MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN DOROTHY BRADLEY**, on February 4, 1991, at 8:10 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: Carroll South, Senior Fiscal Analyst (LFA)
Bill Furois, Budget Analyst (OBPP)
Faith Conroy, Secretary

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

Announcements/Discussion:

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES (SRS)

Tape 1A

CHAIRMAN BRADLEY distributed a draft letter to **U.S. SEN. MAX BAUCUS** from the subcommittee. **SEN. WATERMAN** explained that the letter tells **SEN. BAUCUS** of the Legislature's efforts to develop incentives to encourage people to buy long-term health-care insurance. The subcommittee asked **SEN. BAUCUS** to direct his efforts to allow demonstration projects such as the one described in the letter. She said she would have the letter sent out if it is acceptable to the subcommittee. **EXHIBIT 1A**

EXECUTIVE ACTION ON THE VOCATIONAL REHABILITATION PROGRAM (Voc-Rehab) (CONT.)

DISCUSSION: **CHAIRMAN BRADLEY** said a decision is needed on the Voc-Rehab waiting list. She called for a new motion and said there are 58 people on the waiting list that are not developmentally disabled (DD) individuals. The first motion was to fund 44 additional slots. The second motion was for 22 slots, and the third motion was for 58 slots. She asked the Department what 30 slots would cost. **Peggy Williams, Program Support Bureau Chief,** said it would cost $115,000 per year of the biennium for 22 slots, $228,000 for 44 slots, $302,000 for 58 slots and

$156,000 for 30 slots.

Julia Robinson, SRS Director, recapped the purpose behind the expenditure. She noted that the governor's budget does not expand the program. Extended Employment is financed with General Fund money only. The program provides support for handicapped clients in the work place.

SEN. KEATING asked if the 44 clients are mentally and physically handicapped individuals, and not developmentally disabled. **Jim Smith, Montana Association for Rehabilitation and Montana Association of Rehabilitation Facilities representative,** said there are 118 people on the vocational waiting list. Of the total, 60 have a developmental disability. The remaining 58 have disabilities that are not developmental in nature. They are people with physical disabilities, people suffering from mental illness and the head-injured.

SEN. KEATING asked if they can get jobs to supplement their living income. **Mr. Smith** said yes. **SEN. KEATING** asked what they do while they are on the waiting list. **Mr. Smith** said they often are at home with parents. Sometimes they are in nursing homes. **SEN. KEATING** asked if the work they do is long-term. **Mr. Smith** said it usually is.

SEN. NATHE asked if job coaches are involved. **Mr. Smith** said Extended Employment can be in a supported work setting involving job coaches, or sheltered work shops in a rehabilitation facility, such as Helena Industries.

SEN. NATHE asked if a job coach's supportive function continues for as long as the individual is employed. **Mr. Smith** said responsibilities to the client continue, but at a lesser level, once the individual gets a job. Job coaches serve as intermediaries between employers and employees. They typically work in rehabilitation facilities and developmental disability corporations. They are under contract with the state agency.

SEN. KEATING asked if a job coach's management function ever ends. **Mr. Smith** said job coaches are integral parts of the arrangement. Their duties are ongoing. It isn't typical for the relationship to end.

SEN. KEATING said he is concerned that there will be a need for more job coaches if more people are served. That would add to the overall long-term expense. **Mr. Robinson** said the assessment is accurate. It isn't like the General Assistance program where costs decrease when work becomes available. In some cases, the job coach is not needed as much. But it is a long-term commitment.

SEN. NATHE asked how providers inform the agency when a client no longer needs a job coach and how it is reflected in the budget. **Mr. Smith** said it probably would never show up in budget

deliberations. Money for job coaches is in the contract between the facility and SRS. When one person's needs diminish, another person is served.

SEN. NATHE asked how many people are being served by job coaches. **Ms. Williams** said there are 60-70 Extended Employment slots. Ten of them are supported employment. **Mr. Smith** said the balance work in sheltered workshops.

MOTION: **REP. JOHNSON** moved to fund 30 slots.

SUBSTITUTE MOTION: **REP. COBB** moved to fund 58 slots.

DISCUSSION: **SEN. NATHE** asked where the money would come from to fund 58 slots. **REP. COBB** said he had no idea, but it won't be from a tax increase. He is tired of waiting lists. **SEN. WATERMAN** said she also is tired of waiting lists, but she is concerned about the funding source. She is concerned that the money would be robbed from another program. **CHAIRMAN BRADLEY** stressed the importance of having a budget that can be defended in the full Appropriations Committee.

VOTE: The substitute motion **FAILED** 4-2, with **REP. COBB** and **SEN. NATHE** voting aye.

DISCUSSION: **REP. JOHNSON** asked if there will be a new waiting list in 1993 even if the subcommittee dissolves the current one. **Ms. Robinson** said she wished she could promise an end to waiting lists. She believes fewer people will be on the list, but new people will always be coming into programs.

REP. JOHNSON asked if 30 additional slots would put a dent in the list. **Ms. Robinson** said yes. **REP. JOHNSON** asked if the most needy people will get services. **Ms. Robinson** said client selection is a difficult process that involves painful decisions.

CHAIRMAN BRADLEY said the number of injured or ill people needing services will increase as the state's population grows. Technological advances are saving lives that weren't saved before. **Ms. Robinson** said the Department in the next two years will be putting together proposals for serving the head-injured. Some of them are able to go back to work and others can't.

SEN. NATHE said 60-70 people are served, including 10 in Voc-Rehab employment. He asked if the remainder were in sheltered DD workshops. **Ms. Williams** said they are rehabilitation facilities, like Helena Industries and Easter Seals, not necessarily DD. **Ms. Robinson** said some of the facilities may have two to three funding sources. **SEN. NATHE** asked if they have separate employment programs for these clients or if they are intermingled. **Joe Mathews, Rehabilitative/Visual Services Divisions Administrator,** said they are intermingled among workshops, depending on their abilities.

VOTE: The original motion for 30 slots **PASSED** 5-1, with **REP. COBB** voting no.

REP. COBB referred to language he submitted to the subcommittee at the last hearing that calls for SRS and the Office of Public Instruction to devise a plan to serve special education students as they graduate. He said he wants to include that language. No money is involved. **EXHIBIT 18 from Feb. 1, 1991, minutes.** **CHAIRMAN BRADLEY** said she will work with him on the language and bring it before the subcommittee.

CHAIRMAN BRADLEY provided highlights of the subcommittee's trip to various facilities, including the Montana Development Center at Boulder and the Specialized Services and Support Organization (SSSO) in Missoula. She said operations would be less costly if the Boulder facility is rebuilt as proposed. Savings would come from a decrease in FTEs and campus size. The SSSO tour showed what the state bought last session and what model is being developed for Boulder. This change is necessary for certification and will provide a sense of permanency in the community.

SEN. KEATING said the client population would drop to about 110. There would be 327 FTEs assigned to the facility, which would provide stability in the community. People who work there now come from Butte and Helena. More people may live in Boulder if a permanent facility is there and it may reduce the 30 percent turnover rate in employees.

SEN. NATHE asked if the goal of the SSSO is to reduce the number of patients at Boulder. **CHAIRMAN BRADLEY** said the controversy for the past 20 years has been whether to close Boulder. Community concern was so intense that the subcommittee last session indicated the SSSO would not interfere with the Boulder population but would respond to community concerns. By the time the facilities were being put in place, the executive branch was dealing with court orders and other pressures to decrease the Montana Developmental Center's population.

SEN. NATHE asked if financial resources followed Boulder patients to the SSSOs. **Ms. Robinson** said it follows them to other group homes. A state program is needed because there are always some clients that non-profit facilities won't take.

SEN. NATHE asked if SSSOs get the same reimbursement rate for clients who move into SSSOs from their communities. **Ms. Robinson** said the SSSO is funded by the Legislature. There are no transfer funds from the Department of Institutions. Everyone is treated the same once they are there. Financial support went with the clients when they left Boulder.

SEN. KEATING said the cost for a client at Boulder ranges from $60,000 to $90,000. It costs about $46,000 per client in an SSSO, The savings is at least $15,000 per person per year. It will cost Institutions less and SRS more, but the state is still saving

money.

SEN. NATHE asked what happens when a person enters an SSSO from the community. **Ms. Robinson** said the person is financed with General Fund money. **SEN. NATHE** asked if that money is what the subcommittee appropriates in this budget. **Ms. Robinson** said yes.

SEN. WATERMAN said she is concerned about the continuation of services for people released from treatment centers like Rivendell in Billings. She asked for assurances that the subcommittee will revisit Specialized Family Services. **CHAIRMAN BRADLEY** said the subcommittee can revisit anything it wants.

Ms. Robinson distributed a memo on inpatient psychiatric services, **EXHIBIT 1B**, and a draft bill to continue the moratorium on residential treatment facilities. **EXHIBIT 2**

HEARING ON THE MEDICAID SERVICES DIVISION

John Donwen, Support Services Division, distributed an analysis of the pros and cons of eliminating or modifying the state's Medically Needy Program. **EXHIBIT 3**

Nancy Ellery, Medicaid Services Division Administrator, distributed statistical data on the Medicaid program. **EXHIBIT 4**

Ms. Robinson introduced Division staff and referred to Page 51 of the SRS budget narrative and B81 of the LFA budget. She read Pages 1-7 of **EXHIBIT 15.**

She also noted that each time an adjustment is made to Medicare, it affects Medicaid. A person can be on both programs. Congress is starting to expand Medicaid eligibility. State agencies don't know how many people will be using Medicaid service. Last Summer, SRS estimated costs based on new mandates. Usage was higher than anticipated.

Tape 1B

SEN. KEATING asked for an example of where the change in funding might occur. **Ms. Ellery** said the state's federal match is based on per-capita income. The General Accounting Office recommends it include in-state corporate income and in- and out-of-state personal income. Montana's federal match would drop from 71 percent to 67 percent, and cost about $7 million.

Ms. Robinson resumed testimony on Page 4 of **EXHIBIT 15.** She noted that children who are out of their home for 30 days or more, regardless of income, are Medicaid-eligible. Some low-income Medicare beneficiaries may be eligible to have their Medicare premiums, deductibles and co-insurance paid by Medicaid. The Department will present a proposal to add targeted case-management to the state's Medicaid-covered services. The option would save money and improve services.

PUBLIC COMMENT

Elizabeth Roeth, Executive Director of Healthy Mothers, Healthy Babies and the Chairwoman of the Montana Children's Alliance, read testimony submitted by **Paulette Kohman, Executive Director of the Montana Council for Maternal and Child Health, EXHIBIT 5. Ms. Kohman's** statement urged support for Medicaid expansion, provider reimbursement rate increases for obstetrical and pediatric care, provision of presumptive and continuous eligibility, and targeted case management for pregnant women.

Ms. Roeth testified in support of improved services for pregnant women, including the Kids Count! program, presumptive and continuous eligibility, increases in the eligibility level to 185 percent of poverty, targeted case management, and physician reimbursement rate increases to 90 percent of charges. **EXHIBIT 6**

Maureen O'Reilly, Director of the Co-Management Corp. of West Mont in Helena, stressed the importance of the Personal Care Agenda (PCA) program. She distributed and reviewed improvements in the PCA program since West Mont was awarded contracts. **EXHIBIT 7.** She said wages and training are extremely important. The quality of the program will suffer if increases are not granted.

Judy Backa, a West Mont client for 16 years, expressed gratitude and hope that services will continue. **Ms. O'Reilly** said **Ms. Backa** works as a typist.

Claudia Driscoll, a West Mont home health-care services recipient, expressed gratitude for services. She urged support for continued funding.

Eva Hunt, a West Mont Medicaid Waiver recipient, said she lives in the Sunset Capital Apartments. Without services, she would be living in a nursing home.

Roni Eisenmenger testified on behalf of her mother, Helen, who is a recipient of various services. She said they support case management. Her mother lives with her and has a better quality of life. It also costs less than nursing-home care.

SEN. WATERMAN asked how services are provided. **Ms. Eisenmenger** said a personal-care attendant from West Mont comes to her home and attends to her mother for 40 hours per week, while she is at work. The attendant is funded by the county.

Rose Hughes, Executive Director of the Montana Health Care Association, testified about nursing-home services and the Medicaid reimbursement rate. **EXHIBIT 8.** She urged the subcommittee to increase the budget.

Tape 2A

She said federal regulations require clients to receive the best possible care, which is increasing costs. Activities must be designed for each person, even if the person is in a coma. Group

activities are no longer sufficient. She reviewed **EXHIBIT 8** and testified in support of a 5 percent inflationary increase.

Jean Johnson, Executive Director of the Montana Association of Homes for the Aging, testified in support of increased Medicaid reimbursement rates and inflationary increases for nursing homes. She said one-third of the nursing home population is private pay. That third has to pick up the slack for the other two-thirds, which are inadequately funded by Medicaid. Eventually private pay patients' resources are depleted and they become Medicaid eligible. Equity in the system must be considered. **EXHIBIT 9**

Bob Olsen, Montana Hospital Association Vice President, testified in support of a 5 percent increase in hospital rates for fiscal year FY 92, the nursing home funding request by SRS, the Kids Count! proposal, and inflationary rate increases for other medical providers during the biennium. He testified in opposition to the $1 nursing-home bed fee proposed by SRS. **EXHIBIT 10**

Bill Zepp, Montana Dental Association representative, testified in support of the dental services budget. He noted that 90 percent of Montana's dentists continue to serve Medicaid patients, but only 62 percent are accepting new Medicaid patients. **EXHIBIT 11**

Roger Tippy, Montana Dental Association and Montana State Pharmaceutical Association representative, testified in support of increased prescription-dispensing fees. He said drug manufacturers rebate a portion of the money paid for prescriptions. The rebate will come in the form of credit. It is new money that will reduce the financial burden in the pharmacy budget. The Drug Utilization Review (DUR) system also will save money in the pharmacy budget in the second year of the biennium.

Tape 2B

The DUR program is designed to track the kinds of medication people take to prevent a person from taking an incompatible combination of drugs. He believes Medicaid will set up the DUR system. He distributed a list of the average costs of dispensing prescriptions. **EXHIBIT 12.** He said the maximum reimbursement is $4.08.

Debbie Edsall, Executive Director of the Community Health Center in Butte, said Montana's federally qualified health centers are 100 percent federally funded. There are two community health centers in Montana, one in Butte and one in Billings. The migrant health-care program is in Billings and follows migrant farm workers through the state.

Patients pay for services based on a sliding-fee scale. Medicaid budget constraints force the centers to supplement Medicaid funding. The federal government requires state Medicaid offices to match 100 percent of the reasonable costs for Medicaid patients. The migrant farm worker program hasn't received much Medicaid funding. Clients are eligible for only a short time.

Jack Casey, Administrator of Shodair Children's Hospital in Helena, said General Fund costs for inpatient psychiatric services is significantly less than 10 years ago. The goal is to ensure appropriate use of services and use less restrictive and less costly alternatives. Shodair offers a partial hospitalization program. Children are at the hospital during the day and go home at night. Under the inpatient psychiatric services program, parents' assets are not considered in eligibility determination. Parents' assets are considered for outpatient services, which are half as expensive as inpatient services. He urged the subcommittee to consider eligibility requirements for accessing less restrictive and less costly services.

Ms. Johnson said the **Montana Association of the Homes for the Aging** is seeking $60,000 for a pilot project to provide reimbursement for Medicaid-eligible residents living in personal-care homes. A bill will be submitted. **EXHIBIT 9**

SUBCOMMITTEE QUESTIONS

REP. COBB asked **Mr. Olsen** if Indian Health Services (IHS) takes care of babies. **Mr. Olsen** said IHS used to cover more Indian women in need of prenatal and delivery services. IHS is the only exception to the payer-of-last-resort rule in Medicaid. All other insurers pay ahead of Medicaid. IHS pays after Medicaid. When eligibility expanded, many Indian women who used to have services paid by IHS became eligible for Medicaid. Physicians in those areas now receive only partial reimbursement. **Ms. Robinson** said this is an example of a cost shift. What used to be 100 percent federally funded has shifted to Medicaid. It is a deliberate effort by the federal government to shift costs to states. **Mr. Olsen** said physicians on Indian reservations are having trouble staying in business.

REP. COBB asked if patients can be shown their medical charges and how much is covered by Medicaid. **Mr. Olsen** said it isn't always possible to determine costs until medical services are rendered. **REP. COBB** said there are average costs and payments. If there is going to be an effort to control costs, there has to be some sense of what those costs are. **Mr. Olsen** said hospitals are surveyed each year and the information is published in a booklet that is widely distributed. **REP. COBB** asked if the information is passed on to the person who pays. **Mr. Olsen** said no, not on an inpatient basis.

HEARING ON THE MEDICAID SERVICES DIVISION (CONT.)

Ms. Ellery read Pages 8-15 of **EXHIBIT 15.** She referred to Pages 2-3 of **EXHIBIT 19 from Feb. 1, 1991, minutes,** and charts 10-12 in **EXHIBIT 4.** She reviewed statistics on inpatient psychiatric services. **EXHIBIT 1B**

Ms. Robinson read Pages 16-19 of **EXHIBIT 15** and reviewed charts

13-14 in **EXHIBIT 4.**

Tape 3A

Ms. Ellery read Pages 20-25 of **EXHIBIT 15.**

Mr. South distributed **EXHIBIT 13-14** and reviewed budget issues in **EXHIBIT 13.** He noted that figures in Benefits and Claims are no longer accurate. New figures will be presented. The Psychiatric Utilization Review Contract is shown separately because it is new and not a current level expenditure.

EXECUTIVE ACTION ON THE MEDICAID SERVICES DIVISION

Votes were taken on **EXHIBIT 13.**

Mr. South said the two vacant FTEs are in the executive base, not the LFA base.

MOTION: SEN. KEATING moved the executive budget for FTEs.

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

DISCUSSION: SEN. KEATING asked if the $245,000 expenditure was for the Montana/Wyoming Foundation program. **Ms. Robinson** said the Psychiatric Utilization Review Contract is new and will control youth placements in psychiatric hospitals. It isn't in the LFA base because the Department just started the program. It is in the executive base.

MOTION: SEN. KEATING moved to adopt the LFA base with the Psychiatric Utilization Review Contract included.

DISCUSSION: REP. COBB asked what the savings will be. **Ms. Robinson** said savings are substantial. She will present a chart at the next hearing. Without the contract, the Department estimates it would have to add to the budget $3.5 million in new General Fund money. The contract makes it possible for the Department to hold current rates steady and make money available for transfer to programs in the Department of Family Services. The contract is supposed to stall growth in the program so there will be money for community alternatives. The contract has done that and has prevented federal sanctions.

VOTE: The motion **PASSED** unanimously.

DISCUSSION: SEN. KEATING asked whether the subcommittee needed to vote on equipment. **Mr. South** said that when equipment costs are the same in both budgets, the subcommittee's vote on operations includes equipment.

Ms. Robinson reviewed the Baby Your Baby executive budget modification. She said the program is the public relations campaign portion of the Kids Count! project. It is run by a

private non-profit organization. SRS matches private donations with Medicaid funds. No General Fund money is being used this year. **CHAIRMAN BRADLEY** referred to Page 43 of **EXHIBIT 19 from Feb. 1, 1991, minutes.**

MOTION: **SEN. WATERMAN** moved approval of the Baby Your Baby budget modification.

DISCUSSION: **SEN. NATHE** asked what the $268,000 is spent on. **Ms. Robinson** said the money goes toward public relations materials, advertising and staff. **Ms. Ellery** said it is a media campaign to educate pregnant women about the importance of early prenatal care.

VOTE: The motion **PASSED** unanimously.

Mr. South distributed a summary of previous subcommittee action. **EXHIBIT 14**

ADJOURNMENT

Adjournment: 11:50 a.m.

Dorothy Bradley
REP. DOROTHY BRADLEY, Chairman

Faith Conroy
FAITH CONROY, Secretary

DB/fc

HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUBCOMMITTEE

ROLL CALL **DATE** 2/7/91

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	✓		

DRAFT

This is er

Exhibit # 1 A
2/4/91
Human Services
Subcomittee

EXHIBIT 1 A
DATE 2-4-91
HB

Senator Max Baucus

Dear Senator Baucus:

Montana is currently considering a number of provisions to encourage individuals to purchase insurance coverage for long-term care expenses. In developing these incentives it is important to consider the actions of Federal programs and their impact on state efforts.

A case in point are the spousal impoverishment provisions of the Catastrophic Coverage Act. These provisions provide needed protection for couples, however their implementation has reduced the demand for private insurance among middle class senior citizens. This is precisely the population whose additional insurance would most help control increasing Medicaid long-term care costs.

One proposal which would have addressed this issue was the Connecticut Partnership for Long-Term Care. This private-public program would encourage moderate-income individuals to plan for their long-term care needs by purchasing insurance protection commensurate with the amount of assets they wish to protect. An individual who wished to protect $25,000 of assets would purchase $25,000 in insurance protection. When an individual exhausted their insurance benefits they would apply for Medicaid. Each dollar their insurance had paid towards their care would be an additional dollar they could disregard from the asset test for Medicaid eligibility. In the above case the individual would have been allowed to keep an additional $25,000 in assets.

Montana Long-term Care Program administrators and legislators are very interested in this model. However, recent Federal legislation has prevented this project from going forward.

It is important that State's have the ability to proceed with demonstration projects in attempting to address the increasing cost of health care. This is particularly true in regards to efforts to determine what role private insurance will play in addressing this issue of long-term care costs. Please direct your efforts to allow demonstration projects of this nature to proceed.

2/4/91
Human Serv.
Subc.

STATE OF MONTANA
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

INTER-OFFICE CORRESPONDENCE

TO: Nancy Ellery
Mary Dalton
Terry Krantz

Date: Jan. 29, 1991

EXHIBIT 1B
DATE 2-4-91
HB

FROM: Pat Palm Pat

RE: Statistics on Inpatient Psych

Q: How many in-state face-to-face reviewers does MHMA contract with?

A: MHMA currently contracts with 14 psychologists throughout the state. They are looking for several more to cover the corner areas of the state. MHMA provides ongoing training for their reviewers so there is consistency in quality of the review.

Q: What is the Average Length of Stay (ALOS) for Inpatient Hospitals and Residential Treatment in Montana?

A: The ALOS in the Inpatient hospitals is 39.8 days (at the point of decertification). The ALOS at Yellowstone Treatment Center is 272.5 days. The residential figure reflects those recipients who had been in placement for long periods **prior** to July 1, 1990 and have since been decertified through the review process. A more accurate ALOS for YTC will be evident after residential treatment has been reviewed for one year.

Q: How does the Montana ALOS compare with national data on ALOS? Is there a national recidivism (more than one admission) rate?

A: On the national level, the ALOS in Not-for-profit mental health hospitals is 43 days; in for-profit mental health hospitals is 35 days; and in state or county psychiatric hospitals is 143 days. The national recidivism rate 30-35%.

Q: What is the recidivism rate in Montana?

A: According to MHMA's statisitics, Montana's recidivism rate is approximately 20%. This figure reflects children who have had at least one previous inpatient hospital or residential

placement since 1987, not just since July, 1990.

Q: A) How many reviews have been conducted by MHMA? B) How many initial denials have been issued? C) How many denials resulted in a request for an informal reconsideration by MHMA? D) How many upheld denials resulted in a request for Departmental review? E) How many formal denials from the Department have resulted in a request for an Administrative Review? F) How many Fair Hearings have been conducted?

A: A) Since July 1, 1990, MHMA has conducted 1463 reviews (telephone and face-to-face).

B) MHMA has issued 204 initial denials.

C) Following the initial denials, only 56 requests for an informal reconsideration (by a psychiatrist) have been requested (27.45%).

D) As of 01/29/91, there have been 32 requests for a Departmental Review following the informal reconsideration (15.6% of the initial denials). (Rivendell of Butte - 12 requests; Rivendell of Billings - 12 requests; Shodair - 0 requests; YTC - 8 requests).

E) The Department has issued 8 formal denials following Departmental Review (Billings - 1; Butte - 1; YTC - 6). YTC has requested an Administrative Review for their 6 denials. The Administrative Reviews will be completed by mid-February. The disputed cases involve individuals who have been in residential treatment 18-24 months prior to review.

Of the remaining 24 request for Departmental Review, determinations shall be completed within the next 30 days.

F) There have been no Fair Hearings conducted to date.

2/4/91
Human Serv.
Sub-c.

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

STAN STEPHENS
GOVERNOR

JULIA E. ROBINSON
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STATE OF MONTANA

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EXHIBIT 2
DATE 2-4-91
HB

January 31, 1991

TO: Julie Robinson, Rod Sundsted, Marilyn Miller, Bill Furois, and Nancy Ellery

FROM: Russ Cater
Chief Legal Counsel
Office of Legal Affairs

RC

SUBJECT: Residential treatment facilities

Attached for your information is a draft of a bill to continue the moratorium on residential treatment facilities. The bill is somewhat similar to HB 304 which was passed last session. Significant sections of HB 304 will sunset on July 1st and October 1st of 1991.

The proposed bill will: (1) impose a moratorium on residential treatment facilities, (2) include parental income when determining eligibility (as of July 1, 1992), and (3) allow SRS rules addressing utilization review and least restrictive placement.

The proposed bill is somewhat lengthy but actual changes do not begin until page 7. Restrictions currently in the law restricting these facilities to 30 beds or greater have been removed because that justification may not be reasonably based and a simple moratorium would accomplish our purpose. The moratorium will apply to facilities that were licensed and certified because the Montana "certificate of need" law will sunset on July 1st.

If this proposal is acceptable to those in the Governor's Office I ask that Marilyn Miller present this proposal to Tom Olsen, Dennis Iverson and other appropriate persons.

The deadline for introduction of "general bills" has passed. This bill can only be introduced at the request of a legislative committee.

_____ BILL NO. _____

INTRODUCED BY: _____

~~BY REQUEST OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES~~

A BILL FOR AN ACT ENTITLED: "AN ACT TO GENERALLY REVISE THE LAWS RELATING TO RESIDENTIAL TREATMENT FACILITY"; TO REVISE THE REQUIREMENT FOR A CERTIFICATE OF NEED TO OPERATE A RESIDENTIAL TREATMENT FACILITY; TO ALLOW MEDICAID REIMBURSEMENT FOR INPATIENT PSYCHIATRIC SERVICES FOR PERSONS UNDER 21 YEARS OF AGE IN A RESIDENTIAL TREATMENT FACILITY; TO REQUIRE INCLUSION OF THE INCOME OF PARENTS WHEN DETERMINING A MINOR'S ELIGIBILITY FOR MEDICAID SERVICES; AMENDING SECTIONS 50-5-101, 50-5-316, 50-5-317, AND 53-6-101, MCA; AND PROVIDING AN EFFECTIVE DATE."

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

Section 1. Section 50-5-101, MCA, is amended to read:

50-5-101. *(Temporary)* **Definitions.** As used in parts 1 through 4 of this chapter, unless the context clearly indicates otherwise, the following definitions apply:

(1) "Accreditation" means a designation of approval.

(2) "Adult day-care center" means a facility, freestanding or connected to another health care facility, which provides adults, on an intermittent basis, with the care necessary to meet the needs of daily living.

(3) "Affected person" means an applicant for certificate of need, a member of the public who will be served by the proposal, a health care facility located in the geographic area affected by the application, an agency which establishes rates for health care facilities, a third-party payer who reimburses health care facilities in the area affected by the proposal, or an agency which plans or assists in planning for such facilities.

(4) "Ambulatory surgical facility" means a facility, not part of a hospital, which provides surgical treatment to patients not requiring hospitalization. This type of facility may include observation beds for patient recovery from surgery or other treatment.

(5) "Batch" means those letters of intent to seek approval for new beds or major medical equipment that are accumulated during a single batching period.

(6) "Batching period" means a period, not exceeding 1 month, established by department rule during which letters of intent to seek approval for new beds or major medical equipment are accumulated pending further processing of all letters of intent within the batch.

(7) "Board" means the board of health and environmental sciences, provided for in 2-15-2104.

(8) "Capital expenditure" means:

(a) an expenditure made by or on behalf of a health care facility that, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance; or

(b) a lease, donation, or comparable arrangement that would be a capital expenditure if money or any other property of value had changed hands.

EXHIBIT 2
DATE 2-4-91
HB Dem. Dev. Sub.

(9) "Certificate of need" means a written authorization by the department for a person to proceed with a proposal subject to 50-5-301.

(10) "Challenge period" means a period, not exceeding 1 month, established by department rule during which any person may apply for comparative review with an applicant whose letter of intent has been received during the preceding batching period.

(11) "Chemical dependency facility" means a facility whose function is the treatment, rehabilitation, and prevention of the use of any chemical substance, including alcohol, which creates behavioral or health problems and endangers the health, interpersonal relationships, or economic function of an individual or the public health, welfare, or safety.

(12) "Clinical laboratory" means a facility for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(13) "College of American pathologists" means the organization nationally recognized by that name with headquarters in Traverse City, Michigan, that surveys clinical laboratories upon their requests and accredits clinical laboratories that it finds meet its standards and requirements.

(14) "Comparative review" means a joint review of two or more certificate of need applications which are determined by the department to be competitive in that the granting of a certificate of need to one of the applicants would substantially prejudice the department's review of the other applications.

(15) "Construction" means the physical erection of a health care facility and any stage thereof, including ground breaking, or remodeling, replacement, or renovation of an existing health care facility.

(16) "Department" means the department of health and environmental sciences provided for in Title 2, chapter 15, part 21.

(17) "Federal acts" means federal statutes for the construction of health care facilities.

(18) "Governmental unit" means the state, a state agency, a county, municipality, or political subdivision of the state, or an agency of a political subdivision.

(19) "Health care facility" or "facility" means any institution, building, or agency or portion thereof, private or public, excluding federal facilities, whether organized for profit or not, used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. The term does not include offices of private physicians or dentists. The term includes but is not limited to ambulatory surgical facilities, health maintenance organizations, home health agencies, hospices, hospitals, infirmaries, kidney treatment centers, long-term care facilities, medical assistance facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, residential treatment facilities, and adult day-care centers.

(20) "Health maintenance organization" means a public or private organization which provides or arranges for health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or group of providers.

(21) "Home health agency" means a public agency or private organization or subdivision thereof which is engaged in providing home health services to individuals in the places where they live. Home health services must include the services of a licensed registered nurse and at least one other therapeutic service and may include additional support services.

(22) "Hospice" means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and his family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component.

(23) "Hospital" means a facility providing, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick persons. Services provided may or may not include obstetrical care, emergency care, or any other service as allowed by state licensing authority. A hospital has an organized medical staff which is on call and available within 20 minutes, 24 hours per day, 7 days per week, and provides 24-hour nursing care by licensed registered nurses. This term includes hospitals specializing in providing health services for psychiatric, mentally retarded, and tubercular patients.

(24) "Infirmary" means a facility located in a university, college, government institution, or industry for the treatment of the sick or injured, with the following subdefinitions:

(a) an "infirmary—A" provides outpatient and inpatient care;

(b) an "infirmary—B" provides outpatient care only.

(25) "Joint commission on accreditation of hospitals" means the organization nationally recognized by that name with headquarters in Chicago, Illinois, that surveys health care facilities upon their requests and grants accreditation status to any health care facility that it finds meets its standards and requirements.

(26) "Kidney treatment center" means a facility which specializes in treatment of kidney diseases, including freestanding hemodialysis units.

(27) (a) "Long-term care facility" means a facility or part thereof which provides skilled nursing care, intermediate nursing care, or intermediate

developmental disability care to a total of two or more persons or personal care to more than four persons who are not related to the owner or administrator by blood or marriage. The term does not include adult foster care licensed under 53-5-303, community homes for the developmentally disabled licensed under 53-20-305, community homes for persons with severe disabilities licensed under 53-19-203, youth care facilities licensed under 41-3-1142, hotels, motels, boardinghouses, roominghouses, or similar accommodations providing for transients, students, or persons not requiring institutional health care, or juvenile and adult correctional facilities operating under the authority of the department of institutions.

(b) "Skilled nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed registered nurse on a 24-hour basis.

(c) "Intermediate nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed nurse to patients not requiring 24-hour nursing care.

(d) "Intermediate developmental disability care" means the provision of nursing care services, health-related services, and social services for the developmentally disabled, as defined in 53-20-102(4), or persons with related problems.

(e) "Personal care" means the provision of services and care which do not require nursing skills to residents needing some assistance in performing the activities of daily living.

(28) "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions which is used to provide medical or other health services and costs a substantial sum of money.

(29) "Medical assistance facility" means a facility that:

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(a) provides inpatient care to ill or injured persons prior to their transportation to a hospital or provides inpatient medical care to persons needing that care for a period of no longer than 96 hours; and

(b) either is located in a county with fewer than six residents per square mile or is located more than 35 road miles from the nearest hospital.

(30) "Mental health center" means a facility providing services for the prevention or diagnosis of mental illness, the care and treatment of mentally ill patients or the rehabilitation of such persons, or any combination of these services.

(31) "Nonprofit health care facility" means a health care facility owned or operated by one or more nonprofit corporations or associations.

(32) "Observation bed" means a bed occupied for not more than 6 hours by a patient recovering from surgery or other treatment.

(33) "Offer" means the holding out by a health care facility that it can provide specific health services.

(34) "Outpatient facility" means a facility, located in or apart from a hospital, providing, under the direction of a licensed physician, either diagnosis or treatment, or both, to ambulatory patients in need of medical, surgical, or mental care. An outpatient facility may have observation beds.

(35) "Patient" means an individual obtaining services, including skilled nursing care, from a health care facility.

(36) "Person" means any individual, firm, partnership, association, organization, agency, institution, corporation, trust, estate, or governmental unit, whether organized for profit or not.

(37) "Public health center" means a publicly owned facility providing health services, including laboratories, clinics, and administrative offices.

(38) "Rehabilitation facility" means a facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons by providing comprehensive medical evaluations and services, psychological and social services, or vocational evaluation and training or any combination of these services and in which the major portion of the services is furnished within the facility.

(39) "Resident" means a person who is in a long-term care facility for intermediate or personal care.

(40) "Residential treatment facility" means a facility of not less than 30 beds that is operated by a nonprofit corporation or association for the primary purpose of providing long-term treatment services for mental illness in a nonhospital-based residential setting to persons under 21 years of age.

(41) "State health plan" means the plan prepared by the department to project the need for health care facilities within Montana and approved by the statewide health coordinating council and the governor.

50-5-101. *(Effective July 1, 1991)* **Definitions.** As used in parts 1 through 4 of this chapter, unless the context clearly indicates otherwise, the following definitions apply:

(1) "Accreditation" means a designation of approval.

(2) "Adult day-care center" means a facility, freestanding or connected to another health care facility, which provides adults, on an intermittent basis, with the care necessary to meet the needs of daily living.

(3) "Ambulatory surgical facility" means a facility, not part of a hospital, which provides surgical treatment to patients not requiring hospitalization. This type of facility may include observation beds for patient recovery from surgery or other treatment.

(4) "Board" means the board of health and environmental sciences, provided for in 2-15-2104.

(5) "Chemical dependency facility" means a facility whose function is the treatment, rehabilitation, and prevention of the use of any chemical substance, including alcohol, which creates behavioral or health problems and endangers the health, interpersonal relationships, or economic function of an individual or the public health, welfare, or safety.

(6) "Clinical laboratory" means a facility for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(7) "College of American pathologists" means the organization nationally recognized by that name with headquarters in Traverse City, Michigan, that surveys clinical laboratories upon their requests and accredits clinical laboratories that it finds meet its standards and requirements.

(8) "Department" means the department of health and environmental sciences provided for in Title 2, chapter 15, part 21.

(9) "Federal acts" means federal statutes for the construction of health care facilities.

(10) "Governmental unit" means the state, a state agency, a county, municipality, or political subdivision of the state, or an agency of a political subdivision.

(11) "Health care facility" or "facility" means any institution, building, or agency or portion thereof, private or public, excluding federal facilities, whether organized for profit or not, used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. The term does not include offices of private physicians or dentists. The term includes but is not limited to ambulatory surgical facilities, health maintenance organizations, home health agencies, hospices, hospitals, infirmaries, kidney treatment centers, long-term care facilities, medical assistance facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, residential treatment facilities, and adult day-care centers.

(12) "Health maintenance organization" means a public or private organization that provides or arranges for health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or group of providers.

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(14) "Hospice" means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and his family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component.

(15) "Hospital" means a facility providing, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick persons. Services provided may or may not include obstetrical care, emergency care, or any other service as allowed by state licensing authority. A hospital has an organized medical staff which is on call and available within 20 minutes, 24 hours per day, 7 days per week, and provides 24-hour nursing care by licensed registered nurses. This term includes hospitals specializing in providing health services for psychiatric, mentally retarded, and tubercular patients.

2
DATE 2-4-91
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(c)

(16) "Infirmary" means a facility located in a university, college, government institution, or industry for the treatment of the sick or injured, with the following subdefinitions:

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(b) an "infirmary—B" provides outpatient care only.

(17) "Joint commission on accreditation of hospitals" means the organization nationally recognized by that name with headquarters in Chicago, Illinois, that surveys health care facilities upon their requests and grants accreditation status to any health care facility that it finds meets its standards and requirements.

(18) "Kidney treatment center" means a facility which specializes in treatment of kidney diseases, including freestanding hemodialysis units.

(19) (a) "Long-term care facility" means a facility or part thereof which provides skilled nursing care, intermediate nursing care, or intermediate developmental disability care to a total of two or more persons or personal care to more than four persons who are not related to the owner or administrator by blood or marriage. The term does not include adult foster care licensed under 53-5-303, community homes for the developmentally disabled licensed under 53-20-305, community homes for persons with severe disabilities licensed under 53-19-203, youth care facilities licensed under 41-3-1142, hotels, motels, boardinghouses, roominghouses, or similar accommodations providing for transients, students, or persons not requiring institutional health care, or juvenile and adult correctional facilities operating under the authority of the department of institutions.

(b) "Skilled nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed registered nurse on a 24-hour basis.

(c) "Intermediate nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed nurse to patients not requiring 24-hour nursing care.

(d) "Intermediate developmental disability care" means the provision of nursing care services, health-related services, and social services for the developmentally disabled, as defined in 53-20-102(4), or persons with related problems.

(e) "Personal care" means the provision of services and care which do not require nursing skills to residents needing some assistance in performing the activities of daily living.

(20) "Medical assistance facility" means a facility that:

(a) provides inpatient care to ill or injured persons prior to their transportation to a hospital or provides inpatient medical care to persons needing that care for a period of no longer than 96 hours; and

(b) either is located in a county with fewer than six residents per square mile or is located more than 35 road miles from the nearest hospital.

(21) "Mental health center" means a facility providing services for the prevention or diagnosis of mental illness, the care and treatment of mentally ill patients or the rehabilitation of such persons, or any combination of these services.

(22) "Nonprofit health care facility" means a health care facility owned or operated by one or more nonprofit corporations or associations.

(23) "Observation bed" means a bed occupied for not more than 6 hours by a patient recovering from surgery or other treatment.

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(25) "Outpatient facility" means a facility, located in or apart from a hospital, providing, under the direction of a licensed physician, either diagnosis or treatment, or both, to ambulatory patients in need of medical, surgical, or mental care. An outpatient facility may have observation beds.

(26) "Patient" means an individual obtaining services, including skilled nursing care, from a health care facility.

(27) "Person" means any individual, firm, partnership, association, organization, agency, institution, corporation, trust, estate, or governmental unit, whether organized for profit or not.

(28) "Public health center" means a publicly owned facility providing health services, including laboratories, clinics, and administrative offices.

(29) "Rehabilitation facility" means a facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons by providing comprehensive medical evaluations and services, psychological and social services, or vocational evaluation and training or any combination of these services and in which the major portion of the services is furnished within the facility.

(30) "Resident" means a person who is in a long-term care facility for intermediate or personal care.

(31) "Residential treatment facility" means a facilty ~~of not less than 30 beds that is operated by a nonprofit corporation or association~~ operated for the primary purpose of providing long-term treatment services for mental illness in a nonhospital based residential setting to persons under 21 years of age.

(32) "State health plan" means the plan prepared by the department to project the need for health care facilities within Montana and approved by the statewide health coordinating council and the governor.

Section 2. Section 50-5-316, MCA, is amended to read:

50-5-316. Licensing and Ccertificate of need for residential treatment facility. ~~A~~ Except as provided in 50-5-317, a person may not operate a residential treatment facility unless he has obtained a license and a certificate of need issued by the department as provided under this part chapter.

Section 3. Section 50-5-317, MCA, is amended to read:

50-5-317. Study of residential treatment facility needs — authorization for change of use — licensing of existing facilities. (1) In order to determine the need for services provided by a residential treatment facility, the department, together with the department of family services and the department of social and rehabilitation services, shall:

(a) conduct a review of the need for services provided by the residential treatment facility. The review must include a determination of:

(i) the number of persons between 5 and 21 years of age who:

(A) suffer from mental illness in this state; and

(B) are placed in out-of-state facilities by the department of family services and Montana school districts;

(ii) the appropriate levels of care or treatment for the persons described in subsection (1)(a)(i); and

(iii) the potential number of persons described in subsection (1)(a)(i) eligible for reimbursement of inpatient psychiatric services under 53-6-101;

(b) develop an appropriate methodology for determining the need for residential treatment facility services and beds; and

(c) report their findings to the ~~52nd~~ 53rd legislature.

(2) Except as provided in subsection (3), the department may not issue a license or certificate of need for a new residential treatment facility or for any change in the capacity of an existing facility seeking a license or certificate of need as a residential treatment facility until after October 1, ~~1991~~ 1993.

(3) A person who operates an existing facility that meets the definition of a residential treatment facility on January 1, 1989, may receive a license to operate the facility as a residential treatment facility and need not obtain a certificate of need as otherwise required under 50-5-316.

SECTION 1. Section 53-6-101, MCA, is amended to read:

53-6-101. Montana medicaid program — authorization of services. (1) There is a Montana medicaid program established for the purpose of providing necessary medical services to eligible persons who have need for medical assistance. The Montana medicaid program is a joint federal-state program administered under this chapter and in accordance with Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended. The department of social and rehabilitation services shall administer the Montana medicaid program.

(2) Medical assistance provided by the Montana medicaid program includes the following services:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services;

(d) skilled nursing services in long-term care facilities;

(e) physicians' services;

(f) nurse specialist services;

(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age;

(h) services provided by physician assistants-certified within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;

(i) health services provided under a physician's orders by a public health department; and

(j) hospice care as defined in 42 U.S.C. 1396d(o).

(3) Medical assistance provided by the Montana medicaid program may, as provided by department rule, also include the following services:

(a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(b) home health care services;

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 2;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

(i) prescribed eyeglasses;

(j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;

(k) inpatient psychiatric hospital services for persons under 21 years of age;

(l) services of professional counselors licensed under Title 37, chapter 23, if funds are specifically appropriated for the inclusion of these services in the Montana medicaid program;

(m) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;

(n) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396d(h), in a residential treatment facility as defined in 50-5-101(31) and that is accredited by the joint commission on accreditation of health care organizations; and

(o) ~~(n)~~ any additional medical service or aid allowable under or provided by the federal Social Security Act.

(4) The department may implement, as provided for in Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(5) The department may set rates for medical and other services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

(6) The services provided under this part may be only those that are medically necessary and that are the most efficient and cost effective.

(7) The amount, scope, and duration of services provided under this part must be determined by the department in accordance with Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended.

(8) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

(9) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program.

(10) Community-based medicaid services, as provided for in part 4 of this chapter, must be provided in accordance with the provisions of this chapter and the rules adopted thereunder.

NEW SECTION. **Section 5.** Residential treatment services adoption of rules. (1) To the extent allowed by federal law, the department, beginning July 1, 1992, shall by rule include the income of the parents when determining the eligibility of persons under 21 years of age who are receiving inpatient psychiatric services as provided in [renumbered subsection 53-6-101(h)].

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(2) The department may adopt rules governing the placement and continued stay of persons in residential treatment facilities. These rules may include requirements that the services utilized are medically necessary in a residential treatment facility. Rules may also be adopted to insure that a residential treatment facility is the least restrictive placement.

NEW SECTION. **Section 6.** Coordination instructions. If 50-5-301 through 50-5-310 terminates or is repealed the reference to a "certificate of need" may be deleted from 50-5-316 and 50-5-317.

NEW SECTION. **Section 7.** Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 8.** Effective date. [This act] is effective July 1, 1991.

- End -

Exhibit 3 consists of a 37 page study. The original is available at the Montana Historical Society, 225 N. Roberts, Helena, MT. 59601. (Phone 406-444-4775).

ANALYSIS OF THE PROS AND CONS OF ELIMINATING OR MODIFYING MONTANA'S MEDICALLY NEEDY PROGRAM

EXHIBIT # 3
DATE 2-4-91
HB Dem Law Sub.

January 1991

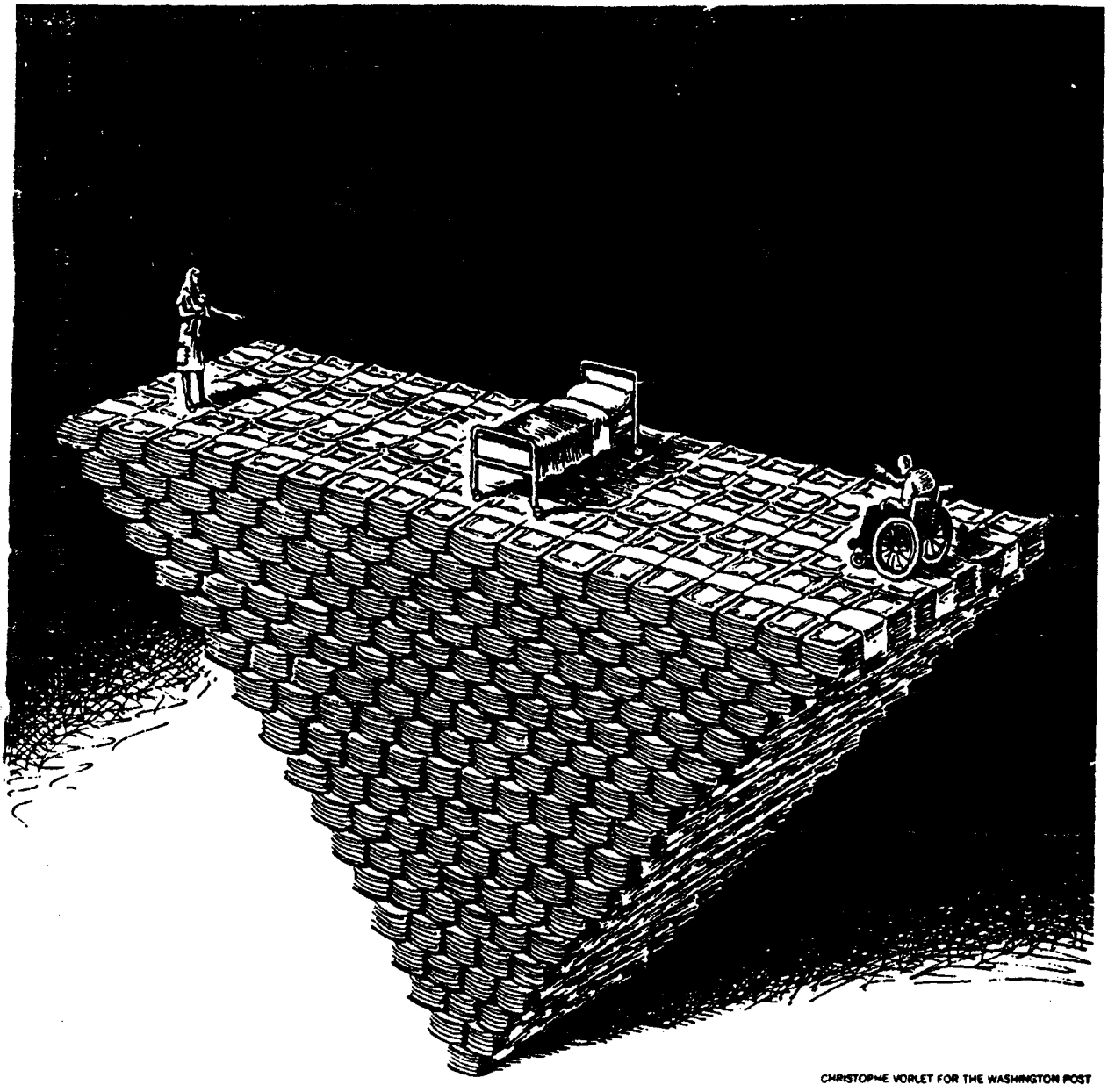
Prepared by:

Mark A. Levy

POLICY STUDIES INC.
1410 Grant Street
Denver, Colorado 80203

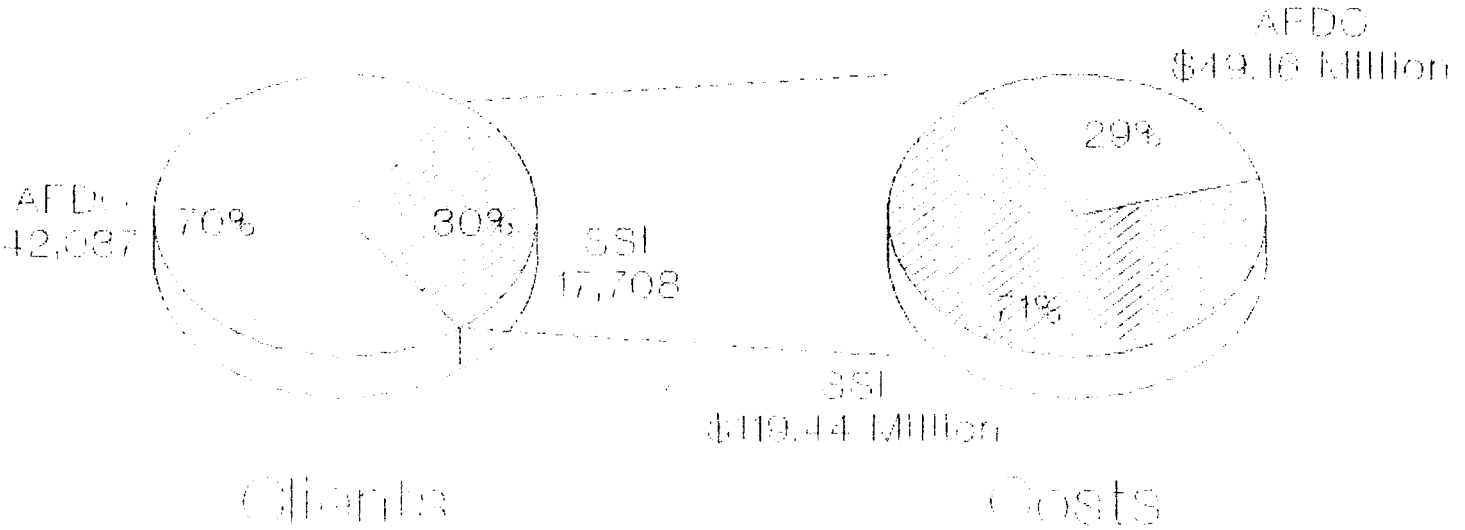
EXHIBIT 4
DATE 2-4-91
HB

Exhibit # 1
2/4/91
Human Serv. Subc.



CHRISTOPHE VORLET FOR THE WASHINGTON POST

Montana Medicaid Program
Medicaid Costs for AFDC/SSI Clients
FY 1990

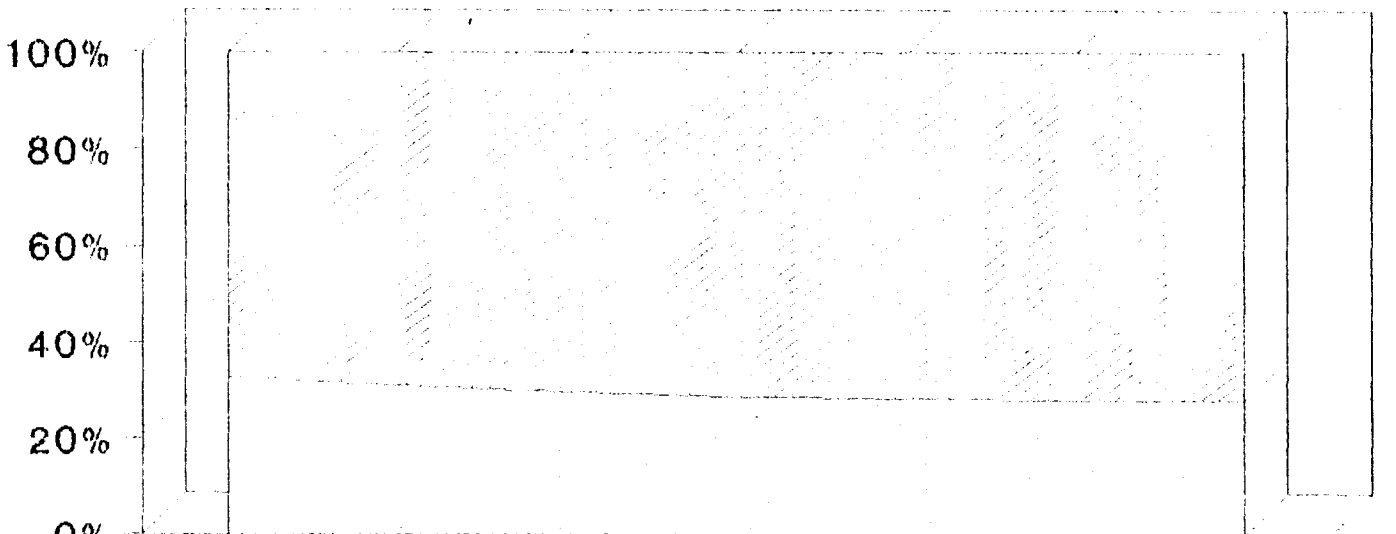


Source is the HCFA 2082

EXHIBIT 4
DATE 2-4-91
HB Dem. Soc. Serv.

Montana Medicaid Program

Federal Medical Assistance Percent



	1987	1988	1989	1990	1991	1992	1993
FMAP	67.18%	68.91%	70.35%	71.17%	71.64%	71.71%	71.9%
State Match	32.82%	31.09%	29.68%	28.83%	28.36%	28.29%	28.1%

State Match FMAP

1993 rate is not yet confirmed by Feds.

MONTANA'S MEDICAID PROGRAM
MANDATORY SERVICES

Hospital (Inpatient and Outpatient)
Physician
Skilled Nursing Care
Early Periodic Screening Diagnosis and Treatment (EPSDT)
Lab and X-ray
Home Health
Family Planning
Rural Health Clinics
Federally Qualified Health Centers

OPTIONAL SERVICES

Intermediate Nursing Care
Prescription Drugs
Dental
Optometrist
Hearing Aids
Podiatry
Private Duty Nursing
Clinic
Physical Therapy
Occupational Therapy
Speech Therapy
Other Practitioners
Dentures
Prosthetic Devices
Eyeglasses
Diagnostic Services
Institutions for Mentally Diseased
Inpatient Psychiatric (under age 21)
Personal Care
Transportation
Hospice

5

Medicaid Payments and Average Monthly Caseload FY 90

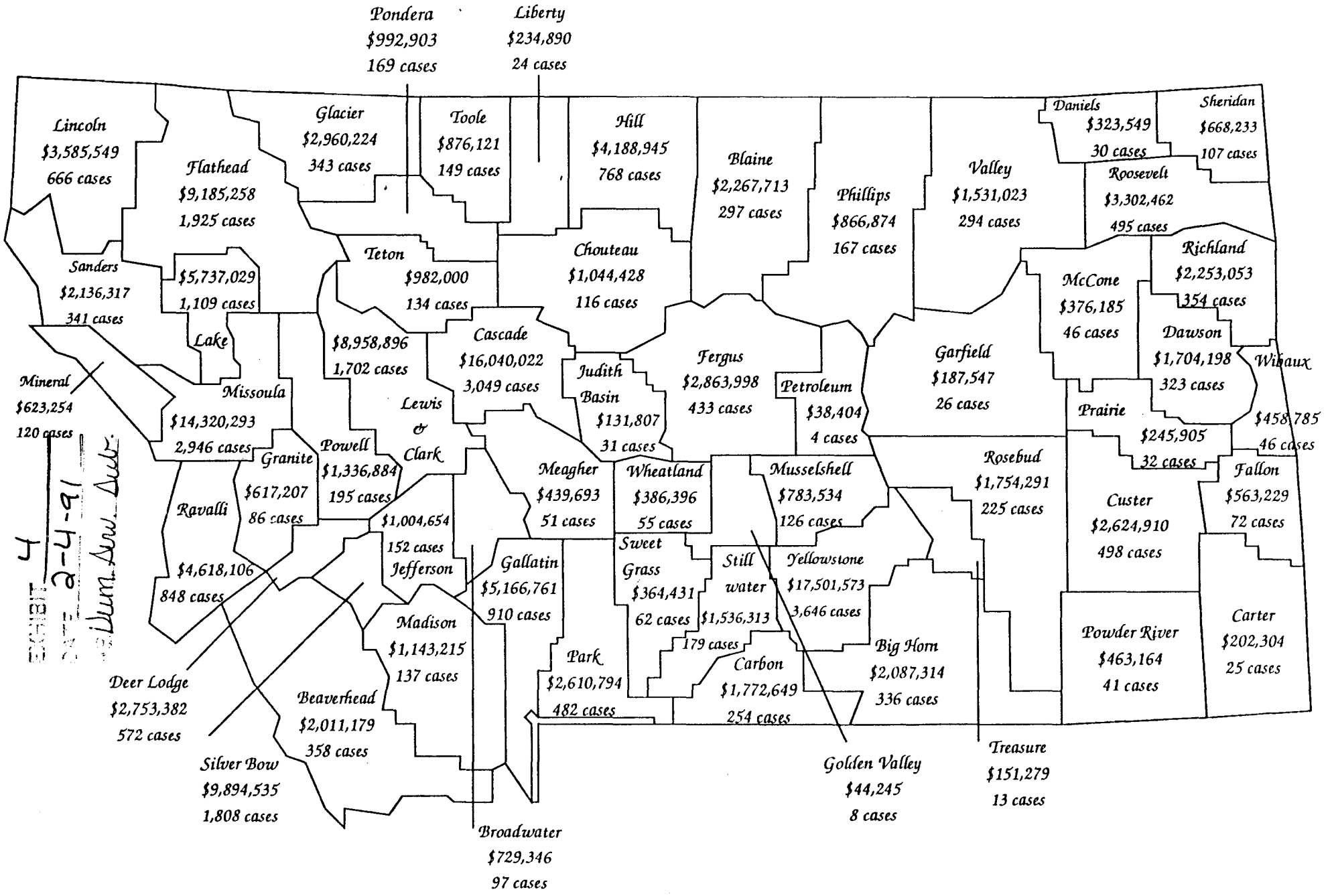
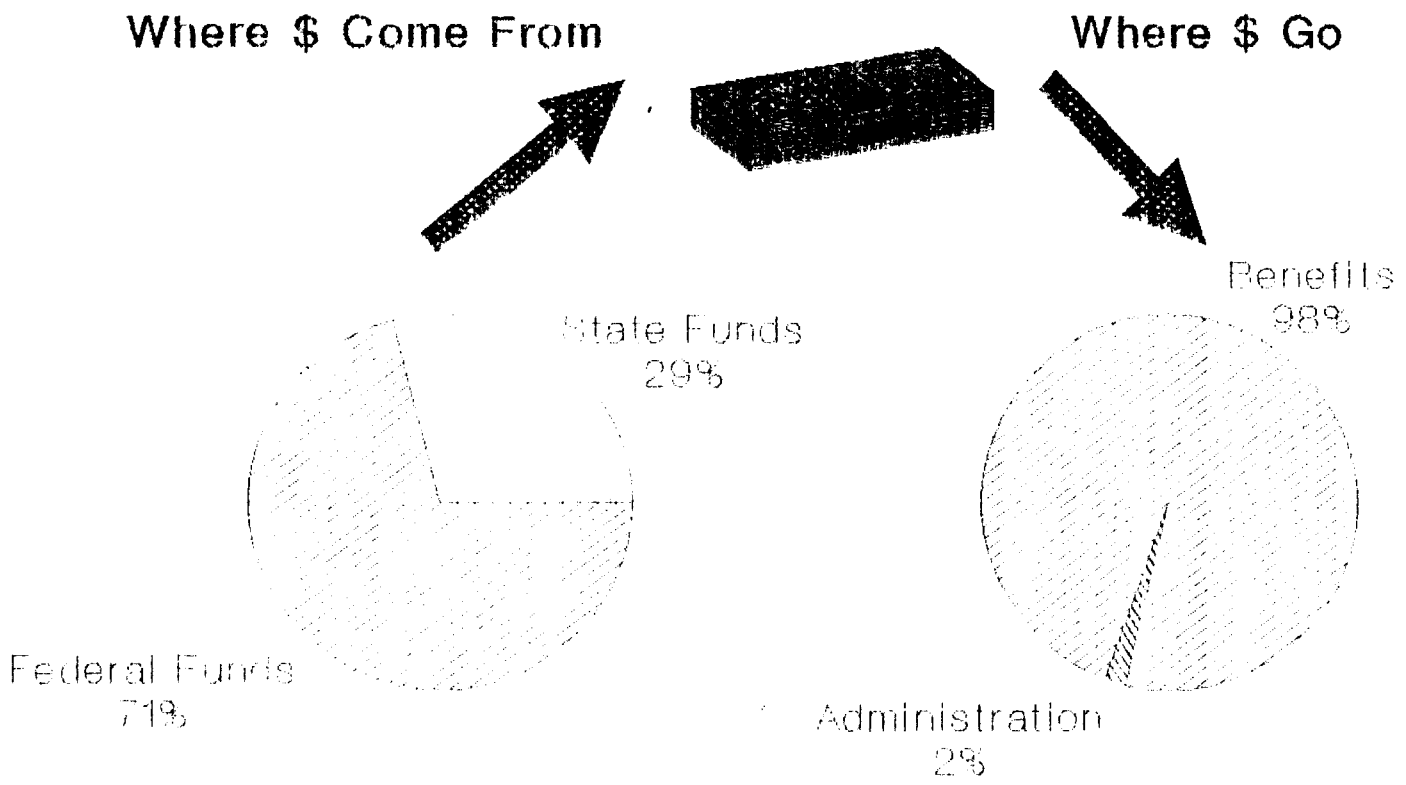


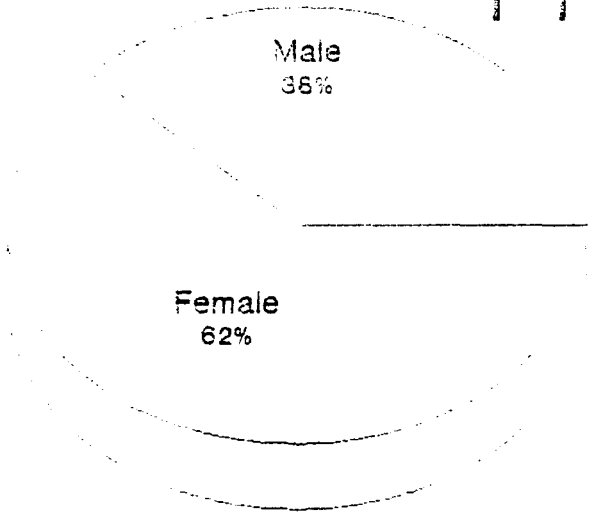
EXHIBIT 4
DATE 2-4-91
Ilum. Aux. Sub.

MONTANA'S MEDICAID PROGRAM

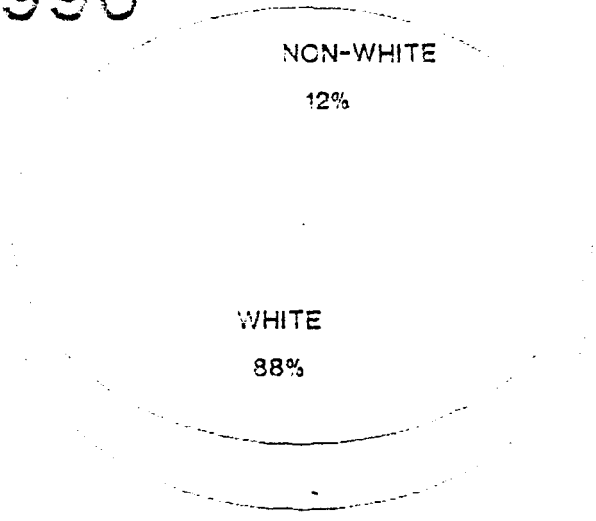


4
2-4-91
Hum. Serv. Sub

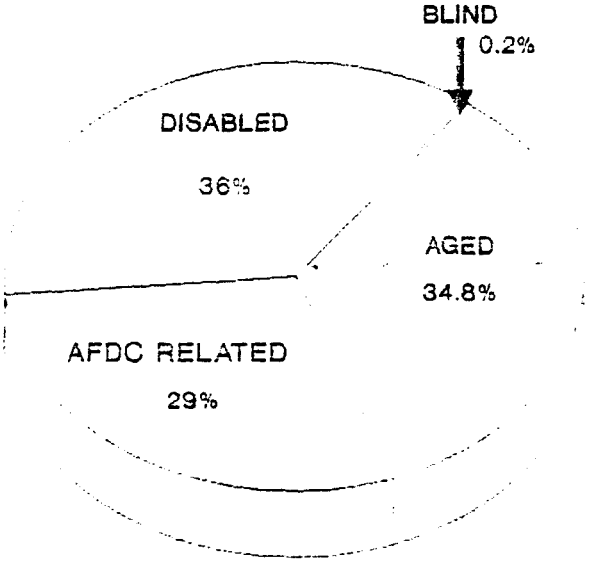
Distribution of Medicaid Payments FY 1990



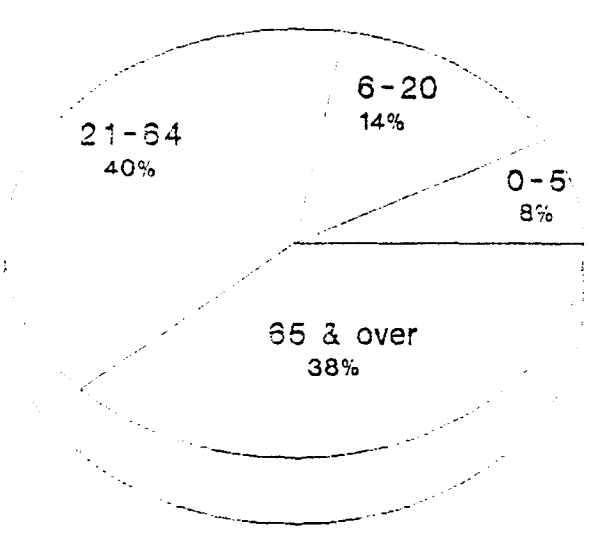
Payments By Sex



Payments By Race



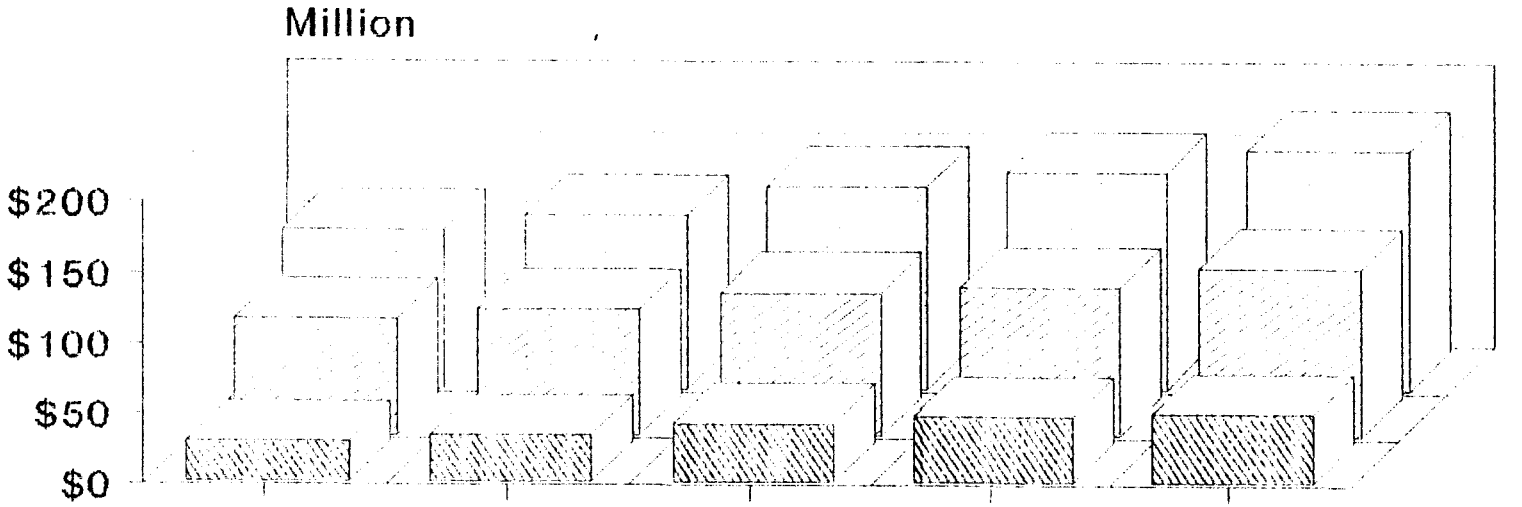
Payments By Category



Payments By Age

Montana Medicaid Program

Medicaid Costs for AFDC/SSI Clients



	1986	1987	1988	1989	1990
Total	$111.99	$122.39	$143.14	$152.86	$168.59
SSI	$83.05	$89.67	$101.54	$105.75	$119.44
AFDC	$28.95	$32.73	$41.59	$47.11	$49.15

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EXHIBIT 4
DATE 2-4-91
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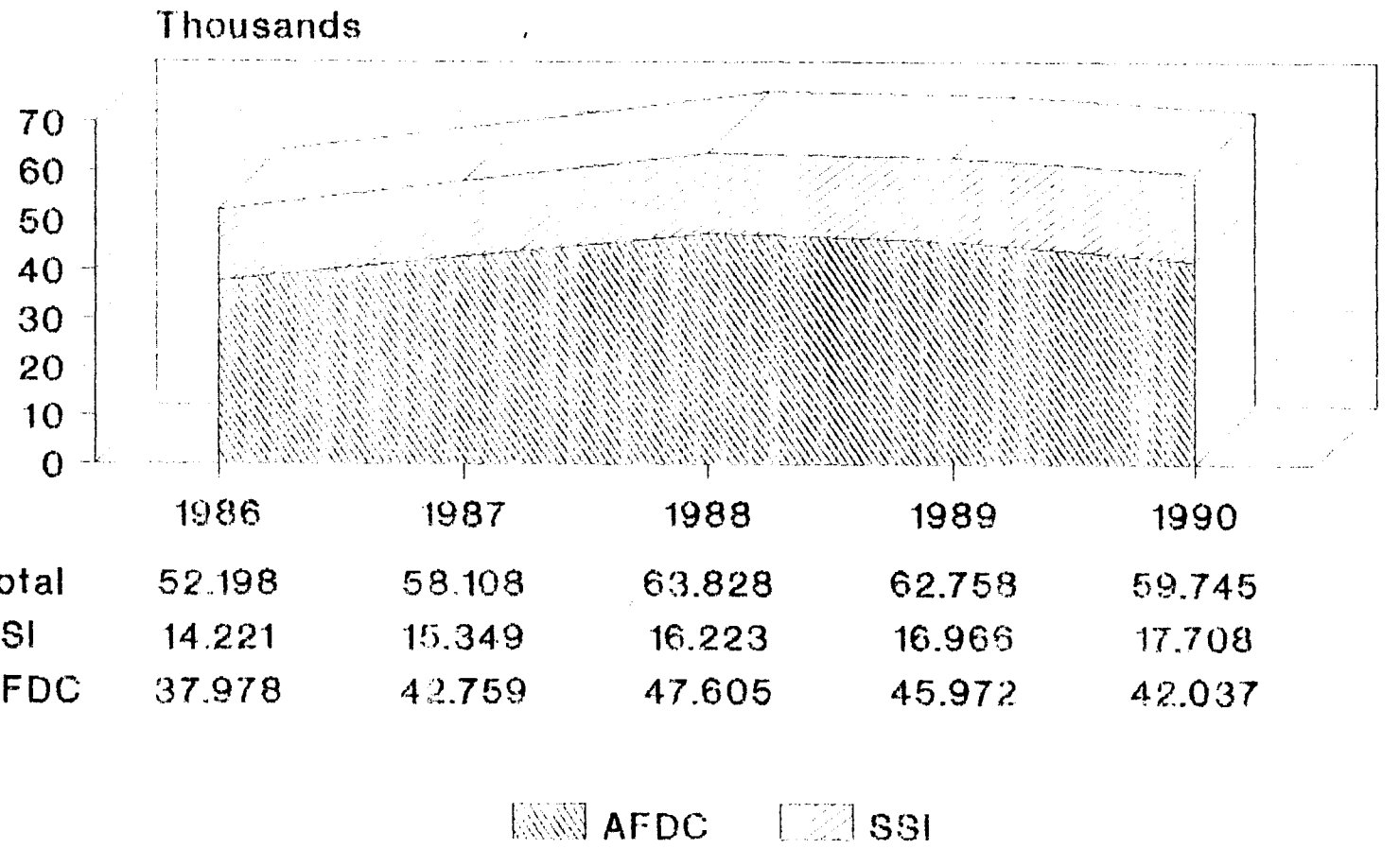
Montana Medicaid Program

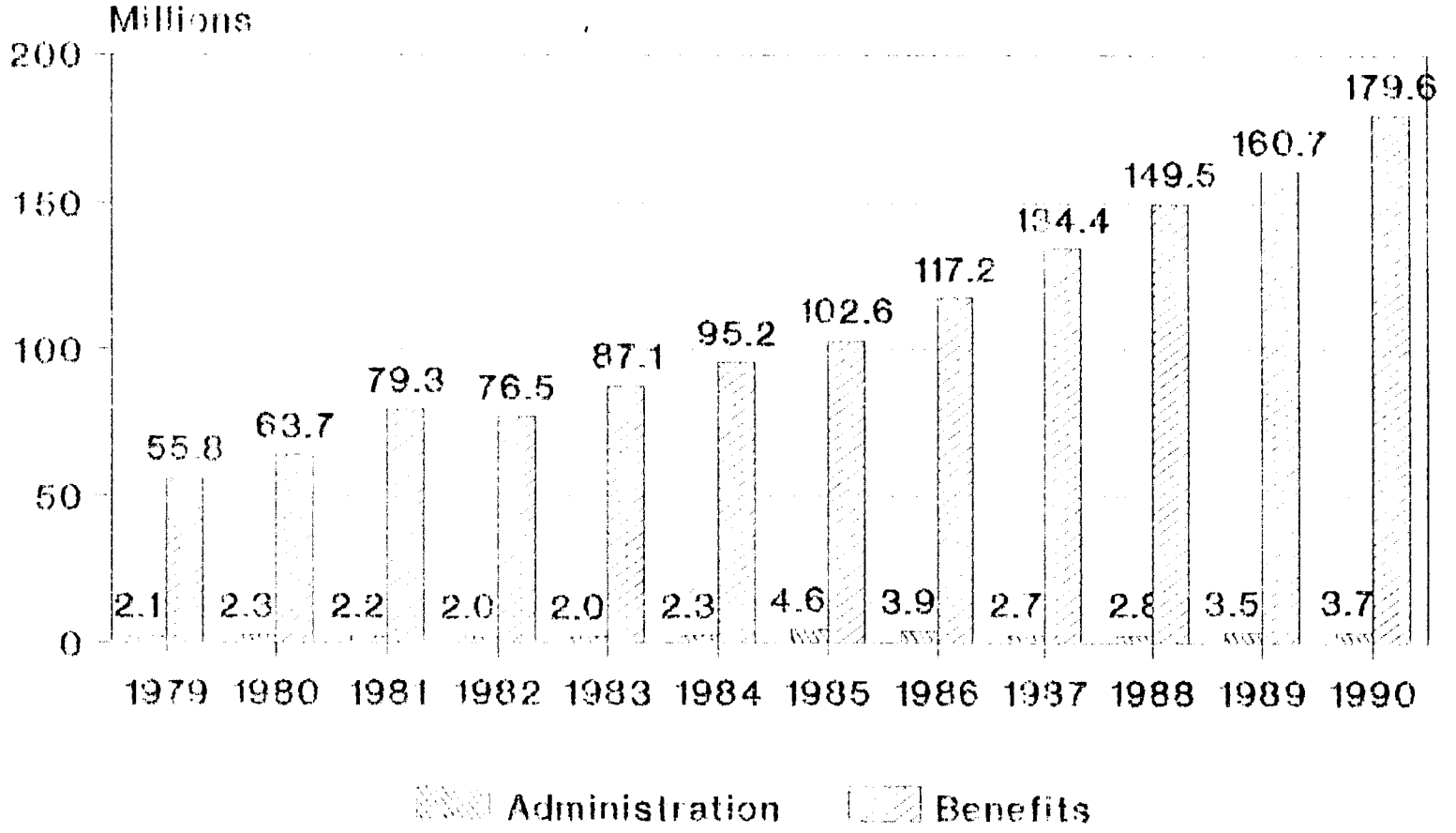
Clients Served by AFDC and SSI



	1986	1987	1988	1989	1990
Total	52.198	58.108	63.828	62.758	59.745
SSI	14.221	15.349	16.223	16.966	17.708
AFDC	37.978	42.759	47.605	45.972	42.037

Data is from HCFA 2082

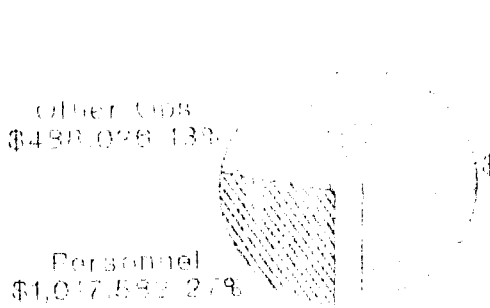
Montana Medicaid Program
Cost Comparison 1979 to 1990



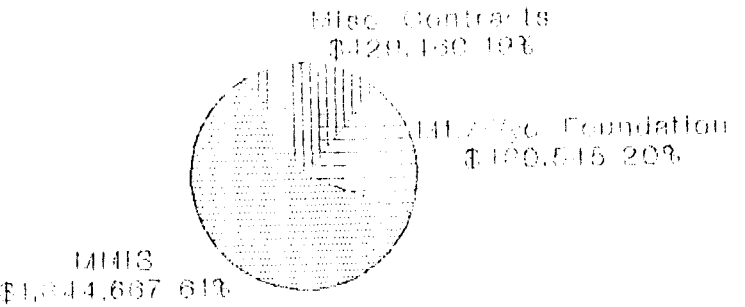
Admin. up by 75%, Benefits up by 222 %

EXHIBIT 4
DATE 2-4-91
SB Hum. Serv. Aging

Montana Medicaid Program
Medicaid Administration
FY 1990



Medicaid Operations



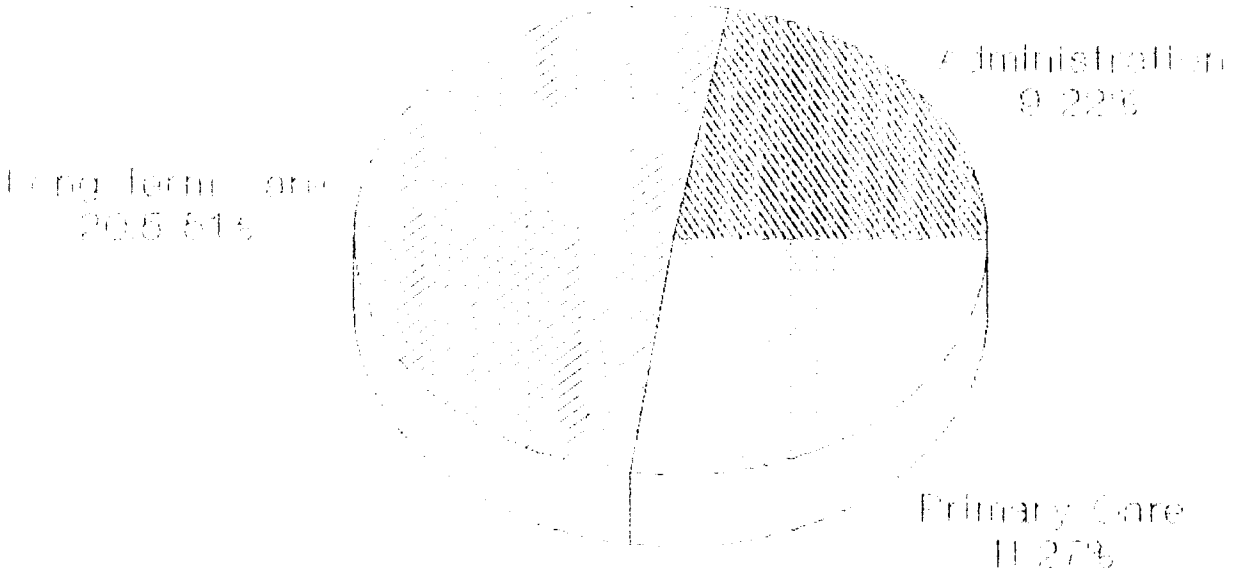
Contracts

Operations for FY 1990 is $3,710,280.

12

Medicaid Services Division

Division Staffing



Total Staff 40.50 FTE

MEDICAID MANDATES
GENERAL FUND IMPACT (Through FY 93)
OMNIBUS BUDGET RECONCILIATION ACT (OBRA) - 1987

EXHIBIT 4
DATE 2-4-91
Hum. Serv. Sub-

NURSING HOME REFORM

- One Level of Nursing Facility Services
- Nurse Aide Training, Testing, and Registration
- New Survey and Certification Requirements
- Pre Admission Screening and Annual Resident Review (PASAAP) of Mentally retarded and Mentally Ill

FISCAL IMPACT - $3,347,349

MEDICARE CATASTROPHIC COVERAGE ACT - 1988

- Coverage of all Infants and Pregnant Women Below 100% Federal Poverty Level
- Coverage of Qualified Medicare Beneficiaries (QMBs) below 100% of Federal Poverty Level by 1992.
- Spousal Impoverishment.

FISCAL IMPACT - $14,201,723

FAMILY SUPPORT ACT - 1988

- Transitional Medicaid to provide twelve months extended coverage for families who lose eligibility because of increased earnings.

FISCAL IMPACT - $2,602,934

OBRA - 1989

- Expansion of EPSDT Program to cover all Medicaid Services.
- Coverage of Pregnant Women and Children up to age Six Below 133% of Federal Poverty Level.
- Requirement to Pay Obstetrical and Pediatric Providers at Rates Which Assure Equal Access.
- Reimburse Federally Qualified Health Centers and their Look-alikes at 100% of Reasonable Costs.
- Coverage of Qualified Working Disabled Individuals.

FISCAL IMPACT - $5,037,887

OBRA - 1990

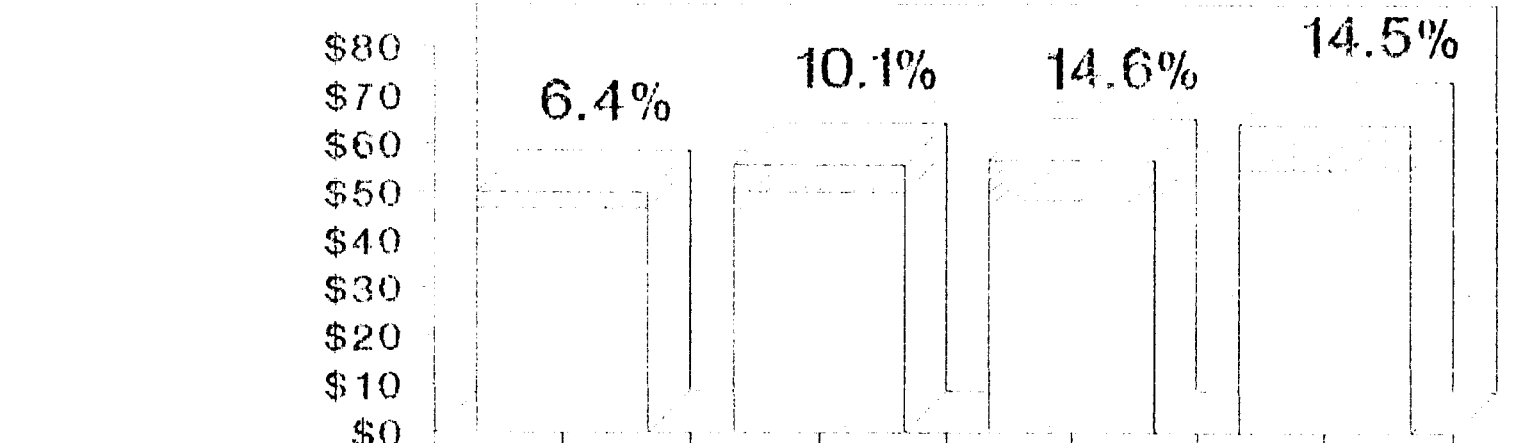
- Phased-in Coverage of all Children Below 100% of Poverty up to Age 18.
- Mandatory Outstationing of Eligibility Workers.
- Requires Rebates from Drug Manufacturers.
- Prospective and Retrospective Drug Utilization Review Programs Including Establishment of Drug Review Boards.
- Cover QMBs up to 100% of Poverty by 1991 and 120% of Poverty by 1995.
- Purchase of Group Health Insurance.
- Veterans Pension Changes.
- Restrictions on use of Taxes, Donations.

FISCAL IMPACT - $1,280,115

A:NSE.52

Montana Medicaid

The Effect of New Federal Mandates on State General Fund



	1990	1991	1992	1993
Federal Mandates	$3.192	$5.653	$8.289	$9.336
Other General Fund	$46.913	$50.167	$48.539	$54.961

EXHIBIT 5
DATE 2-4-91
EXHIBIT #5
2/4/91
Human Services Subc.

Montana Council for Maternal and Child Health

The Voice of the Next Generation
in Montana's State Capitol

2030 11th Ave., Suite 10 Helena, MT 59601 (406) 443-1674

TESTIMONY FOR THE JOINT SUBCOMMITTEE ON HUMAN SERVICES OF THE HOUSE APPROPRIATIONS AND SENATE FINANCE AND CLAIMS COMMITTEES

Supporting increased Medicaid Appropriations

Date: February 4, 1991

The Montana Council for Maternal and Child Health. a non-profit public policy research, education, and advocacy organization, has studied the implications on the Montana health care system of various modifications to the Medicaid program. Our recommendations are as follows:

(1) Expand Medicaid eligibility to the maximum allowed by federal law for pregnant women and young children, currently 185% of the federal poverty level, resulting in a medicaid match of $2.55 for each state dollar. Expansion to 100% of poverty was mandated by the MIAMI act (Montana Initiative for Abatement of Mortality in Infants) in 1989, and to 133% by OBRA '89. The federal poverty level for a family of four (with an unborn child counting as a member of the family) is $12,695 per year. 185% of poverty level for the same family of four would be $23,485. For a single pregnant woman, the federal poverty guideline (family of 2) is $8,418, and 185% of poverty would be $15,573 per year.

Medicaid is not only a lifeline for the "working poor," families for whom the private market for insurance has failed to offer affordable coverage, but for rural communities struggling to maintain vital health care services. Local health care providers are a major portion of the economy, with rural hospitals often providing employment second only to the school system. Without hospitals and health care providers, local communities in Montana cannot maintain a business economy either. Investment in health care is an investment in the economic future of Montana.

(2) Increase provider reimbursement levels for obstetrical and pediatric care providers to 90% of the usual and customary rate. Currently the level of reimbursement is about 40%, and does not cover expenses of providing care. Recruitment of providers into the Medicaid system is mandated by OBRA '89, and this is one of the methods provided by federal law to avoid forfeiture of the state's Medicaid matching funds. These increases are included in the Executive budget request for SRS.

(3) Provide for presumptive eligibility (streamlined application process) and continuous eligibility (Medicaid pays for the full pregnancy and aftercare without having to requalify each month) for pregnant women. Presumptive eligibility was mandated by the 1989 MIAMI bill. Both presumptive and continuous eligibility have been adopted in the proposed Executive budget request for SRS.

(4) Providing targeted case management for pregnant women. This program, a Medicaid option, pays for nursing services which go beyond mere physical diagnosis and treatment, to include assistance with transportation, encouragement, referrals to other services, advocacy to enroll her in care, and other necessary services to enable the woman to enter and continue in her prenatal care.

Targeted case management for pregnant women is vital to the extension and expansion of the Montana Perinatal Program's low birthweight program, to allow for the setting up of 9 additional project sites, primarily in county health departments, so that 90 percent of Montana's pregnant women will have access to targeted case management and prenatal care.

Targeted case management in other areas of concern is supported by the Council as a general concept leading to improved care and conservation of resources.

(5) Fund additional Medicaid expansion options, including utilizing the maximum eligibility guidelines for all Montanans, to maximize federal matching funds.

Respectfully Submitted,

Paulette Kohman

Paulette Kohman
Executive Director

MONTANA COALITION

DATE 6
DATE 2-4-91

Exhibit #6
2/4/91
Human Services
Sub-

healthy mothers, healthy babies

TESTIMONY FOR SUPPORT

MEDICAID CHANGES IMPROVING SERVICES FOR PREGNANT WOMEN
FEBRUARY 4, 1991

SUPPORT KIDS COUNT

SUPPORT MANDATING PRESUMPTIVE AND CONTINUOUS ELIGIBILITY

SUPPORT INCREASING ELIGIBILITY LEVEL TO 185% OF POVERTY

SUPPORT TARGETED CASE MANAGEMENT

SUPPORT INCREASING PHYSICIAN PAYMENT TO 90% OF REASONABLE & CUSTOMARY CHARGES

WE MUST REDUCE THE BARRIERS TO PRENATAL CARE

We can't afford NOT to take care of pregnant women.

It is cost effective to take care of our pregnant women

We must maintain our physicians as providers for obstetrical care

IT IS OUR MORAL AND ETHICAL AND FINANCIAL RESPONSIBILITY TO PROVIDE SERVICES TO THE PREGNANT WOMEN OF MONTANA

SAVING ONE "BAD BABY" PAYS FOR PRENATAL CARE

D. Elizabeth Roeth
Executive Director
Healthy Mothers, Healthy Babies
Chair Montana Children's Alliance

2-4-91

HB

Exhibit # 7
2/4/91
Human Serv.
Subc.

IMPROVEMENTS IN THE PCA PROGRAM SINCE WEST MONT AWARDED CONTRACTS

Prior to West Mont

- PCAs are independent contractors.
- $3.85--no benefits, no unemployment, no worker's compensation, keep own records of income and file self employment taxes, wages through Consultec often delayed for weeks or months.
- No training.
- Very little contact with Nurse Supervisor.

Since West Mont Awarded Contract

- PCAs are employees of West Mont.

1987

- Wage $3.35 plus worker's compensation, unemployment, health insurance for full time PCAs, taxes withheld, paid every two (2) weeks.
- Prescreening test prior to employment.
- One on one training by Nurse Supervisor for difficult clients.
- Nurse Supervisors visit client on regular basis and evaluate clients and PCAs.

1988

- Wage $3.85--other benefits continue.
- Hired Education Coordinator. Developed 16 hours training programs for all PCAs. Nurse Supervisors begin formal training of PCAs.

1989

- Wage $4.00--$4.30 after three (3) months. Other benefits continue. * Reduced qualifying hours for insurance to 32 per week. PCAs offered up to seven (7) days per year personal leave for full time.
- Continued development of training programs:
  First Year.....16 Hours
  Each Year Thereafter....8 Hours

PCA PROGRAM STATISTICS

	FY87	FY88	FY89	FY90
Total # of recipients served	621	1,005	1,260	1,420
Total # of attendant units	242,198	526,471	653,048	748,554

1989

408 Surveys Sent Out

	Statewide			Eastern			Western			Central		
Total Surveys Returned:	262 (64%) returned			81			98			83		
Number of hours received:	4808			1338			2056			1414		
If Personal Care were not available, would you:	Yes	No	?	Yes	No	?	Yes	No	?	Yes	No	?
A: Continue present living situation.	154	92	15	45	23	12	65	30	3	44	39	0
B: Move to Institution	63	92	63	17	34	29	22	18	15	24	40	19
The supervising nurse is sensitive to your needs?	238	17	6	68	6	6	96	2	0	74	9	0
PCA's are available when you need them?	231	22	8	64	8	8	94	4	0	73	10	0
Are you satisfied with your PCA & his/her capabilities?	248	8	5	70	5	5	96	2	0	82	1	0
Are capable replacement PCA's available when requested?	186	46	29	53	13	14	80	14	4	53	19	11
You have sufficient input in:												
- selecting PCA's	185	52	24	53	11	16	73	25	0	59	16	8
- scheduling PCA's	200	18	40	50	12	15	96	2	0	54	4	25
- duties assigned	212	12	37	56	8	16	96	2	0	60	2	21
Male	69 (26%)			26			25			18		
Female	193 (74%)			54			74			65		
Disabled	80 (31%)			34			33			26		
Elderly	182 (69%)			43			60			55		
Mentally Ill	3			0			1			2		
Blind	4			1			1			2		
	(8 unspecified)			(3 unspecified)			(5 unspecified)					

EXHIBIT 7
DATE 2-4-91
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1989
Suveys Returned
by Elderly Clients

	Statewide		Eastern		Western		Central	
Total Surveys Returned:	182 (69%)		52		70		60	
Number of hours received:	3109 (65%)		738		1391		980	
If Personal Care were not available, would you:	Yes	No	Yes	No	Yes	No	Yes	No
A: Continue present living situation.	103	73	28	16	43	24	32	33
B: Move to Institution	48	57	14	20	17	3	17	34
The supervising nurse is sensitive to your needs?	165	15	42	6	69	1	54	8
CA's are available when you need them?	160	17	41	5	66	4	53	8
Are you satisfied with your PCA & his/her capabilities?	173	5	45	3	69	1	59	1
Are capable replacement PCA's available when requested?	133	32	35	7	61	9	37	16
You have sufficient input in:								
- selecting PCA's	123	37	32	6	48	22	43	11
- scheduling PCA's	143	11	30	9	73	0	40	2
- duties assigned	155	4	36	4	74	0	45	1
Male	43 (69%)		18		13		12	
Female	139 (72%)		39		58		42	

1989
Suveys Returned
by Disabled Clients

	Statewide		Eastern		Western		Central	
Total Surveys Returned:	80 (31%)		29		28		23	
Number of hours received:	1699 (35%)		600		665		434	
If Personal Care were not available, would you:	Yes	No	Yes	No	Yes	No	Yes	No
A: Continue present living situation.	51	19	17	7	22	6	12	6
B: Move to Institution	15	35	3	14	5	15	7	6
The supervising nurse is sensitive to your needs?	73	2	26	0	27	1	20	1
CA's are available when you need them?	71	5	23	3	28	0	20	2
Are you satisfied with your PCA & his/her capabilities?	75	3	25	2	27	1	23	0
Are capable replacement PCA's available when requested?	53	14	18	6	19	5	16	3
You have sufficient input in:								
- selecting PCA's	62	15	21	5	25	3	16	5
- scheduling PCA's	57	7	20	3	23	2	14	2
- duties assigned	57	8	20	4	22	2	15	1
Male	26 (37%)		8		12		6	
Female	54 (28%)		15		16		23	

EXHIBIT 7
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SB Dem. Dev. Sub.

1990
400 Surveys Sent Out

	Statewide			Eastern			Western			Central		
Total Surveys Returned:	158			43			71			44		
Number of hours received:	3209			605			1646			958		
If Personal Care were not available, would you:	Yes	No	?	Yes	No	?	Yes	No	?	Yes	No	?
A: Continue present living situation.	87	49		31	12		35	30	6	21	19	4
B: Move to Institution	45	81	32	7	31	5	28	21	22	10	29	5
The supervising nurse is sensitive to your needs?				41		2	68	1	2	41	2	1
PCA's are available when you need them?	150	3	5	37	5	1	67	3	1	36	3	5
Are you satisfied with your PCA & his/her capabilities?	149	8	1	39	4		69	1	1	41	3	0
Are capable replacement PCA's available when requested?	104	28	26	21	15	7	50	13	8	33	0	11
You have sufficient input in:												
- selecting PCA's	95	29	22	28	10	5	42	12	17	25	7	
- scheduling PCA's	102	23	20	31	6	6	48	13	10	23	4	
- duties assigned	115	12	14	32	5	6	58	5	8	25	2	
Male		35			15			9			11	
Female		123			29			62			32	
Disabled		63			15			28			20	
Elderly		92			26			43			23	

1990
Suveys Returned
by Disabled Clients

	Statewide		Eastern		Western		Central	
Total Surveys Returned:	77		29		28		20	
If Personal Care were not available, would you:	Yes	No	Yes	No	Yes	No	Yes	No
A: Continue present living situation.	15	12	4	1	3		8	11
B: Move to Institution	59	1	24		25		10	1
The supervising nurse is sensitive to your needs?	76		29		28		19	
PCA's are available when you need them?	77		29		28		20	
Are you satisfied with your PCA & his/her capabilities?	74	2	29		27	1	18	1
Are capable replacement PCA's available when requested?	64	7	26	3	23	2	15	2
You have sufficient input in:								
- selecting PCA's	55	17	15	12	21	4	19	1
- scheduling PCA's	55	17	15	12	21	4	19	
- duties assigned	52	14	12	7	20	7	20	
Male	22		4		9		9	
Female	55		25		19		11	

EXHIBIT 7
DATE 2-4-91
HB Dem. Serv. Subc.

1990
Suveys Returned
by Elderly Clients

	Statewide		Eastern		Western		Central	
Total Surveys Returned:	81		14		43		24	
If Personal Care were not available, would you:	Yes	No	Yes	No	Yes	No	Yes	No
A: Continue present living situation.	25	38	6	8	12	16	7	14
B: Move to Institution	30	6	4		8		18	6
The supervising nurse is sensitive to your needs?	75	5	13	1	39	3	23	1
CA's are available when you need them?	79	4	13	1	38	3	24	
Are you satisfied with your PCA & his/her capabilities?	79	2	13	1	38	1	24	
Are capable replacement PCA's available when requested?	47	2	8		22		17	2
You have sufficient input in:								
- selecting PCA's	51	14	9	2	32	6	10	6
- scheduling PCA's	31	18	7	3	19	3	5	12
- duties assigned	15	12	4		8	10	3	2
Male	21		3		7		11	
Female	60		11		36		13	

Exhibit 8
2/4/91
Human Serv.
Subcom.

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

EXHIBIT 8
DATE 2-4-91
HB

TESTIMONY OF ROSE M. HUGHES, EXECUTIVE DIRECTOR

OF THE THE MONTANA HEALTH CARE ASSOCIATION

BEFORE THE

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN SERVICES

RELATING TO THE BUDGET OF THE

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

(MEDICAID - NURSING HOMES)

FEBRUARY 4, 1991

WHAT'S INCLUDED IN NURSING HOME SERVICES AND A FACILITY'S MEDICAID RATE?

1. 24-hour nursing services

   Each resident must receive "the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and plan of care."

   In Montana each patient requires an average of 3.346 hours of nursing services (provided by RNs, LPNs, and aides) per day at a weighted average cost of $7.36 per hour.

   Thus, each patient on average requires $24.62 per day of direct nursing care. This does not include the cost of administrative personnel, such as the licensed nursing home administrator required by law, the director of nursing services, bookkeepers and secretarial staff, housekeepers, food service workers, laundry workers, social workers, activities personnel and the like.

2. Activities

   The facility must provide for an ongoing program of activities "designed to meet in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident."

3. Social services

   The facility must provide "medically-related social services to attain or maintain the highest practicable physical, mental or psychosocial well-being of each resident."

   A facility with over 120 beds must employ a full-time qualified social worker.

4. Dietary services

   The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. The facility must employ a qualified dietitian. The facility must provide three meals a day plus a bedtime snack. The facility must also provide special eating equipment and utensils for residents who need them.

EXHIBIT 8
DATE 2-4-91
HB Dum. Law Adv.

5. Laundry

The facility is responsible for washing, drying, ironing, etc., of residents' personal clothing.

6. Room - physical plant

The facility must be "designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public." An emergency power system must be available. Stringent fire and life safety standards must be met. Resident rooms must be of a specified size and be "designed and equipped for adequate nursing care, comfort and privacy of residents."

7. Additional services:

Housekeeping

Maintenance

Administration

Managing resident funds

COMPARISON OF FACILITIES' COSTS VS. MEDICAID RATES

Sample facilities, Myers & Stauffer study:

FY	Cost	Rate	$ Under-funded
86	47.79	44.93	$2.86
87	50.10	46.87	$3.23
88	52.44	48.51	$3.93
89	56.56	49.86	$6.70

All facilities, Myers & Stauffer study:

87	52.05	48.27	$3.78
91	64.85	56.05	$8.80

FY93 Biennium Proposal:

92	68.09*	59.82	$8.27
93	71.49*	63.76	$7.73

*Assumes 5% inflation each year of the biennium.

EXHIBIT 8
DATE 2-4-91
HB Dum Sen. Soc. Myers & Stauffer Report

F. Projection of Costs

1. Average Per Day Cost Projection for Fiscal Year 1991

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

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

WHAT IS NOT INCLUDED IN COSTS DETERMINED BY STUDY?

The Myers & Stauffer study identified FY91 costs as being:

$64.85

The study did not adequately account for increased costs due to:

...Resident assessment and care planning using federal MDS

...Restraint free environment

..."Highest possible" level of functioning for each resident

...OSHA - required to provide Hepatitis B vaccine to employees without charge (Approx. $150/person)

...Laboratory requirements

...Ripple effect of minimum wage

...Increase in workers' compensation premiums
1987 base - $6.20 per $100 payroll
1991 -$10.67 per $100 payroll
(72% increase)

EXHIBIT 8
DATE 2-4-91
HB Dem. Serv. Sub.

FAILURE OF MEDICAID PROGRAM TO PAY COST OF CARE ADVERSELY AFFECTS THOSE WHO PAY FOR THEIR OWN CARE AND COUNTY PROPERTY TAX PAYERS WHO SUBSIDIZE COUNTY-RUN FACILITIES

The following examples show the affect on privately paying nursing home patients and on county taxpayers who subsidize some of our county-run facilities. These examples assume a 100 bed facility and the average Medicaid occupancy rate of 62%.

The examples assume what a facility would have to charge just to break even. Any additional amounts for increased costs for wages, additional staff, new regulations, etc., or for building reserves, return on equity, or profits would have to be added to those amounts.

Since 62% of all patients are Medicaid, costs that Medicaid fails to pay are passed along to privately paying patients. Each private pay patient, pays the shift for about 2 Medicaid patients.

FY 91 - CURRENT YEAR:

Costs: $64.85 (per SRS study) Medicaid Rate: $56.05

Per day costs: $64.85 x 100 patients = $6485

Revenue:

Medicaid:	$56.05 x 62	=	$3475.10
Private:	$79.21 x 38	=	3009.98
			$6485.08

Summary:		
	Medicaid rate	$56.05
	Private rate	79.21
	Difference	$23.16
	Amount of cost shift	$14.36

FY 92:

Costs: $68.09 ($64.85 + 5% inflation)
Proposed Medicaid rate: $59.82

Per day costs: $68.09 x 100 patients = $6809

Revenue:

Medicaid:	$59.82	x 62	=	$3708.84
Private:	$81.58	x 38	=	3100.16
				$6809.00

Summary:

Medicaid rate	$59.82
Private rate	81.58
Difference	$21.76
Amount of cost shift	$13.49

FY 93:

Costs: $71.49 ($68.09 + 5% inflation)
Proposed Medicaid rate: $63.76

Per day costs: $71.49 x 100 patients = $7149

Revenue:

Medicaid:	$63.76	x 62	=	$3953.12
Private:	$84.10	x 38	=	3195.88
				$7149.00

Summary:

Medicaid rate	$63.75
Private rate	84.10
Difference	$20.34
Amount of cost shift	$12.61

SUMMARY:

FY	Cost of Care	Medicaid pays	Shortfall	Cost Shift
91	64.85	56.05	$8.80	$14.36
92	68.09	59.82	$8.27	$13.49
93	71.49	63.76	$7.73	$12.61

EXHIBIT 8
DATE 2-4-91
HB Dum Sw. Sub.

PROPOSAL TO ADD 5% INFLATION

The Governor's budget includes increases designed to "rebase" the nursing home rates to take into account the actual costs of providing care. The proposal phases in 90% of the difference in the cost base, so at the end of the biennium the rate is $63.76, as compared to FY91 costs of $64.85. Inflation has not been taken into account.

The progress made in the rebase is lost if inflation is not taken into account. Also, the federal Boren Amendment requires state Medicaid programs to take into account the effects of inflation on facility costs.

We proposed that a 5% inflator, such as has been added to other health care services, be added each year of the biennium to account for expected inflation. We suggest that the inflator be applied to the FY91 rate of $56.05, rather than the FY91 costs of $64.85. The result would be:

FY	Cost	Inflation	Medicaid Rate Proposed	Medicaid Rate New	Shortfall	Cost Shift
91	64.85		56.05		8.80	$14.36
92	68.09	2.80 +	59.82	= 62.62	5.47	$ 8.92
93	71.49	3.13 +	63.75	= 66.89	4.60	$ 7.50

Cost of proposal to add 5% inflation:

FY92 $2.80 x 1,365,432 days = $3,823,209.60

FY93 $3.13 x 1,392,741 days = $4,359,279.30

General fund required:

FY92 $1,070,498.60
FY93 $1,220,598.20

Attachment 1

Boren Amendment (1396a)

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

McKnight's
Long-Term Care
NEWS
formerly
Today's Nursing Home

McKnight Medical
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A division of
Medical Economics Co., Inc.

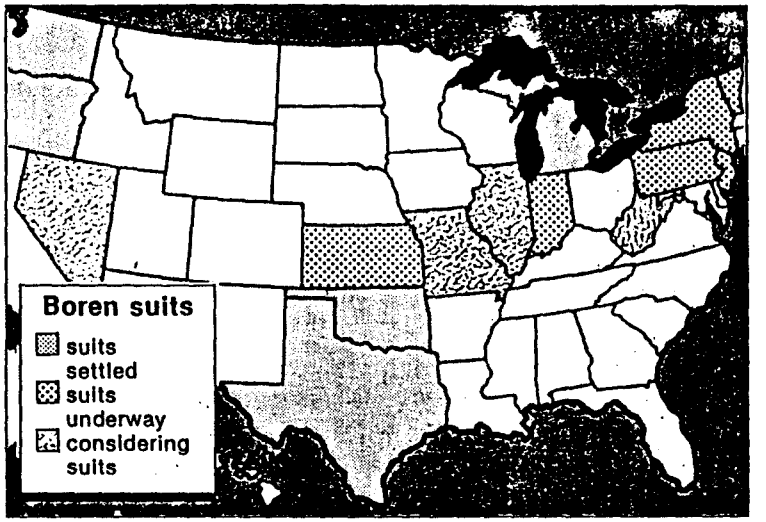
Medicaid rates spur Boren lawsuits

They can cost millions of dollars and take years to resolve. And legal experts say that they should be pursued only as a last resort.

But increasingly, desperate providers are turning to Boren Amendment lawsuits as a way to resolve Medicaid reimbursement disputes with states.

The Boren Amendment, a provision of the Medicaid law, requires that states reasonably and adequately reimburse the costs of running a nursing home efficiently and economically. Further, the law prohibits states from setting reimbursement rates based on budgetary constraints.

Dina Elani, a representative of the American Association of Homes for the Aging (AAHA), said that providers should seek legal reimbursement remedies only after every other option has been exhausted. She added that the increasing number of such suits has surprised her. "The numbers are higher than I imagined they would be," she said.



Armed with last year's Supreme Court's *Wilder vs. Virginia Hospital Association* decision — which affirmed the right to sue for adequate reimbursement — more providers are employing this option, often successfully.

At press time, Boren lawsuits had been or were about to be filed in at least 15 states, and at least four had already been resolved.

In an out-of-court settlement, state officials in Texas agreed to raise Medicaid per diem rates by about $5 per patient — an action that both Texas provider associations hailed as a long-overdue victory. Despite the state's concession, however, providers remain upset that Texas continues to base reimbursement on a flat rate rather than actual costs.

An out-of-court settlement in Oregon will give providers a $10 million to $12 million funding increase this year. Pending approval by the state legislature, a new reimbursement system will begin July 1.

Continued on page 15.

Initiatives big losers on

Attachment 2

8
2-4-91
HB Dum. Sw. Sub.

January 1991, Vol. 12 #1
McKnights Long Term Care News

Boren lawsuits

From page 3.

"There are a lot of caveats to this thing, but we're happy with the way this turned out," said Ed Sage, executive director of the Oregon Health Care Association.

Oklahoma providers also reached a favorable out-of-court settlement. And at press time, a resolution was reached in Michigan. There, the state had earlier offered to settle out of court. But providers considered the state's proposal inadequate, especially after sinking more than $1 million into legal fees.

The thrust of the Michigan case was that the state had consistently failed to account for rising inflation, according to Don Bentsen, president of the Michigan Nonprofit Homes Association.

Providers in Kansas filed a Boren suit against the Department of Social and Rehabilitation Services, in an attempt to challenge the state's rate freeze.

The complaint contended that the payment system was violating the federal law requiring states to pay "reasonable and adequate costs" for nursing home care.

"The fastest growing age group is the 85 and older group, who have a high incidence of nursing home usage. It is becoming increasingly more costly to care for the sick elderly who deserve quality care," said Butch Eaton, Kansas Health Care Association president.

In Indiana, providers filed a Boren suit protesting the state's payment methodology. While provider costs have risen at about a 10% annual clip, rate increases have been around 3%, said a spokesman of the Indiana Association of Homes for the Aging.

In Pennsylvania, several Boren-type lawsuits are pending. The suits were spurred in part by a move by state lawmakers in 1990 to trim $39 million from state Medicaid spending. The cuts were approved as part of a $12.3 billion 1991 budget.

In New York, one class action and two independent provider suits had been filed at press time. Vermont also had multiple lawsuits pending against the state.

In New Jersey, both sides have prepared for a major battle by hiring well-known Washington-based law firms. The state's two provider groups and four homes filed a class action lawsuit in May, arguing the state was in violation of the Boren Amendment.

If providers win the case, it will cost the state and federal government about $35 million each annually. According to state figures, providers lost $95.1 million in nursing home payment in 1988 alone.

At least four states — Illinois, Missouri, Nevada and West Virginia — were planning to file Boren lawsuits at press time.

Filing a suit does not automatically guarantee success, as providers in Washington discovered last year.

Can backfire

But filing a suit does not automatically guarantee success, as providers in Washington discovered last year. A Boren suit challenging the state's reimbursement policies for nursing home services was dismissed by a U.S. district court. The judge ruled that the Medicaid agency complied with requirements when establishing its rates.

And while Florida has not yet submitted its Medicaid plan amendment under the Omnibus Budget Reconciliation Act of 1987, providers there do not plan to take the state to court, said Erwin P. Bodo, M.D., director of reimbursement with Florida Health Care Association.

"We're don't expect to file such a suit. It can be pretty expensive, but it's much more than just the financial incentive or disincentive. You also need to look at the relationship with the state and the legislature. Given that we do not have a rate freeze here anymore, I do not think our case would be nearly as strong as it would have been last January, when I believ that the state was clearly violating th [Boren] amendment," he said.

Noted AAHA's Elani, "We don't ge erally recommend lawsuits. They ca be very expensive and time consur ing. And there's no a guarantee th you'll win the case."

Hospital officials support rationing

About 75% of 700 hospital officia nationwide support health care r tioning, according to a survey co ducted by the Estes Park Institut Englewood, CO. About half of t respondents (51%) also said they b lieve it is "very likely" or "probabl that federal or state governments w ration care within the next five year

If government did ration health ca access to basic health care would crease for uninsured Americans, cording to 55% of responding of cials. In addition, 49% said they b lieve that rationing would increa the percent of the Gross National Pro uct spent on health care, while 37 said it would stay the same.

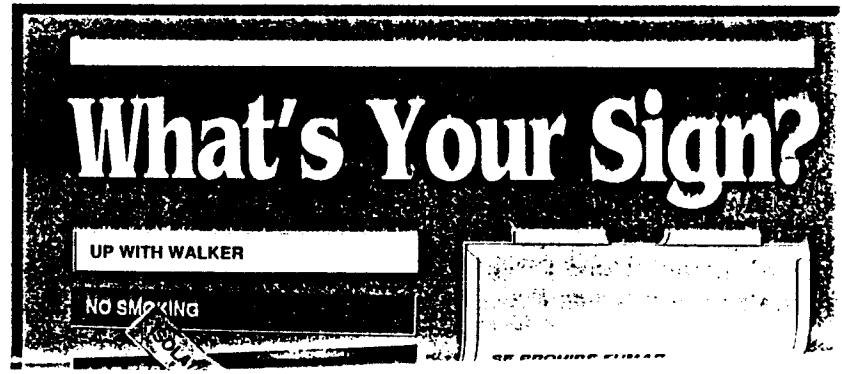


EXHIBIT 8
DATE 2-4-91
HB Dum. Sew. Sub.

USER FEE INFORMATION:

Result of $1 user fee on Medicaid population:

State pays	Feds pay	Facility receives	Facility pays state	State has	Feds pay	Total $ available
.28	.72	1.00	1.00	1.00	2.57	$3.57

Result of paying facility $1 without user fee:

.28	.72	1.00	0	0	0	0

Difference:

With user fee: State pays .28 and ends up with $3.57 available to fund nursing home program.

Without user fee: State pays .28 and ends up with $1.00 available to fund nursing homes.

USER FEE INFORMATION

Example of use of user fee to raise nursing home rates by $4 per patient day, from $56 to $60:

State pays	Feds pay	Facility receives	Facility pays state	State has	Feds pay	Total $ available
1.40	3.60	5.00	1.00	1.00	2.57	$3.57

Result of raising rate $4 without user fee:

1.12	2.88	4.00	0	0	0	0

Difference:

With user fee: State pays $1.40 to fund a $4 increase and has $1 left to match with federal dollars to provide $3.57 in additional funding for Medicaid services.

Without user fee: State pays $1.12 to fund a $4 increase in nursing home services.

EXHIBIT O
DATE 2-4-91
HB Dum. Sew. Sub.

EFFECT OF USER FEE ON PRIVATE PAY RATE - HYPOTHETICAL FACILITY

ASSUME "AVERAGE" FACILITY: 100 BEDS 62% MEDICAID

COST: $65/DAY

Without user fee:

Per day costs - $65 x 100 patients = $6500

Revenue:

Medicaid - $56 x 62 patients	=	$3472
Private - $80 x 38 patients	=	3040
		$6512

Facility would have to charge private pay $80 just to break even - no reserves, profits, etc.

With proposed user fee and Medicaid reimbursement increase:

Per day costs - $65 x 100 + $100 fee = $6600

Revenue:

Medicaid - $65 x 62 patients	=	$4030
Private - $68 x 38 patients	=	2584
		$6614

Facility would have to charge private pay $68 just to break even - no reserves, profits, etc.

With proposed Medicaid reimbursement increase, but no user fee:

Per day costs - $65 x 100 = $6500

Revenue:

Medicaid - $64 x 62 patients	=	$3968
Private - $67 x 38 patients	=	2546
		$6514

Facility would have to charge private pay $67 just to break even - no reserves, profits, etc.

SUMMARY:

Charge required to private pay
to break even:

Currently.....$80
With increase plus user fee.....$68
With increase & no user fee----------$67

*Any additional amounts for increased costs for wages, additional staff, new regulations, etc., or for building reserves, return on equity, or profits would have to be added to the amounts listed above.

**This reflects the "average" facility. Results will change for individual facilities based on their costs, Medicaid rate (which varies), patient acuity, availability of staff, and percentage of Medicaid utilization.

MHA MONTANA HOSPITAL ASSOCIATION
1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT 59604 • (406) 442-1911

TESTIMONY OF
Robert W. Olsen, Vice President
Montana Hospital Association
House Bill 2, Medicaid

The Montana Hospital Association supports the Governor's budget request for Medicaid services. MHA appreciates the effort of SRS director Julia Robinson to address Medicaid funding needs at a time of limited budgetary resources. However, while MHA supports House Bill 2, there are portions of the budget that MHA urges the committee to amend.

ABOUT MONTANA'S HOSPITALS

The Montana Hospital Association is the primary spokesman for 58 Montana community hospitals. These facilities are the cornerstone of Montana's health care system. In most communities hospitals are the largest employer. In addition to hospital care, hospitals in Montana also operate 35 nursing facilities providing 20 percent of the nursing home beds in Montana. Half of the home health agencies are operated by hospitals. Most rural communities obtain physicians through the recruitment efforts of the hospital.

Payments for various hospital-provided services will account for nearly 40 percent of the Medicaid budget in the upcoming biennium. The actions of this committee have a direct impact on the financial viability of Montana's hospitals and on the access to care for the 60,000 Montanans dependant on Medicaid.

The past few years have been financially difficult for both consumers and providers of health care. For hospitals, budget constraints coupled with expanded coverage, threaten to erode the quality of health care.

As the demand for services has increased, the pool of money to pay for them has shrunk. Payment reductions made by the government have not made health care less costly. Instead, cost shifting of medical expenses has become common practice. As a result health insurance costs are rising much faster than medical inflation. The loss in payments from government insured programs are made up by the patients with private insurance and those who pay out of their own pocket.

Medicare and Medicaid are the two largest government insurance programs. In 1989 Montana's hospitals were paid $80 million less than they charged these programs. Medicaid accounted for $13 million of this amount.

Additionally, hospital rates paid by Workers' Compensation insurers have been frozen since 1986. This freeze cost hospitals an estimated $10 million.

Montana's health care costs are among the lowest in the country. Even so hospitals are working very hard to contain medical costs.

To contain costs hospitals share equipment and professional personnel whenever possible. Two examples of hospitals sharing capital costs are a mobile magnetic resonance imaging (MRI) machine serving four Eastern Montana hospitals and a mobile lithotripsy machine (used for treating kidney stones) serving urban Montana hospitals.

In addition, wages paid by Montana's rural hospitals are significantly lower than the National Average. In a recent federal wage survey Montana's rural hospital wages were determined to be 18 percent below average. Low wages make attracting and keeping health care professionals in Montana very difficult.

Hospitals also bulk purchase supplies, have formed insurance pools and networks to work cooperatively.

All of these activities have worked to reduce medical costs. Hospital costs are not "out of control". Many of the costs are beyond the hospitals' control.

RECOMMENDED CHANGES TO HOUSE BILL 2

Despite hospitals' efforts to hold down costs the tab for treating Medicaid patients continues to increase.

MHA supports the budget request for State Fiscal Year 1993 and the funding request for a hospital payment study planned by SRS. We also urge the committee to make one change: a payment update for the first year of the biennium.

MHA supported adoption of the DRG payment system with the understanding that the state would maintain a fair price. Without a fair price there is no profit potential and DRGs becomes a way to arbitrarily reduce payments below operating costs.

MHA estimates that Medicaid payments are currently 5 percent below the actual allowable cost of providing services. MHA urges the committee to provide a 5 percent adjustment to hospital rates for Fiscal Year 1992. This adjustment would provide fair payment rates under the DRG system.

Second, MHA supports the nursing home funding request by SRS. According to the Myers and Stauffer study commissioned by SRS, an increase of $25 million is necessary to pay all current nursing home costs. The Department has requested $17.3 million, or 70 percent of the needed funds. Although the fund request is well below the identified need, the increase will go a long way toward closing the gap between costs and payments.

MHA is opposed to the $1 nursing home bed fee proposed by SRS. Many people have said this is a "creative way" to increase federal funding. Any dollar the state spends on Medicaid is matched by the federal government. The nursing home bed fee is no more creative than any other plan to increase state taxes to support Medicaid.

MHA members have indicated that they believe it is poor public policy to fund the state Medicaid plan by placing user fees--taxes--on the all Montanans.

Third, MHA supports the "Kids Count" proposal. The plan to improve access to preventive services will help avoid higher medical costs later.

MHA also urges this committee to consider inflationary rate increases for other medical providers during the next biennium.

Thank you for the opportunity to present our comments on House Bill 2. MHA is available to answer any of your questions.

Exhibit 10 consists of a 12 page booklet. The original is available at the Montana Historical Society, 225 N. Roberts, Helena, MT. 59601. (Phone 406-444-4775).

EXHIBIT 10
DATE 24-91
HB Dum Dew Sub.

1990 MHA Hospitals At-A-Glance

Montana Hospital Association

EXHIBIT 11
DATE 2-4-91
HB

Exhibit #1
2/4/91
Human Serv. Subc

MDA

Montana Dental Association
P.O. Box 281 • Helena, MT 59624 • (406) 443-2061

Constituent: AMERICAN DENTAL ASSOCIATION

February 4, 1991

To: Members of the House Human Services Appropriations Subcommittee

From: Bill Zepp, Montana Dental Association

Re: Medicaid Dental Services

The Montana Dental Association represents 82% of the active dental practitioners in the state of Montana and has historically maintained a positive relationship with the Medicaid Division of the Department of Social and Rehabilitation Services. Meetings between representatives of the Medicaid Division and the SRS Committee of the MDA have often resulted in constructive solutions to problems relating to the provision and compensation of dental services.

However, the portion of the Medicaid budget designated for dental services in Montana has been minimal. The two percent, across-the-board increase in provider compensation made virtually no impact on the continuing disparity between Medicaid reimbursement and the average usual and customary fees. In fact, a recent Medicaid Services Division survey, conducted with the assistance of the Montana Dental Association, revealed that simple, single surface fillings are being compensated at an average of 50% of the usual and customary fee and that simple tooth extractions, performed on a Medicaid patient, are reimbursed at 48% of the standard fee. Situations such as these, combined with the fact that there is no reimbursement whatsoever for palliative treatment preparatory to the provision of other necessary services, creates a less than positive and cooperative atmosphere in the dental community. The abovementioned survey also indicated that while a majority of dental practitioners - 90% of those responding - continue to see Medicaid patients of record, those accepting <u>new</u> Medicaid patients drops significantly to 62%. In addition to the resistance towards accepting new or additional Medicaid patients, the survey indicates strong dissatisfaction with various aspects of the program; the strongest single negative response being reserved for the fee structure.

Reimbursement and excessive paperwork aside, another situation must be addressed in Medicaid dental services. In no area of health care services is the prevention of disease more feasible and predictable that in dentistry. Examples of readily available preventative services would include fluoride treatments and the application of sealants. Sealants are not currently included in reimbursable Medicaid services; fluoride treatments are available, but limited in number and frequency. Yet the combination of these services, provided to children, virtually eliminates the possibility of dental caries or decay, as well as eliminating the need for more costly procedures and treatments in the future.

The Montana Dental Association met with Medicaid Division personnel to discuss new requirements enacted by the Early and Periodic screening, Diagnosis and Treatment Program (EPSDT). The MDA indicated the support of the dental community for increased services to children and youth, with emphasis on services to developmentally disabled individuals, sealants,and other preventative services. An increase in the dental services budget, justified by the predictable prevention of disease, combined with a change in the mix of existing services, will insure the provision of effective services to Medicaid clients.

To quote Dr. Ed Lawler, former Chief Dental Officer of the Montana Department of Health and Environmental Services, "...a window of opportunity exists at this time to modify a program so that responsible people who need assistance can get assistance from the majority of dentists in the state of Montana."

MSPA: Questionnaires sent to SRS Oct. 1989 thru 1990

2/4/91 Human Services Subc.

12

2-4-91

DATE SENT	PHARMACY	AVG. EXP. FIGURE
1989		
10 04	Western Manor Pharmacy - N/A	5.68
	Drower Pharmacy - Livingston	7.51
	Culbertson Drug - Culbertson	4.15
	Medicine Shoppe - Great Falls	5.14
	Cottonwood Pharmacy - Broadus	8.66
	Hart's Clinic - Glasgow	8.46
	Glacier Pharmacy -	4.34
	Gene's Pharmacy - Laurel	5.83
	Medical Arts Pharmacy - Glasgow	7.67
	Shopko #275 - Missoula	3.81
	" #262 - Great Falls	4.00
	Cole Drug - Big Timber	11.03
	Doe's Repall Drug - Philipsburg	8.11
	Owl Rx Pharmacy - Havre	5.77
	Osco Drug #2044 - Great Falls	5.17
	" # 938 - Bozeman	5.71
	" #2043 - Billings	7.87
	" #2051 - Butte	4.88
	" #2247 - Billings	12.44
	" # 929 - Miles City	5.50
10 11	Western Drug #10 - Glasgow	6.45
	Bergum Drug - Helena	7.21
10 17	Community Memorial - Sidney	8.12
	Keystone Drug - Deer Lodge	6.87
	Valley Drug - Malta	4.87
	Cascade Co. Convalescent - G.F.	638
10 31	East Gate Drug - Missoula	637
1990		
2 06	Choteau Drug - Choteau	544
3 21	HPC Health Care Plus - Polson	540
	Western Drug - Livingston	423
4 02	Super I Pharmacy	419
4 10	Bergum Drug - Euclid - Helena	503
	Bergum Drug - Mont. Ave. - Helena	453
4 23	Chalet City Pharmacy - Whitefish	434
5 21	Bungalow Drug - Bozeman	581
	Western Drug #6 - Bozeman	691
5 24	Livingston Drug - Livingston	468
	Valley Drug - Glasgow	1021
	Whitehall Drug - Whitehall	566

(over)

DATE SENT	PHARMACY	AVERAGE EXPENSE	
5 24	Northern Montana Hospital - Haure	506	
5 29	Riverside Health Care Center - Missoula	773	
	Gardiner Drug - Gardiner	801	
6 05	Bitterroot Drug - Hamilton	714	
	Hamilton Pharmacy - Hamilton	757	
	Village Health Care Center - Missoula	806	
	Cascade Co. Conv. Nursing Home - Gr. Flls.	25000	?
6 13	Payless Drug Store #5501 - Bozeman	2775	?
	Fred Meyer - Kalispell	566	
6 25	Absarokee Drug	645	
7 30	Olsons Drug - Conrad	572	
8 15	Eagle Drug - Ronan	458	
9 12	Sykes Pharmacy - Kalispell	563	
	K-Mart Pharmacy #7029 - Helena	738	
	K-Mart Pharmacy #3622 - Billings	696	
10 23	Downey Drug - Butte	640	

6901 DEPT SOCIAL & REHAB SERVICES
07 MEDICAID SERVICES
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	41.99	40.50	38.50	2.00	40.50	38.50	2.00
Personal Services	1,017,583	1,295,929	1,233,289	62,640	1,294,132	1,231,659	62,473
Operating Expenses	2,573,229	2,892,433	2,641,283	251,150	2,890,646	2,642,054	248,592
Equipment	79,472	3,198	3,198	0	3,198	3,198	0
Benefits and Claims	183,780,182	199,823,421	212,771,098	12,947,677-	214,280,046	230,012,992	15,732,946-
Total Expend.	$187,450,466	$204,014,981	$216,648,868	$12,633,887-	$218,468,022	$233,889,903	$15,421,881-
Fund Sources							
General Fund	48,887,272	47,300,118	54,240,796	6,940,678-	50,936,809	58,441,992	7,505,183-
State Revenue Fund	6,906,998	6,961,000	8,288,096	1,327,096-	7,157,000	8,557,418	1,400,418-
Federal Revenue Fund	131,656,196	149,567,934	154,119,976	4,552,042-	160,045,719	166,890,493	6,844,774-
Proprietary Fund	0	185,929	0	185,929	328,494	0	328,494
Total Funds	$187,450,466	$204,014,981	$216,648,868	$12,633,887-	$218,468,022	$233,889,903	$15,421,881-

07
PAGE REFERENCES:

LFA Current Level Analysis Reference: B 81-92
Executive Budget Summary Reference: 126-128
Executive Budget Narrative Reference: 51-104

EXECUTIVE AND LFA CURRENT LEVEL DIFFERENCES

Personal Services: LFA Eliminated Two Positions

1.0 FTE	**Administrative Officer IV**	**Vacant 1/8/90 through 9/21/91**
1.0 FTE	**Program Officer I**	**Vacant 7/1/89 through 9/21/91**

Operations:	**Executive (Under)Over LFA 1992**	**1993**
1) Inflation	**(3,142)**	**(6,016)**
2) Psychiatric Utilization Review Contract	**245,000**	**245,000**
3) Base Difference	**9,292**	**9,608**
Total Difference	**251,150**	**248,592**

Exhibit #13
2-4-91
2/4/91
Human Serv.
Subc.

EXECUTIVE BUDGET MODIFICATIONS:

Budget Modifications	General Fund	Other Funds	Total
1) EPSDT Case Management/Screening	$180,346	$459,494	$639,840
2) Case Management Pregnant Women	278,058	708,138	986,196
3) Children's Dental Expansion	122,641	312,333	434,974
4) Baby your Baby	0	268,000	268,000
5) Ob/Ped Rate Increases	2,730,827	6,954,674	9,685,501
6) Hospital Rate Rebase	1,227,484	3,140,787	4,368,271
7) Nursing Home Rate Rebase	4,476,613	11,419,548	15,896,161
8) Nursing Home Fee Adjustment	391,350	1,001,354	1,392,704
9) Ambulance Rate Increase	278,520	709,316	987,836
10) Elderly Waiver Expansion	175,022	446,043	621,065
11) Health Clinic Expansion	36,653	93,347	130,000
12) Res. Psychiatric Treatment	0	9,006,383	9,006,383
13) OBRA-1987 DD Treatment	644,600	762,470	1,407,070
14) Nurse Aid Testing	172,800	172,800	345,600
15) Hospital Rate Study	152,780	152,780	305,560
16) Cost Containment	330,600	30,600	361,200
17) OBRA 1990*	~~1,604,143~~ 2,417,579	~~7,151,904~~ 5,424,388	~~8,756,047~~ 7,841,962
Total	$12,802,437	$42,789,971	$55,592,408

*Includes 3 FTE each year of the biennium

January 26, 1991

EXHIBIT #14
2/4/91
Human Serv
Subc.

HUMAN SERVICES SUBCOMMITTEE

Summary of Subcommittee Action

EXHIBIT 14
DATE 2-4-91
HB

The Human Services Subcommittee has taken the following action within the Department of Health and Environmental Sciences:

1. Added a **medical director** to advise the department on medical issues and policies.

2. Changed **funding of the Legal Unit** from general fund to proprietary income, while ensuring that general funded programs will receive legal counsel as needed.

3. Added **3.0 FTE in the laboratories** to ensure that testing of newborns for PKU and of water are completed in a timely manner. The additional staff are completely supported with laboratory income.

4. Funded **increases in pay** approved by the Department of Administration to enhance the state's ability to attract and retain qualified environmental specialists and health care facility surveyors.

Public Health Programs

5. Added $400,000 over the biennium, including $194,588 of general fund and $205,412 of Maternal and Child Health Block Grant, to ensure the availability of sufficient measles, mumps, and rubella (MMR) **vaccine** to provide the recommended second dose.

6. Voted to allocate any **additional funds received from the maternal and child health block grant** over the amount anticipated to the counties to provide local services, and any **additional funds received from the preventive health block grant** to meet recognized health care needs.

7. Expanded the **MIAMI program** by $341,076 over the biennium, which can also be used to secure additional federal funding.

8. Allocated $20,000 each year of the preventive health block grant to the **counties for AIDS education activities.**

9. Added authority in the **AIDS, Sexually Transmitted Diseases, Chronic Diseases, Women, Infants, and Children, and Child Nutrition** programs to maximize total federal funds.

10. Added 15.0 FTE surveyor staff and funds to conduct resident hearings in the Licensing, Certification, and Construction Bureau to ensure that medicaid licensure of health care facilities is completed in a timely manner and that all federal regulations and requirements are met.

Environmental Programs

11. Added 6.0 FTE in the Air Quality Bureau to ensure that permitting for new projects is done in a timely manner.

12. Added 10.0 FTE to the Solid Waste/Landfill program to provide for necessary monitoring of landfills and assistance to operators to protect the environment from contamination.

13. Added 11.0 FTE in the Water Quality Bureau to provide assistance to public water system operators to meet mandatory federal standards and to ensure that clean drinking water is available to all communities.

14. Added 3.5 FTE to the Water Quality Bureau to enhance the state's efforts to maintain the integrity of groundwater.

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SRS Staff: Nancy Ellery, John Chappius, Norm Rostocki, Mary Dalton, Mike Hanshew

MONTANA'S MEDICAID PROGRAM

History

Medicaid was created in 1965 by the federal government along with a sound-alike sister program, Medicare. Medicaid is jointly financed by the state and federal government and is designed to provide health care to low income individuals. Every state's Medicaid program has different services and different matching rates. Medicare is a health insurance program primarily for elderly persons, regardless of income. It is 100% federally financed through Social Security taxes and premiums. Medicare is the same throughout the country.

Many people think of Medicaid as just a "welfare medicine" program. It is much more than that. It is the nation's first and only catastrophic care program. It is a safety net for not only low-income people but also in states with the medically needy option, it is also for those who start out as middle class and have to exhaust all their resources on health problems.

Medicaid is the only resort for those in deepest need. It provides health care for children born with developmental or other physical disabilities. It provides coverage for people of all ages who are crippled by accidents and disease and the elderly suffering from

Alzheimers and other diseases.

Medicaid is the largest single payer for nursing homes and ICF/MRS. This explains part of the reason for the huge cost of the program. Catastrophic and institutional care are expensive. Services for women and children are being squeezed out by the Long Term Care needs of the State. (Refer to cartoon) 1.

Mothers and children make up 70% of the clients and only 29% of the expenditures. The elderly and disabled make up 30% of the clients and 71% of the expenditures. This is because they get sick more and need more care provided in institutional settings. (Refer to Chart 2 for a breakout of AFDC/SSI costs)

Medicaid is the payor of last resort. Unlike other programs, it doesn't have anyone else to pass the costs on to. This means if a recipient has other insurance coverage like private insurance or Medicare, they pay first. The only exception to this is Indian Health Service.

While Medicaid is the primary source of health care coverage for the poor, it doesn't cover all the poor. If you use the Federal Poverty Level to define who is poor, only 51% of the poor in Montana are covered by Medicaid (Poverty level for family of 3 is $10,060.) There are higher income standards for individuals in nursing homes and for pregnant women and young children.

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A State Program

Medicaid is a state-administered health care assistance program. Almost all states, the District of Columbia and some territories have Medicaid programs. Medicaid is governed by federal guidelines, but state programs vary in eligibility criteria, service coverage, and limitations.

Funding Formula

The federal-state funding ratio for Medicaid varies from state to state based on each state's per capita income. Because Montana is a relatively poor state, our federal match is one of the largest. During fiscal year 1990, the formula was approximately 71% federal funds and 29% State funds. For every dollar the state spends the federal government contributes $2.50. The federal match for the 1993 biennium is 71.9%. The U.S. General Accounting Office has recommended to Congress that federal matching be based on a state's total taxable resources rather than per capita income. If this change is made, Montana's federal Medicaid match rate and corresponding federal funds could be reduced significantly. (Refer to chart 3 on Federal Match Rates)

Eligibility

Persons must fit into one of several categories in order to qualify for Medicaid in Montana and eligibility is determined by one of two different agencies.

Eligibles include:

- Persons receiving Supplemental Security Income from the Social Security Administration, who determines their eligibility. This is important to remember as we look toward recommended changes in the State Medical Program.
- Persons approved for cash assistance through the county Department of Human Services, which determines their eligibility. Most people in this category receive Aid to Families with Dependent Children. (AFDC)
- Certain pregnant women and children who do not receive an AFDC cash payment and foster children in the custody of the state.
- Some low income Medicare beneficiaries may be eligible to have their Medicare premiums, deductibles, and coinsurance paid by Medicaid.

Covered Services

The Federal Government requires that all states provide certain medical services. (Refer to chart 4 outlining mandatory and optional services). Montana provides 21 out of the 24 optional services allowed under Medicaid statute. The only services not currently covered under Montana's Medicaid program are targeted case management, chiropractic services and Christian Science Sanitoria.

How the Program Works

A family or individual who is eligible for Medicaid is issued an eligibility card, or "Medicaid card," each month. This is essentially good for medical services from one of 6,000 providers in the state. Providers include physicians, pharmacists, hospitals, nursing homes, dentists, optometrists and others. These

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providers bill the Medicaid program for their services. Medicaid never reimburses recipients directly for services.

MEDICAID'S IMPACT

Since its implementation in 1967, Montana's Medicaid program has had a significant impact on the overall quality of health care in the state. Medicaid has provided hundreds of thousands of citizens access to quality health care they could not otherwise afford.

Citizens who are not eligible for Medicaid also benefit from the program. Health care is one of the state's most important industries, and Medicaid contributes to that industry in a significant way. For instance, during FY 90, Medicaid paid approximately $180 million to providers on behalf of persons eligible for the program. The federal government paid approximately three-quarters of this amount. These funds paid the salaries of thousands of health care workers who bought goods and services and paid taxes in the state. Using the common economic multiplier effect of three, Medicaid expenditures generated over $540 million worth of business in Montana in FY 90. A strong health care delivery system is vital to Montana's economy.
(Refer to chart 5 which breaks out Medicaid benefits and caseload by county).

Revenue, Expenditures and Prices

Of the $~~178~~ 180 million spent by Medicaid in FY 90, only $3.7 million (or 2% of the budget) was spent to administer the program. This

means that about 98 cents of every Medicaid dollar went directly to benefit recipients of Medicaid services.

(Refer to Chart 6 on where the Medicaid dollar comes from and where it goes).

HC Costs

Nationally, the cost of health care doubled in the eighties. It is expected to double again in the nineties with costs of $1.5 Trillion expected by the year 2000. In 1970, health care represented 7 1/2% of the GNP. It increased to 9% in 1980 and is 12% in 1990.

Medicaid budgets on the average are growing 40% faster than state revenues. Currently 31 states are struggling with budget shortfalls. In 1980 it accounted for 9% of state budgets. In 1990, it accounts for nearly 14% of all state spending.

Use and Cost

Most Medicaid payments are made on behalf of recipients in the aged and disabled categories, females, whites and persons 21-64 years of age. (Refer to chart 7 that breaks out by category, sex, age race).

(Refer to charts 8 and 9 to compare AFDC and SSI costs and clients served.)

Eligibles

During FY 90, there was an average of 48,780 persons eligible for

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Medicaid each month. The monthly average is the most useful measure of Medicaid coverage since it takes into account length of eligibility.

Ms. Ellery and her staff have been working closely over the last year with the Departments of Health, Institutions and Family Services and private agencies including Healthy Mothers Healthy Babies to improve services and maximize federal Medicaid reimbursement for these services. These efforts include organizing a maternal and child health committee that developed the KIDS COUNT proposals, participating in planning and implementing the Baby your Baby campaign and designing target case management for high risk pregnant women, developmentally disabled adults, chronically mentally ill adults and emotionally disturbed children. The efforts represent a true interagency effort to coordinate service delivery and maximize existing state resources. Ms. Ellery will discuss targeted case management later in more detail.

Now I would like to have Ms. Ellery discuss the administration and organization of Montana's Medicaid Division.

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STATE OF MONTANA - MEDICAID PROGRAM

DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES

MEDICAID ADMINISTRATION

Madame Chairman, members of the committee, for the record, my name is Nancy Ellery. I am the Administrator of the Medicaid Services Division. The mission of the Medicaid Division is to ensure that Montana's low income individuals have access to medically necessary care at a cost which is equitable to both the provider of the medical service and to the taxpayer. The Division is responsible for the management and administration of Montana's Medicaid Program. Major responsibilities include developing and implementing program and reimbursement policy, administering the provider payment system, provider relations and training, interfacing with the regional Health Care Financing Administration (HCFA) Office in Denver, and performing utilization review. The Montana Medicaid Program administers a very complex system of Federal and State laws, rules, and regulations.

Medicaid Administrative costs totaled over $3.7 million dollars in FY 1990. As Julie mentioned, administrative costs represent only 2% of the total Medicaid budget. This is much less than the administrative costs of other private and public insurance programs. (Refer to chart 10 for a description of Medicaid Benefit and Administration costs from 1979 to 1990). Eighty seven percent of our administrative costs are for contracted services and

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salaries. (Refer to Chart 11 for a breakdown of administrative costs). The largest single contract cost is for the operation of the Medicaid Management Information System (MMIS). This is the system through which provides timely payment to over 6,000 providers enrolled in the program. The MMIS system processes over 1,500,000 claims per year and cost the Medicaid Program $1,344,667 in 1990.

The second largest contract is with the Montana/Wyoming Foundation for Medical Care. This contract is to determine the medical necessity of hospital and nursing home admissions. Other contracts are mainly for medical professional consulting to assist the division in making medical determinations and developing policy. It should be noted that two large one time contracts were entered into in 1990. One was for the study of the Department's definition of medical necessity as mandated by the 1989 legislature and the other was to study the nursing home rate structure. I will discuss the results of these studies in more detail later.

The organization of the Medicaid Services Division is described in the beginning of your notebook. The Administrative Unit consists 22% of the staff of the Administrator, Assistant Administrator and staff responsible for budget analysis, state medical, MMIS, clerical support, and technical services. This section also includes the Medical Support Section which is responsible for the planning and implementation of

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utilization review policies to ensure that only medically necessary services are provided. The Medical Support Section also manages the Foundation contract and contracts with 13 medical consultants. I serve as the chairman of the Medicaid Advisory Council which has provider and consumer representatives appointed by the Governor to provide input on the Medicaid Program. The Long Term Care Bureau manages the Nursing Home and Community Service programs. The Primary Care Bureau manages the rest of the services including acute care and non-hospital based services. All of these services are described in detail in your notebook.

There are 40.5 FTEs assigned to the Medicaid Division. Twenty of the positions are assigned to Long Term Care, half of which are located in the field offices. The field staff are called Long Term Care Specialists. Their major responsibility is to perform screens and evaluations concerning the appropriateness of placements in long term care facilities and the waiver. Primary Care includes 11 positions and the remaining 9 positions are assigned to the Administrative Support Unit. refer to Chart 12 for a description of Medicaid staffing.

I feel that the reorganization of SRS that established Medicaid as a separate division in November 1989 has achieved Julie's goal of improving the delivery of Medicaid services in the State.

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I would now like to address the differences between the Executive and LFA budget in the operations area.

The LFA Budget does not include 2 FTEs that are essential to the operation of the Medicaid Program.

One FTE is a Nursing Home reimbursement specialist who is responsible for supporting the nursing home reimbursement functions. The position was filled the month after LFA completed the study of positions who had been vacant for 6 months. The position is absolutely crucial to the proper management of the nursing home program.

The second position is the supervisor of the Medicaid Support Services Section. This position was advertised and closed last month.

This position supervises a crucial part of the division which relates to utilization review. Utilization review ensures that only medically necessary services are provided. It includes management of over $800,000 in contracts to determine the medical necessity of admissions to hospitals, nursing homes, psychiatric hospitals, waiver and out of state medical.

The other major difference in the Operations Budget is the UR

Contract for psychiatric services for children.

VA Aid and Attendance

In May, 1990 efforts were made to increase the number of recipients referred to the VA office for VA pension aid and attendance benefits. Preliminary estimates show that VA will award benefits 50 150 Medicaid recipients who are in nursing homes. Based on an average VA benefit of $4,476, estimated savings to the Medicaid program will be $671,400 by the end of FY 91. Unfortunately, OBRA 90 contains a provision which eliminates the savings for Medicaid recipients. Not only will these new savings be lost but so will benefits that were already being received.

Third Party Liability

In April 1990, SRS provided comprehensive training to eligibility technicians on how to detect potential sources of third party liability. (i.e., private insurance, etc). Estimates are that the training has resulted in a 3% growth in third party collection. Based on an increase of 84.5 cases at an average of $1,090 savings per case, net savings of $92,000 have been realized.

Medical Support Enforcement

This program requires that absent parents obtain medical insurance for children they are legally responsible for. Child Support Enforcement Division estimates as of 12/1/90 that a total of 223

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MHMA CONTRACT

There have been a lot of questions about why a contractor from Tennessee is doing reviewing inpatient and residential psychiatric services for Montana's children. I would like to address what this contract is about and why we are using the service.

As Julie mentioned, costs in the Inpatient Psychiatric Services program have increased 1000% since program began in 1987. The Department contracted with the Foundation until July 1990. The Foundation specializes in medical reviews not psychiatric reviews. SRS felt the tax payers of the state would be better served if utilization review was performed by an organization that specializes in that area. ($910,000 in 1987 to $9,344,173 in 1990). Because of the rapidly escalating costs and the addition of Residential Treatment Services in July 1990, SRS issued a Request For Proposal in April for psychiatric utilization review (UR) services. On June 1, 1990 the contract was awarded to Mental Health Management of America (MHMA). Affectionately known as MHMA, MHMA was selected because of their expertise in Medicaid, Mental Health systems, and the Medicaid Psychiatric Program for Individuals Under 21 in particular. Based in Nashville, MHMA currently has UR contracts with five other states as well as contracts with the private sector. OLG Audits - $ million tried to get in front of this. MHMA's UR philosophy emphasizes the dignity of the patient and seeks to assure that the patient receives the appropriate mental health services in the least restrictive setting

possible.

MHMA uses a combination of telephone reviews and face to face reviews conducted by Montana Mental Health professionals. The face to face reviews are conducted by 14 psychologists.

Through the UR contract with MHMA, SRS is able to establish the medical need for the service upon admission and the necessity of continued stays in inpatient hospital and residential treatment. MHMA conducts annual inspections of care using a team of Montana psychiatrists, psychologists and R.Ns. It is important to note that MHMA does not make placement decisions. They only determine when Medicaid can pay. The Department of Family Services or the placing agency make the placement decisions. They may place, using their own funds, if they decide this is in the best interest of the child. Federal Certification of need guidelines are being adhered to and children are being treated in more appropriate, less restrictive settings. Through the contract, SRS has been able to use their expertise to provide case management services to three severely emotionally disturbed children who seemed destined to be institutionalized but are now being appropriately maintained in community-based services. By reducing inappropriate placements in restrictive psychiatric facilities, MHMA, in conjunction with SRS, is seeking to strengthen the linkage between cost containment and quality of care in the Medicaid Under 21 Psychiatric Program.

In the first five months of the contract, MHMA was able to cost

avoid 1050 bed days in inpatient facilities while assuring that individuals who were admitted received active treatment for their admitting psychiatric condition. SRS is reducing the astounding rate of growth in the psychiatric services budget but more importantly, it is ensuring that children are appropriately placed and freeing up money for DFS to further develop alternative placements for children in the community.

In addition to their UR functions, MHMA has made their staff available to Montana's providers to provide training to staff on procedures and program design and information on trends in community mental health services and alternatives to inpatient care. Montana is pleased to be working with MHMA and utilizing their experts in the mental health management field.

A:Speech

MEDICAID MANDATES

I have indicated at various committee presentations that new federal mandates on the Medicaid Program have had a large impact on costs of the program. I would like to take this opportunity to highlight for you how this has occurred.

A major trend toward congressional mandates in the Medicaid Program began with the Omnibus Budget Reconciliation Act (OBRA) of 1987. Every year since then, new mandates have been added which have expanded eligibility, service coverage, and payment standards for institutional and noninstitutional providers. The mandates clearly established the precedent of service coverage whether or not included in a state's Medicaid plan. (Refer to chart 13 and 14 which describe mandates and costs)

All states, including Montana, are having increasing difficulty coping with the growth in Medicaid expenditures caused by the mandates. Governor Stephens has joined other Governors in expressing their opposition to further mandates that limit their ability to direct the program to local needs.

The National Governors' Association passed a resolution in July 1989 calling for a two year moratorium on further program mandates in hopes of influencing the budget reconciliation process that year. American Public Welfare Association passed a resolution opposing further mandates in February of 1990. These resolutions

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apparently had no impact on congress since OBRA 90 brought additional federal mandates. Another resolution by the Governors, opposing these recent mandates, is currently being circulated and we believe will be passed at the National Governor's conference this week.

Given new program mandates, increased medical inflation, declining state revenues, and unexpected caseload growth ~~in the potentially eligible population~~ due to the spreading recession, states are searching for ways to provide funding for new mandates while maintaining current service levels in all parts of the program.

It is difficult to reduce eligibility, services, or payments because of federal statutory restrictions in most program areas and the lawsuits brought with ever greater frequency by providers seeking higher payment rates.

Provider Lawsuits

Hospital associations have sued states for higher reimbursement on a regular basis over the past few years. While nursing home associations have also sued, the number of suits is likely to grow as a result of both nursing home reform and the recent statutory change in nursing facility reimbursement requirements that place high, but unquantifiable, standards in statute. Individual physicians, especially dentists, have begun to sue and win, based on the equal access clause passed in OBRA 89. Clearly states

cannot ignore or adversely affect provider payments in the search for cost containment. Similarly, so much of Medicaid eligibility is now a mandate that states are left with few alternatives that evenly distribute the effects of cost-containment efforts.

Outlook

By opposing further mandates, Montana Medicaid and SRS is ironically going against many of their usual allies - advocates for children, the elderly and low-income individuals. While APWA, Medicaid directors, and others are calling for broad reform of health care financing, it is the perception of many knowledgeable in this area that comprehensive health care reform is a long way off and Medicaid national mandates are a feasible incremental approach to achieve more immediate goals.

The worsening fiscal position of many states may finally have an impact on Congress, although worsening economic conditions have been in evidence in some areas of the ~~county~~ country for some time. Even without more federal mandates, Montana must fund the current program, the expenditures for which will grow substantially even at current service levels, while state revenues in many areas will likely not keep pace with expenditure growth.

The Department will continue to look for creative ways to implement cost-containment measures that are politically acceptable and that do not violate federal rules.

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Mrs. Ellery will now discuss some of these cost containment efforts.

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Cost Containment

The cost of health care in our state and our nation is increasing much faster than the cost of any other service. Medicaid cost containment has been the focus of much attention due to dramatic increases in expenditures and continuing increases in the cost of providing care. Cost containment in Medicaid is not an easy process. It is difficult to implement cost containment measures that control the growth of expenditures without restricting access to health care. It is frustrating to the provider who argues that you are shifting costs from one payor to another, it is frustrating to the consumer and their advocates who demands the best medical care no matter what it costs, and it is frustrating for other insurers who want to exclude high risk patients.

The cost containment dilemma is one of how to reduce cost without reducing access to health care. If you are successful in cutting costs, you are accused of restricting access to care.
In 1986, Medicaid recommended cuts in eyeglasses, hearing aids and dentures. There was a tremendous reaction from clients, providers and advocacy groups. The rule hearings packed the SRS auditorium and produced over 700 written comments all in opposition to the changes. The rules were never filed due to issues raised in the hearing.

Despite the difficulties in containing Medicaid costs, SRS remains committed to containing costs while assuring a high quality of care and improving services wherever possible. Containing Medicaid

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costs is not new to SRS. The Medicaid Division spends a lot of time trying to identify cost containment measures. Efforts have been concentrated in the administrative area since the legislature restricts SRS from limiting the amount, duration and scope of Medicaid benefits without specific Legislative authority. While spending continues to grow, SRS has attempted to control that rate of growth by implementing a variety of cost containment measures. Some examples of cost containment measures that are currently in place:

- Review of all hospital admissions for medical necessity.
- Pre-admission screening of all Medicaid nursing home and waiver admissions for appropriateness of placement.
- Reimbursing in-state hospitals under the prospective DRG system.
- Establishing home-based and community alternatives to nursing homes and hospitals.
- Placing limits on amount, duration and scope of services. (Example - 70 hour limit on therapies).
- Requiring recipients to pay a nominal portion of their care. This is called copayment. Montana has one of the most restriction copayment programs in the country. Estimated savings in FY 90 to the state due to the copayment program are $815,825. SRS will not be expanding copayment since a recent study completed by Peat Marwick for SRS indicates that while copayment may result in short term savings, it does not necessarily save money in the long run. If the recipient cannot pay

their copayment, they may put off receiving necessary medical care resulting in higher costs later.

- Restricted access Program which require individuals who abuse the program to receive care from only one physician or pharmacy.
- Aggressive and successful efforts to collect from other third party sources such as Medicare and private insurance.
- Review of admissions and continued stays in inpatient psychiatric hospitals and residential treatment facilities.
- Prior authorization for out of state medical care to ensure that the services are not available within the state.

SRS presented a report to the Governor in March 1990 which identified over 16 cost containment proposals with projected savings of $2.1 million. The proposals included increased emphasis on third party collection, child support collections and enhanced utilization and review. Not all of the proposals were able to be implemented but many were. These savings were not considered in the LFA Budget but should be based on savings to date.

I would like to highlight the major proposals implemented and the cost savings that have been realized to date.

~~VA Aid and Attendance~~

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Contract for psychiatric services for children.

VA Aid and Attendance

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Third Party Liability

In April 1990, SRS provided comprehensive training to eligibility technicians on how to detect potential sources of third party liability. (i.e., private insurance, etc). Estimates are that the training has resulted in a 3% growth in third party collection. Based on an increase of 84.5 cases at an average of $1,090 savings per case, net savings of $92,000 have been realized.

Medical Support Enforcement

This program requires that absent parents obtain medical insurance for children they are legally responsible for. Child Support Enforcement Division estimates as of 12/1/90 that a total of 223

children have been identified to have health insurance through the absent parent. At an annual savings of $1,522 per child, total savings estimated for FY 91 are $680,000.

Additional TPL Staff

Two additional FTEs were added in FY 90 to perform TPL duties. To date, these two FTEs have achieved over $300,000 in cash recoveries, plus will realize another $300,000 in cost avoidance savings.

Data Matches - BC/BS DEERS

A data match was conducted with the DEERS system to identify recipients who have CHAMPUS coverage. $230,000 in claims were billed to CHAMPUS as a result of the match. If only 25% of that amount is paid by CHAMPUS, recoveries will be $57,500.

The 1989 legislature directed SRS to evaluate the definition of medical necessity used by Medicaid to determine whether a more restrictive definition would result in cost savings. SRS contracted with Peat Marwick who compared Montana's definition to that used in other states. Only 2 states (California and Oregon) were found to have more restrictive definitions. California has an extensive in-house staff of 500 persons to prior authorize almost all Medicaid services. While cost savings may occur from implementing a more restrictive definition of medical necessity,

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much of the savings would be offset by an increase in administrative costs and would result in fewer services to clients. A copy of the study has been made available to the Legislature to determine if SRS should pursue further action in this area.

SRS plans to continue to explore ways to control the growth of Medicaid expenditures without restricting access to care for those in need.

Looking ahead to cost containment plans for the future, Montana Medicaid will be developing the following programs:

1) Managed Care

SRS plans to implement a managed care program for Medicaid population. Managed care is a term heard more and more often these days and it can mean a lot of different things. The broad definition is that managed care is the coordination and oversight of health care delivery. The goal is to reduce costs by decreasing the unnecessary or inappropriate use of medical services.

The model that Medicaid is interested in is called the primary care case management model. We would enroll primary care physicians who agree to act as case managers for a target population e.g. AFDC clients. The recipient chooses among

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providers enrolled in the program and must get all care and referrals from that provider. This model guarantees access to care for the recipient and eliminated "doctor shopping." Many other states have implemented this approach and have seen significant cost savings due to reduced use of hospitals including emergency rooms.

2) Competitive Bids

A contract will be awarded in March to a single manufacturer of eyeglasses which may reduce the price of eyeglasses for Medicaid recipients by 40%.

Next year we hope to be able to also purchase major medical equipment items like wheelchairs, at volume purchase prices.

3) Targeted Case Management

In 1986, Congress gave states the statutory authority to provide case management as an optional medical service. Forty-one states already include this service in their state plan. Case management is not currently a service under Montana's state plan but a bill sponsored by Senator Keating would add it as a Medicaid-covered service.

Targeted case management should not be confused with case management that is currently provided in Montana under the Home and Community Services waiver.

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The federal Medicaid statute defines targeted case management as "services which will assist individuals under the plan in gaining access to needed medical, social, education, and other services". Case management services can include such activities as development of a care plan, assessment of client needs and referral or arrangement of treatment. Case management does not include the actual treatment.

This definition gives states a lot of flexibility as to what services they can offer as case management. It allows the state to target case management services to specific populations, providers, and to specific areas of the state. This is not true of other Medicaid services which require you to provide the same services to all Medicaid eligibles on a statewide basis.

SRS has been working with the Departments of Family Services, Institutions, and Health to provide Medicaid reimbursement for case management services to the following target groups:

--High-risk pregnant women
--Chronically mentally ill adults
--Developmentally disabled
--Seriously and emotionally disturbed children

The Departments are working together to define the population

to be served, the geographic area, the payment methodology, and the qualifications of case management providers. Case management providers are most often individuals who have experience with the target population. The case managers could be DHES, DFS or DOI staff or the staff of local agencies who provide the service through a contract. Case managers are most often a registered nurse or a social worker. Funds to provide the state match for services to pregnant women, chronically mentally ill adults, and developmentally disabled have been identified in the appropriate Department's budget request.

To the extent that these services are currently provided with state dollars, the increased in federal funds from Medicaid will allow more people to be served.

4) Purchase of Health Insurance

SRS will be implementing a program which assures that recipients keep their health insurance by paying their premiums for them. This program will prevent Medicaid from assuming the entire burden for several hundred higher risk recipients. Projected annual net savings are $675,000.

These measures are a small representation of initiatives the Medicaid Division will be involved in next year to help strengthen the health care delivery system. Although federal mandates have

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caused serious budget restraints recently and more mandates are expected, the Montana Medicaid Division will not be discouraged in efforts to do everything possible to continue to improve medical services for Medicaid eligibles statewide.

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Maureen O'Reilly	West Mont - PCA	
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Charles Bissak	MT Private Amb.	
Lorie Eckenberger	Case mgmnt/h&C hlth dept	
Rose Hughes	[redacted] MT. HEALTH CARE	SRS Budget
Robert W Olsen	MT Hospital Assoc.	
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Roger Tippy	M.D.A. (Dentists) M.S, P.A. (Pharmacists)	
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