MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By Rep. Angela Russell, Chair, on January 14, 1991, at 3:00 p.m.

ROLL CALL

Members Present:

Angela Russell, Chair (D)
Tim Whalen, Vice-Chair (D)
Arlene Becker (D)
William Boharski (R)
Jan Brown (D)
Brent Cromley (D)
Tim Dowell (D)
Patrick Galvin (D)
Stella Jean Hansen (D)
Royal Johnson (R)
Betty Lou Kasten (R)
Thomas Lee (R)
Charlotte Messmore (R)
Jim Rice (R)
Sheila Rice (D)
Wilbur Spring (R)
Carolyn Squires (D)
Jessica Stickney (D)
Bill Strizich (D)
Rolph Tunby (R)

Staff Present: David Niss, Legislative Council
Jeanne Krumm, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

HEARING ON HB 93

Presentation and Opening Statement by Sponsor:

REP. JOHN COBB, House District 42, Augusta, stated that HB 93 creates a nursing home utilization fee of one dollar per day for each bed day. The purpose is to allow SRS to reimburse Medicaid and Medicare. An unofficial grey bill was given to the committee for review. **EXHIBIT 1**

Proponents' Testimony:

Julia Robinson, Director, Department of Social & Rehabilitive Services (SRS), submitted written testimony. **EXHIBIT 2**

Rose Hughes, Executive Director, Montana Health Care Association, submitted written testimony. **EXHIBIT 3**

Hank Hudson, Governor's Advisory Council on Aging, submitted written testimony. **EXHIBIT 4**

Jean Johnson, Executive Director, Montana Homes for the Aging, submitted written testimony. **EXHIBIT 5**

Opponents' Testimony:

REP. CODY stated that she represents the seniors in nursing homes. It has been stated the poor will not have to pay the fee, however, the perception of many people is that they will. SRS has stated that they are going to reimburse $9. If they are going to take that $1 tax out of that $9, then they are actually only reimbursing $8. The $1 is going to come from that Medicaid increase. Be realistic and have the courage to do something about the situation. Nursing homes are not reimbursed the way they should be. How many fees will be initiated before the real problem which is taxes is addressed?

REP. BRADLEY stated more state funds are needed to match federal Medicaid dollars. This bill is not a utilization fee; it is a selective sales tax on medical service. **EXHIBIT 6**

Jim Ahrens, President, Montana Hospital Association, submitted written testimony. **EXHIBIT 7**

Informational Testimony:

Mike Hanshew, Medicaid Services Division, Bureau Chief of Longtime Care Unit, stated there are 7,000 health care beds in Montana, that includes three state facilities which operate as licensed nursing homes. The amendments to this bill would only exclude Montana Developmental Center, Eastmont Services Center, and Warms Springs State Hospital. Of the 90% occupied beds, Medicaid pays for 62% of them. That percent is consistent with data that has been provided for the last four years. The percent of payment will fluctuate slightly with 1% or 2% occupancy and 1% or 2 % Medicaid utilization. The only additional money required would come from the General Fund and then go back to the state as income, at about $400,000. That is the cost of raising the rates to Medicaid to account for the fee. The rest of the revenue will be provided from the federal government and private payers for Medicare.

Questions From Committee Members:

REP. BOHARSKI asked why people on Medicare and Medicaid will not be required to pay this cost. **Ms. Robinson** stated at the present time the federal requirement is this tax cannot be passed on to individuals on Medicare and Medicaid.

REP. STICKNEY asked if there is new money or is this a never ending thing. **Ms. Robinson** stated that this is one reason the set provision would allow some monitoring to see if that would happen.

REP. MESSMORE asked what is the threat regarding the lawsuit. **Ms. Robinson** stated that this amendment allows nursing home providers to ask for what they believe is reasonable and cost effective. States have lost previous lawsuits over the legality of legislation similar to the proposed fee.

REP. S. RICE asked if anything in the bill would prevent the nursing home from assessing the utilization fee to private pay patients based on the patients ability to pay. **Ms. Hughes** stated that the amendment addresses what the facility can or cannot pass on.

Closing by Sponsor: **REP. COBB** closed the hearing on HB 93.

HEARING ON HB 118

Presentation and Opening Statement by Sponsor:

REP. JAN BROWN, House District 46, Helena stated that HB 118 would allow a licensed pharmacist to use a pharmacy technician to perform certain tasks that would not involve the pharmacist's judgment. They must be tasks the pharmacist can verify. Many pharmacists use technicians to free themselves to perform the important functions of patient education and counseling. As more drugs become available, pharmacists need to spend more time with the patient explaining drug interaction and other effects.

Proponents' Testimony:

Dave Runkel, Montana State Pharmacist Association, stated his support and submitted written testimony. **EXHIBIT 8**

Ann Gidel, Registered Pharmacist in Helena, stated her support and submitted written testimony. **EXHIBIT 9**

Dennis Yost, Registered Pharmacist in Helena, stated that HB 118 would change household pharmacy practice in the state. HB 118 would allow pharmacists to redirect their resources into areas that give more clinical benefits to the patient without a loss of quality.

Dee Dee Cress, Pharmacist, spoke in support of HB 118.

Donna Nopp, Pharmacy Technician, stated her support and submitted written testimony. **EXHIBIT 10**

Lori FitzGerald, Pharmacist Fort Harrison Veterans Administration Medical Center, stated her support and submitted written

testimony. **EXHIBIT 11**

John Woon, President Montana State Hospital Pharmacists, stated that as the health field changes, the well being of the patient is a major concern of pharmacists.

Jim Ahrens, President, Montana Hospital Association, stated his support.

Mark Eichler, Vice President, Montana Clinical Association of Registered Pharmacist in Helena, stated that HB 118 represents a significant step for pharmacists and the health care system in Montana. It will allow pharmacists freedom from the technical aspects of the retail setting and allow more time to discuss with patients how to take medications. Proper safeguards and guidelines are in place to verify the technical aspects.

Mary McCue, Montana State Pharmacist Association, stated that section 1 defines a pharmacy technician as a person who simply helps the pharmacist. The more significant definition is the one in the utilization plan which makes it clear that the pharmacy technician can only perform tasks that don't require the pharmacists independent judgment and are verified by the pharmacist. Section 3 sets the requirement for the technicians. It is contemplated that the pharmacists will prepare this detailed utilization plan in the pharmacy and then submit it to the board or its designee. Section 5 addresses training of the technician. The pharmacist is responsible for providing training. This training will be uniform. The statement of intent reads that the board is to prescribe the specific functions a technician may perform.

Charles Brooks, Executive Vice President, Montana Retail Association, favors HB 118.

Questions From Committee Members: None

Closing by Sponsor: **REP. JAN BROWN** closed on HB 118.

EXECUTIVE ACTION ON HB 118

Motion: **REP. SQUIRES MOVED HB 118 DO PASS.**

Discussion:

REP. BROWN stated there are amendments to HB 118 and one is not prepared.

REP. SQUIRES WITHDREW her motion.

Ms. McCue stated that in the statement of intent it is contemplated that each pharmacist may use one technician when they are performing certain tasks, but no more than two

technicians at a time are to be used overall. It is contemplated that all 650 pharmacists will use at least one technician. The plan describes how each pharmacist may use one or two technicians. If this is a problem of clarity, insert the word technicians on page 8, line 18.

Motion/Vote: **REP. BROWN** moved to adopt amendments to HB 118. Motion carried unanimously.

Motion/Vote: **REP. BROWN MOVED HB 118 DO PASS AS AMENDED.** Motion passed unanimously.

ADJOURNMENT

Adjournment: 5:40 p.m.

Angela Russell
REP. ANGELA RUSSELL, Chair

Jeanne Krumm
Jeanne Krumm, Secretary

AR/jck

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL **DATE** 1-14-91

NAME	PRESENT	ABSENT	EXCUSED
REP. ANGELA RUSSELL, CHAIR	✓		
REP. TIM WHALEN, VICE-CHAIR	✓		
REP. ARLENE BECKER	✓		
REP. WILLIAM BOHARSKI	✓		
REP. JAN BROWN	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. PATRICK GALVIN	✓		
REP. STELLA JEAN HANSEN	✓		
REP. ROYAL JOHNSON	✓		
REP. BETTY LOU KASTEN	✓		
REP. THOMAS LEE	✓		
REP. CHARLOTTE MESSMORE	✓		
REP. JIM RICE	✓		
REP. SHEILA RICE	✓		
REP. WILBUR SPRING	✓		
REP. CAROLYN SQUIRES	✓		
REP. JESSICA STICKNEY	✓		
REP. BILL STRIZICH	✓		
REP. ROLPH TUNBY	✓		

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HOUSE STANDING COMMITTEE REPORT

January 15, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 118 (first reading copy -- white) do pass as amended .

Signed: _____
Angela Russell, Chairman

And, that such amendments read:

1. Page 6, line 21.
Strike: "verifiable"
Insert: "verified"

2. Page 8, line 18.
Following: "technician"
Insert: "or technicians"

3. Page 9, line 4.
Following: "board"
Insert: "or its designee"

4. Page 9, line 7.
Following: "assigned"
Insert: ", verified"
Strike: "supervised"
Insert: "documented"

5. Page 11, line 16.
Following: "board"
Insert: "or its designee"

6. Page 11, line 17.
Following: "board"
Insert: "or its designee"

7. Page 11, line 19.
Strike: "to the board"

8. Page 11, line 21.
Following: "board"
Insert: "or its designee"

9. Page 11, line 23.
Following: "board"
Insert: "or its designee"

10. Page 11, line 25.
Following: "board"
Insert: "or its designee"

11. Page 12, line 5.
Strike: "The"
Insert: "If the board sets the fees, the"

Gray HB 93 -- Unofficial
January 11, 1991

A BILL FOR AN ACT ENTITLED: "AN ACT TO IMPOSE A UTILIZATION FEE ON EACH NURSING FACILITY FOR EACH BED DAY BEGINNING IN FISCAL YEAR 1993; TO AUTHORIZE THE DEPARTMENT OF REVENUE TO COLLECT THE FEE; TO REQUIRE PROCEEDS FROM THE FEE TO BE DEPOSITED IN THE GENERAL FUND; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because [section ~~10~~ 15] grants the department of revenue authority to adopt rules necessary to implement and administer [sections 1 through ~~10~~ 15].

It is the intent of the legislature that, in adopting rules, the department:

(1) provide procedures and forms for reporting bed days that are subject to payment of the utilization fee imposed in [section 2];

(2) establish requirements for the maintenance of records and other documents required to ensure proper payment of the utilization fee;

(3) develop a process for the estimation and collection of delinquent or unpaid fees;

(4) provide a process for the reconciliation of disputes relating to the payment of utilization fees; and

(5) establish other procedures for the efficient administration of the utilization fee.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1.** Definitions. For purposes of [sections 1 through ~~10~~ 14], unless the context requires otherwise, the following definitions apply:

(1) "Bed day" means each whole 24-hour period that a resident of a nursing facility is present in the facility and receiving skilled nursing care~~,~~ OR intermediate nursing care, ~~or intermediate developmental disability care~~ or in which a bed is held for a

resident while he is on temporary leave from the facility, regardless of the source of payment for the resident's care. The term also includes the day of a resident's admission to a nursing facility and the day of the resident's death, even though the resident is present less than a whole 24-hour period on these days.

(2) "Calendar quarter" means the period of 3 consecutive months ending March 31, June 30, September 30, or December 31.

(3) "DEPARTMENT" MEANS THE DEPARTMENT OF REVENUE.

(~~3~~4) "Nursing facility" or "facility" means a health care facility licensed by the department of health and environmental sciences as a long-term care facility to provide skilled nursing care~~,~~ OR intermediate nursing care~~, or intermediate developmental disability care~~. The term includes ~~all~~ SUCH nursing facilities, whether they are:

(a) operated as nonprofit or for-profit facilities;

(b) freestanding or part of another health care facility, or

(c) publicly or privately operated.

(5) [THIS ACT] AND THE FEE ESTABLISHED UNDER [SECTION 2] DO NOT APPLY TO FACILITIES LICENSED TO PROVIDE INTERMEDIATE DEVELOPMENTAL DISABILITY CARE AND FACILITIES REIMBURSED AS INSTITUTIONS FOR MENTAL DISEASE UNDER THE MEDICAID PROGRAM.

(~~4~~6) "Skilled nursing care"~~,~~ AND "intermediate nursing care"~~, and "intermediate developmental disability care"~~ have the same meaning as those terms are defined in 50-5-101.

(~~5~~7) "Report" means the report of bed days required in [section 3].

(~~6~~8) "Utilization fee" or "fee" means the fee required to be paid for each bed day in a nursing facility, as provided in [section 2].

NEW SECTION. **Section 2.** Utilization fee for bed days in nursing facilities. A nursing facility in the state shall pay to the department of revenue a utilization fee in the amount of $1 for each bed day in the facility.

NEW SECTION. **Section 3.** Reporting and collection of fee.

(1) A nursing facility shall report to the department of revenue, following the end of each calendar quarter, the number of bed days in the facility during the quarter. The report must be in the form prescribed by the department and is due ~~within 30 days following the end~~ ON OR BEFORE THE LAST DAY OF THE MONTH FOLLOWING THE CLOSE of each calendar quarter. The report must be accompanied by a payment in an amount equal to the fee required to be paid under [section 2].

(2) THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES SHALL PROVIDE THE DEPARTMENT AT THE END OF EACH CALENDAR QUARTER WITH A LIST OF FACILITIES AS DEFINED IN [SECTION 1(4)].

NEW SECTION. **Section 4.** Audit -- records. (1) The department of revenue may audit the records and other documents of any nursing facility to ensure that the proper utilization fee has been collected.

(2) The department may require the facility to provide records and other documentation, including books, ledgers, and registers, necessary for the department to verify the proper amount of the utilization fee paid.

(3) A facility shall maintain and make available for inspection BY THE DEPARTMENT sufficient records and other documentation to demonstrate the number of bed days in the facility subject to the utilization fee. The facility shall maintain these records for a period of at least 5 years from the date the report is due.

~~(4) The amount of the fee due based on a report must be determined by the department within 5 years after the date the report is due. Except in the case of a facility that purposely and knowingly files a false report with the intent to evade payment of the fee, the department is barred after the 5-year period from revising the report or recomputing the amount of the utilization fee owed. A proceeding for the collection of unpaid fees may not be instituted unless notice for collection of the unpaid fee is provided within the 5-year period after the report is due.~~

~~(5) A nursing facility may file an application with the department to revise a report if the application is filed within 5 years from the date the report was due.~~

NEW SECTION. **SECTION 5.** PERIODS OF LIMITATION. (1) EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, NO DEFICIENCY SHALL BE ASSESSED OR COLLECTED WITH RESPECT TO THE QUARTER FOR WHICH A REPORT IS FILED UNLESS THE NOTICE OF ADDITIONAL FEES PROPOSED TO BE ASSESSED IS MAILED WITHIN 5 YEARS FROM THE DATE THE REPORT WAS FILED. FOR THE PURPOSES OF THIS SECTIONS, A REPORT FILED BEFORE THE LAST DAY PRESCRIBED FOR FILING SHALL BE CONSIDERED AS FILED ON SUCH LAST DAY. WHERE, BEFORE THE EXPIRATION OF THE PERIOD PRESCRIBED FOR ASSESSMENT OF THE FEE, THE FACILITY CONSENTS IN WRITING TO AN ASSESSMENT AFTER THE TIME, THE FEE MAY BE ASSESSED AT ANY TIME PRIOR TO THE EXPIRATION OF THE PERIOD AGREED UPON.

(2) NO REFUND OR CREDIT SHALL BE ALLOWED OR PAID WITH RESPECT TO THE YEAR FOR WHICH A REPORT IS FILED AFTER 5 YEARS FROM THE LAST DAY PRESCRIBED FOR FILING THE REPORT OR AFTER 1 YEAR FROM THE DATE OF THE OVERPAYMENT, WHICHEVER PERIOD EXPIRES THE LATER, UNLESS BEFORE THE EXPIRATION OF SUCH PERIOD THE FACILITY FILES A CLAIM OR THE DEPARTMENT HAS DETERMINED THE EXISTENCE OF THE OVERPAYMENT AND HAS APPROVED THE REFUND OR CREDIT. IF THE FACILITY HAS AGREED IN WRITING UNDER THE PROVISIONS OF SUBSECTION (1) OF THIS SECTION TO EXTEND THE TIME WITHIN WHICH THE DEPARTMENT MAY PROPOSE AN ADDITIONAL ASSESSMENT, THE PERIOD WITHIN WHICH A CLAIM FOR REFUND OR CREDIT MAY BE FILED OR A CREDIT OR REFUND ALLOWED IN THE EVENT NO CLAIM IS FILED SHALL AUTOMATICALLY BE SO EXTENDED.

NEW SECTION. **Section ~~5~~ 6.** Penalty and interest for delinquent fees -- waiver. (1) ~~Utilization fees are delinquent if they are not paid within the time specified in [section 3]. The department shall assess a penalty of 10% of the amount of delinquent fees plus interest at the rate of 1% a month computed on the total of fees and penalty due. Interest is computed from the date the fees were due to the date of payment.~~ IF THE FEE FOR ANY FACILITY IS NOT PAID ON OR BEFORE THE DUE DATE OF THE REPORT

AS PROVIDED IN [SECTION 3(1)], THERE IS ASSESSED A PENALTY OF 10% OF THE AMOUNT OF THE FEE DUE, UNLESS IT IS SHOWN THAT THE FAILURE WAS DUE TO REASONABLE CAUSE AND NOT NEGLECT.

(2) ~~The penalty provided for in subsection (1) may be waived by the department if the facility demonstrates to the department reasonable cause for the failure to file the report or to pay the fee within the time specified in [section 3].~~ IF ANY FEE DUE UNDER [SECTION 2] IS NOT PAID WHEN DUE, INTEREST IS ADDED TO THE TAX DUE AT THE RATE OF 12% A YEAR FROM THE DUE DATE UNTIL PAID.

NEW SECTION. **Section ~~6~~ 7.** ~~Estimation of fee upon failure to file a report or pay the fee -- notice. (1) If a nursing facility fails or refuses to file the report or pay the fee within the time specified in [section 3], the department of revenue shall estimate the total number of bed days in the facility during the calendar quarter and calculate the amount of the fee due.~~ ESTIMATED FEE ON FAILURE TO FILE. (1) IF ANY FACILITY FAILS TO FILE THE REPORT AS REQUIRED, THE DEPARTMENT IS AUTHORIZED TO MAKE AN ESTIMATE OF THE FEES DUE FROM SUCH FACILITY FROM ANY INFORMATION IN ITS POSSESSION.

(2) ~~The department shall mail to the facility described in subsection (1) a notice stating the basis and amount of the fee and demanding payment of the fee, including penalties and interest. The notice must advise the facility that if payment is not made, a warrant for distraint may be filed.~~ FOR THE PURPOSE OF ASCERTAINING THE CORRECTNESS OF ANY REPORT OR FOR THE PURPOSE OF MAKING AN ESTIMATE OF BED DAY USE OF ANY FACILITY WHERE INFORMATION HAS BEEN OBTAINED, THE DEPARTMENT SHALL ALSO HAVE POWER TO EXAMINE OR TO CAUSE TO HAVE EXAMINED BY ANY AGENT OR REPRESENTATIVE DESIGNATED BY IT FOR THAT PURPOSE ANY BOOKS, PAPERS, RECORDS, OR MEMORANDA BEARING UPON THE MATTERS REQUIRED TO BE INCLUDED IN THE REPORT AND MAY REQUIRE THE ATTENDANCE OF ANY OFFICER OR EMPLOYEE OF THE FACILITY RENDERING SUCH REPORT OR THE ATTENDANCE OF ANY OTHER PERSON HAVING KNOWLEDGE IN THE PREMISES AND MAY TAKE TESTIMONY AND REQUIRE PROOF MATERIAL FOR ITS INFORMATION.

NEW SECTION. **SECTION 8.** DEFICIENCY ASSESSMENT -- HEARING.

(1) IF THE DEPARTMENT DETERMINES THAT THE AMOUNT OF FEES DUE ARE GREATER THAN THE AMOUNT DISCLOSED BY THE REPORT, IT SHALL MAIL TO THE FACILITY A NOTICE OF THE ADDITIONAL FEES PROPOSED TO BE ASSESSED. WITHIN 30 DAYS AFTER THE MAILING OF THE NOTICE, THE FACILITY MAY FILE WITH THE DEPARTMENT A WRITTEN PROTEST AGAINST THE PROPOSED ADDITIONAL FEES, SETTING FORTH THE GROUNDS UPON WHICH THE PROTEST IS BASED, AND MAY REQUEST IN ITS PROTEST AN ORAL HEARING OR AN OPPORTUNITY TO PRESENT ADDITIONAL EVIDENCE RELATING TO ITS FEES LIABILITY. IF NO PROTEST IS FILED, THE AMOUNT OF THE ADDITIONAL FEES PROPOSED TO BE ASSESSED BECOMES FINAL UPON THE EXPIRATION OF THE 30-DAY PERIOD. IF SUCH PROTEST IS FILED, THE DEPARTMENT SHALL RECONSIDER THE PROPOSED ASSESSMENT AND, IF THE FACILITY HAS SO REQUESTED, SHALL GRANT THE FACILITY AN ORAL HEARING. AFTER CONSIDERATION OF THE PROTEST AND THE EVIDENCE PRESENTED IN THE EVENT OF AN ORAL HEARING, THE DEPARTMENT'S ACTION UPON THE PROTEST IS FINAL WHEN IT MAILS NOTICE OF ITS ACTION TO THE FACILITY.

(2) WHEN A DEFICIENCY IS DETERMINED AND THE FEES BECOME FINAL, THE DEPARTMENT SHALL MAIL NOTICE AND DEMAND TO THE FACILITY FOR PAYMENT, AND THE FEES SHALL BE DUE AND PAYABLE AT THE EXPIRATION OF 10 DAYS FROM THE DATE OF SUCH NOTICE AND DEMAND. INTEREST ON ANY DEFICIENCY ASSESSMENT SHALL BEAR INTEREST FROM THE DATE SPECIFIED IN [SECTION 6] FOR PAYMENT OF THE FEES. A CERTIFICATE BY THE DEPARTMENT OF THE MAILING OF THE NOTICES SPECIFIED IN THIS SUBSECTION SHALL BE PRIMA FACIE EVIDENCE OF THE COMPUTATION AND LEVY OF THE DEFICIENCY IN THE FEES AND OF THE GIVING OF THE NOTICES.

NEW SECTION. **SECTION 9.** CLOSING AGREEMENTS. (1) THE DIRECTOR OF REVENUE OR ANY PERSON AUTHORIZED IN WRITING BY HIM IS AUTHORIZED TO ENTER INTO AN AGREEMENT WITH ANY FACILITY RELATING TO THE LIABILITY OF SUCH FACILITY IN RESPECT TO THE FEES IMPOSED BY THIS CHAPTER FOR ANY PERIOD.

(2) ANY SUCH AGREEMENT IS FINAL AND CONCLUSIVE, AND EXCEPT UPON A SHOWING OF FRAUD OR MALFEASANCE OR MISREPRESENTATION OF A

MATERIAL FACT:

(a) THE CASE MAY NOT BE REOPENED AS TO MATTERS AGREED UPON OR THE AGREEMENT MODIFIED BY ANY OFFICER, EMPLOYEE, OR AGENT OF THIS STATE; AND

(b) IN ANY SUIT, ACTION, OR PROCEEDING UNDER SUCH AGREEMENT OR ANY DETERMINATION, ASSESSMENT, COLLECTION, PAYMENT, ABATEMENT, REFUND, OR CREDIT MADE IN ACCORDANCE THEREWITH, THE AGREEMENT MAY NOT BE ANNULLED, MODIFIED, SET ASIDE, OR DISREGARDED.

NEW SECTION. **SECTION 10.** CREDIT FOR OVERPAYMENT -- INTEREST ON OVERPAYMENT. (1) IF THE DEPARTMENT DETERMINES THAT THE AMOUNT OF FEES, PENALTY, OR INTEREST DUE FOR ANY YEAR IS LESS THAN THE AMOUNT PAID, THE AMOUNT OF THE OVERPAYMENT SHALL BE CREDITED AGAINST ANY FEES, PENALTY, OR INTEREST THEN DUE FROM THE FACILITY AND THE BALANCE REFUNDED TO THE FACILITY OR ITS SUCCESSOR THROUGH REORGANIZATION, MERGER, OR CONSOLIDATION OR TO ITS SHAREHOLDERS UPON DISSOLUTION.

(2) EXCEPT AS PROVIDED IN SUBSECTIONS (a) AND (b), INTEREST SHALL BE ALLOWED ON OVERPAYMENTS AT THE SAME RATE AS IS CHARGED ON DELINQUENT FEES DUE FROM THE DUE DATE OF THE REPORT OR FROM THE DATE OF OVERPAYMENT (WHICHEVER DATE IS LATER) TO THE DATE THE DEPARTMENT APPROVES REFUNDING OR CREDITING OF THE OVERPAYMENT. INTEREST SHALL NOT ACCRUE DURING ANY PERIOD THE PROCESSING OF A CLAIM FOR REFUND IS DELAYED MORE THAN 30 DAYS BY REASON OF FAILURE OF THE FACILITY TO FURNISH INFORMATION REQUESTED BY THE DEPARTMENT FOR THE PURPOSE OF VERIFYING THE AMOUNT OF THE OVERPAYMENT. NO INTEREST SHALL BE ALLOWED:

(a) IF THE OVERPAYMENT IS REFUNDED WITHIN 6 MONTHS FROM THE DATE THE REPORT IS DUE OR FROM THE DATE THE RETURN IS FILED, WHICHEVER IS LATER; OR

(b) IF THE AMOUNT OF INTEREST IS LESS THAN $1.

(3) A PAYMENT NOT MADE INCIDENT TO A BONA FIDE AND ORDERLY DISCHARGE OF ACTUAL UTILIZATION FEE LIABILITY OR ONE REASONABLY ASSUMED TO BE IMPOSED BY THIS LAW SHALL NOT BE CONSIDERED AN OVERPAYMENT WITH RESPECT TO WHICH INTEREST IS ALLOWABLE.

NEW SECTION. **SECTION 11.** APPLICATION FOR REFUND -- APPEAL FROM DENIAL. IF THE DEPARTMENT DISALLOWS ANY CLAIM FOR REFUND, IT SHALL NOTIFY THE FACILITY ACCORDINGLY. AT THE EXPIRATION OF 30 DAYS FROM THE MAILING OF THE NOTICE, THE DEPARTMENT'S ACTION SHALL BECOME FINAL UNLESS WITHIN THE 30-DAY PERIOD THE FACILITY APPEALS IN WRITING FROM THE ACTION OF THE DEPARTMENT TO THE STATE TAX APPEAL BOARD. IF SUCH APPEAL IS MADE, THE BOARD SHALL GRANT THE TAXPAYER AN ORAL HEARING. AFTER CONSIDERATION OF THE APPEAL AND EVIDENCE PRESENTED, THE BOARD SHALL MAIL NOTICE TO THE TAXPAYER OF ITS DETERMINATION. THE BOARD'S DETERMINATION IS FINAL WHEN IT MAILS NOTICE OF ITS ACTION TO THE TAXPAYER.

NEW SECTION. **Section ~~7~~ 12.** Warrant for distraint. If the utilization fee is not paid when due, the department of revenue may issue a warrant for distraint as provided in Title 15, chapter 1, part 7. ~~The resulting lien has precedence over any claim, lien, or demand filed and recorded after the lien under the warrant is perfected.~~

NEW SECTION. **Section ~~8~~ 13.** Disposition of fee. All proceeds from the collection of utilization fees, including penalties and interest, must be deposited in ~~the state general fund~~ AN ACCOUNT IN THE STATE SPECIAL REVENUE FUND TO BE USED FOR MEDICAID REIMBURSEMENT TO LONG TERM CARE FACILITIES.

NEW SECTION. **Section ~~9~~ 14.** Relation to other taxes and fees. The utilization fee imposed under [section ~~32~~] is in addition to any other taxes and fees required by law to be paid by nursing facilities.

NEW SECTION. **Section ~~10~~ 15.** Rulemaking authority. The department of revenue may adopt rules necessary to implement and administer [sections 1 through ~~10~~ 15].

NEW SECTION. **Section ~~11~~ 16.** Codification instruction. [Sections 1 through ~~10~~ 15] are intended to be codified as an integral part of Title 15, and the provisions of Title 15 apply to [sections 1 through ~~10~~ 15].

NEW SECTION. **SECTION 17.** IF [LC 981] IS PASSED AND APPROVED

AND IF IT INCLUDES A SECTION ADOPTING A UNIFORM TAX APPEAL PROCEDURE THEN THE LANGUAGE CONTAINED IN [SECTIONS 8(1) AND 11] IS VOID AND THE PROVISIONS OF [LC981] SHALL GOVERN THE APPEAL PROCEDURES.

NEW SECTION. **Section ~~12~~ 18.** Effective dates -- applicability. (1) [Sections ~~10, 11,~~ 15, 16, and this section] are effective October 1, 1991.

(2) [Sections 1 through ~~9~~ 14] are effective July 1, 1992, and apply to all bed days on or after July 1, 1992.

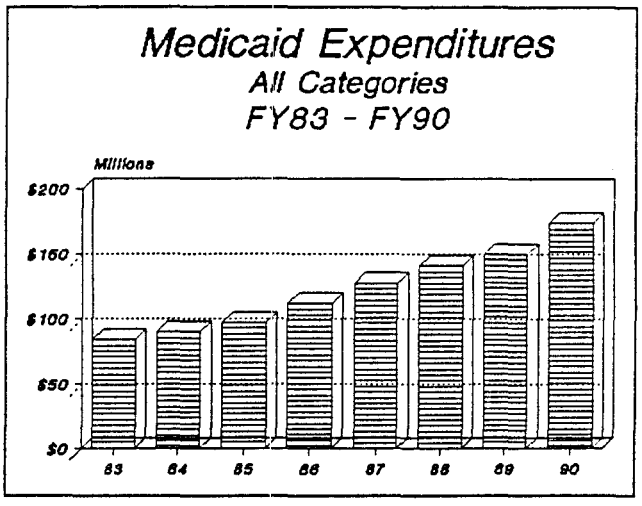
NEW SECTION. **SECTION 19.** TERMINATION. [THIS ACT] TERMINATES JUNE 30, 1993.

DATE 1-14-91
HB 93

Presentation User Fee
Health and Human Services and Aging Committee

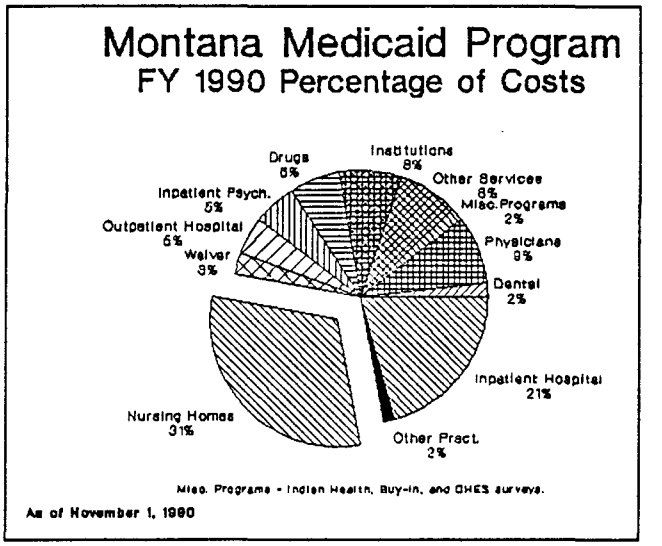
Good afternoon, Chairman Russell and members of the committee. Thank you for the opportunity to testify.

As director of SRS, I represent the portion of health care financing in this country that covers the poor. This program is known as Medicaid. The other public program is Medicare for the elderly and some disabled. In Montana our costs in Medicaid have grown from $78 million in 1982 to over $187 million in 1991 or an increase of 140% and we estimate costs in Medicaid will continue to grow to $234 million in fiscal year 1993. The costs of Medicaid are shared, 28% state and 72% federal. In 1989 expenditures for Medicaid alone accounted for approximately 13.5% of Montana's entire general fund.

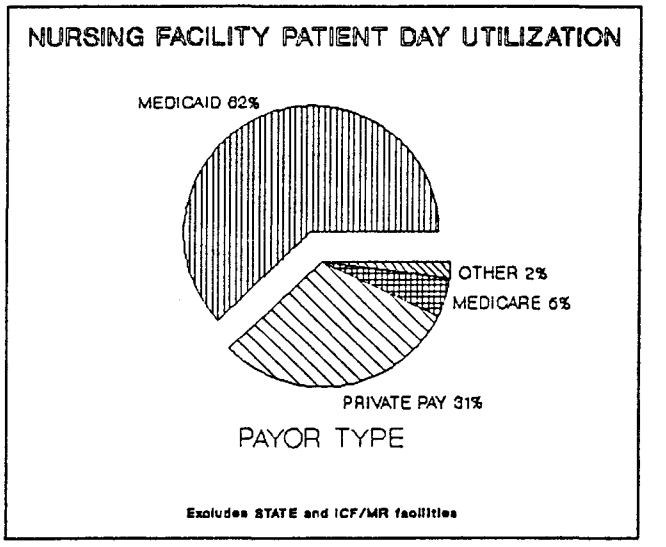


The dilemma for those of us involved in government policy making is that in spite of huge increases in the last decade in government spending in the health care area, the hard facts are that we are not providing equal access to services and we are not meeting provider costs in all service areas.

Licensed nursing facilities are the most widely available long term care service option purchased with public funds in Montana. In 1990 nursing home payments accounted for 31% of all Medicaid expenditures. There are 98 licensed nursing homes in the state, with a total of about 7,000 beds. Facilities range in size from 6 to 278 beds. Nursing homes are located in fifty-three of Montana's fifty-six counties.



Medicaid is the primary payer of nursing home costs. Montana Medicaid pays for 62% of all nursing home beds in the state. Only about 7% of all nursing beds are paid by Medicare or other insurers. Thirty-one percent are private pay.

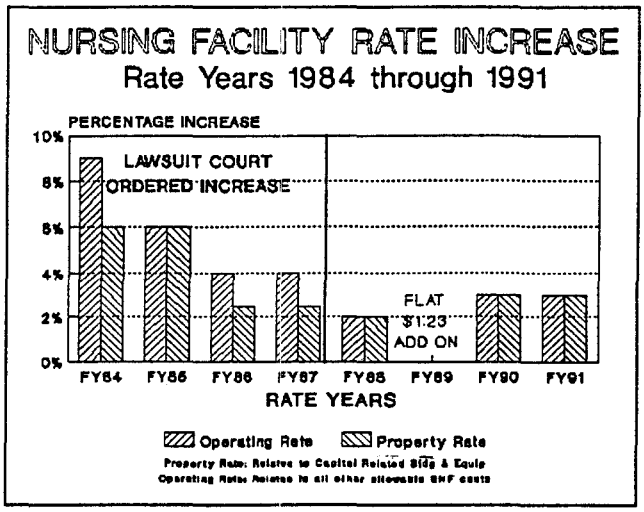


In the past, the two major factors affecting nursing home costs have been the growth in the number of licensed nursing home beds, and the level of reimbursement provided to facilities. Over the past five years the number of licensed nursing home beds has

increased at about 2% per year.

The second major factor affecting rising costs is the rate the state is willing to pay. Reimbursement rates for nursing facilities are established by the Medicaid Services Division of SRS. The system for developing rates is very complicated and takes fiscal experts to decipher. There are a couple of key points, however, that laymen such as myself have to know in order to understand how we got to the financial point we are at today.

First, all Medicaid programs are required to be in compliance with the "Boren Amendment" (See Attachment 1) that says states must set reimbursement rates that are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities. When states have failed to adjust rates in a reasonable manner, providers have successfully gone to court to secure more funding. Montana, in fact, was sued in 1984 and, in an out of court settlement, Medicaid rates were increased between 9% and 4% from 1984 through 1987. Since 1987, when the settlement agreement lapsed, rate increases have averaged less than three percent per year.



After the last legislature, the nursing home providers met with me and asserted that Medicaid reimbursement rates for nursing facilities were inadequate and did not meet the criteria established by the Boren Amendment. Specifically, nursing homes contended that the rate increases over the past several years have failed to keep pace with the rising costs of providing care.

I researched my options at length. After such research, it became clear to me that states that had been sued and lost in court, have had to spend considerably more money on back payments, etc. than would have been spent at tax payers expense had the state chosen a more direct method of addressing the problem. This does not take into consideration the costs of the lawsuit to the public or the wear and tear on agency staff of being in an adversarial role with the very agencies they are supposed to be working with.

In addition to the threats of a lawsuit, there are several other even more insidious results of a state failing to adequately fund nursing homes. I believe these are important considerations for you to take into account as you establish laws which provide direction for public policy. These considerations are:

1. Are we providing adequate state funding to insure ongoing quality care by quality staff?
2. Is the state's failure to adequately fund facilities resulting in an onerous cost shift to private pay residents or to

county governments which operate 20% of the homes? Data gathered in 1989 indicate that a private pay resident paid an average of 10% more than Medicaid per bed per day for the same level of service. This figure does not include additional charges residents may have paid that are not included in the rate.

With the three goals of (a) improving quality of service, (b) preventing cost shifting to the private pay and (c) avoiding a lawsuit which the state probably couldn't win and would be more costly than correctly addressing the problem in the first place, I agreed to finance a reimbursement study and present the legislature the findings of this study. The study, completed by a nationally recognized independent consulting firm, showed that Medicaid nursing home reimbursement in Montana is substantially less than the identified cost of providing care. It's important to remember that states are not required to reimburse all costs. Medicaid rates must, however, be reasonable and adequate in order to comply with the Boren Amendment.

SRS is proposing a nursing home rate increase that complies with the federal requirements, but more importantly will enable nursing facilities to provide quality care. In fiscal year 1992 average Medicaid reimbursement would go from $56.00 to about $60.00 dollars per day. The following year, rates would rise an additional $4.00 per day. This represents about a six and one-half percent increase

in reimbursement rates for each of the next two years. The total cost to the general fund of this initiative is about 4.5 million dollars for the biennium.

When my staff first brought me these cost estimates, I was appalled at their size and the impact on the SRS budget. The Governor has been very generous with SRS and has allocated more than 17.9 million dollars in new general fund to the agency. However, as you can see, without identifying an additional revenue source, this increase would gobble up a major part of the SRS new funds like an out-of-control pack man. This gobbling is done at the expense of other programs such as children's health, handicapped services, welfare reform, the home and community based waiver for elderly and disabled, all of which I believe deserve equal attention.

Given that I felt we had to meet our commitment to providers but at the same time I felt it was unconscionable not to fund other needs in the SRS budget, I asked my staff to research how other states were trying to meet the ever increasing costs of Medicaid. They came back with a variation of a creative financing approach currently used in California, Florida, Georgia, Ohio, Tennessee and Texas. The approach is to assess $1.00 per day on every occupied nursing home bed in order to raise a large portion of the state funds required for the nursing home reimbursement increase. When we developed this proposal last summer we included funds in the SRS

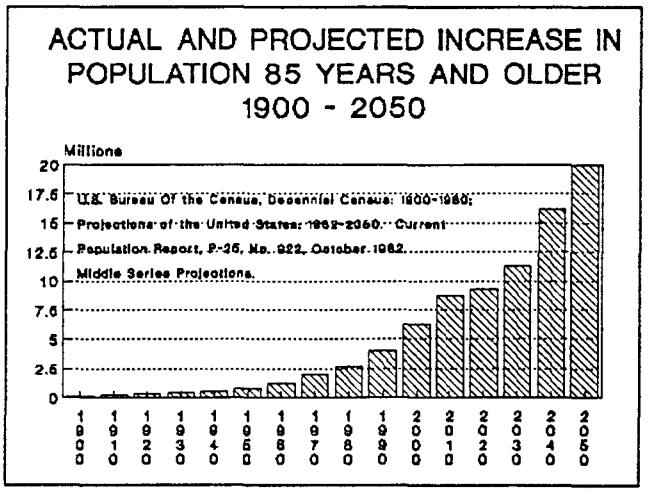
budget to raise nursing home rates an additional $1.00 per day to pay the utilization fee. Because the federal government pays 72% of each dollar spent, there are obvious advantages to the state to include the payment of the fee in facilities' reimbursement rates. Modifications to federal law in the past several months have changed the mechanics of the way the funds will be delivered, but the amount of money providers will receive remains the same. The fee is expected to raise 2.3 million dollars per year in revenue for the state to use as matching funds in the nursing home program.

We have called the proposal a utilization fee. Some groups have derogatorily labeled it a bed tax. The name at this point is irrelevant. What is relevant is that this proposal takes a creative approach to financing a growing segment of the state budget by taking advantage of the substantial federal match the state of Montana receives from the federal government. Through a small investment of state funds, the state is rewarded with a large return in federal dollars.

Medicaid recipients, in other words, low income individuals, will not pay the fee from their own funds, nor will Medicare recipients, a group of people who do not necessarily have low incomes. By law the cost cannot be passed on to these individuals. For private pay persons, it is up to the facility to decide whether or not to pass along the cost. It is our hope with the substantial new funds in state money, this cost would not be passed on. We have been told

by facilities, however, they probably will pass the cost on. Even in this case there should be a long term cost savings to private pay through reduced cost shifting of Medicaid costs. An additional benefit to persons paying for their own care is the improvement in services the additional Medicaid dollars should bring.

I think there is another public policy issue at stake here. The costs that we are looking at today to provide elderly services represent just the tip of the iceberg in potential public costs as we look towards the future. We are experiencing a dramatic increase in the number of seniors in the United States, especially in the over 85 age group. This is occurring at a time when the number of working taxpayers is going down. There are presently four tax payers for every senior. When the babyboom generation retires there will be four seniors for every tax payer. It is imperative that we begin looking at ways to finance necessary services as the babyboomers age, and part of that answer has to lie with those receiving the service. We think that this proposal helps us in Montana begin that process.



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In summary, the need for this bill is a direct outgrowth of Montana's failure to keep up with the increasing costs of nursing home rates over time and the need to look at creative ways of financing the ever increasing costs of human services. I am sorry for this lengthy and technical explanation. However, I believe it is essential that you as representatives of the people understand the problems of administering this complex program so you can make well informed decisions. I would appreciate your support of this creative opportunity.

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Attachment 1

Boren Amendment (1396a)

A State Plan for medical assistance must provide for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title) for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title) which the State finds, **and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards** and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to impatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports.

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MONTANA
HEALTH
CARE
ASSOCIATION

36 S. Last Chance Gulch, Suite A · Helena, Montana 59601
Telephone (406) 443-2876 · FAX (406) 443-4614

January 14, 1991

HOUSE HUMAN SERVICES AND AGING COMMITTEE

HOUSE BILL 93 - NURSING HOME USER FEE

TESTIMONY OF MONTANA HEALTH CARE ASSOCIATION

For the record, I am Rose Hughes of Helena, Executive Director of the Montana Health Care Association, an association representing 75 of Montana's 95 skilled and intermediate care facilities. We are here to offer testimony in support of House Bill 93 and the amendments proposed by Representative Cobb.

For at least the last two legislative sessions, our association has stressed the need for increased Medicaid reimbursements to nursing homes, stating that the gap between what we are paid and what it actually costs to provide nursing home care to Medicaid beneficiaries is widening. Our assertions have now been confirmed by an independent study contracted by the Dept. of Social and Rehabilitation Services.

The final report, dated July 1990, concludes that the gap between costs and rates was $2.86 in 1986 and has grown to nearly $9 during the current fiscal year. This is happening at a time when new federal regulatinos are requiring costly changes in the way we provide care.

While our nursing homes have some concerns about this proposal, which assesses a provider-specific fee against the services they offer, we feel that House Bill 93, particularly with the amendments offered by Rep. Cobb which insure that the funds generated will be used in the manner intended and which sunset this fee at the end of the biennium, is a reasonable approach to financing a portion of the increased reimbursement that is required if the state Medicaid program is to begin to fill the gap between costs and rates and meet its obligations under federal law.

This fee allows the state to rebase Medicaid reimbursement rates to our facilities, maximizing the use of federal funds. We believe this is a desirable goal.

It is very important that the Medicaid program pay its proper share of the costs of providing care to nursing home patients. Our facilities lose approximately $9 per patient day caring for Medicaid beneficiaries. These costs are shifted to those patients who pay for their own care. In addition to the

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legal requirements that rates reimburse the reasonable costs associated with providing nursing home care, equity demands that the gap be closed and the cost shift reduced.

We urge your support of House Bill 93 and the amendments offered by Rep. Cobb.

Thank you for the opportunity to express our views. I would be happy to answer any questions you may have or to provide additional information.

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F. Projection of Costs

1. Average Per Day Cost Projection for Fiscal Year 1991

Average per day cost from 1987 cost per day analysis (Source: Medicaid days weighted average cost from 1990 findings file.)	$ 50.34
Index trend adjustment (DRI Health Care Costs, Nursing Home Market Basket adjustment from the mid-quarter of cost report to fourth quarter 1990. This is equal to a 25% increase over 1987.)	12.59
Adjust for OBRA '87 requirements (See discussion later in this section.)	1.92
Average per day cost projection to Fiscal Year 1991	$ 64.85
Estimated Annual Medicaid Resident Days (Source: FY1990 Medicaid days per SRS)	1,289,322
Total (Average per day cost projection times estimated resident days.)	$ 83,612,500
Less Estimated Patient/Resident Obligation (Recent average of $14.34 per day trended forward to FY 1991)	$ 18,862,800
Projected Cost to be Allocated to Federal and State Shares	$ 64,749,700
Less Estimated Allocation to Federal Share (Using State FY91 blended FMAP of 71.64%)	$ 46,386,700
Projected State Share Allocation	$ 18,363,000

Note: This projection is based on an estimate of weighted average cost of nursing facility services in Montana and does not imply any particular level of funding. Nothing presented here implies any particular level of Medicaid funding. Such issues are policy decisions, properly made by the state agency in accordance with Medicaid program requirements. See also Section 4.G. and 4.H. of this report.

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funds, the general fund appropriation in DFS would be decreased and the general fund appropriation in SRS would be increased by a like amount. The total appropriated by the legislature for provision of the service would remain the same.

Caseload and expenditure growth projections have been included in the base in the nursing home, primary care, medicare buy-in, and state medical portions of the budget. The medicare buy-in budget was reduced in the base to reflect actual FY90 expenditure patterns projected into the 1993 biennium. Projections of primary care for FY92-93 have been included in the base. The primary care estimates included in the executive recommendation are based upon September 1990 month-end paid claims data and a model jointly established among the department, LFA, and OBPP. The primary care projections included in this budget are approximately $25 million higher in FY92 and $40 million higher in FY93 than the actual FY90 expenditure. A requirement of OBRA 89 that medicaid eligibility be extended to pregnant women whose family income is less than 133% of the federal poverty level and to children up to age six was effective April 1, 1990, and has been taken into account in the base primary care projections. Adjustments downward for the effect of continuing cost containment, refunds, and state medical transfers to medicaid reduce these amounts by $2.8 million in each fiscal year.

Decreases to the base have been included as follows:
1. A significant reduction in the state medical program is proposed which will provide service in the 12 state-assumed counties more closely attuned to service provided in the remaining 44 non-state-assumed counties. Savings from this initiative will be available to provide funding for the recommended program increases outlined below.
2. The base for nursing home expenditures was originally established by increasing the FY91 appropriation 4% per year. As additional data has become available, the actual FY90 bed-days are lower than anticipated by the 1989 Legislature. A decrease to the nursing home base to reflect this lower number of bed-days is recommended. Savings are available to assist in funding the recommended increase outlined below to re-base nursing home medicaid rates.
3. The base contained federal funds for reimbursement of the medicaid share of the survey and certification activities of the Department of Health and Environmental Sciences (DHES). As of FY91, DHES has access to bill directly the federal government for these costs. Therefore, the funds need no longer be appropriated in the SRS budget.
4. Transfer of the general fund portion of the budget for in-patient youth psychiatric services to the Department of Family Services is recommended during the 1993 biennium. DFS will utilize these funds, along with other current and increased funding in that department, to provide a continuum of care for youth psychiatric services through in-patient hospitals, residential facilities, and community-based therapeutic group and foster care settings.
5. Revenue projections indicate that the 12-mill levy for state-assumed counties will produce revenue slightly below the FY91 base in FY92 and above the FY91 base in FY93. General fund in the base would change a like amount. This revenue is budgeted in the medicaid primary care area.
6. Legislation will be introduced to allow a portion of the income generated for the state by the Child Support Enforcement Program to be used as state match for medicaid expenditures. The recommended budget includes approximately $500,000 of such funding in the 1993 biennium for primary care.
7. Implementation in FY92 of The Economic Assistance Eligibility Management System (TEAMS) computer system is projected to reduce medicaid expenditures below projections by approximately $2.6 million in FY92 and $3.1 million in FY93.

The following Medicaid Services Program increases are recommended:
1. An increase in the contracted services budget to include study of hospital rates, a managed care system for the state medical program, and increased nursing home audits is proposed. The 1993 biennium cost of this recommendation is $666,760 of which $483,380 is general fund and the remainder is federal revenue.

2. Extension of a FY91 budget amendment into FY92 for the Baby your Baby project which is contracted to DHES will match private donations with federal medicaid funds. FY92 cost of the increase is $268,000. The program is operated by DHES under the authority provided by the Montana Initiative for the Abatement of Mortality in Infants (MIAMI) Act (HB773).

3. Implementation of the OBRA 87 requirement of treatment for developmentally disabled nursing home residents who either choose to remain in a nursing home or move to a community placement is recommended for FY93. Estimated cost of the program is $644,600 general fund and $762,470 federal revenue.

4. An increase in nursing home rates, paid under the Medicaid Program, to be partially offset by a $1.00 per bed-day user fee is recommended. The fee would be implemented in FY93 and is projected to produce approximately $2.2 million in revenue to the general fund. The portion of this fee attributable to medicaid patients (approximately 62%) would be reimbursed through the rate structure to the facilities at a cost of $391,350 general fund and $1,001,354 federal revenue. Income from the fee would be placed in the general fund, thus providing matching funds for a portion of the proposed rebased rate. The estimated cost of the provider increase to rebase rates is $4.5 million general fund and $11.4 million federal revenue over the 1993 biennium.

5. An expansion of the medicaid home and community-based waiver will provide home-based services to an additional 38 people during FY92 and an additional 12 people during FY93 for a total increase of 50 slots during the biennium. The estimated cost of this recommendation is $175,000 general fund and $446,000 federal revenue over the 1993 biennium.

6. A 20% increase in dentist fees, for children only, is recommended. This increase will raise medicaid payments from 65.5% of charges to 79%. Cost of this recommendation is approximately $122,000 general fund and $312,000 federal revenue over the 1993 biennium.

7. The federally-funded portion of the addition of residential youth psychiatric services as mandated by OBRA 89 is recommended. The general fund portion of the program is included in a recommended increase in the Department of Family Services budget. Approximately $9 million in federal revenue is included in the SRS budget over the 1993 biennium.

8. A medicaid rate increase to 90% of the average allowance of private insurers for obstetric services and to 80% for pediatric services is proposed. This increase will add approximately $6.6 million to obstetric fees and $3 million dollars to pediatric fees paid by medicaid in the 1993 biennium. Approximately $2.7 million of the increase is general fund and $6.9 million is federal revenue.

donations matched by 50 percent federal funding. The program addresses access of pregnant women to medical care, healthy habits during pregnancy, and other pregnancy-related issues. Media public service announcements and posters and pamphlets are used to reach as many women as possible. This modification is also a component of the "Kids Count" initiative.

Obstetric/Pediatric Rate Increases

The Executive Budget includes $9,685,501 to increase medicaid reimbursement rates to physicians for providing obstetrical and pediatric services to medicaid recipients. Federal regulations specifically require states to document that these services are available to medicaid recipients at least to the extent that the services are available to the general population in a geographic area.

Hospital Rate Rebase

The Executive Budget includes $4,368,271 to increase medicaid reimbursement rates for services provided by hospitals to medicaid recipients in fiscal 1993. Federal regulations require states to set medicaid rates which cover costs incurred by efficiently and economically operated facilities in complying with medicaid regulations. This modification will allow medicaid reimbursement rates to cover a larger portion of hospital costs.

Nursing Home Rate Rebase

The Executive Budget includes $15,896,161 to increase medicaid reimbursement rates to nursing homes based on more recent cost data. A nursing home reimbursement study, conducted to determine the actual costs incurred by nursing facilities, found that current medicaid reimbursement rates fell short of meeting facility costs. This modification will permit the phasing-in of higher rates costing $5.154 million in 1992 and $10.742 million in 1993.

Nursing Home Fee Adjustment

Beginning in fiscal 1993, the executive proposes to levy a $1.00 per bed day-user fee in all nursing facilities within the state. The revenue would be deposited in the state general fund to partially offset the cost of proposed nursing home medicaid rate increases. The Executive Budget includes $1,392,704 in addition to the $15,896,161 listed above for increased medicaid reimbursement to nursing facilities.

Ambulance Provider Rate Increase

The Executive Budget includes $987,836 to increase medicaid reimbursement rates for ambulance services provided to medicaid recipients. According to department staff, ambulance medicaid reimbursement rates have been frozen since 1982, except for the annual 2 percent increases approved for the 1991 biennium. Department staff estimate that ambulance providers are currently reimbursed approximately 50 percent of their cost of providing basic life support services and only 10 percent of costs for advanced life support and air ambulance services.

Medicaid Waiver Expansion

The Executive Budget includes $621,065 to expand home and community-based waiver services for elderly and disabled persons as an alternative to placement in nursing facilities. According to department records, there were 21 elderly and 73 disabled persons waiting for waiver services as of September 1990.

Health Clinic Expansion

The Executive Budget includes $130,000 to provide reimbursement to all community and migrant health clinics currently funded under the Public Health Act. According to department staff, states have, in the past, been able to limit covered services in these facilities but now must reimburse for all services provided by these facilities.

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GOVERNOR'S OFFICE ON AGING

STAN STEPHENS, GOVERNOR

(406) 444-3111

STATE OF MONTANA

CAPITOL STATION
HELENA, MONTANA 59604

January 14, 1991

To: House Human Services Committee
Chairperson Rep. Angela Russell

From: Hank Hudson, Aging Coordinator

Re: Testimony regarding HB 93,
Nursing Home Bed Utilization Fee

As the Governor's Coordinator on Aging I support the proposed 1$ per day utilization fee for nursing home beds. This fee represents a realistic and effective means for increasing the Medicaid reimbursement rate for nursing home services.

The Governor's Advisory Council on Aging works with the Coordinator to listen to the views of Montana's senior citizens and advise the Governor based on those views. This group has also reviewed and endorsed this proposal. During our deliberations we considered a number of factors, including:

1. Does this proposal place an unfair burden on the elderly and disabled, particularly the low-income nursing home residents?

2. Will this proposal contribute to a better quality of life for individuals residing in nursing homes?

3. Does this proposal offer the potential to reduce the current cost shifting which is responsible for considerably higher rates for private pay residents than Medicaid residents?

The Council determined that this proposal will not burden the lower-income residents because as Medicaid residents their $40/month personal needs allowance will remain the same. It has the potential to improve the quality of life for all residents by allowing facilities the resources to hire more staff, and to provide more training and reimbursement for staff. Finally, increased Medicaid reimbursement rates will relieve some of the pressure on private pay residents to compensate for uncompensated care of Medicaid recipients.

The Long-term Care working group of the Governor's "Health Care For Montanans" project has also endorsed this proposal. This group included representatives of the Governor's Advisory Council on Aging as well as the Area Agency on Aging Association.

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Montana Association of Homes for the Aging
P.O. Box 5774 • Helena, MT 59604 • (406) 443-1185

Testimony in Support of HB 93
(House) Human Services and Aging Committee
January 14, 1991

For the record, my name is Jean Johnson and I am the executive director of the Montana Association of Homes for the Aging, representing retirement, personal care and nursing homes.

HB 93 has probably generated as much rhetoric as will any measure dealing with nursing homes this session. You've had testimony that traces the history of the legislature's underfunding of nursing homes in Montana, and you've had testimony of what has led us to HB 93 and exactly how it will work.

My purpose today is to go on record with this committee reporting that the Montana Association of Homes for the Aging supports HB 93. We should add here that the two amendments — the 1993 sunset and the earmarking of funds — has contributed a great deal to our decision to support this measure.

While no one is anxious to see a fee levied against nursing home beds, we believe that extreme measures will likely be necessary to ensure a more adequate funding for nursing homes that serve Medicaid-eligible patients.

For the past year, we have watched the Department of Social and Rehabilitation Services strive to address the issue of inadequate funding, beginning with an independent audit of the reimbursement methodology. And when that audit pointed to the need to rebase the reimbursement significantly higher, we saw SRS devise a way to at least partically fund what is needed.

We have seen a commitment to working <u>with</u> nursing homes that is unusual and sincerely appreciated. And while the members of this association would prefer an unincumbered measure of funding, the bottom line is, we support the Department's good faith efforts to adequately fund the nursing homes in Montana. For that reason, our association fully supports the Department's efforts and encourages you to give serious consideration to passing HB 93.

Exhibit from Dorothy Bradley

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time compensation (for a period of up to 90 days, or longer if provided by the Secretary), payment may be made to the first physician, so long as the claim identifies the physician who actually furnished the service.

Effective date: Applies to services furnished on or after the date of enactment.

Conference agreement

9. Miscellaneous Provisions Relating to Payments.—

(a) State Medicaid Matching Payments through Voluntary Contributions and State Taxes.—The conference agreement on voluntary contributions includes the Senate amendment with an amendment to extend the moratorium on final regulations re voluntary contributions to December 31, 1991. The conference agreement on provider-specific taxes includes the House bill with an amendment to exclude taxes from a provider's cost base for purposes of Medicaid reimbursement.

(b) Disproportionate Share Hospitals.—The conference agreement includes item (1), (3), and (4) of the House bill, and item (6) of the Senate amendment, with amendments.

(c) Federally Qualified Health Centers.—The conference agreement includes the House bill with technical amendments.

(d) Hospice Payments.—The conference agreement includes the House bill.

(e) Limitations on Disallowance of Certain Inpatient Psychiatric Hospital Services.—The conference agreement includes the Senate amendment.

(f) Treatment of Interest on Indiana Disallowance.—The conference agreement includes the House bill.

(g) Billing for Services of Substitute Physician.—The conference agreement includes the Senate amendment with an amendment to follow Medicare policy.

10. Miscellaneous Provisions Relating to Eligibility and Coverage (Sections 4451-4458 of the House bill, sections 6243, 6265, 6266, 6267, and 6271 of the Senate amendment)

Present law

(a) Providing Medical Assistance for Payments for Premiums for COBRA Continuation Coverage Where Cost Effective.—The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272), provided that an employer with 20 or more employees that offered a group health plan must offer employees the opportunity to continue coverage under that plan after certain "qualifying events," such as termination of employment, that would ordinarily end the coverage. For most qualifying events, coverage can continue for 18 months, with the employee responsible for the premium (up to 102 percent of the premium otherwise applicable). OBRA 89 allowed an extension of coverage up to 29 months for persons with a disability at the time they terminated employment. For months after the 18th month, the employee's maximum premium is 150 percent of the premium otherwise applicable.

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1989. The calculation of state error rates and financial penalties must exclude Medicaid payments made for infants and pregnant women whose eligibility is based on income received on or after July 1, 1989, and before the first calendar quarter beginning more than 12 months after submission of the report.

Part 4—Miscellaneous

Subpart A—Payments

Sec. 4701. State Medicaid matching payments through voluntary contributions and state taxes.—Extension of provision on voluntary contributions and state taxes.—The statute prohibiting HHS from issuing final regulations before December 31, 1990, that would change the treatment of voluntary contributions or provider-paid taxes used by states to receive federal Medicaid matching funds, is extended until December 31, 1991.

State tax contributions.—The Secretary may not limit payments to a state on the grounds that the state spending was financed by taxes on providers. Provider-specific taxes must be excluded from a provider's cost base for purposes of Medicaid reimbursement. Effective January 1, 1991.

Sec. 4702. Disproportionate share hospitals: Counting of inpatient days.—For the purpose of calculating Medicaid disproportionate share adjustments, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, even in a specialized ward, or while is waiting for suitable placement elsewhere. Effective July 1, 1990.

Sec. 4703. Disproportionate share hospitals: Alternative state payment adjustments and systems.—Alternative state payment adjustments.—States may use payment-increase adjustment alternatives for disproportionate share hospitals that vary for each type of hospital.

Clarification of special rule for states using health insuring organizations.—The three-year period beginning July 1, 1988, during which states using health insuring organizations can use an alternate system for classifying hospitals as disproportionate share hospitals and for computing payment adjustments if the state's aggregate adjustments are at least equal to ordinary adjustments and disproportionate hospitals assure availability of obstetricians, is made permanent.

Effective date. Effective as if included in enactment of Sec. 412(a)(2) of 1987 OBRA (P.L. 100-203).

Sec. 4704. Federally qualified health centers.—Clarification of use of Medicare payment.—Medicaid programs must use Medicare reasonable cost methodology to reimburse federally qualified health centers.

Minimum payment rates by health maintenance organizations.—Medicaid prepaid risk contracts with HMOs must provide that, if the contractor is, or provides services through, a federally qualified health center, the state's prepayment rates must reflect Medicare payment methodology. The organization must pay an FQHC for services at Medicare payment rates.

Clarification in treatment of outpatients.—FQHC services mean services provided to "patients," rather than "outpatients," as specified in prior law.

Treatment of Indian tribes.—An FQHC is an "entity" rather than a "facility." An FQHC can include an outpatient health program or facility operated by a tribe or a tribal organization under the Indian Self-Determination Act.

Technical correction.—Payment requirements for obstetric and pediatric services are generally effective on the date of enactment of 1989 OBRA (P.L. 101-239).

Effective date.—The FQHC provisions are effective as if included in 1989 OBRA (P.L. 101-239).

Sec. 4705. Hospice payments.—This provision clarifies that an additional amount is paid for nursing home room and board used by hospice patients. Conforming changes

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(b) ERROR RATE TRANSITION.—There shall not be taken into account, for purposes of section 1903(u) of the Social Security Act, payments and expenditures for medical assistance which—

(1) are attributable to medical assistance for individuals described in subparagraph (A) or (B) of section 1902(l)(1) of such Act, and

(2) are made on or after July 1, 1989, and before the first calendar quarter that begins more than 12 months after the date of submission of the report under subsection (a).

PART 4—MISCELLANEOUS

Subpart A—Payments

SEC. 4701. STATE MEDICAID MATCHING PAYMENTS THROUGH VOLUNTARY CONTRIBUTIONS AND STATE TAXES.

(a) EXTENSION OF PROVISION ON VOLUNTARY CONTRIBUTIONS AND PROVIDER-SPECIFIC TAXES.—Section 8431 of the Technical and Miscellaneous Revenue Act of 1988 is amended by striking "December 31, 1990" and inserting "December 31, 1991".

(b) STATE TAX CONTRIBUTIONS.—(1) Section 1902 (42 U.S.C. 1396a) as amended by section 4604, is further amended by adding at the end the following new subsection:

"(t) Except as provided in section 1903(i), nothing in this title (including sections 1903(a) and 1905(a)) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes (whether or not of general applicability) imposed with respect to the provision of such items or services.".

(2) Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by striking the period at the end of paragraph (9) and inserting "; or"; and

(B) by adding at the end the following new paragraph:

"(10) with respect to any amount expended for medical assistance for care or services furnished by a hospital, nursing facility, or intermediate care facility for the mentally retarded to reimburse the hospital or facility for the costs attributable to taxes imposed by the State solely with respect to hospitals or facilities.".

(c) EFFECTIVE DATES.—The amendment made by subsection (b) shall take effect on January 1, 1991.

SEC. 4702. DISPROPORTIONATE SHARE HOSPITALS: COUNTING OF INPATIENT DAYS.

(a) CLARIFICATION OF MEDICAID DISPROPORTIONATE SHARE ADJUSTMENT CALCULATION.—Section 1923(b)(2) (42 U.S.C. 1396r-4(b)(2)) is amended by adding at the end the following new sentence: "In this paragraph, the term 'inpatient day' includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on July 1, 1990.

EXHIBIT #7
DATE 1-14-91
SB 93

MHA MONTANA HOSPITAL ASSOCIATION

720 NINTH AVE.
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HELENA, MT
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(406) 442-1911
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Testimony by
James F. Ahrens, President
Montana Hospital Association
before the
House Human Services & Aging Committee
January 14, 1991

Thank you for this opportunity to testify on House Bill 93.

The Montana Hospital Association represents 58 community hospitals. Thirty-five of these facilities also provide nursing home services.

It's not news that the Medicaid reimbursement rate for nursing homes is below the cost of providing care, and has been for several years. This is especially true for nursing homes associated with hospitals.

I applaud the Governor and SRS for their efforts to close this gap between reimbursement levels and the cost of providing care.

Medicaid funding is one of the few programs due for an increase in the Governor's budget proposal for the biennium -- and, MHA wants to make clear that we appreciate the Governor's support for strengthening Montana's health care system.

However, as much as we support his proposal for more equitable nursing home rates, we have to oppose House Bill 93.

We recognize that House Bill 93 would raise a significant amount of new revenue, and that these funds would, under the federal-state Medicaid matching formula, result in a major infusion of new money into the Medicaid nursing home rate structure.

But House Bill 93 is nothing less than a selective tax on Montana's sick and elderly.

MHA believes the burden of paying for Medicaid nursing home services should be borne by all Montanans -- not by a few.

Second, SRS estimates that this tax would raise about $2 million a year. That money will support the proposed rate increase.

Testimony

EXHIBIT 8
DATE 1-14-91
HB 118

HOUSE BILL 118 - PHARMACY TECHNICIAN
January 14, 1991

Presented by
Dave Runkel, Rph, F.A.S.C.P.
Mt. State Pharmaceutical Association/Mt. Society of Hospital Pharmacists
Liaison and Board Member

Good afternoon, my name is Dave Runkel and I am a Hospital Pharmacist. I am employed at the Deaconess Hospital in Great Falls and have been practicing for 9 years.

My goal over the next few minutes is to provide you with a short history on how the idea of Technicians (Techs) has evolved, what roles the techs will fill, how this will allow the Pharmacist to more fully utilize his or her knowledge and outline the positive effects of expanding the Pharmacist and tech roles for both the patient and health care system.

The idea of using Techs in pharmacy is not new. It has been discussed since the late 1950s. As you will hear later the Federal Government has used Techs in the Veterans Administration (VA) hospitals since the late 1960s. Private institutions and retail pharmacies have employed Techs since the mid 1970s.

As the profession of pharmacy has developed over the years, pharmacists have become experts in drug distribution and medication use. While gaining this expertise, we have analyzed the various functions performed. These analyses have shown many tasks involved non-judgemental, repetitive work. These non-judgemental duties, have been proven to be verifiable by a Pharmacist.

The Tech role is seen as a progression or an updating of the practice of pharmacy, similar to the progression of many other health care professions and their increasing use of technical personnel. The progression of the practice of pharmacy also involves expanding the role of the Pharmacist. The expanding role of the pharmacist will benefit both the patient and the public.

The individual patient is benefited by the pharmacist being able to spend more time with patient concerns. The specific concerns a Pharmacist can address are:

1. Individual patient counseling on how to take their medications properly.
2. Providing the patient with knowledge of side effects and how to avoid or handle these potential problems.
3. Patient referral within the Health Care System.

4. More complete Drug-Drug, Drug-Allergy, Drug-Food and Drug-Disease state screening.

5. Drug Regimen review. A process that helps to eliminate unnecessary drugs and avoid duplication.

All of these activities combine to provide better health care to the patient.

Health Care dollars are also spent more efficiently. Below are two examples of this.

1. Pharmacists that consult for Nursing Homes have been able to show better patient care and a net savings of a projected 220 million dollars annually. These are 1983 dollars.
2. The Federal Government has passed laws requiring States to provide:
   a. Retrospective reviews of all Medicaid patient drug regimens.
   b. Physician and Pharmacist education in areas that are shown to be a problem as a result of drug regimen review.
   c. Patient counseling by Pharmacists when the prescription is dispensed.

   These activities have increased the quality of patient care and paid 1.5 to 3.0 dollars back for every dollar spent.

As you can see there is a role for Pharmacists and Techs to fill. The new roles will not only save money but increase the quality of services provided to the individual patients. The safety of using Techs has been demonstrated not only in the VA hospitals, but also in private settings in other states. The passage of this bill will be the first step in a progression of activities that will update the practice of pharmacy and keep the individual patient's safety and welfare as the number one concern.

EXHIBIT 9
DATE 1-14-91
HB 118

P.O. Box 683
Helena, Montana 59624
January 14, 1991

Health and Human Services Committee
Angela Russell, Chairperson
House of Representatives
State of Montana
Helena, Montana 59601

Dear Chairperson Russell and Members of the Committee:

My name is Ann Gidel. I am a registered pharmacist in the State of Montana, graduating from the University of Montana School of Pharmacy in 1975. I have spent my career working for the Department of Veterans Affairs and am currently employed at the Fort Harrison VA Medical Center as the Pharmacy Supervisor and Clinical Pharmacy Coordinator. I am also here today representing the Montana Society of Hospital Pharmacists. I have served on the Board of Directors of that organization since 1985 and am currently the Immediate Past-President.

I am here to express my support for House Bill 118 that will update the Pharmacy Practice Act to allow pharmacists to utilize technical help for distributive functions. The Montana Society of Hospital Pharmacists has looked at the need to update the Pharmacy Practice Act for years. This is felt necessary for several reasons:

1. A shortage of pharmacists is becoming apparent in the state. Certain functions such as counting medications, compounding IV solutions, filling unit dose cassettes, and pre-packaging medications do not require the judgement of a pharmacist and therefore could be performed by trained technical help. This would enable us to reserve pharmacist's time for more professional responsibilities such as patient education and drug usage evaluations.

2. The current law does not establish standards of practice where auxiliary personnel may be utilized. In addition it does not specify training requirements of these individuals. The proposed changes will more clearly define the responsibilities technicians would be able to perform and the training required. Furthermore the changes will ensure the establishment of utilization plans that outline procedures for a pharmacist's final check of all products prior to their reaching the patient. This standardization is felt to be an improvement in assuring patient safety over the current law.

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HB 118

Although the Montana Society of Hospital Pharmacists has felt changes in the law were necessary for years, we have not pursued Legislative changes previously, because we felt that careful review of the issue was necessary. In that time, we have developed a consensus of opinion with the Montana State Pharmaceutical Association, and among hospital and retail pharmacists on specifically what regulations should be suggested to the State Board of Pharmacy to govern the responsibilities, supervision, training, and quality assurance of technicians in distribution functions. During this process, we have kept the State Board of Pharmacy informed of our activities and utilized them as a reference source regarding regulations currently in place in other states and for input on how such regulations could be implemented in our state.

As I previously stated I am an employee of the Department of Veterans Affairs. As a federal institution we are exempt from the state regulations governing the use of technical help. Since my employment with the Department of Veterans Affairs, I have worked closely with and supervised technicians performing distributive functions. I can verify that mechanisms have been developed to ensure the quality of work and the patient's safety are maintained. Procedures require a pharmacist to maintain the ultimate responsibility for the drug delivered to the ward or dispensed to the patient. This assurance is refined through performance requirements and quality management monitors as part of our "utilization plan":

1. Using IV compounding as an example, certification training is initially required. Procedures require a pharmacist's check of the technician's calculations required for compounding, and the assurance of proper solution and additives. Errors identified in the checking process are recorded. This is linked to performance standards which take in to consideration the number of errors recorded and the potential severity of the error. As a matter of record it is important to note that errors are essentially non-existent. In addition to error documentation, our quality management plan requires regular aseptic technique monitoring and sterility monitoring to ensure proper technique by all employees is maintained.

2. With respect to unit dose cart filling, pharmacists check all carts to ensure the proper drugs have been dispensed. Errors are again recorded in a log book, which are periodically tabulated and applied to the technician's performance standards. Satisfactory performance is dependent upon maintaining an error rate less than that specified in the standard. To reflect upon the trained technician's capabilities in this area our average error rate equates to 0.06%.

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HB 118

Through the utilization of technical help, we have been able to free up our pharmacists' time to perform more professional tasks. Tangible benefits are many. We calculate conservative estimates of cost savings achieved through pharmacists' interventions with physicians on such things as receiving authorization to use lower cost therapeutically equivalent drugs and recommendations to eliminate unnecessary drugs from a patient's drug regimen. The estimated savings for FY89 was $89,674 and for FY90 was $94,820. These savings are based upon the federal government's drug costs and do not even closely represent the savings that can be achieved in the private sector. Intangible benefits that increase patient safety are also evident through such efforts. Pharmacists' monitoring of patient's drug therapy has been shown extremely effective in preventing adverse drug reactions that occur from drug toxicity or drug interactions. Pharmacists are the ideal professionals to educate patients on their medications, which has been shown to decrease hospital admissions through improved compliance in taking medications, earlier identification of adverse drug reactions and taking medications at the proper times to avoid food and drug interactions.

I will close with the summary that I have worked with technical help for the past 15 years. I strongly feel that such assistance is a great asset to the profession of pharmacy in providing cost-effective and safe drug therapy to our patients. I thank you for your time.

Ann Gidel

DATE 1-14-91
HB 118

2770 Howard Road
Helena, MT 59601
January 14, 1991

Health and Human Services Committee
Angela Russell, Chairperson
House of Representatives
State of Montana
Helena, Montana 59601

I worked as a Licensed Practical Nurse for 13 years. Four years ago I changed my profession to become a Pharmacy Technician at the VA Medical Center.

Pharmacy Technicians are now responsible for many areas of pharmacy service including clerical duties, inventory and stock control, budget control, processing prescriptions and refill requests, and preparing intravenous solutions. Pharmacy Technicians are given thorough training in all areas they are responsible for. We work along with and under the supervision of a pharmacist. In addition to writing policies and procedures, there are regular methods in place to assure the ability and competency of all pharmacy staff, and to ensure the quality of medications received by the patient.

The roles of many medical professions have changed in the past years. Historically it had been the responsibility of Registered Nurses to provide patients with medications and I.V. solutions. As the RNs role changed LPNs were given the training and responsibility for the service.

Historically, pharmacists have been the sole provider of all services from a pharmacy. The pharmacy technician is now trained to take over some of this responsibility, thus allowing the pharmacist more time for direct patient counseling, providing information to physicians, and other clinical duties.

I support House Bill 118 and want my written testimony to be part of the permanent record.

Donna Nopp
Donna Nopp

EXHIBIT 11
DATE 1-14-91
HB 118

212 Blake Street
Helena, Montana 59601
January 14, 1991

Health and Human Services Committee
Angela Russell, Chairperson
House of Representatives
State of Montana
Helena, Montana 59601

My name is Lori FitzGerald and I am a pharmacist at Ft. Harrison VA Medical Center in Helena. I am also a 1987 graduate of the University of Montana School of Pharmacy. I have just recently moved back to Montana from Minnesota, where I was a staff pharmacist in a large hospital in Duluth. Minnesota is a state where technicians are extensively and productively used in the pharmacy setting. Through my experience there, I found that a properly trained and adequately supervised technician can be indispensable for tasks such as unit dose filling and IV admixture preparation. Trained, supervised technicians can produce a large volume of accurate work, that is safe and cost-effective for the patient, while freeing up the pharmacist for other clinical functions. Therefore, I support House Bill 118.

Lori FitzGerald

Lori FitzGerald

VISITORS' REGISTER

Human Services & Aging COMMITTEE

BILL NO. 93 DATE 1-14-91

SPONSOR Rep. Cobb

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Jill Miller Dept of Revenue			
Jack Ellery " "			
D. Bradley - Leg			✓
Hank Hudson	Helena	✓	
MIKE HANSHAW SRS	HELENA	✓	
Rep. Dorothy A. Cody	N. P.		✓
Clark K Johnson	Helena	✓	
Joe Roberts		✓	
Rose Hughes YHCA	Helena	✓	
James F. Peters	Helena		✓
Steve Bowman	MT Hop Assn		✓

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

Human Services & Aging COMMITTEE

BILL NO. 118 DATE 1-14-91

SPONSOR J. Brown

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
MARK EICHLER RPh FASCP	Helena	X	
Dave Runkel RPh FASCP	Great Falls	X	
John Doe RPh	Great Falls	X	
Dee Dee Cress Pharm D.	Helena	X	
Ann Gidel, RPh	Helena	X	
Dennis Gant RPh	Helena	X	
Lori Fitzgerald	Helena	X	
Warren Fredo, RPh	Dept Commerce Helena		
Donna Nopp	Helena	X	
Mary K. McCue	MSPA, MPHARMSHP	X	
Charles R. Brooks	MT Rets. Lgssor - Helena	X	
Bonnie Tippy	MSPA, Helena	X	
Helen Shertzer	Helena	X	
Jan F Ahrens	Helena	X	
KAREN J MOORE LPN	Helena		X
MARSHA DALLTON. LPN	Helena		X
STEPHEN H. MELOY	Dept of Comm/HLN		

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