MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN DOROTHY BRADLEY**, on January 11, 1991, at 8:00 a.m.

ROLL CALL

Members Present:

Rep. Dorothy Bradley, Chairman (D)
Sen. Mignon Waterman, Vice Chairman (D)
Rep. John Cobb (R)
Rep. John Johnson (D)
Sen. Tom Keating (R)
Sen. Dennis Nathe (R)

Staff Present: Taryn Purdy (LFA), Dan Gengler (OBPP), and Faith Conroy, secretary.

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

Announcements/Discussion:

HEARING ON DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

CENTRALIZED SERVICES DIVISION

Tape 1

CHAIRMAN BRADLEY said executive-budget travel in Central Services includes an extra $2,000 per year for an information gathering trip to Washington, D.C. **EXHIBIT 3 from Jan. 10, 1991 Minutes, Page 1.** Program Issue No. 2 calls for a $50,000 per year contingency fund for the laboratory if fees don't cover testing costs. The question is, should the subcommittee include $50,000 each year or a single biennial appropriation of $50,000, as in the past. **Taryn Purdy, Legislative Fiscal Analyst,** noted the contingency adds additional authority to provide for reimbursable lab services.

SEN. KEATING asked how much money the lab needed and suggested the subcommittee approve $100,000 spending authority for the biennium. **CHAIRMAN BRADLEY** said **SEN. KEATING**'s suggestion may be the proper approach. The issue would be dealt with later.

CHAIRMAN BRADLEY said Program Issue No. 3 is for Chemistry Lab equipment and Program Issue No. 4 is for equipment in the Support Services Bureau.

Ms. Purdy reminded the subcommittee of the Department's request for an additional $6,000 in lab income due to increased maintenance costs for a piece of equipment purchased in FY 90. The current budget includes $13,000 for that purpose and the maintenance contract came in at $20,000.

Ms. Purdy distributed a corrected second page for the Central Services budget that reflects $47,000, which was inadvertently left out of the lab budget. **EXHIBIT 1.** She added the type of fund that would finance the modified addition and corrected first year totals.

Ms. Purdy said the Vital Statistics Bureau has three types of income: two federal contracts and vital statistics income from the sale of copies of such things as birth and death certificates. The LFA budget assumes $110,000 of income the first year and $102,000 the second year. The executive budget assumes about $116,000 the first year and $107,000 the second year. The General Fund provides the difference between other income sources and what has been appropriated for the Bureau.

SEN. NATHE wanted to know the relationship between the Public Health Laboratory under Program Issue No. 2 and PKU testing under the executive budget modified additions. **CHAIRMAN BRADLEY** said the PKU testing was funded by fees and new federal requirements have complicated the tests. The modification in Support Services staff involves two additional positions, paid for by indirect dollars. The safe drinking water modification, paid for by fees, includes one additional position.

REP. COBB asked if an additional full-time equivalent (FTE) position would enable the Department to handle all the safe water testing needed. **Ray Hoffman, DHES Administrator,** said the Department received a budget amendment for an additional position in the Public Health Lab for safe drinking water in FY 91 that was not reflected in the LFA or executive budgets. The Department wants to continue the additional FTE to cover water testing demand.

EXECUTIVE ACTION ON CENTRALIZED SERVICES

Votes were taken on issues identified in **EXHIBIT 3 from Jan. 10, 1991, Minutes.**

CHAIRMAN BRADLEY asked for a motion on Program Issue No. 1.

MOTION: **REP. COBB** moved approval of the travel request.

VOTE: The motion **PASSED** unanimously.

MOTION: **REP. COBB** moved approval of the $50,000 in the Public Health Laboratory as a contingency, then withdrew his motion to allow **SEN. KEATING** to provide the motion.

SEN. KEATING moved to approve $100,000 biennial spending authority for the Public Health Laboratory.

DISCUSSION: **SEN. JOHNSON** asked why the Department was seeking the spending authority if none of it had been used in the last biennium. **Mr. Hoffman** said the Department doesn't know what public health issues the lab will have to address in the future. Without a contingency fund to address the issues as they occur, the Department cannot respond to them without coming back for a budget amendment.

SEN. KEATING said the subcommittee isn't appropriating any money, just spending authority. The Department wouldn't have legislative authority to spend money if it weren't included in the budget. The spending authority is for a specific purpose and the money isn't used if it isn't needed.

SEN. NATHE asked if the money can be tracked. **CHAIRMAN BRADLEY** said yes and **Ms. Purdy** would modify the language to reflect a biennial appropriation at the level moved by **SEN. KEATING.**

AMENDMENT: **SEN. KEATING** amended his motion to indicate the amount was a contingency appropriation that could be used only if the demand for reimbursable services requires expenditures for supplies, materials and communications in excess of the appropriated levels as approved by the subcommittee. **EXHIBIT 2**

VOTE: The motion **PASSED** unanimously.

MOTION: **REP. COBB** moved to include $32,000 for laboratory equipment as noted in Program Issue No. 3.

VOTE: The motion **PASSED** unanimously.

CHAIRMAN BRADLEY called for a motion for equipment in the Support Services Bureau.

MOTION: **REP. COBB** moved to approve Program Issue No. 4 to include $1,927 for equipment in the Support Services Bureau.

VOTE: The motion **PASSED** unanimously.

CHAIRMAN BRADLEY said the easiest way to make a motion on Funding Issue No. 1 is to accept either the executive or LFA figures. **EXHIBIT 1**

Ms. Purdy said if the subcommittee accepted LFA funding for the Division, the program would be funded with $110,000 the first year and $102,000 the second year. If the subcommittee accepts executive funding, the program would be funded with $116,000 of vital statistics income in the first year and $107,000 in the

second year. The General Fund would provide the balance of financing.

Bill Opitz, DHES, said more General Fund money would be spent under the LFA budget than the executive budget.

MOTION: **REP. COBB** moved to use the executive budget approach to funding.

VOTE: The motion **PASSED** unanimously.

CHAIRMAN BRADLEY said item No. 1 under Executive Budget Modified Additions involves two people and, if the item remains in the Health Department, funding would be indirect dollars.

MOTION: **REP. JOHNSON** moved to approve the executive budget modified addition for support service staff.

VOTE: The motion **PASSED**, 5-1, with **REP. COBB** voting no.

MOTION: **SEN. KEATING** moved to approve the newborn PKU testing to be paid by fee revenues.

VOTE: The motion **PASSED** unanimously.

Mr. Hoffman explained that the safe drinking water executive budget modification involved one FTE. The additional position in the Public Health Laboratory and the increased maintenance costs for the Chemistry Lab were not contained in the modification.

MOTION: **REP. COBB** moved to approve the safe drinking water executive budget modification.

VOTE: The motion **PASSED** unanimously.

CHAIRMAN BRADLEY postponed discussion on the additional position for the Public Health Lab and asked **Ms. Purdy** to provide a separate analysis. She asked **Mr. Hoffman** to explain the need for an increase in the maintenance contract. He said increased costs cannot be absorbed by the lab and the Department is seeking an additional $6,781 in the Chemistry Lab budget each year to be funded by fees. **Mr. Hoffman** said that if the equipment malfunctions, repair costs would exceed the cost of the maintenance contract.

MOTION: **SEN. KEATING** moved to increase the service contract in the Chemistry Lab.

VOTE: The motion **PASSED** unanimously.

MOTION: **REP. JOHNSON** moved to approve the LFA 1992 and 1993 budget figures under personal services as adjusted by the subcommittee.

VOTE: The motion **PASSED** unanimously.

MOTION: **REP. JOHNSON** moved to approve operating expenses.

VOTE: The motion **PASSED** unanimously.

MOTION: **SEN. KEATING** moved approval of the executive funding for 1992 and 1993.

VOTE: The motion **PASSED**, 5-1, with **REP. COBB** voting no.

CHAIRMAN BRADLEY said Central Services is funded through the indirect costs. The concept is to determine the amount internal divisions would pay as their share of costs. The LFA assumes vacancy savings when determining indirect costs and the amount will be collected through a rate determined to be about 15 percent. The executive negotiated a 19 percent rate this year with the federal government. The 19 percent would be applied instead of the LFA rate. The federal system allows the Department to make up for under-collections in the next biennium, but if the Department over-collects, it may have to pay a penalty and under-collect in the next biennium.

CHAIRMAN BRADLEY said the Department under-collected during the last biennium and wants to over-collect this time to be safe, using 19 percent across the board. The LFA says if the 19 percent rate is used across the board, it will involve an additional $110,000 from the General Fund.

CHAIRMAN BRADLEY said the subcommittee will use the 19 percent negotiated rate established with the federal government, but will line-item the additional $110,000 of General Fund monies to ensure it is not used in Central Services. She predicted some of the $110,000 would revert and some would not be spent. Language will be inserted so the money cannot be used to expand Central Services in any way.

Mr. Hoffman said all indirects should be a line-item so the 19 percent will be applied to both fiscal years. The 1993 rate could be below 19 percent because the rate isn't determined until the end of the current fiscal year. If the rate is 15 percent, the Department will have too much authority, causing the money to revert. He agreed to work out the language with **Ms. Purdy.**

Dan Gengler, Office of Budget and Program Planning, said the LFA and executive budgets use the same method to calculate indirects. The difference in the numbers is due to the executive assuming

the reorganization and program expansions. The method outlined by **CHAIRMAN BRADLEY**, including the line-item policy, would be acceptable to the Office of Budget and Program Planning.

SEN. NATHE asked if reversions occur at the end of each fiscal year of the biennium. **CHAIRMAN BRADLEY** said yes, unless it was a biennial appropriation. **Ms. Purdy** said the appropriation would be for each year and line-item language would apply to each year.

CHAIRMAN BRADLEY said **Ms. Purdy** would adjust all figures according to the formula agreed to by the subcommittee and present the figures for review.

HEARING ON HEALTH SERVICES DIVISION

Tape 2

Dale Taliaferro, Health Services Division Administrator, provided an overview of the Division. **EXHIBIT 3-4**

Ms. Purdy distributed budget comparisons on the Maternal Child Health (MCH) and the Preventive Health block grants. **EXHIBIT 5-6**

SEN. KEATING asked if there were any significant differences in the funding balance between the executive and LFA budgets in 1992 in the MCH block grant. **Ms. Purdy** said funding in each program in the LFA budget is determined from the 1990 base for continued prior-year funding. In both budgets, the total amount anticipated had not been allocated. The allocation in the LFA budget was not designed to create a fund balance, but to fund the programs at current level.

SEN. WATERMAN asked the fate of the money if it were left in the fund balance. **Mr. Hoffman** said the money would revert to the federal government at the end of the biennium to the federal government.

Mr. Taliaferro suggested $88,000 in the executive budget be moved to the grants-to-counties budget. **Ms. Purdy** said the 1989 Legislature stated any funds not allocated would go to counties. The funds in FY 90 were over the amount originally anticipated by the 1989 Legislature and the 1991 Legislature can specify use of unexpended funds within the parameters of the grant.

Mr. Hoffman said there is no fund balance. The monies were distributed to the counties at the end of FY 90.

Ms. Purdy distributed the Health Services Medical Facility budget summary. **EXHIBIT 7**

Mr. Taliaferro testified on Division administration. **EXHIBIT 8**

Mr. Gengler said the federal grant award for under-served populations in rural areas referred to by **Mr. Taliaferro** is

included in HB 4, the budget amendment bill.

EMERGENCY MEDICAL SERVICES BUREAU

Drew Dawson, Emergency Medical Services Bureau Chief, testified. **EXHIBIT 9-10**

Charles Aagenes, Health Services Division Assistant Administrator and Health Planning Program Manager, testified on health planning. **EXHIBIT 11**

Mr. Gengler referred to **Mr. Dawson's** testimony about the highway traffic safety contract, noting it would extend into FY 92 but would not necessarily be an ongoing program. He suggested staff be handled through HB 4. The bill can allow a program to continue to Sept. 30 of FY 92.

SEN. KEATING asked what health programs would be affected by HB 4. **Mr. Gengler** said Centralized Services' social security contract, the public health service grant for under-served populations in rural areas. It also could extend the highway traffic safety contract into the next fiscal year.

SEN. NATHE asked **Mr. Dawson** if fixed-wing aircraft were grandfathered. **Mr. Dawson** said fixed-wing aircraft and volunteers do not have to be licensed. There was some grandfathering of personnel, not services. Unlicensed personnel cannot get Medicare reimbursement. However, Division rules provide for licensure of basic life support service that fixed-base operators could comply with.

Tape 3

SEN. WATERMAN asked if the basic licensing requirement would qualify operators for Medicaid funding. **Mr. Dawson** said he thought it was possible at the basic life support level, though Medicare will differentiate between basic and advanced life support. There may be a differential in reimbursement. He predicted the Federal Aviation Administration would establish standards for air ambulances in the next year to year and a half.

CHAIRMAN BRADLEY said the subcommittee needed to address **Mr. Dawson's** concern about spending authority as a fourth program issue on the budget summary.

Ms. Purdy explained Program Issue No. 1, **EXHIBIT 7**, saying communications, supplies and other expenses previously were charged to the Health Planning, and Licensing and Certification bureaus. The Department and executive budget propose those budgets be reduced by a corresponding $562 per year and added to Division administration, to be funded by the General Fund.

The Department and executive include an additional $9,000 per year for travel under Program Issue No. 2, to be financed by the

General Fund. Supplies in Program Issue No. 3 will be funded from the Preventive Health block grant.

The fourth issue relates to a coding error in expenditures. The correction would reduce certification fee appropriation by $6,920, with a corresponding amount added to the Preventive Health block grant.

SEN. KEATING asked if the block grant funding in Program Issue No. 3 involved a match of General Fund and federal money. **Ms. Purdy** said no. It involved only federal funds.

Ms. Purdy said the spending authority for certification fees would be reduced if the funding switch were enacted by the subcommittee. The Department's original request was to increase the certification authority by a corresponding $6,920. **Mr. Dawson** said the Department is seeking authorization only. Without spending authority, the Department may not be able to spend the certification fees received to offset costs.

EXECUTIVE ACTION ON EMERGENCY MEDICAL SERVICES BUREAU

Votes were taken on issues identified in **EXHIBIT 7.**

MOTION: REP. COBB moved to approve $562 for communications and supplies in Division administration.

VOTE: The motion **PASSED** unanimously.

SEN. KEATING asked what constituted the state special source. **Ms. Purdy** said it comprises emergency certification fees charged to trainees. The $9,000 for travel would be spent for licensing activities.

Mr. Dawson said travel expenditures were down because inspections were not done in FY 90 while the Bureau geared up for new regulations. The inspections now need to be done.

SEN. NATHE asked if the Bureau inspects ground-based ambulances and what was inspected. **Mr. Dawson** said all ground-based services, non-transporting quick response units and air ambulance services are inspected. The number of inspections has increased from 100 to 180. The Bureau inspects equipment, records and personnel training levels to ensure they comply with Bureau rules. The Bureau licenses 35 organized units in the state and there are probably many other responders who are not licensed.

SEN. KEATING asked if the travel money was in any budget. **Ms. Purdy** said the money was in the executive budget only.

MOTION: SEN. KEATING moved to approve the $9,000 per year increase in Emergency Medical Services Bureau travel.

VOTE: The motion **PASSED** unanimously.

MOTION: **REP. JOHNSON** moved to approve the additional $13,000 in supplies funding as identified in program issue No. 3.

VOTE: The motion **PASSED** unanimously.

MOTION: **REP. JOHNSON** moved to approve the $6,920 coding error correction.

DISCUSSION: **CHAIRMAN BRADLEY** asked if correction of the coding error would reduce certification spending authority. **Ms. Purdy** said the executive budget already includes the funding switch.

AMENDMENT: **SEN. KEATING** amended the motion to adjust the LFA budget to the executive formula.

VOTE: The motion **PASSED** unanimously.

MOTION: **SEN. KEATING** moved to adopt the LFA budget with adjustments for personal services and operating expenses.

DISCUSSION: **Ms. Purdy** said she would reduce state special revenue by $7,000 and increase the Preventive Health block grant by a corresponding amount in response to the funding switch. The subcommittee needed to decide if it wanted to increase spending authority in the certification fee account by $7,000 to maintain the level at about $46,000. Otherwise it would drop to about $40,000. **Mr. Dawson** said the Bureau wants the spending authority because it is difficult to anticipate how many people will seek certification. Without the spending authority, the Bureau would not be able to use the money to offset certification costs.

AMENDMENT: **SEN. KEATING** amended his motion to allow the Bureau to maintain its spending authority at the level requested for personal services and operating expenses.

VOTE: The motion **PASSED** unanimously.

CHAIRMAN BRADLEY said the subcommittee needed to vote on equipment under budget items. **EXHIBIT 7**

Mr. Hoffman said the equipment budget is based on anticipated costs. The budget can't be determined by a three-year average, as is done by the LFA. **SEN. NATHE** asked whether purchases are scrutinized to ensure the same equipment is not being requested every year. **Ms. Purdy** said the LFA looks at requests from past years to see what was requested, and a three-year average is a tool for providing an appropriation.

MOTION: **REP. COBB** moved to approve the executive budget for equipment.

VOTE: The motion **PASSED**, 5-1, with **CHAIRMAN BRADLEY** voting no.

CHAIRMAN BRADLEY asked if subcommittee members were satisfied they had voted on funding issues. Members nodded yes.

FAMILY/MATERNAL AND CHILD HEALTH BUREAU

CHAIRMAN BRADLEY referred subcommittee members to LFA analysis pages B36-38.

Maxine Ferguson, Family/MCH Bureau Chief, provided an overview of the Bureau.
Judith Wright, Handicapped Children's Services Program Manager, testified.
Suzanne Nybo, Family Planning Program Manager, testified.
Dave Thomas, Program Coordinator for the Special Supplemental Food Program For Women, Infants and Children (WIC), testified.
Peggy Baraby, Child Nutrition Program Supervisor, testified.
EXHIBIT 12

Karen Wojtanowicz, Montana Children's Alliance, testified in support of a Family Planning health education specialist position. **EXHIBIT 13**

SEN. NATHE asked that if he sponsored legislation to authorize a health education specialist for schools, could the money be used to educate high school students, especially boys, about the responsibility and repercussions of teen pregnancy. **Ms. Wojtanowicz** said she didn't know, but the money would be aimed at prevention to deter indiscriminate sexual behavior and promote responsibility.

ADJOURNMENT

Adjournment: 10:25 a.m.

Dorothy Bradley
REP. DOROTHY BRADLEY, Chairman

Faith Conroy
FAITH CONROY, Secretary

DB/fc

HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUBCOMMITTEE

ROLL CALL **DATE** 1/11/91

NAME	PRESENT	ABSENT	EXCUSED
REP. JOHN COBB	✓		
SEN. TOM KEATING	✓		
REP. JOHN JOHNSON	✓		
SEN. DENNIS NATHE	✓		
SEN. MIGNON WATERMAN, VICE-CHAIR	✓		
REP. DOROTHY BRADLEY, CHAIR	✓		

HR:1991
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correction of page 2
Exhibit #3, 1/10/91

EXHIBIT #1
1/11/91
Human Servic
Subcommitt

unding Issues
. Due to including a higher funding base, the Executive Budget includes $6,394 in fiscal 992 and $5,523 in fiscal 1993 more vital statistics income than LFA current level

	$6,394	$5,523

Executive Budget Modified Additions

1. Support Service Staff Proprietary Funds (Indirect Charges)	$48,895	$48,788
2. Newborn PKU Testing Laboratory Income	$78,238	$31,007
3. Safe Drinking Water Laboratory Income	$42,241	$42,182

EXHIBIT 1
DATE 1-11-91
HB

EXHIBIT 2
DATE 1-11-91
HB

Exhibit #2
1/11/91
Hum SVC
Subc.

HUMAN SERVICES SUBCOMMITTEE

Potential Laboratory Contingency Language

Item __ is a contingency appropriation that may be used only if the demand for reimbursable services requires expenditures for supplies, materials, and communications in excess of the appropriated levels ~~of $___ in fiscal 1990 and $___ in fiscal 1991~~.

as approved by the subcommittee.

EX. 3
DATE 1-11-91
HB

Exhibit #3
1/11/91
Hum Svc
Subc.

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
HEALTH SERVICES DIVISION REPORT TO
HUMAN SERVICES JOINT SUBCOMMITTEE OF
HOUSE APPROPRIATION AND SENATE FINANCE AND CLAIMS COMMITTEES
January 10, 1991

Representative Bradley and Members of the Committee. My name is Dale Taliaferro. I am Administrator of the Health Services Division. The Division is responsible for programs directed to the promotion and preservation of the health of Montana residents.

The Division includes four bureaus with a total of fifteen programs directed to different aspects of public health. The Division Administration office includes the Health Planning Program that serves a variety of Health Planning functions for the Department and currently administers the Certificate of Need Program for Medical Facilities.

The four Bureaus are (1) Emergency Medical Services, (2) Family/Maternal and Child Health, (3) Preventive Health Services, and (4) Licensing, Certification and Construction. The Emergency Medical Services Bureau is responsible for planning, education, regulation and implementation of statewide emergency medical services. The Family/Maternal and Child Health Bureau has programs directed to health and nutrition needs associated with women of childbearing age and children. The Preventive Health Services Bureau has programs that provide a variety of services to prevent or reduce the effects of communicable and chronic diseases. The Licensing, Certification and Construction Bureau provides state licensing and regulatory activities for Medicaid and Medicare certification of Montana's health care facilities.

The Division programs are funded through (1) Federal Health and Human Services (HHS) Block grant for Maternal and Child Health, (2) HHS Block grant for Preventive Health Services, (3) Federal Department of Agriculture Nutrition grants, (4) Federal Health Care Financing Administration contracts, (5) State general funds, and (6) a number of smaller special purpose grants.

The Maternal and Child Health Block grant can be used for health care services for mothers and children with limited income. These services may be directed to reduction of infant mortality, disease prevention, immunization, preventive services for children, and rehabilitation and treatment services for children with special health care needs. A state match of 3 dollars for every 4 federal

dollars is required. The grant funds are available for a 2-year period and cannot be carried over beyond the second year. The funds cannot be used for individuals other than women of childbearing age, infants, or children. Funds cannot be used to supplant state funds.

The Federal Omnibus Budget Reconciliation Act of 1989 placed new restrictions on the MCH Block grant. Administrative costs are limited to 10% of the grant. The State must maintain level funding by the State for MCH programs at least at the 1989 level. A summary of the major provisions is provided on the handout on OBRA 1989. There is a requirement for a detailed needs assessment and five-year plan for MCH services. Unless the needs assessment justifies a waiver, 30 percent of the grant must be spent for services to children with special health care needs and 30 percent for primary care services to children. Currently, the state is not meeting the requirement for primary services to children, but exceeds 30 percent in the category for children with special health care needs. We recommend holding the Handicapped Children's Program at the base level and placing the MCH block grant expansion in the grants to counties program. Any expansion of the program should go to services provided from the local level. The only change in the grants to counties program will be some restriction on expenditure categories so that the total block grant will meet the federal requirements. (Exh. #4)

The Preventive Health Services Block Grant is used for preventive health services for health priorities in Montana. These services include a wide range of education and treatment services in a variety of programs throughout the Department. Communicable disease, chronic disease, emergency medical services, maternal and child health services all have preventive activities funded through this grant. The Sexual Assault Prevention and Treatment Services are an earmarked part of the grant. There are no matching requirements for this grant. There is a limit of 10% for documented administrative costs. Grant funds may not be used for inpatient services, cash payments, purchase of land, facilities or major medical equipment. Funds may not be used to supplant state funds.

Since the budgets were prepared, we have been notified that the federal grant will be more than anticipated. The additional funds are approximately $20,000 per year. The

Department recommends use of these funds for vaccine in the immunization program.

Other federal changes that have impact on the Division have occurred in the area of Health Care Financing Administration requirements for survey and certification. There have been considerable changes and expansions in requirements for which we have already added staff through the budget amendment process. There have also been changes in the requirements for funding distribution that are not reflected in the budgets that you have before you.

The details of the programs will be presented by the individual Bureau Chiefs and Program Managers. I will answer any general questions you have concerning the Health Services Division.

DATE 1-11-91

Exhibit 1/11/91 Human Svc. Subc.

MCH

001 L Street, N.W. Suite 308
Washington, D.C. 20036
202-775-0436

Association of Maternal and Child Health Program

OBRA of 1989 (H.R. 3299):

HIGHLIGHTS OF AMENDMENTS TO TITLE V AND INDEPENDENT PROVISIONS FOR THE SECRETARY OF HHS

AUTHORIZED FUNDING (S.501)

* A $125 MILLION INCREASE in authorizations (to $686 million) for FFY 1990 and years thereafter.

PURPOSES (S.501)

* Promotion of family-centered, community-based, coordinated care replaces prior purpose for CSHCN.

SECOND SET-ASIDE (S.502)

* Of AMOUNTS APPROPRIATED IN EXCESS OF $600 MILLION, 87 1/4% is subject to the ordinary 85% (State block grant allotments)/15% (Federal set-aside) split; the remaining 12 3/4% must be set aside for the following new, Federally administered demonstration programs: maternal and infant health home visiting programs; projects to increase obstetrician/pediatrician participation in Title V/Title XIX; integrated MCH service delivery systems; MCH centers for prenatal care, delivery and postpartum care directed by non-profit hospitals; MCH projects serving rural populations; and outpatient and community based services programs for children with special health care needs whose medical services are provided primarily through inpatient institutional care.

ADMINISTRATIVE COSTS (S.504)

* NO MORE THAN 10% of Federal Title V allotment may be used to cover State's administrative (undefined) costs.

APPLICATION (FORMERLY R.I.E.) (S.505)

* Effective for FY 1991, the R.I.E. is changed to an application in a standardized form specified by the Secretary. The application must be developed by or in consultation with the state maternal and child health agency. The application must contain a statewide needs assessment (to be conducted every 5 years) for preventive and primary care services for pregnant women, infants, children; and for services for children with special health care needs which

is consistent with year 2000 national health objectives and health status goals. The application must also contain a plan for meeting identified needs and a description of how allocated funds will be used to carry out such plan.

EARMARKS (S.505)

* * Effective for FY 1991, the Title V "application" must provide that 30% of Federal Title V funds will be spent on PREVENTIVE AND PRIMARY CARE SERVICES FOR CHILDREN and 30% will be spent on SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS. HOWEVER, the Secretary of DHHS may waive these requirements upon a showing of "extraordinary unmet need" for certain activities and that a waiver is justified.

* STATE MAINTENANCE OF EFFORT (S.505)

* Effective FY 1991, the application must provide that the State will maintain the level of funding provided solely by the State for MCH programs at least equal to FY 1989 levels.

HOTLINES (S.505)

* Effective in FY 1991, State MCH agency (or agencies) must have a toll-free hotline which provides parents with information regarding health care providers participating in Titles V and XIX programs.

IDENTIFICATION AND ASSISTANCE FOR MEDICAID ELIGIBLES (S.505)

* Effective FY 1991, the State must provide services to identify pregnant women and infants eligible for Medicaid, and assist them in applying.

ANNUAL REPORT (S.506)

* Effective for FY 1991, the annual report must be prepared by, or in consultation with, the State MCH agency and must include information on: (1) number of individuals served under Title V by class of individuals [classes: pregnant women, infants to age one, CSHCN, other children under age 22, other individuals]; (2) proportion of each class which has health insurance; (3) types of services provided to individuals, by class; (4) amounts spent on each type of service, by class; (5) information on status of maternal and child health in the state. This latter category requires submission of information: (a) by county and by racial and ethnic group on infant mortality rate and rate of low-birth

4

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weight births; (b) on a statewide basis: maternal mortality rate; rate of neonatal deaths; rate of perinatal deaths; number of children with chronic illness and types; proportion of infants born with fetal alcohol syndrome; proportion of infants born with drug dependency; proportion of women delivering who did not receive prenatal care during first trimester; proportion of children who, at second birthday, have been vaccinated against measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis and hepatitis B;
(c) information by racial and ethnic group on number of deliveries to women who were provided care under Title V or were entitled to Title XIX benefits with respect to such deliveries; number of infants in the State; and number of infants who received Title V services or were entitled to Medicaid benefits; and (d) information on the number of State licensed obstetricians, family practitioners, certified family nurse practitioners, certified nurse midwives; pediatricians, and certified pediatric nurse practitioners.

REQUIREMENTS FOR HHS SECRETARY
(INDEPENDENT FROM TITLE V)

* Within one year after enactment, the Secretary of DHHS must develop a "model application form" for use by pregnant women and children up to age 6 in applying simultaneously for maternal and child assistance programs (which includes any of the following: Title V, Title XIX, community and migrant health centers, Section 340 (homeless), WIC and Head Start).

* Within 1 year after enactment, the Secretary of DHHS must develop a model Medicaid application form for use by individuals who are not receiving cash assistance under part A of Title IV of the Social Security Act (AFDC), and who are not institutionalized. The Secretary may not require any State to use the model form.

* The Secretary of DHHS must develop a national data system for linking, for any infant: (1) the infant's birth record; (2) any death record for the infant; and (3) information on any Medicaid claims for health care furnished to the infant or with respect to the birth of the infant.

* Authorization of $5 million for each of 3 years (FY 1991-FY 1993) for up to 4 demonstration projects to provide health insurance coverage through an eligible plan to "medically uninsurable children" under age 19.

* Authorization of $1 million for each of 3 years (FY 1991-FY 1993) for development, dissemination and evaluation of "MCH Handbooks" by DHHS, in consultation with NCPIM and other public and private organizations interested in MCH.

uman Services Subcommittee
aternal and Child Health Block Grant
anuary 11, 1991

The following shows the total federal fiscal year 1991 appropriation to the Department of Health and Environmental Sciences for the aternal and Child Health Block Grant, and the allocations in the Executive Budget and the LFA current level.

evenue	Actual FY 90	Executive FY 92	LFA FY 92	Difference	Executive FY 93	LFA FY 93	Difference
otal Federal Fiscal 1991 Appropriation	$2,396,333	$2,204,426	$2,204,426	$0	$2,204,426	$2,204,426	$0
isbursements							
ental/Medical Unit	$55,369	$93,087	$70,094	$22,993	$93,632	$69,927	$23,705
ealth Services Administration	$28,340	$31,579	$29,932	$1,647	$31,719	$29,879	$1,840
amily Planning	$29,000	$29,000	$29,000	$0	$29,000	$29,000	$0
amily/Maternal & Child Health Admin	$184,978	$236,519	$195,809	$40,710	$236,441	$195,697	$40,744
andicapped Children	$835,083	$845,468	$873,279	($27,811)	$846,407	$907,883	($61,476)
erinatal Program/Preventive Health Bureau Admin	$152,894	$127,231	$194,721	($67,490)	$127,142	$196,926	($69,784)
reventive Health Bureau Admin		$15,278		$15,278	$15,260		$15,260
rants to Counties	$671,765	$672,316	$689,090	($16,774)	$672,316	$689,090	($16,774)
ow Birthweight Prevention*	$65,999	$65,000		$65,000	$65,000		$65,000
ase Management	$21,117			$0			$0
arryover to Counties	$278,526			$0			$0
Total Disbursements	$2,323,071	$2,115,478	$2,081,925	$33,553	$2,116,917	$2,118,402	($1,485)
nding Fund Balance	$73,262	$88,948	$122,501		$87,509	$86,024	

Part of Perinatal Program/Preventive Health Bureau Administration in LFA current level.

Exhibit 5
1-11-91
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uman Services Subcommittee
reventive Health Block Grant
anuary 11, 1991

The following shows the total federal fiscal year 1991 appropriation to the Department of Health and Environmental Sciences for the reventive Health Block Grant, and the allocations in the Executive Budget and the LFA current level.

evenue	Actual FY 90	Executive FY 92	LFA FY 92	Difference	Executive FY 93	LFA FY 93	Difference
otal Federal Fiscal 1991 Appropriation	$590,597	$644,771	$644,771	$0	$644,771	$644,771	$0
isbursements							
ublic Health Laboratories	$66,743	$66,837	$67,000	($163)	$66,837	$67,000	($163)
ealth Services Administration	$12,633	$13,678	$13,404	$274	$13,668	$13,380	$288
mergency Medical Services	$166,797	$185,779	$168,291	$17,488	$186,888	$169,824	$17,064
amily Planning	$202,015	$203,878	$205,000	($1,122)	$203,865	$205,000	($1,135)
erinatal Program/PH Bureau Admin	$69,667	$8,576	$76,299	($67,723)	$8,739	$74,574	($65,835)
H Bureau Admin		$69,081		$69,081	$68,768		$68,768
ealth Education	$42,631	$61,148	$47,275	$13,873	$61,488	$47,491	$13,997
ape Crisis	$11,968	$11,968	$11,968	$0	$11,968	$11,968	$0
irector's Discretion	$18,143			$0			$0
Total Disbursements	$590,597	$620,945	$589,237	$31,708	$622,221	$589,237	$32,984
nding Fund Balance	$0	$23,826	$55,534		$22,550	$55,534	

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5301 DEPT HEALTH & ENVIRON SCIENCES
06 HEALTH SERVICES/MEDICAL FAC
00000

DATE : 01/08/91
TIME : 21/29/24
CURRENT LEVEL COMPARISONS

Budget Item	Actual Fiscal 1990	Executive Fiscal 1992	LFA Fiscal 1992	Difference Fiscal 1992	Executive Fiscal 1993	LFA Fiscal 1993	Difference Fiscal 1993
FTE	15.52	13.02	13.02	.00	13.02	13.02	.00
Personal Services	469,656	421,864	422,764	900-	421,713	422,613	900-
Operating Expenses	317,219	355,849	306,365	49,484	357,453	307,943	49,510
Equipment	1,595	4,240	3,481	759	4,240	3,481	759
Total Expend.	$788,470	$781,953	$732,610	$49,343	$783,406	$734,037	$49,369
Fund Sources							
General Fund	541,619	505,806	474,663	31,143	505,857	474,613	31,244
State Revenue Fund	39,079	45,111	46,320	1,209-	45,274	46,341	1,067-
Federal Revenue Fund	207,772	231,036	211,627	19,409	232,275	213,083	19,192
Total Funds	$788,470	$781,953	$732,610	$49,343	$783,406	$734,037	$49,369

LFA Current Level Analysis Reference: page B-34
Executive Budget Summary Reference: page 73
Executive Budget Narrative Reference: page 54

Current Level Issues	---Exec Over (Under) LFA--- FY 92 FTE	FY 93 FTE	FY 92 Amount	FY 93 Amount
Reorganization Issues				
1. Indirect Charges			$17,671	$17,929
Appropriation Policy Issues				
1. Difference in the funding base			$6,106	$5,925
2. Difference in computer network charges			$4,142	$4,142
3. Difference in inflation			($238)	($289)
Program Issues				
1. Communications and supplies in division administration due to previously coding these expenses to other division programs			$562	$562
2. Travel in the Emergency Medical Services Bureau due to a reduced fiscal 1990 base and an increase in duties			$9,000	$9,000
3. Supplies reduced from the fiscal 1990 base in the LFA current level			$13,000	$13,000
Total	0.0	0.0	$50,243	$50,269

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Date Initiative

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DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
PROGRAM NARRATIVE FOR HEALTH SERVICES DIVISION

PRESENTED TO: HUMAN SERVICES JOINT SUBCOMMITTEE OF
HOUSE APPROPRIATION AND SENATE FINANCE AND CLAIMS COMMITTEES
January 10, 1991

The Health Services Division is responsible for the administration of the Bureaus and Programs of the Division. There are 2.5 FTE's assigned to Division Administration. Following the reduction of the scope of the Certificate of Need program in the last legislative session, the Health Planning Bureau was reduced to a Program and the Program Manager duties were assumed by the Administrative Officer in the Division office.

Subsequent to the budget preparation, the Department received a grant of $95,694 for the development of health services for rural underserved populations. A budget amendment has been submitted for this grant and the Department requests inclusion of $95,694 for each year of the biennium. These funds include $85,694 in contracted services and the remainder in Department personnel and operating costs. No FTE's are included. The grant application was written in cooperation with the Montana Primary Health Care Association and the Montana Area Health Education Center.

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EMERGENCY MEDICAL SERVICES BUREAU
MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

January 11, 1990

Madam Chair, and members of the committee. I am Drew Dawson, Chief of the Emergency Medical Services Bureau.

GENERAL OVERVIEW OF EMERGENCY MEDICAL SERVICES BUREAU

The EMS Bureau is responsible for the establishment of a statewide emergency medical services program. We work cooperatively with a variety of emergency medical services providers including ambulance services (air and ground), quick response units, fire departments, law enforcement agencies and other volunteer and paid personnel such as physicians, nurses, EMTS, paramedics and others.

With the tremendous dedication and support of both volunteer and paid personnel in Montana communities, we are gradually making significant improvements in Montana's emergency medical services system. There are many folks in each of your communities who dedicate countless hours to improving Montana's EMS system.

The EMS Bureau currently has eight (8) staff members-all of whom are very dedicated to EMS. In addition to their employment in the EMS Bureau, each of the professional staff also provides emergency medical services in a volunteer capacity with neighboring ambulance services, quick response units or law enforcement agencies. This helps us to understand the problems faced by EMS personnel, allows us to be responsive to their needs and generally, we hope, improves our credibility with field providers.

The Bureau is funded with a combination of general fund and preventive health block grant funding. In addition, there is a special revenue account to accommodate the fees charged for certification of emergency medical technicians and for the occasional sale of training materials and supplies to local personnel.

TRAINING AND CERTIFICATION

- We conduct classes to train local EMS personnel to coordinate First Responder and EMT training programs. Since we are not able to provide direct training to all EMS providers, this "train the trainers" approach is a reasonable alternative. We help to offset the lodging and perdiem costs of local EMS providers who travel to our "train the trainers" sessions.

- To accommodate the needs of rural volunteers, we have designed and are implementing a training program to allow First Responders to progress to EMT training without having to repeat the skills and knowledge they already possess. This should assist tremendously with the recruitment of volunteers and help ease the burden of staffing an ambulance service.

- Our film library continues to make training films and other training aids available to local emergency medical services training programs.

- On behalf of the Montana Board of Medical Examiners, we certify, by written and practical examination, EMT-Basic, EMT-Defibrillation, EMT-Intermediate and EMT-Paramedic personnel. To assure the EMT examination

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these course management training sessions.

1. The EMS Bureau received federal funding from Highway Traffic Safety effective on October 1, 1990, to implement the Montana Trauma Register and received a budget amendment. The contract is effective from October 1, 1990 to September 30, 1991. The anticipated amount of this contract to be expended during FY 92 (July 1, 1991 to September 30, 1991) is $11,126 which will support .25 FTE.

   We request additional FY 92 authorization for this $11,126 and .25 FTE. A breakout by category of expenditure is attached.

STATE SPECIAL REVENUE

This authorization in state special revenue allows us to receive and to expend fees charged for EMT certification and for the sale of training supplies and materials. This is an authorization level only; if we do not receive the funds, we cannot expend them. There is no state or federal money involved.

As has been done in previous years, we again request permission to continue the state special revenue fund without the balance being transferred to the general fund. Since an individual's certification process often crosses fiscal year boundaries, it is essential that the year-end balance not be reverted to the General Fund.

Thank you for the opportunity to present our program to you. I would be pleased to answer any questions about the EMS Bureau programs or funding.

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Health Planning Program
Health Services Division
Department of Health and Environmental Sciences

Testimony for the Appropriations Joint Subcommittee
on Human Services

Representative Bradley and Committee Members. My name is Charles Aagenes and I am the Assistant Administrator of the Health Services Division. In addition, I am the Program Manager for the Health Planning Program. Until last summer Health Planning was a Bureau, but minor reorganization within the Health Services Division resulted in Health Planning being designated as a program attached to the Health Services Division Administration. This reorganization has reduced Health Planning staff from 4.75 FTE to 2.25 FTE.

The duties and responsibilities of the Health Planning Program are essentially the same even though the title has changed and the staff has been reduced. The program is responsible for providing a State Health Plan, we conduct other forms of planning functions and research relative to health services, we administer the Certificate of Need Program, we collect, maintain and distribute health facility data. Health Planning staff, as part of their duties, also maintain the End Stage Renal Disease subsidy payment function. We also provide technical assistance in various ways to the Department in grant writing, special surveys, data collection and evaluation and other special projects affecting the Department of Health and Environmental Sciences and other Departments.

Our workload has not decreased in Health Planning's responsibilities to Certificate of Need, the State Health Plan and data collection and publication. In some areas, such as the provision of support services and research, the End Stage Renal Disease Program and other special projects, the Health Planning Program has experienced increases in its responsibilities. Present budget recommendations may result in Health Planning not being able to maintain current level activities.

FAMILY/ MATERNAL AND CHILD HEALTH BUREAU

Montana Department of Health and Environmental Sciences

January, 1991

Family/MCH Administration

Family/Maternal and Child Health Bureau
Montana Department of Health and Environmental Sciences

Representative Bradley and Members of the Committee, I am Maxine Ferguson, recently hired as Bureau Chief of Family/Maternal and Child Health Services.

PURPOSE: The Family/Maternal and Child Health Bureau carries major responsibility for maternal and child health services in Montana. Bureau programs include:

Handicapped Children's Services;
Family Planning;
Special Supplemental Food Program for Women, Infants and Children (WIC);
Child Nutrition Program (CNP) and Child and Adult Care Food Program (CACFP);
Montana Perinatal Program -- which was moved from Preventive Health Services to Family/MCH Bureau during recent Department reorganization.

RESPONSIBILITIES: Family/MCH Bureau Administration activities entail coordination of the above programs, supervision of special projects or grants and administration of the MCH Block Grant (Title V) to counties. Educational and technical assistance are provided to county personnel to help them meet program and reporting requirements. Changes in the MCH Block Grant were enacted by OBRA '89, with additional changes anticipated under OBRA '90. Mr. Taliaferro alluded to these changes in his introductory remarks. Briefly, those changes which are effective with FFY '91 include:

- the Report of Intended Expenditures has been changed to an application in a standardized form specified by the Secretary of U. S. Department of Health and Human Services;
- a state-wide needs assessment (to be conducted every 5 years) for preventive and primary care services for pregnant women, infants and children; and services for children with special health care needs.
- The needs statement must be consistent with the year 2000 national health objectives and health status goals.
- 30% of the Title V funds must be spend on preventive and primary care services for children and 30% on services for children with special health care needs. These requirements may be waived with appropriate documentation based on needs assessment.
- States must maintain the level of funding provided solely by the State for MCH programs at least equal to FY '89 levels;
- A toll-free hotline to provide parents with information regarding health care providers participating in Titles V (MCH Block Grant) and XIX (Medicaid) programs must be available;
- Services must be provided to identify pregnant women and infants eligible for Medicaid and assist them in applying;
- Annual reporting requirements have been increased.

The block grant must be matched on a ratio of 3/7 state funds to 4/7 federal funds. The state match in fiscal 1990 was met with general funds appropriated to: 1) the Montana Medical Genetics Program at Shodair Hospital; 2) the immunization, family planning, and communicable disease programs plus the newborn screening test expenditures in the public health laboratory, all in DHES; and 3) through services provided by the counties.

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During this biennium, Family/MCH Bureau Administration has been responsible for two major grants: 1) Staff Development, which provided opportunity for some capacity building of MCH staff as well as a beginning assessment of MCH needs in the state; and 2) Children With Special Health Care Needs. The latter was a SPRANS grant (MCH Block Grant money set aside at the federal level for Special Projects of Regional and National Significance) which developed capacity of public health nurses in several smaller counties to provide and coordinate services for children with special health care needs. Services developed by Roosevelt county as part of this grant received national recognition. The model used in service development will be shared with other areas as a way in which to better serve handicapped children and their families in areas where services are scarce.

FUNDING: Funding for Family/MCH Bureau Administration is from federal MCH Block Grant monies.

STAFF: The staff includes three full time employees:

Bureau Chief
Public Health Nurse Consultant
Administrative Aide

PRESENTATIONS: The Programs will present in the following order:

Handicapped Children's Services	Judith Wright, Program Supervisor
Family Planning	Suzanne Nybo, Program Supervisor
WIC	Dave Thomas, Program Supervisor
Child Nutrition	Peg Baraby, Program Supervisor
Perinatal Program	Jo Ann Dotson, Nurse Coordinator

I will be pleased to answer questions from the Committee or to refer them to Program Managers or others attending today. Thank you for the opportunity to meet with you.

January, 1991

January, 1991

HANDICAPPED CHILDREN'S SERVICES
FAMILY/MATERNAL AND CHILD HEALTH BUREAU
DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

Madame Chair and members of the committee, I am Judith Wright, Program Manager for Handicapped Children's Services.

Handicapped Children's Services (HCS) Program is responsible for serving children who are physically handicapped or suffering from physical afflictions or chronic diseases, such as asthma, diabetes, PKU and cystic fibrosis, that might lead to handicapping conditions. It is the aim of HCS that these children be served in their communities or as close to home as is possible in our very rural state. Services provided to a child can include payment for diagnosis, evaluation, treatment and rehabilitation, specialty medical clinics, and case management.

Montana's children are served by the program from birth to age 18, and on to age 21 in some cases. Women are covered for emergency maternal transports only. Eligibility for payment for medical treatment is determined by the child's condition and by income criteria currently set at 185% of the federal poverty level, with a deduction allowed for out of pocket expenses for health insurance. Services funded can include office visits with physicians and other health care providers, laboratory tests, surgery and hospitalizations, medications and special formulas, braces, ambulance transports, and other therapies such as physical or occupational therapy as needed. Payments are made directly to providers. During state fiscal year (SFY) 1989 HCS authorized payment for treatment of 368 infants and children and 11 women. During SFY90 400 infants and children were served and 4 women. HCS does not pay for services that are covered by Medicaid, and any other possible payment resources from private insurers are explored and utilized before HCS payments are made.

There are no income guidelines for attendance at the specialty clinics. The clinics provided are for those children with cardiac, neurological, cleft lip and cleft palate, and arthritic conditions. They are held at sites around the state. The clinics bring specialists to the children and their families rather than the other way around. They save many families the expense and trouble of having to go vast distances or even out of state for diagnosis, follow-up and management of their child's condition. During SFY90, 674 children were seen at cardiology clinics by pediatric cardiologists from Denver, Salt Lake City, and Great Falls. Cleft lip and cleft palate teams saw 149 children. The pediatric neurology clinics served 564 children, while 65 were seen at the clinics for children with juvenile rheumatoid arthritis and related conditions. HCS also provides funding for other specialty medical clinics held at the Montana Center for Handicapped Children in Billings. Approximately 160 children were seen at these clinics for disorders that included neural tube defects, orthopedic anomalies, and communication, speech and hearing disorders. During SFY90 an additional site for the cardiac clinics was added, and clinic types expanded to include the neurological and arthritic conditions.

HCS staff assist families with referrals to other health care providers in their communities or in the state. If necessary, provisions are made for complicated procedures which are only available out-of-state, such as all cardiac surgery and major cleft palate/craniofacial repairs. Every effort is made to provide in-state follow-up for these major surgeries. Families are also assisted with often lengthy and cumbersome insurance procedures. HCS staff coordinate

referrals with local public and tribal health nurses to assure local follow-up, and with any other resources available to the children.

Four HCS staff carry out the responsibilities of the program: a program supervisor, a public health nurse, an administrative assistant and an administrative aide. Medical questions and concerns are referred to the program Medical Director. Guidance is provided by the HCS advisory committee which is comprised of physicians, other health care providers, and a consumer.

During SFY90, all program funds were obligated by fiscal year end. We have seen an increase in the cost of procedures to correct handicapping conditions due to inflationary costs as well as to the complexity of procedures now available for conditions previously only partially correctable or even un-correctable. We have also experienced the slight increase in the number of children served. The Handicapped Children's Services Program is funded entirely by Title V, the Maternal and Child Health Block Grant.

TESTIMONY

State Family Planning Program
Department of Health and Environmental Sciences (DHES)
Prepared for: Human Services Appropriations Subcommittee
January 11, 1991

Madam Chair and members of the Subcommittee: My name is Suzanne Nybo and I am the Program Manager for the State Family Planning Program.

INTRODUCTION:

The State Family Planning Program (FPP) is a preventive health program responsible for planning, developing, implementing, and evaluating quality reproductive and preventive health care services that positively impact the health status of men, women, and children in Montana. This includes, but is not limited to, fiscal management and administration, service delivery, data collection and analysis, staff development, and monitoring and evaluation of family planning services.

FPP staff consists of 4 FTEs: A full-time Program Manager, Program Officer (job-shared position), Administrative Assistant and a Nurse Consultant.

PURPOSE AND PROGRAM IMPACT:

The primary purpose of FPP is the provision of comprehensive medical, health education, social, counseling and referral services that lower the incidence of unintended pregnancy (including adolescent pregnancy), improve maternal/child health, reduce abortions and improve the reproductive health status of all Montanans. Priority for services is given to persons from low income families.

Effective family planning programs are an essential health care delivery intervention. Preventing high-risk or unintended pregnancy is the most cost effective means of reducing the incidence of both low birth weight and infant mortality. The health of women and children is also improved through detection and prevention of cancer and sexually transmitted diseases with women.

PROGRAM DESCRIPTION:

FPP provides comprehensive family planning services through 14 local agencies and satellite programs which include seven city/county health departments, four private community agencies and three planned parenthood affiliates. Each program functions under the medical supervision of a licensed physician. Some of the services offered are: physical examinations including breast exams and cervical cancer screening (Pap smears); pregnancy testing; lab testing; blood pressure recordings; contraceptive dispensing, screening and treatment for sexually transmitted diseases, as available; immunization for rubella or referral to available services; health education and counseling; and referral to public and private health care, medical and social service providers.

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ACCOMPLISHMENTS:

In SFY 1990, 23,057 persons from 55 counties in the state were served by FPP, a 489 percent increase in case load since the program's inception in 1972. 83 percent of all persons served were from low income families. In 1989, it is estimated the 14 family planning programs prevented 7,138 unplanned pregnancies which would have resulted in 4,929 births, 908 abortions and 1,301 miscarriages. This would have included approximately 148 cases of congenital abnormalities, 148 cases of hypoxic brain damage, 25 cases of chromosomal abnormalities and 330 high-risk premature deliveries.

In SFY 1990, the programs detected and referred for treatment: 592 positive Pap smears for cervical cancer; 222 cases of anemia; 951 cases of breast diseases or other physical findings (heart, thyroid, etc.); 3,804 of vaginal infections and sexually transmitted diseases; and 417 cases of high blood pressure.

COST EFFECTIVE SERVICE DELIVERY:

FPP meets the needs of those who otherwise cannot afford services and could eventually become dependent on federal agencies. Through family planning, the reproductive health care needs of poor women, the availability of services to meet their needs and the access to equitable low cost, quality health care are met.

* In Montana, the cost to the government for a mother on welfare and an unplanned child averages $3,432 per year plus food stamps and Medicaid.

A recent study shows for every government dollar spent on family planning, from $2.90 to $6.20 (an average of $4.40) is saved as a result of averting [short-term] expenditure on medical services, welfare and nutritional services.

FUNDING:

FPP is funded with federal Title X grant funds, maternal/child health and preventive health block grant funds and state general fund dollars. The block grant and state general funds are directly allocated to the 14 local programs in the state to provide services; no administrative dollars are retained at the state office.

REQUEST FOR AUTHORIZATION TO ACCEPT ADDITIONAL FEDERAL TITLE X FUNDS:

There is discussion at the federal level about distributing additional Title X funds to the regions as special project monies for efforts to outreach and serve substance abusers and HIV positive women or for service delivery to low-income women. We request authorization to accept additional federal Title X funds for these purposes.

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January 1991

MONTANA STATEWIDE FAMILY PLANNING PROJECT

In Montana, 23,057 clients were served by programs in SFY 1990. This is a 489% increase in caseload since the program's statewide inception in 1972.

Each program functions under the medical supervision of a licensed physician.

Family Planning meets the needs of those who otherwise cannot afford services and could eventually become dependent on government agencies.

-- The cost to the government for a mother on welfare and an unplanned child averages $3,432 per year plus food stamps and Medicaid.

-- The average cost per family planning medical encounter is $24.

-- The short-term benefits (savings) to federal, state, and local governments are estimated to be an average of $4.40 for each dollar invested in family planning.

-- The long-term benefits are estimated to be $26 for each dollar invested.

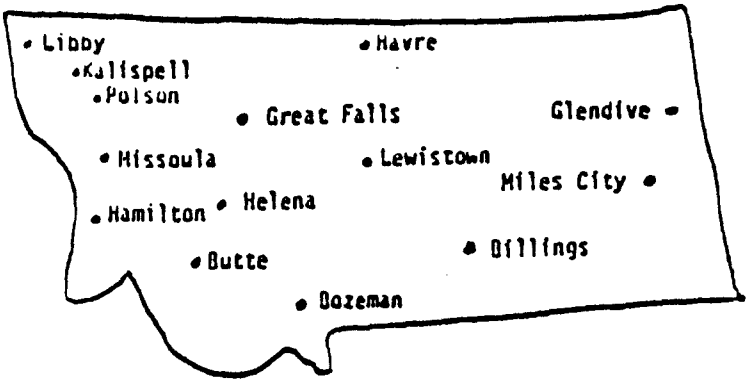
Family Planning is a preventive health effort with potential to reduce significantly certain social, psychological and medical problems of women and children. It is characterized by two important aspects:

-- Improvement of the health of women and children.

-- The acceptance of family planning services must always be the voluntary decision of the individual.

The goal of Montana family planning services is to maintain or improve the reproductive health of Montana people in their reproductive years.

In Montana there are presently 14 family planning clinics. Currently the funding is provided by: Federal Title X, Preventive Health (PH) Block Grant, Maternal and Child Health (MCH) Block Grant funds, and State General Fund through the Health Services Division of the Montana State Department of Health and Environmental Sciences; third party reimbursement; local funds; and direct fees paid by the clients based on their ability to pay. In addition, some counties have elected to utilize MCH Block Grant funds for Family Planning. Total funds expended in SFY 1990 were approximately $2,170,995.



The preventive health based programs provide:

- counseling in all aspects of family life
- educational services
- physical examinations
- cervical cancer screening
- self-breast exams
- blood tests for anemia, rubella & syphilis
- immunization for rubella
- referrals to private MDs
- blood pressure recordings
- urinalysis for sugar and protein
- inter-agency referral for other problems
- dispensation of contraceptives
- testing and treatment for gonorrhea
- pregnancy tests
- STD testing and treatment as available

Family planning services are directed toward the accomplishment of the following major health goals:

- Improve and maintain the emotional and physical health of men, women, and children, particularly through the detection and prevention of cancer and sexually transmitted disease with women.

- Prevent birth defects and mental retardation. Mental retardation tends to be associated with prematurity and low birth weight. The Comptroller General's report to Congress on Mental Retardation, 1977, identified the family planning program as an existing program with the ability to make a significant contribution towards reducing the incidence of mental retardation.

- Reduce the incidence of abortion by preventing unplanned pregnancies.

- Assure that more children are "wellborn" by decreasing the incidence of prematurity and birth defects.

- Decrease maternal and infant mortality and morbidity.

- Assist couples who want to have children but cannot.

- Prevent unplanned pregnancies (particularly in child abuse and poverty situations).

- Improve pregnancy outcome by correction of health problems between pregnancies and by proper spacing and timing of pregnancy.

- Assist couples in having the number of children they desire so that every child is intended and loved.

The Need:

- There are an estimated 41,730 women-in-need of subsidized family planning services in Montana.

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-- About 46% of these women (19,244) are being served by the 14 programs. Roughly estimated, an additional 8,763 women-in-need (or 21%) are being provided family planning services by private physicians.

-- This leaves approximately 13,723 (33%) Montana women needing family planning services who are not receiving them. They are at risk for unplanned children.

Accomplishments:

-- 83% of the 23,057 clients served in SFY 1990 lived in families with incomes at or below 150% of the poverty level.

-- Medical and/or education services were provided by programs to women in 55 counties in SFY 1990.

In SFY 1990 the 14 programs detected and/or referred for treatment:

-- 592 positive pap smears for cervical cancer
-- 222 cases of anemia
-- 299 abnormal urine chemistry results
-- 23 cases of gonorrhea
-- 3,804 cases of vaginal infections/STD's
-- 630 cases of chlamydia
-- 951 cases of breast diseases or other physical findings (heart, thyroid, etc.)
-- 417 cases of high blood pressure

MONTANA STATEWIDE FAMILY PLANNING PROJECT

ESTIMATED SFY 1990 FUNDS EXPENDED: $2,170,995

Family Planning Programs	SFY 1990 Patient Load
Cascade	2,462
Custer	657
Dawson	568
Fergus	424
Flathead	1,321
Gallatin	3,578
Hill	742
Lake	353
Lewis & Clark	1,866
Lincoln	829
Missoula	3,683
Phillips	159
Ravalli	223
Silver Bow	1,685
Yellowstone	4,507
TOTAL	23,057

County	SFY 1990 Patient Load
Beaverhead	332
Big Horn	34
Blaine	91
Broadwater	20
Carbon	118
Carter	10
Cascade	2,274
Chouteau	71
Custer	517
Daniels	6
Dawson	300
Deer Lodge	235
Fallon	50
Fergus	378
Flathead	1,321
Gallatin	3,108
Garfield	30
Glacier	13
Golden Valley	11
Granite	44
Hill	627
Jefferson	81
Judith Basin	27
Lake	388
Lewis and Clark	1,816
Liberty	19
Lincoln	831
Madison	34

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McCone	23
Meagher	7
Mineral	38
Missoula	3,399
Musselshell	34
Park	72
Petroleum	19
Phillips	165
Pondera	26
Powder River	45
Powell	62
Prairie	14
Ravalli	330
Richland	204
Roosevelt	8
Rosebud	47
Sanders	37
Silver Bow	1,313
Stillwater	79
Sweetgrass	14
Teton	31
Toole	24
Treasure	4
Valley	5
Wheatland	30
Wibaux	19
Yellowstone	4,031
Out-of-state	130
Unknown	61
TOTAL	23,057

FAMILY PLANNING PROGRAM

UNPLANNED PREGNANCIES PREVENTED

In 1989 the 14 family planning programs in Montana prevented an estimated 7,138 unplanned pregnancies. These pregnancies would have resulted in 4,929 births, 908 abortions, and 1,301 miscarriages. This would have included approximately 148 cases of congenital abnormalities, 148 cases of hypoxic brain damage, 25 cases of chromosomal abnormalities and 330 high-risk premature deliveries.

PROGRAM	Pregnancies Prevented	Births Prevented	Abortions Prevented	Miscarriages Prevented
Billings	1,352	933	173	247
Bozeman	1,132	782	144	207
Butte	436	300	56	79
Glendive	198	138	25	36
Great Falls	878	607	112	161
Hamilton	78	54	10	14
Havre	278	193	35	50
Helena	591	407	75	106
Kalispell	399	276	51	73
Lewistown	111	76	14	20
Libby	262	180	33	47
Miles City	195	135	24	36
Missoula	1,114	769	142	204
Polson	114	79	14	21
STATEWIDE	7,138	4,929	908	1,301

SOURCE: Trussell Method Effectiveness Estimates, "Cost Versus Effectiveness of Different Birth Control Methods", T. James Trussell

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Figure 3

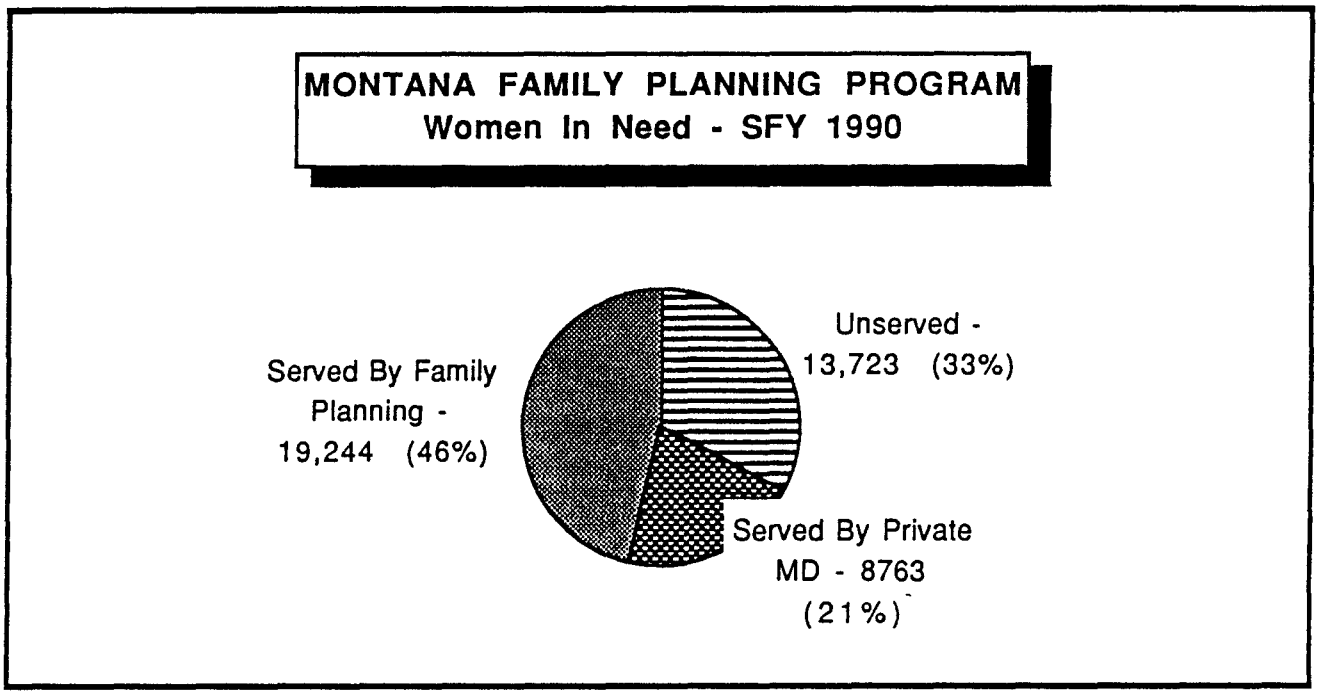
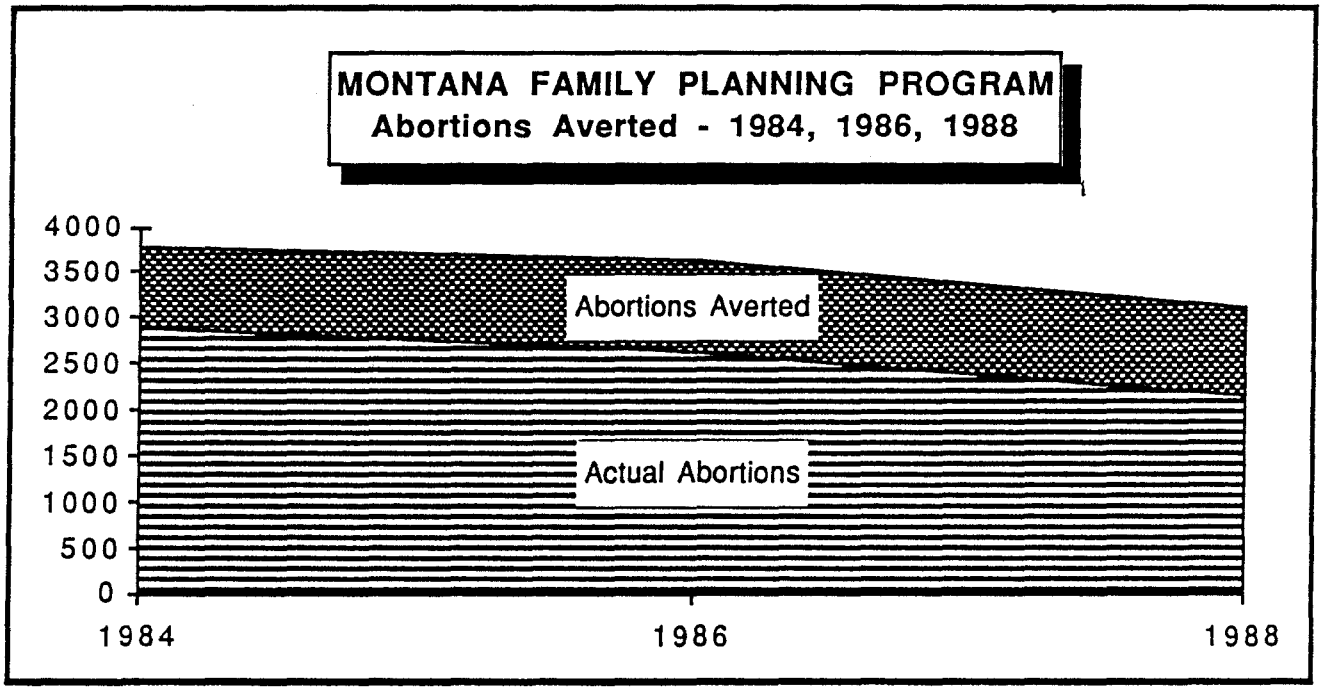


Figure 4



Montana Family Planning Facts

Figure 1

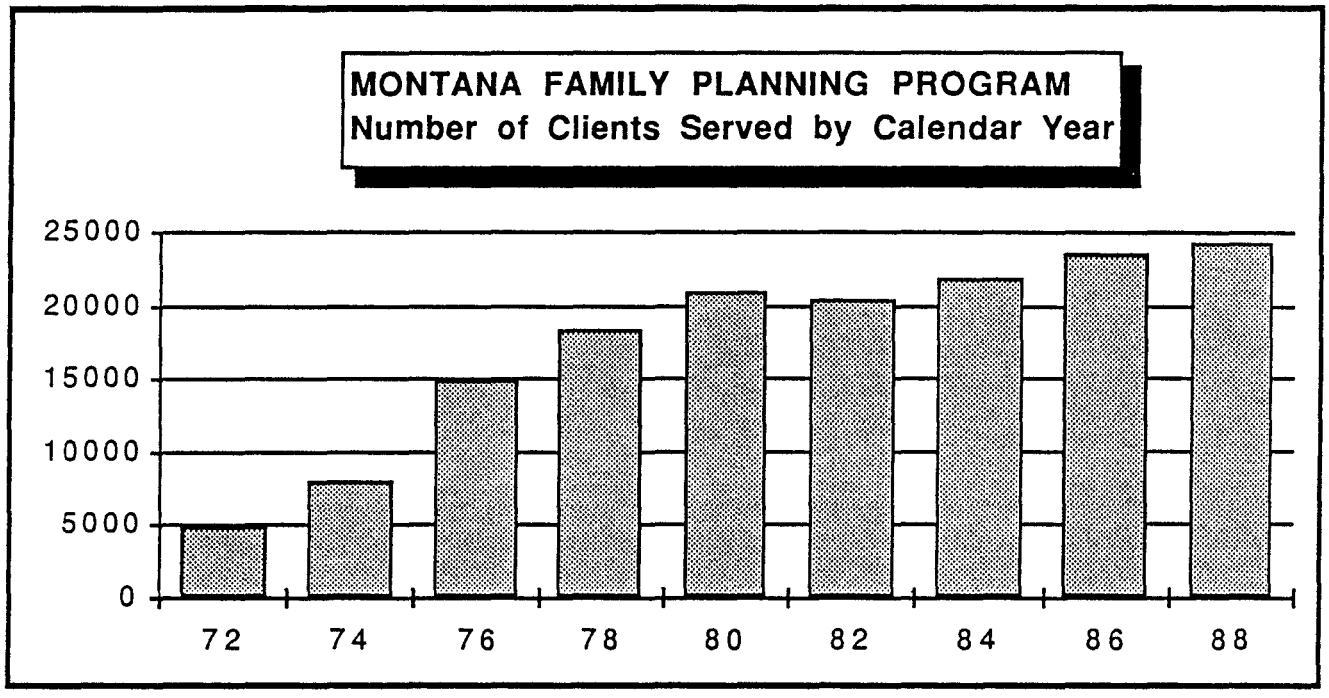
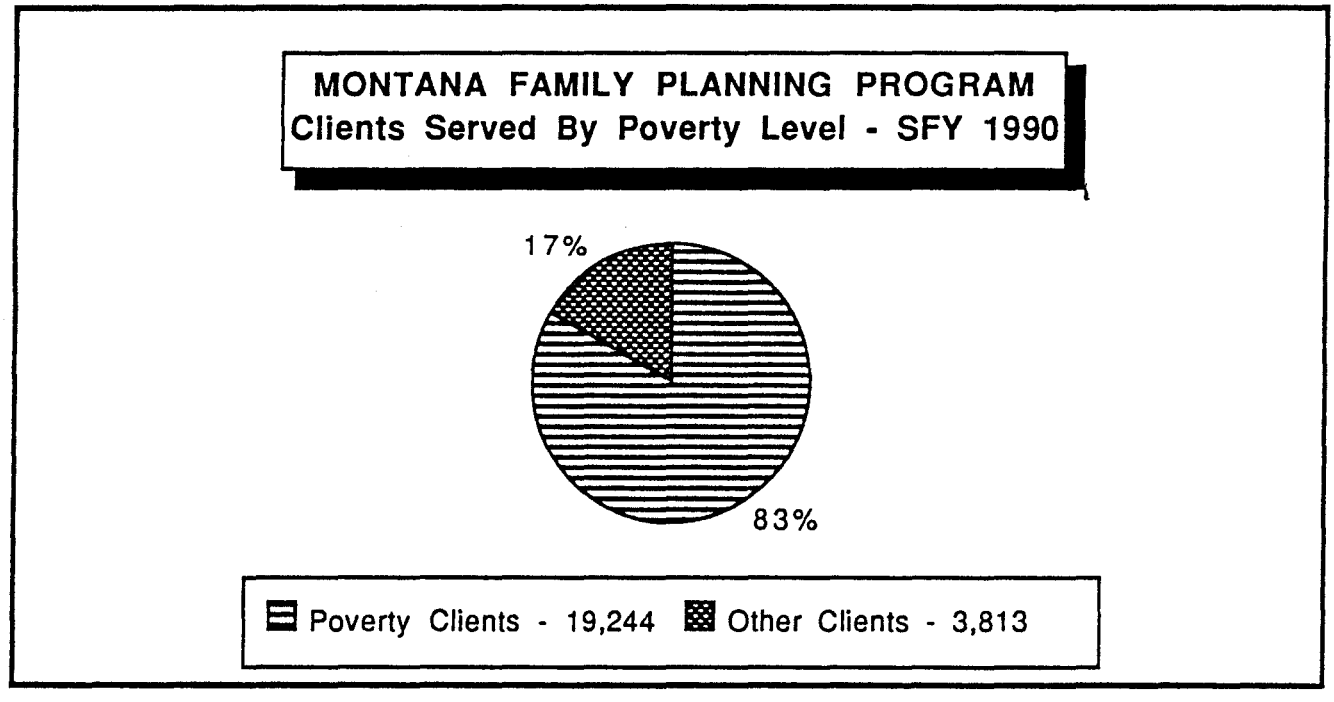


Figure 2



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SUPPLEMENTAL FOOD PROGRAM
FOR WOMEN, INFANTS AND CHILDREN (WIC)
January 10, 1991

Representative Bradley and members of the Subcommittee: My name is Dave Thomas and I am the Program Coordinator for the Special Supplemental Food Program for Women, Infants and Children (commonly known as WIC).

WIC is a major component of the Nutrition Programs, serving about 15,500 clients each month. Approximately 2,000 participants were added to our monthly client caseload this past federal fiscal year (FFY) from increased federal funding and receipt of $786,253 in infant formula rebates from 3 major formula companies. Formula rebate dollars are added back into the WIC food budget to serve more clients.

On January 3, 1991, the U. S. Department of Agriculture (USDA) awarded the State $8,846,902 for its FFY 91 WIC grant. This represents an increase of $715,000 above the FFY 90 grant award and was unavailable for inclusion in the 1993 biennium budget. WIC is 100% federally funded.

WIC provides low income, pregnant, postpartum, and lactating women, infants and children up to age five, at nutritional risk, with the following benefits: (1) nutrition assessment, education and counseling to improve eating behaviors and reduce nutritional problems; (2) selected foods to supplement diets lacking in nutrients needed during this critical time of growth and development; and (3) access to preventive health programs and referral to private and public health providers.

In October, 1990, USDA released a five-state study demonstrating that participation in WIC can lower Medicaid costs for mothers, newborns and for the federal government.* Further, the study shows that savings to the government exceed the cost of funding WIC.

Madam chairperson, that concludes my testimony.

* The Savings in Medicaid Costs for Newborns and Their Mothers from Prenatal Participation in the WIC Program: Executive Summary, October. 1990; Prepared by: Mathematica Policy Research, Inc.; States in the Study: Florida, Minnesota, North Carolina, South Carolina, and Texas.

MONTANA WIC PROGRAM
INFORMATIONAL PROFILE
UPDATED: 1/10/91

DESCRIPTION AND GOAL

WIC is the Special Supplemental Food Program for Women, Infants & Children.

WIC helps low-income pregnant and breastfeeding women, women who recently had a baby, and infants and children (up to age five) who are at health risk.

WIC benefits include:

1. Nutrition assessment, education and counseling to improve eating behaviors;
2. Supplemental, highly nutritious foods such as iron-fortified cereal, milk, eggs, peanut butter or dried beans, juice and for the mother who chooses not to breast-feed, iron-fortified infant formula;
3. Access to health care programs and referral to private and public prenatal and pediatric care providers.

PROVEN TRACK RECORD

WIC improves pregnancy results by providing or referring to support services necessary for full-term pregnancies.

WIC cuts down infant mortality by reducing the incidence of low birth weight babies (babies under 5.5 pounds are at greater risk of breathing problems, brain injuries, and physical abnormalities).

WIC gives infants and children a healthy start in life by combatting poor and/or insufficient diets.

ELIGIBILITY

To qualify for WIC benefits, a person must be:

1. Pregnant, or a breastfeeding woman; a woman who recently had a baby;
   an infant, birth to 12 months;
   a child, 1-5 years;
2. Determined by the health professional to be at medical/nutritional risk;
3. below 185% of Federal Poverty Income Guidelines

Family of 2 = $1,298/mo	$15,577/year
Family of 4 = $1,958/mo	$23,495/year

EFFECTIVENESS

WIC is a proven effective health care program. From the National WIC Evaluation, conducted by Research Triangle Institute of North Carolina and Dr. David Rush of Albert Einstein College of Medicine of Yeshiva University of New York City, we know:

- WIC **helps pregnant women see doctors earlier** and increases the number of women receiving timely prenatal care
- WIC participation **improves the length of pregnancy and birth weight**

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- WIC participation **reduces late fetal deaths**
- WIC **improves the diets** of women, infants and children
- WIC participation results in **increased head circumference (reflecting brain growth) of infants** whose mothers receive WIC during pregnancy
- WIC children are better immunized and are more likely to have a regular source of health care
- Children in WIC do better on vocabulary scores

From the Centers for Disease Control in Atlanta, Georgia, we know that Montana children who participate in WIC have shown a drop in their rate of anemia.

From a study entitled The Savings in Medicaid Costs for Newborns and Their Mothers from Prenatal Participation in the WIC Program we know that participation in WIC can lower Medicaid costs for mothers, newborns and the government.

AUTHORITY

WIC is managed by the United States Department of Agriculture (USDA) under Public Law 95-627, Child Nutrition Act of 1966. Current federal regulations were consolidated September, 1990.

In Montana, the Department of Health and Environmental Sciences (DHES) administers the grant from USDA through state administrative rules.

WIC IN MONTANA

- Began in 1974
- Caseload: November, 1990 15,672
  Number of Women 2,662
  Number of Infants 3,781
  Number of Children 9,229
- Potentially Eligible Women, Infants, Children 34,304
- Percent of potentially eligible served 45.69%
- Federal Fiscal Year (FFY) 91 Grant
  - -- $6,650,490 for food benefits
  - -- $2,196,412 for nutrition services and program administration costs
  - -- $8,846,902 total grant
  - -- $786,253 received from infant formula rebates in (FFY) 90
  - -- Allows DHES to contract with 32 local agencies in 48 counties and 7 Indian reservations
  - -- Average monthly food package totals about $ 39.00
  - -- Average monthly administrative cost/client is $7.50
  - -- 100% Federally funded
  - -- 9 full time staff at the State Agency
  - -- 320 grocery stores statewide participate
  - -- A typical woman participant receives six 12 oz. cans of vitamin-C enriched frozen juice concentrate; 28 quarts of milk; 2 dozen eggs; 36 ounces of hot or cold iron-enriched cereal; and one jar of peanut butter every other month.
  - -- A typical infant (not breastfeeding) receives 31 cans of iron-fortified formula. At six months add juice and cereal.

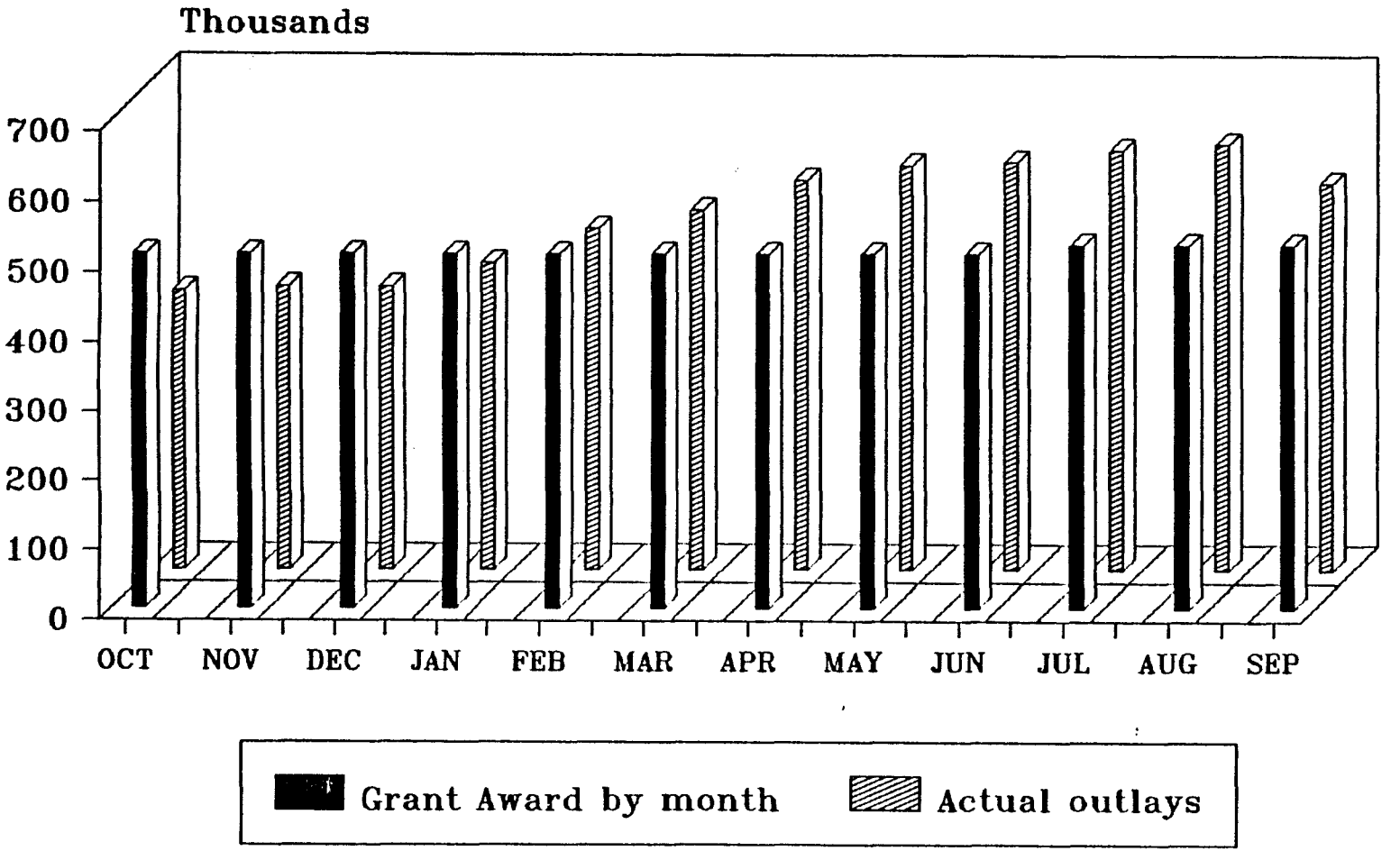
-- The typical child participant receives four 12 oz. cans of vitamin-C enriched frozen juice concentrate; 20 quarts of fresh milk; 2 dozen eggs; 36 oz. of iron-enriched hot or cold cereal; and one jar of peanut butter each month.

o Nutrition Education and Counseling

-- Focuses on prevention of Low Birth Weight Babies, prevention of Baby Bottle Tooth Decay, and Promotion of Breastfeeding
-- Coordinates with Healthy Mothers/Healthy Babies; Maternal and Child Health; Montana Perinatal Program; Handicapped Children's Services; Medicaid; Food Stamps; and other private and public health providers

o Routinely collects extensive information about nutrition problems for research and analysis by state and local WIC agencies

MONTANA WIC PROGRAM
FFY 90 FOOD GRANT



(Data incomplete for August and Sept)

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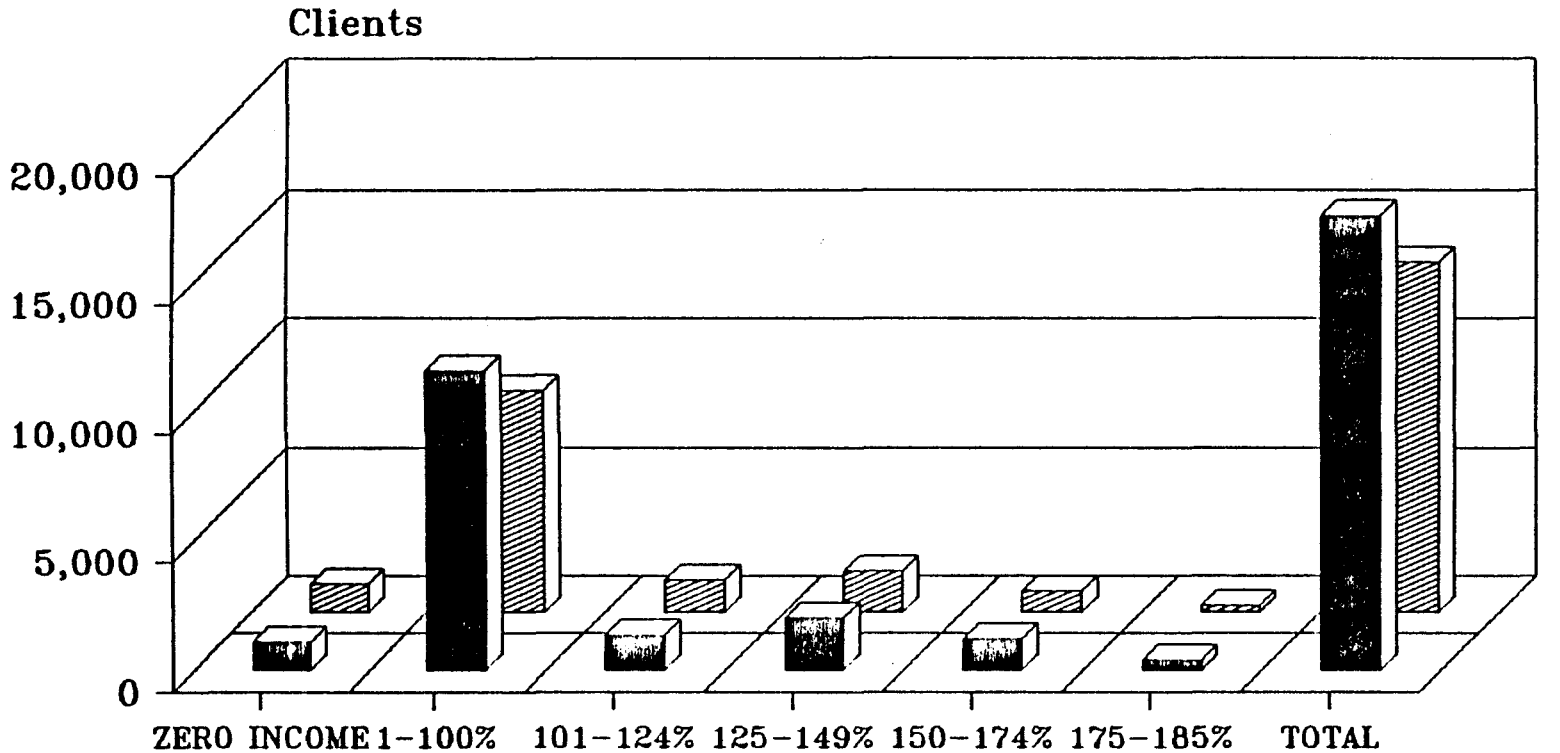
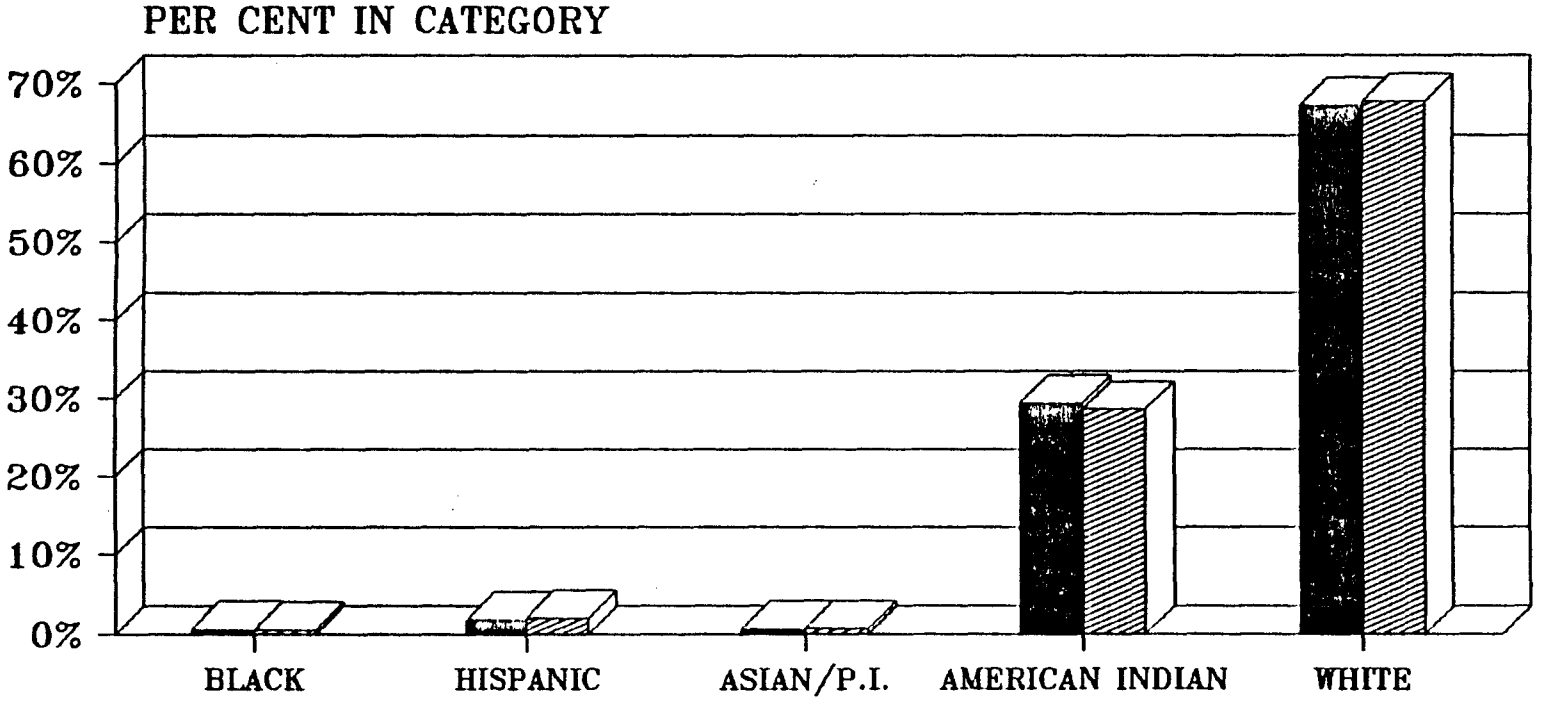
MONTANA WIC PROGRAM
Client Summary by Financial Category



Date Prepared: 9/5/90

MONTANA WIC PROGRAM
RACIAL/ETHNIC PARTICIPATION



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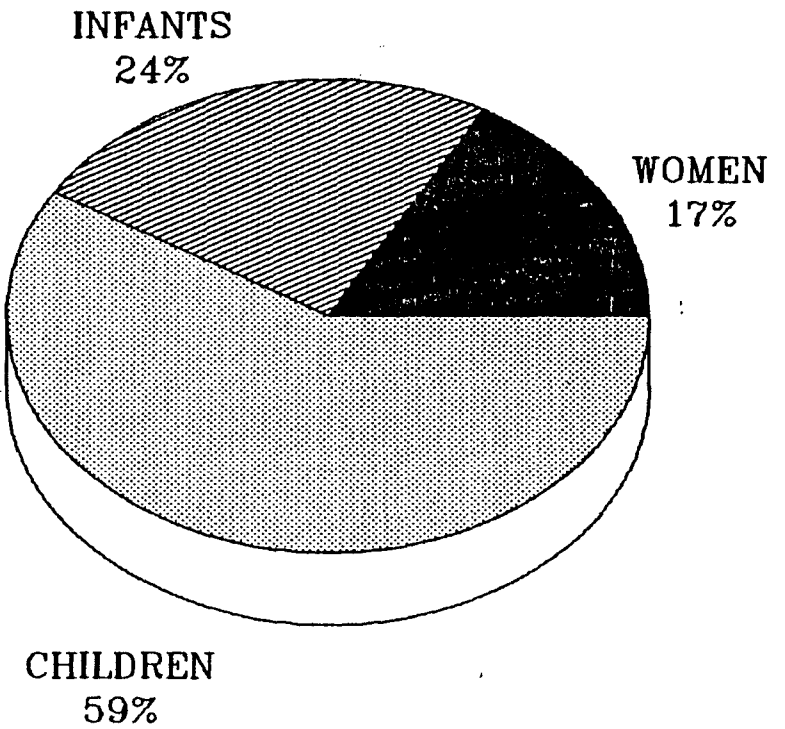
MONTANA WIC PROGRAM
Participation by Category



Date Prepared: 1/10/91

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DEPARTMENT OF HEALTH & ENVIRONMENTAL SCIENCES
HEALTH SERVICES AND MEDICAL FACILITIES DIVISION
MATERNAL AND CHILD HEALTH BUREAU

CHILD NUTRITION PROGRAM
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

Madam Chair and members of the Committee:

My name is Peggy Baraby. I am the Program Supervisor for the Child Nutrition Program

The Child Nutrition Program - Child and Adult Care Food Program is a USDA Food & Nutrition Service Program which operates under Federal Regulations..

GOAL: To improve the nutritional status of Montana's children by enabling institutions participating in the Child and Adult Care Food Program to serve wholesome, attractive meals that meet children's nutritional needs, to make mealtime a pleasant and sociable experience and to teach children to make wise food choices.

FUNDING: Funding for the program is 100% Federal $$. Funding for reimbursement to local programs for meals meeting specific nutritional requirements which are served to enrolled children is open-ended and depends on the number of meals served and the family size and income of the children enrolled in centers and Head Start programs. The reimbursement rate for meals served in centers is based on family size and income status and is higher for children from low income families. Reimbursement for meals served in day care homes is based on one rate per type of meal served. The Program also reimburses local Sponsoring Organizations of Day Care Homes for administrative expense associated with the CACFP. Funding for State Administrative Expense is per a formula based on the amount of reimbursement paid to local programs in the prior second year.

STAFF: 3.5 FTE

STATE AGENCY RESPONSIBILITIES: The Child Nutrition Program administers the program, assures local participants compliance with Federal Regulations, and provides reimbursement for meals meeting specific nutritional requirements that are served to children enrolled in participating facilities. The staff provide training and technical assistance in the areas of Program operations, nutrition, nutrition education, menu planning, meal service, food service and sanitation. Training and technical assistance are provided through on-site visits to new centers and new directors, menu evaluations, statewide training sessions and on-site reviews

of all participating institutions on a regular basis.

PARTICIPATION: Participation in the Program is voluntary. Participants must be licensed or approved public or private nonprofit, nonresidential, child care centers, Head Start Programs, day care homes, and outside-school-hours programs. Day care homes participate under a public or private non-profit sponsoring organization. All children enrolled in participating facilities are eligible to participate in the CACFP. In FFY 88 the Program was expanded to include Adult Day Care Centers.

Adult Day Care Centers must be public or private nonprofit organizations which are licensed or approved by Federal, State or local authorities to provide nonresidential adult day care services to functionally impaired adults, or persons 60 years of age or older in a group setting outside their homes on less than a 24 hour basis. Adult day care centers shall provide a community-based group program designed to meet the needs of functionally impaired adults through an individual plan of care.

Currently there are 16 Head Start Programs and 59 child care centers, with 104 sites. There are 11 sponsors of day care homes with 729 homes. During SFY90 there were 4.8 million meals served to approximately 17,000 enrolled children. There are no Adult Day Care Centers participating at this time. Over $4 million was reimbursed to local participants in SFY90. (See attached charts)

CONCERNS: Need for Budget Modification

As you can see from the attached charts, the program continues to grow each year. The number of children in the Program and the number of meals served increases each year. The reimbursement rates for meals also increase each year. Federal funding to reimburse local participants for the meals they serve is open-ended.

Based on past experience, we estimate that they Program will continue to grow approximately 23% each year. Based on this estimate, the Child Nutrition Program will need authority for an additional $2,033,313 in fiscal year 1992 and $3,433,313 in fiscal year 1993 to reimburse local participants for the meals they serve to enrolled children. This would bring the total $$ for grants to $6.1 million in 1992 and $7.5 million in 1993.

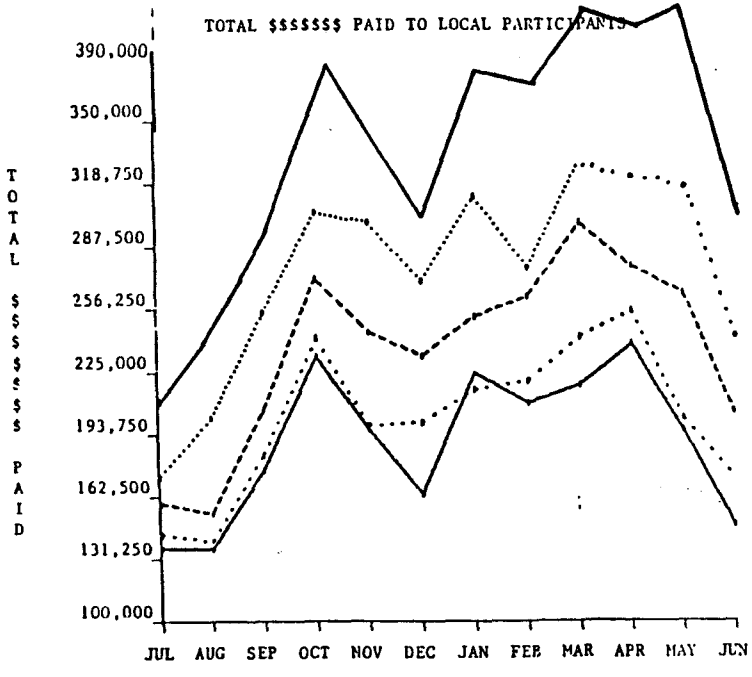
Thank you, that concludes my testimony.

$$ PAID TO LOCAL PARTICIPANTS

CHILD CARE FOOD PROGRAM COMPARISON

STATE FISCAL YEAR 1986
STATE FISCAL YEAR 1987
STATE FISCAL YEAR 1988
STATE FISCAL YEAR 1989
STATE FISCAL YEAR 1990

TOTAL $$$$$$$ PAID TO LOCAL PARTICIPANTS



TOTAL:	FY 86	FY 87	FY 88	FY 89
	2,274,174	2,429,878	2,818,419	3,299,733

SFY 90 4,034,769

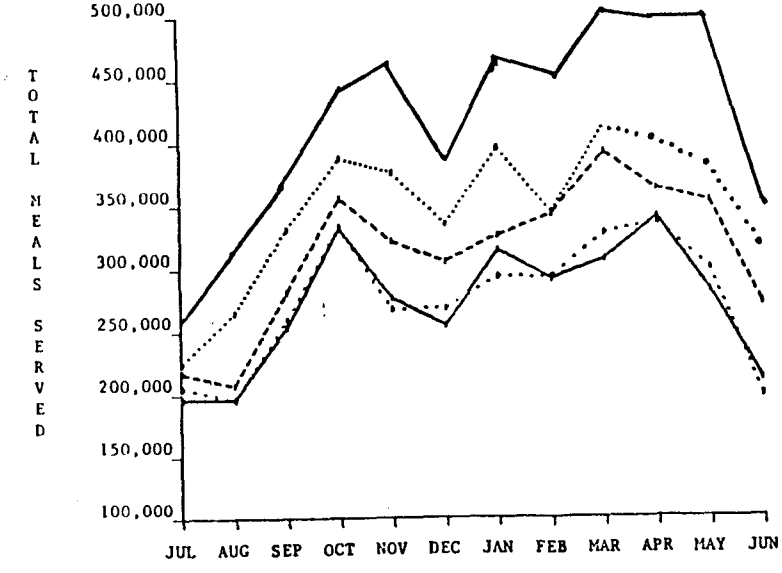
CCFP-4

NUMBER OF MEALS SERVED TO CHILDREN

CHILD CARE FOOD PROGRAM COMPARISON

STATE FISCAL YEAR 1986
STATE FISCAL YEAR 1987
STATE FISCAL YEAR 1988
STATE FISCAL YEAR 1989
STATE FISCAL YEAR 1990

TOTAL MEALS SERVED TO ENROLLED CHILDREN



TOTAL:	SFY 86	SFY 87	SFY 88	SFY 89
	3,249,637	3,279,901	3,741,510	4,173,461

SFY 90 4,873,615

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ENROLLMENT: 1986 9,900
1990 17,154

Enrollment Centers 1990 6,368
Homes 1990 10,786

TESTIMONY FOR THE JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
on the

MONTANA PERINATAL PROGRAM

Family/Maternal Child Health Bureau
Montana Department of Health and Environmental Sciences

Representative Bradley and members of the committee, I am Jo Ann Dotson, Nurse Coordinator of the Montana Perinatal Program. For the convenience of the committee, I have italicized some terms and provided definitions for them on page three of this testimony.

Purpose

The purpose of the Montana Perinatal Program is to improve the outcome of pregnancy in Montana by reducing the risk of preventable mortality, morbidity and disability during the *perinatal period*. During FY 91 the Perinatal Program was transferred from the Preventive Health Bureau to the Family/Maternal and Child Health Bureau. The department determined that MPP responsibility is more consistent with the mission of the Family/MCH Bureau.

Staff

Current staff consists of a full-time program manager, a full-time nurse coordinator, and a full-time administrative assistant. I would like to call your attention to the manner in which the positions for the Perinatal Program are represented in the LFA budget. Only the program manager position appears in the Perinatal Program; the nurse coordinator and administrative assistant positions are still included in the Preventive Health Services Bureau administrative budget. That funding needs to be moved to the Perinatal Program Budget in the Family/Maternal Child Health Bureau.

Funding

Program funding consists of federal Maternal Child Health Block Grant monies with State General funds providing partial support of the MIAMI Project (Montana's Initiative for the Abatement of Mortality in Infants).

Program Overview and Accomplishments

The Perinatal Program's main focus during the last two years has been executing the MIAMI legislation (MCA 50-19-301 to 323). MIAMI was developed to:

1) assure that mothers and children receive access to quality maternal and child health services

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2) reduce *infant mortality* and the number of *very low and low birth weight* babies, and

3) prevent the incidence of children born with chronic illness, birth defects, or severe disabilities as a result of inadequate prenatal care.

The MIAMI Executive Summary which is included in your packet is a complete description of the MIAMI Project. Briefly, accomplishments are:

- *Low Birth Weight Prevention Projects* - Seven projects are presently providing *care coordination* services to over 1300 *high risk pregnant women* per year. At a cost in state program dollars of $113.00 per woman, the state has saved a projected cost of over $800,000 in just four of those projects, by decreasing the incidence of low birth weight babies.

- *Infant Mortality Review* - Three counties have participated in a 6 month pilot project which completed data collection in December of 1990, and is scheduled for review in January of 1991. The questionnaires developed have been adopted as prototypes in other northwestern states.

- Medicaid changes - The MIAMI project directed coordination of efforts to increase accessibility of health care to pregnant women and young children. The Perinatal Program, along with SRS and other programs has worked to facilitate the changes and comply with OBRA mandates. The KID'S COUNT report describes the accomplishments.

- Public education - Recognizing the importance of educating the public about the importance of good prenatal care, the Perinatal Program has contracted with Healthy Mothers, Healthy Babies - The Montana Coalition to coordinate the "Baby Your Baby" campaign. Extensive work has gone into the funding package for the campaign, which will begin airing in January 1991.

The seven-member MIAMI Advisory Council which was appointed by Governor Stephens has compiled their recommendations regarding the MIAMI project and maternal and child health services in the form of the MIAMI Executive Summary. The MIAMI project has successfully addressed all aspects of its legislative mandate, within budget, and with excellent results in terms of services provided and money saved.

In addition to the MIAMI Project, the Perinatal Program continues to educate health professionals and the public regarding perinatal issues. During FY 90, the Program supported eight workshops for community based health professionals, and program staff made 20 presentations across the state on perinatal issues. Three

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MONTANA PERINATAL PROGRAM

SUPPLEMENTAL INFORMATION

January, 1991

I am presenting the following information in response to the issue raised about Maternal and Child Health funds which, in the past, have been used for case management or for treatment services for mothers and children. In the Executive Budget, the dollar amount is included in contracted services for Bureau Administration.

These services were mandated by the Federal government in the past; that mandate is not part of current MCH Block Grant requirements, however the services provided are important and necessary to continue. Partial funding of low birth weight prevention projects within the MIAMI Project, services (primarily dental) for migrant children, and education of public health nurses and other health professionals have been major ways in which these funds have been used and will continue to be used. These dollars are totally contracted for local services or services which benefit local communities.

Service development and inherent delays in contract devleopment and processing occurred during the base year, SFY '90.

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Montana's Initiative for the Abatement of Mortality in Infants

M I A M I

CONTENTS

EXECUTIVE SUMMARY
Accomplishments and Recommendations

INFANT MORTALITY: A GROWING CONCERN

The death of an infant is a profound human tragedy. Each year, some 40,000 American infants die before their first birthday. The rate of infant death is a major standard, accepted throughout the world, for measuring a society's overall health status and a nation's health and well being.

As a society, we have made great gains in ensuring the survival of our infants and improving the quality of their lives. However, **among industrialized nations, the U.S. has one of the highest rates of infant mortality (9.9 deaths per 1,000 live births in 1988)**, ranking 19th behind such countries as Singapore, Hong Kong and Spain.

In Montana, a low birth weight baby is born every 12 hours and every 3 days one baby under one year of age dies.

The high U.S. mortality rate is brought about largely by low birth weight babies (LBW) being born too soon or too small (from prematurity or from not growing adequately during pregnancy), and by increases in infant death rates during the first year of life (postneonatal mortality). During this period babies are most vulnerable to damaging effects of poverty and inadequate health care.

Care for pregnant women is at most a 10 month commitment. SHORT TERM COMMITMENT REAPS LONG TERM BENEFITS.

THE "MIAMI" CONCEPT

Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) was developed to address issues critical to the well being of pregnant women, women anticipating pregnancy, and children. Despite our "low risk" (primarily Caucasian) population, in 1987 Montana ranked 29th in the nation in infant mortality, down from our 20th rank in 1986. The major reason Montana babies die before their first birthday is low birth weight. The most effective tool to decrease the incidence of low birth weight is early, comprehensive and continuous prenatal care.

For further information and copies of the complete report, contact the Montana Perinatal Program (MPP), Family/MCH Bureau, Montana Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. Phone (406) 444-4740.

The MIAMI concept faces those issues identified nationally, and encompasses the best of what has been learned in Montana and recommended nationally. Goals of the MIAMI project are:

*The MIAMI project builds on the concept that the **whole is greater than the sum of the parts.***

- assuring that mothers and children, regardless of income or availability of health services, receive access to quality maternal and child health services;
- reducing infant mortality and the number of low birth weight babies; and
- preventing the incidence of children born with chronic illnesses, birth defects, or severe disabilities as a result of inadequate prenatal care.

A seven-member MIAMI Advisory Council was appointed by Governor Stephens to advise the Montana Department of Health and Environmental Sciences (MDHES) on "matters pertaining to the MIAMI project and to make recommendations regarding maternal and child health services." Members of the Council include:

Marietta Cross, R.N., Missoula, Chairperson, representing a non-profit child health organization (Healthy Mothers, Healthy Babies);
Jeffrey Hinz, M.D., Great Falls, pediatrician, representing the medical profession;
Cherry Loney, Great Falls, Health Officer, Cascade City-County Health Department, representing local health departments.
Lil Anderson, Billings, Associate Director, Yellowstone City-County Health Department, representing a local service provider;
Nancy Colton, Bozeman, parent, representing a parent support group;
J. Dale Taliaferro, Helena, Administrator, Health Services Division, representing MDHES; and
Nancy Ellery, Helena, Administrator, Medicaid Services Division, representing the Montana Department of Social and Rehabilitation Services (MDSRS).

MIAMI ADVISORY COUNCIL

Marietta Cross, R.N., Chairperson, Missoula
Jeffrey P. Hinz, M.D., Great Falls
Cherry Loney, R.N., Great Falls
Lil Anderson, R.N., Billings
Nancy Colton, Bozeman
J. Dale Taliaferro, Helena
Nancy Ellery, Helena

MIAMI PROJECT/MPP STAFF

Maxine Ferguson, Bureau Chief, Family/MCH, MDHES
Jo Ann Dotson, Nurse Coordinator, MPP
Cindy Little, Admin. Assistant, MPP
Sidney C. Pratt, M.D., Medical Advisor

Four components make up the MIAMI Project. They are:

- Low Birth Weight Prevention
- Infant Mortality Review
- Medicaid Changes for Pregnant Women
- Public Education ("Baby Your Baby")

Descriptions of each component and accomplishments to date appear on the following pages.

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LOW BIRTH WEIGHT PREVENTION

Low birth weight prevention services utilize a care coordination approach based on **screening** eligible pregnant women for medical and/or psychosocial risk of preterm labor or low birth weight; assisting these women to **access** prenatal care, preferably during the first trimester of pregnancy; **education** about signs and symptoms of preterm labor; **education and assessment** of the use of alcohol, tobacco and other drugs; **assessment** of nutritional status and risk; **referral** to WIC, other agencies and programs for services, treatment, and other assistance. A program model identifying these components has been developed and is utilized by local projects.

DEFINITIONS:

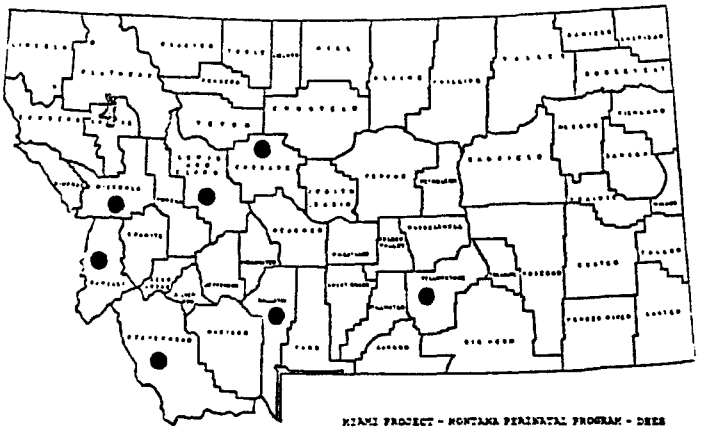
Low Birth Weight (LBW) -2500 grams (5 lb., 8 oz.) or less;

Very Low Birth Weight (VLBW) - 1500 grams (3.3 lbs.) or less.

Low birth weight prevention projects are located in public health departments or hospitals in seven counties where approximately 50% of Montana's births occur. Nearly 1,350 women received services from the projects during the past year. Locations of these services are shown on the map.

Many factors interact to produce a low birth weight baby. These include environment, culture, politics, economics and health systems as well as social class factors, health behaviors, access to prenatal care, stress, age, race, marital status, education, maternal complications and preterm labor.

LOCATION OF LOW BIRTH WEIGHT PREVENTION PROJECTS
DECEMBER, 1990



MCH/C PROJECT - MONTANA PERINATAL PROGRAM - DHES

A total of $152,150 for the 7 projects was administered by the Montana Perinatal Program during FY '90. This does not include funding provided by local health departments and hospitals in support of these projects.

Low birth weight prevention projects are impacting Montana babies. Only 4.92% of births to project clients were low birth weight, compared to a pre-project rate of 9.2%.

Sources of state-administered funds included Federal Maternal/Child Health and Preventive Health Block Grants and State General Fund dollars. Costs per client are shown in the table below.

Table 1
Funds Contracted for LBW Prevention Projects
and Costs Per Client Served

Data Sources: Project Application/Contracts

Total Funding to Projects	$152,250.00
Number of Women Served	1,341.00
Cost/Client	$ 113.46

$113.46 of state-administered funds can save approximately $32,558 in acute care costs when used to prevent one "high cost" baby.

In Montana, a low birth weight baby costs a minimum of $610 per day and may be hospitalized 7 to 20 days. A very low birth weight survivor (one who eventually goes home) averages $31,000 to $71,000 in hospital costs alone. Very low birth weight infants are more likely to have problems requiring lifetime care. Lifetime costs for a VLBW infant average $415,588.

Several sites were able to determine the rate of low birth weight among client populations prior to beginning a low birth weight prevention project. Based on current LBW rates, the number of LBW babies prevented were calculated for four sites. Potential savings by these prevention efforts are shown in the table below.

Table 2

Cost Savings of Four Projects Through LBW Prevention

Project	Projected LBW Babies*	Actual LBW Babies	Number of LBW Babies Prevented	Acute Care Savings•
A	9	5	4	$130,232
B	2	1	1	32,558
C	22	9	13	423,254
D	19	12	7	227,906
		TOTAL POTENTIAL SAVINGS		$813,950

** Number of LBW babies which would have occurred to FY'90 LBWPP clients if calculated at preproject rates*

• Based on figure from Montana SRS "High Cost Babies" study, 1988.

The Wall Street Journal [June 24, 1988] concluded that for each week of prematurity prevented, a company may save as much as $10,000 in insurance costs. In an article titled "What Price Prematurity?", Rachel Schwartz calculated costs saved by the upward shifting of infants into the next higher birth weight category. Postponing delivery through monitoring and early detection of two 800 gram infants (approximately 1 lb., 12 oz. each) **even for one week** may result in savings of up to $33,700. These figures underscore the importance of educating pregnant women about the **signs and symptoms of preterm labor.**

The care coordination approach's success is demonstrated in one project's quarterly report, which states:

> *"Kate" went into preterm labor at 25 weeks due to premature rupture of the membranes. She was hospitalized for a total of ten days and was sent home on oral [medication] and strict bed rest for the duration of pregnancy. . . . The community health nurse provided support and education throughout "Kate"'s difficult pregnancy. . . . "Kate" delivered a healthy baby boy at 39 weeks . . ."*

Successful as the care coordination model for low birth weight prevention has been, it does not tell the entire story. Community changes are evident in each area where a low birth weight prevention project has been in existence for two or more years. Community coalitions composed of persons from many agencies and organizations concerned with improved care for mother and children are working together. Referrals to the projects have increased, both in number of women referred and source of referrals. Creative approaches to educating clients about preterm labor have been developed. One example is a wallet size card which lists the signs of preterm labor.

"Studies have documented that indigent women have better outcomes as a result of prenatal care in organized, publicly supported settings such as health departments and community health centers. . . ."

PREVENT PREMATURITY

Call right away if
- you have any fluid from your vagina
- you have any blood from your vagina
- you have a sudden increase in vaginal discharge

If you are having any of these warning signs —
- menstrual-like cramps
- low, dull backache
- pelvic pressure
- abdominal cramps
- vaginal discharge changes

Lie down and check for contractions. If you have five or more contractions in one hour, or if the warning signs do not go away in one hour, CALL:
1. Your physician or C.N.M.
2. Your local hospital or O.B. unit

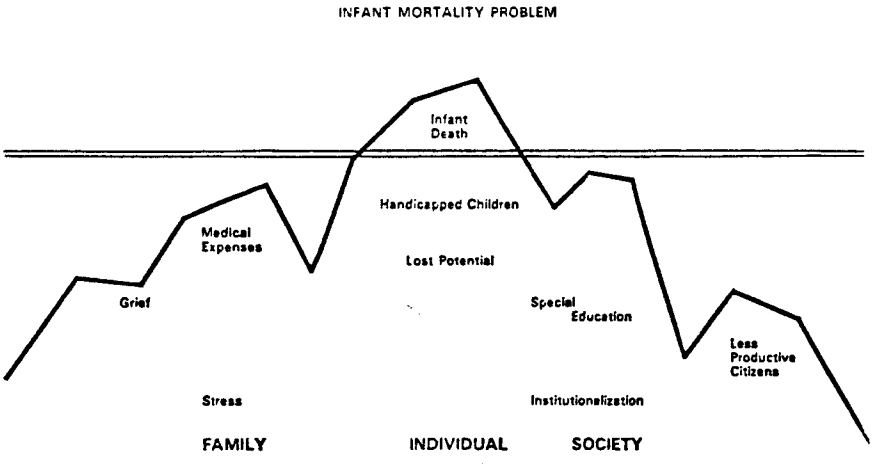
A wallet card listing signs of preterm labor has proved successful in educating pregnant women.

EXHIBIT 12
1-11-91
Hum. Serv. Sub.

INFANT MORTALITY REVIEW

Infant mortality has a major impact on the lives of all Montanans. The tragedy of death, while devastating to the family and friends, is actually only the tip of the iceberg. As depicted in a model developed by South Carolina (Figure 1), its impact on society is actually only the most visible effect, with family stress, medical costs, special education needs, and lost potential affecting the society in many other ways. The problem requires careful study, so that not only the actual deaths may be reduced, but also the other consequences may be decreased.

Figure 1



Infant death is like the tip of an iceberg. It is easy to see and its cost is measured in lives lost. Handicaps occuring in the perinatal period are less obvious but just as costly to individuals, families and society.

QUALITY PRENATAL, DELIVERY AND NEWBORN CARE CAN REDUCE INFANT DEATH AND DISABILITY ASSOCIATED WITH PREGNANCY AND EARLY CHILDHOOD.

(Figure adapted from South Carolina DHEC/MCH 1983)

Fetal and infant mortality is more than a medical problem; socio-economic impacts cannot be ignored. According to a 1986 Innovations report, government has begun to enter the arena of health care delivery to infants and pregnant women, " because there are . . . people who are in great need of perinatal and maternal care that is unavailable due to cost, ignorance, or lack of accessibility." The report further states that "the mere presence of medical services does not necessarily mean that they are available and will be used by all people. Indeed, the primary obstacles for indigent patients are cost and lack of accessibility."

- What are the obstacles resulting in Montana's high mortality rates?
- How much do we really know about pregnant women's perceptions of health care, and reasons for their health care practices?
- But most importantly, **WHY ARE MONTANA'S BABIES DYING?**

WHY ARE MONTANA'S BABIES DYING?

INFANT MORTALITY REVIEW:

A process for examining factors which contribute to infant death through a systematic evaluation of individual cases in order to identify potential opportunities to maternal and infant health.
--William Sappenfield M.D.

DEFINITIONS:

Infant = child aged 1 year and under

Neonate = child aged 28 days and under

Postneonatal = period of time from age 29 days to 1 year

Fetal death = The birth of a fetus after 20 weeks gestation which shows no evidence of life after complete birth.
(Montana Vital Statistics definitions)

"A child doesn't have to be in a wheelchair to have a birth defect. Limiting a child's full potential, even by a small amount, is going to have an effect on society."
Lawton Chiles, Chairman
National Commission to Prevent Infant Mortality

These questions are the impetus for Montana's ongoing work on infant mortality. Montana's infant mortality rate of 11.3 in 1989 is our highest since 1980, and represents a 31 % increase from the 1988 rate of 8.6. (See Table 3) While this figure may be only a "blip" on a statistical screen, it does serve as a reminder to all concerned with the welfare of our children that infant deaths in our state are still a major problem.

Montana's 1989 infant mortality rate among Native Americans is over double the rate of infant mortality in the Caucasian population.

Table 3

Montana Statistics

Year	Live Births	Infant Deaths	Infant mortality rate (Deaths per 1000 births)
1989	11667	132	11.3
1988	11682	100	8.6
1987	12239	121	9.9
1986	12728	122	9.6
1985	13497	139	10.3
1984	14141	125	8.8
1983	14054	126	9
1982	14538	147	10.1
1981	14309	153	10.7
1980	14208	176	12.4

Montana's Native American infant mortality rate of 25.2 in 1989 is extremely high, rivaling the rates reported in minority populations in large urban settings in other states. The initial response to dismiss these figures as a result of low numbers or other reasons unique to Montana must be suppressed; North Dakota, a bordering state with many similar characteristics including weather, access, and population, had the best ranking in infant mortality among the 50 states in 1986, compared to Montana's dismal 20th ranking.

The MIAMI legislation (MCA 50-19-301 to 323) mandated the MDHES to conduct an Infant Mortality Review (IMR). Prior to the mandate, the MDHES contracted with Drs. Fred Reed and William McBroom of the University of Montana Center for Population Research to conduct research on the infant mortality issue. Their data set includes over 84,000 birth certificates for the time period from 1980 through 1985 and the linked birth-death certificates for that same time period. Their research made it very clear that further evaluation was needed, and data sources beyond the birth and death certificates were also needed.

In July of 1990, the MDHES began infant mortality review which reflects Dr. Sappenfield's definition requiring individual case review. Three counties, selected because of their size, interest, and ability to fund data collectors, have been participating on a voluntary basis in data gathering during a 6 month pilot study (July 1990 through December 1990). Although urban Native American babies are included in the current study, expansion plans need to include Indian infant mortality in all settings.

12
1-11-91
Dem. Sen. Sub.

MEDICAID CHANGES FOR PREGNANT WOMEN

In 1984, 17 percent of women of reproductive age lacked insurance to pay for prenatal care and another 9 percent had only Medicaid coverage. . . As of 1985, the United States had made virtually no progress in meeting the goals set in 1980 by the Surgeon General for (1) reducing the percentage of babies born with low birth weight to no more than 5 % of live births and (2) ensuring that 90% of pregnant women obtain care within the first 3 months of pregnancy. *A substantial Medicaid effort, linked with other programs, can help to erase this country's poor performance among industrialized nations in terms of infant mortality. The effort can also help to reduce the disgracefully high infant mortality rates currently found among minorities.*

Under the auspices of the Governor's Human Services Sub-Cabinet, a subcommittee on Maternal Child Health was appointed. Their first report, KIDS COUNT, included MCH issues and initiatives, along with recommendations. Expanding medicaid eligibility for pregnant women and increasing access to providers through fee improvements are among the issues included:

- Increasing the eligibility income level to 133% of the federal poverty level (FPL) was implemented on April 1, 1990.
- Implementation of "presumptive eligibility" is targeted for January 1, 1991.
- "Continuous eligibility" is also targeted for implementation on January 1, 1991.
- Statewide, eligibility staff have been educated about the importance of early prenatal care and are expediting Medicaid applications for pregnant women.
- Outstationing eligibility staff has been determined unfeasible at this time.
- Increasing the eligibility income level to 185% of the federal poverty level will require state legislation.
- Reimbursement for delivery services has been increased to $756-$806, approximately 42% of usual and customary charges.

DEFINITIONS:

Presumptive eligibility - allows qualified providers to certify Medicaid eligibility for pregnant women while a formal application is being processed.

Continuous eligibility - allows Medicaid eligibility to continue in cases where the pregnant woman would no longer be eligible for financial assistance based on a change in income.

In 1988, Montana Medicaid spent $4.2 million (51% of the total delivery budget) on only 4% of the births. A majority of the births were low birth weight which could have been prevented with early, regular prenatal care.

Medicaid pays an average of $19.48 for each prenatal visit. Compare that cost to neonatal intensive care costs of $610 - $2000+ per day!

PUBLIC EDUCATION -- "BABY YOUR BABY"

One of the answers to improved infant health and survival is the development of a multi-media awareness and public education campaign that will communicate with expectant mothers. The "Baby Your Baby" (BYB) campaign is designed to educate and motivate expectant mothers (and those who care about them, i.e., relatives, friends, parents) to enroll in a medical support program in the first trimester of pregnancy.

"Baby Your Baby" is directed primarily to high risk women. Specific target groups include teenagers, alcohol and/or drug addicted or affected women, and low socio-economic groups, including the homeless.

Many public and private organizations are supporting the BYB campaign through funding or other support. **Major funders** have contributed $7500 or more to the campaign effort. **Sponsors** also provide funding for the campaign. **Endorsing organizations** support the concept and approaches of the campaign, and recognize the importance of educating the public about the needs of pregnant women.

Elements of the statewide campaign include, but are not limited to television and radio public service advertising, print advertising, billboards, posters, video documentaries, television news series and insert segments, newspaper tabloids, incentives and referrals. A toll free information line (1-800-421 MOMS) has been established so women can register for the program. Airing of the television and radio spots will begin in January 1991.

Public/Private Partnership

The BABY YOUR BABY campaign is a public\private partnership. The cost of the campaign is being underwritten by sponsors from both the public and private sectors.

Securing funding and developing contracts for service have occupied a major portion of the past year. A contract has been developed between MDHES and Healthy Mothers, Healthy Babies for conducting the education campaign, in response to a Request for Qualifications issued by MDHES. Other contracts and agreements permit Medicaid match of state general funds and all private sector donated funds. HMHB purchased program rights from the Utah Department of Health and KUTV in Salt Lake City, established KTGF in Great Falls as the program originator and network anchor in Montana, and has retained a technical advisor, a public relations firm and a production company.

Brochures about health services, child care, pregnancy care and social service programs make up an information packet which will be mailed to women who register in the BABY YOUR BABY program. Incentives designed to attract expectant mothers into the program have been field tested. The registration also serves as a referral and tracking system.

Community forums held in 17 Montana cities in November and December of 1990 informed health care, social services and other community professionals about the program, and even more important, assisted communities in developing local activities and referral services for the BYB campaign.

Careful evaluation of the project will be done so that the findings can be utilized by MDHES, MDSRS, HMHB and others.

BYB Major Funders

- *Blue Cross and Blue Shield of Montana*
- *Healthy Mothers, Healthy Babies -- The Montana Coalition*
- *St. Peter's Community Hospital, Helena*
- *State of Montana*
  - *Department of Family Services*
  - *Department of Health and Environmental Sciences*
    - *Family/MCH Bureau*
    - *Perinatal Program*
    - *WIC Program*
    - *Immunization Program*
  - *Department of Social and Rehabilitation Services*
    - *Child Support Enforcement Bureau*
    - *Medicaid Division*
    - *Developmental Disabilities Division*

BYB Sponsors

- *Children's Trust Fund*
- *Dr. Leonard Kaufman*
- *Kiwanis of Helena*
- *March of Dimes, Montana Big Sky Chapter*
- *Montana Medical Genetics Program at Shodair Hospital*
- *Montana Area Health Education Center*
- *The Doctors' Company*

BYB Endorsing Organizations

- *Local health departments*
- *Local HMHB coalitions*
- *Montana Academy of Family Physicians*
- *Montana Academy of Pediatrics*
- *Montana Children's Alliance*
- *Montana Hospital Association*
- *Montana Council for Maternal Child Health*
- *Montana Medical Association*
- *Montana Medical Auxiliary*
- *Montana Nurses' Association*
- *Montana Section - American College of Obstetricians and Gynecologists*
- *Montana Section of Nurses Association of the American College of Obstetricians and Gynecologists*
- *Montana State Governor's Office*

Date of report release: 12/90

Exh. 12
1-11-91
Hum Serv. Sub

RECOMMENDATIONS OF THE MIAMI ADVISORY COUNCIL

1. **Extend the sunset on MIAMI legislation to June 30, 1993.**

2. **Create a state center for health statistics, which will facilitate the retrieval of information needed to guide health provision and planning.**

3. **Develop a rural health planning commission, which will provide support and consultation to rural health practitioners, as well as guide state planning for rural health provision.**

4. **Encourage policy changes which will improve health care of infants and pregnant women through tort reform.**

5. **Support the Montana Medical Genetics program.**

6. **Support the public vaccine program so that no child will be denied vaccine and potentially pass preventable illnesses on to women and/or their fetuses.**

7. **Facilitate the creation of a central registry and tracking system for infants who have a high risk of experiencing developmental delay.**

LOW BIRTH WEIGHT PREVENTION

8. Accommodate increased client loads by additional funding to the existing seven (7) low birth weight prevention projects.

9. Contingent on adequate funding of existing projects, fund an additional nine (9) low birth weight prevention project sites.

10. Facilitate the role of mid-level health care providers in Montana.

11. Collaborate with Indian Health Services, tribal health and urban Indian centers to improve coordination of services to Native Americans.

12. Facilitate home visits for all high risk and/or first time mothers.

13. Increase referrals of Low Birth Weight Prevention Project clients to local family planning clinics and other applicable services.

INFANT MORTALITY REVIEW

14. Expand infant mortality review to additional sites, including more locations where Native American populations may be accessed.

15. Fund expansion of the review process to include low birth weight births, to allow examination of causes of infant morbidity.

MEDICAID CHANGES FOR PREGNANT WOMEN

16. Expand Medicaid eligibility coverage for pregnant women and children up to age six to 185 percent of the federal poverty level.

17. Increase reimbursement for prenatal and delivery services to 90% of actual fee.

18. Implement a targeted case management system for high risk pregnant women.

19. Maintain presumptive and continuous eligibility as a Medicaid priority.

20. Support low cost health insurance packages which include maternity and well-child services.

PUBLIC EDUCATION

21. Promote public education of perinatal issues through the media, especially in the form of the Baby Your Baby campaign.

Human Serv. Subc.

Exhibit #13
1/11/91

PLEASE PRINT YOUR NAME

WITNESS STATEMENT EXHIBIT 13 DO NOT ABBREVIATE

DATE 1-11-91

HB

NAME KAREN WOJTANOWICZ BILL NO.

ADDRESS 4448 BANNOCK BOZEMAN DATE 1/11/91

WHOM DO YOU REPRESENT? MONTANA CHILDREN'S ALLIANCE
FAMILY PLANNING-HEALTH

SUPPORT EDUCATION SPECIALIST POSITION OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

I support the reinitiation of the Health Education position in the state Family Planning program for the purpose of statewide education and outreach to further enhance the delivery of family planning services including the reduction of teenage pregnancy, the education regarding the importance of annual pap smear screening and the education regarding ways to prevent sexually transmitted diseases. The Department of Health and Human Services in their 1989 federal audit recommended the reinstatement of this position.

VISITOR'S REGISTER

Human Services Subcommittee SUBCOMMITTEE

AGENCY(S) _____ DATE 1/11/91

DEPARTMENT _____

PLEASE PRINT DO NOT ABBREVIATE

NAME	REPRESENTING	SUPPORT	OPPOSE
Ray Hoffman	Dept of Health		
Charles F. Stahl	Dept of Health.		
John D. Hawthorne	Dept of Health & E.S.		
Doug Abbott	" " "		
Drew Dawson	" "		
Dale Taliaferro	DHES		
Charles Magnes	Dept of Health		
Judith Carlson	local health depts		
Robert R Johnson	L & C Co. H.D.		
Mary Beth Hridin	L & C. Co. H. D.		
Paulette Kohman	MT Council for Maternal & Child Health		
Karen Wojtanowicz	Family Planning		
Bill Opitz	DHES		
Dave Depew	MPEA		

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT.
IF YOU HAVE WRITTEN COMMENTS, PLEASE GIVE A COPY TO THE SECRETARY.

FORM CS-33A
Rev. 1985