTEENTH STREET, N.W., WASHINGTON, D.C. 20005

Memorandum W-6

July 5, 1988

Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360)

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VISITORS' REGISTER

Human Services SUBCOMMITTEE

BILL NO. _____ DATE 1/31/89

SPONSOR _____

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