MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN DOROTHY BRADLEY**, on February 5, 1991, at 8:05 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)

EXECUTIVE ACTION ON THE MEDICAID SERVICES DIVISION (CONT.)

Votes were taken on **EXHIBIT 13 from Feb. 4, 1991, minutes.**

Tape 1A

Carroll South, Legislative Fiscal Analyst, distributed the Medical Benefits budget summary. **EXHIBIT 1**

Nancy Ellery, Medicaid Services Division Administrator, distributed Department testimony on the Primary Care Program; and information on nurses aide testing and certification, ambulance provider-rate increases, the Kids Count! project, Medicaid funding for infants and funding for youth psychiatric services. **EXHIBIT 2-3**

She said the Nurses Aide Testing and Certification budget modification is needed for training nurses. Nursing homes used to train nurses using curricula approved by the Department of Health. New regulations require independent contractors to provide training. The Health Department is negotiating the contract. It will cost about $172,800 over the biennium to train 2,000 aides.

SEN. KEATING asked if the money is in the executive budget. **Julia Robinson, SRS Director,** said yes. **Ms. Ellery** said the money is needed to administer the test.

MOTION: **SEN. KEATING** moved approval of the Nurses Aide Testing and Certification budget modification.

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

Ms. Ellery reviewed the Hospital Rate Study budget modification, referring to Page 42 of **EXHIBIT 19 from Feb. 1, 1991, minutes.** She said the LFA put some components of the budget modification in a cost-containment category.

CHAIRMAN BRADLEY asked why so much money has to be spent on the study when the Department already knows what the results will be and how much money will be saved. **Ms. Ellery** said the Department doesn't know how much money will be saved. The system will be studied to determine how it should be updated.

CHAIRMAN BRADLEY asked if rebasing and updating will have to be done on a continuing basis. **Ms. Ellery** said rates will constantly need to be rebased. **Ms. Robinson** said it takes well-trained fiscal experts to do the study. The Department doesn't have the staff or expertise, so it contracts out the work.

CHAIRMAN BRADLEY asked if a new study must be contracted out every four years. **Ms. Robinson** said yes, because of the way the system is set up at the national level. **Ms. Ellery** said the Department's computer system needs to be updated to ensure hospital reimbursements are accurate.

SEN. NATHE asked if General Fund money is being saved. **Ms. Ellery** said General Fund will be saved as reimbursement accuracy improves. A study is needed to determine what to pay hospitals in the future. **Ms. Robinson** said a direct cash savings to the General Fund will not occur. Savings will be in terms of program growth.

MOTION: **SEN. KEATING** moved approval of the Hospital Rate Study budget modification.

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

HEARING ON THE PRIMARY CARE PROGRAM

Ms. Robinson provided an overview of the Primary Care program. She read Pages 1-4 and 6-8 of **EXHIBIT 2.** She noted that primary care is the largest single expenditure in the Medicaid budget. In fiscal year (FY) 1992, primary-care expenditures are expected to reach $145 million, or 70 percent of the Medicaid budget.

She referred to Chart 17 in **EXHIBIT 3,** which shows increasing youth psychiatric costs and funding. She said the $3.5 million put into the budget is what would have been spent if the system remained the same. The Department has been able to stabilize the number of placements. That level should be maintained. New money is built into the budget to cover projected growth. It can be used by the Department of Family Services (DFS) for new services.

Tom Olsen, DFS Director, said an increasing number of children are being placed in out-of-state services. Alternatives are not available in Montana. He will not allow a child to be placed in an inappropriate treatment program just because the program is in the state. Montana has few placement options below the inpatient psychiatric hospitalization and intensive residential medical treatment level.

Efforts should be made to work with families so that children can remain in the family. The only option now is to place the child in foster care. There are no resources or staff to help return the child to the family.

DFS plans to develop a system of care that strengthens families and enables in-home treatment. With the transfer of money, DFS will have $500,000 to work with families. Right now, the state intervenes at the last possible moment, taking children from their families in crisis situations, often placing them inappropriately. The transfer is needed to provide a system of care that meets families' needs.

Ms. Robinson distributed and reviewed an amendment to the appropriations bill that would prevent the Medicaid program and restrictive placements from depleting the foster-care budget. The amendment would allow Medicaid money to be transferred to less restrictive programs, but no funds from less restrictive programs could be transferred to Medicaid. **EXHIBIT 4**

SEN. KEATING asked if the new system of care will reduce foster-care costs. **Mr. Olsen** said he doesn't know. It will take 2-4 years before foster-care placements slow down. Permanency planning for children is a priority. Right now, DFS does not have the staff or resources to work on permanent adoptive placements. But DFS intends to revise the way records are evaluated and closed, which will get children off foster-care rolls more quickly and into permanent families. As the agency works with families, foster-care placements will decrease. The transfer will allow the agency to develop a pilot program in each region of Montana. The regional programs would serve between 100 and 200 families.

HEARING ON THE KIDS COUNT! PROGRAM

Ms. Ellery reviewed Chart 15 in **EXHIBIT 3.** She said the proposed increase in obstetric and pediatric provider fees would increase Medicaid reimbursements from 50 percent of charges to 90 percent

of charges. Physician rates have not been increased since 1982, except for 2 percent increases in the last biennium. Access to care is an increasing problem for Medicaid recipients. Nearly 30 percent of the births in Montana are covered by Medicaid.

The federal government disapproved Montana's State Plan Amendment, which details Montana's fee structure, because the state could not guarantee access to Medicaid clients at the same level of the general public. If fees are increased to the level SRS is requesting, the federal government has indicated it will approve the State Plan Amendment. Without approval, federal money can be withheld from the program. The physician-fee portion of the proposal amounts to $11 million.

Targeted case management for high-risk pregnant women and children will allow Medicaid to contract with the Department of Health and its Low Birth-Weight Prevention Project to provide Medicaid reimbursement for case-management services. She reviewed Chart 16 of **EXHIBIT 3,** which shows that expenses for 129 babies, or 4 percent, used up more than half the Medicaid budget. Case-management services can do a lot to change that.

Kids Count! is Medicaid's well-child program. It provides regular child care through age 21. SRS wants to add case management to this service. The Department does not have the staff to ensure clients get proper care. SRS will contract with an outside agency to provide case management. Costs are a third less for children participating in the Kids Count! program.

The federal government mandated that by 1995 the state screen at least 80 percent of its eligible children. The state screens about a third of that. A case-management contract would help SRS meet mandates and save money through early detection. SRS can require the contractor to hire former or current AFDC recipients to provide case management. SRS also wants to increase the number of screenings that children are eligible for, from 12 to 20, to match the schedule recommended by the American Academy of Pediatricians. Kids Count! also provides services for teens. SRS hopes to increase dental-fee reimbursements for children's services. Dentists are refusing to see Medicaid patients.

Dr. Van Kirke Nelson, an obstetrician and gynecologist from Kalispell, distributed and reviewed recommendations from the Governor's Health Care Services Availability Advisory Council. **EXHIBIT 5**

Tape 1B

He said Montana's neonatal death rate is 4.8 percent, the second lowest in the United States. Montana is 32nd in the nation in infant mortality in the first year of life because of the rural nature of the state and a lack of physicians.

The number of physicians providing obstetrical care in rural areas has dropped 40 percent in the last 5 years. The drop may be due to a declining population, cost of liability insurance and

the level of compensation for services. About 12,000 babies are delivered in Montana each year. Approximately 3,100 of them are Medicaid recipients.

Physicians will stop delivering babies if they do not receive sufficient payment. Increases in physician reimbursements will help keep doctors practicing obstetrics in rural areas and may attract others back into the practice. He referred to Chart 2 in **EXHIBIT 5,** which shows the counties without obstetricians.

He said care is not necessarily more accessible to Medicaid recipients in larger cities. He referred to Chart 5 in **EXHIBIT 5,** which shows an increasing number of patients are Medicaid-eligible. Urban areas also are losing family practitioners who do not want to serve Medicaid recipients. If reimbursement rates are increased to 90 percent of charges, there will be more providers, access will increase and program costs will drop.

Dr. Jeffrey Strickler, a pediatrician in Helena, testified on the importance of preventative care and the Kids Count! project. He said a way to eliminate barriers to care is to increase physician fees to 90 percent of usual and customary charges, as is recommended. Some doctors are seeing an increasing number of Medicaid patients because other doctors are refusing to see them. Rural doctors are not being replaced.

Mary Costello, a registered nurse with Access Links in Missoula, said Access Links is the low birth-weight prevention program in Missoula County. Access Links began case management two years ago. She described services provided by the program and the stories of two clients.

SEN. NATHE asked **Ms. Costello** who she represents. **Ms. Costello** said the Missoula City-County Health Department. She noted that about 220 low-income women are served each year. **SEN. NATHE** asked if Access Links also handles the WIC program. **Ms. Costello** said it is housed in the Health Department building. **SEN. NATHE** asked if the Healthy Mothers/Healthy Babies and Baby Your Baby programs are in the same building. **Ms. Costello** said no. **SEN. NATHE** expressed concern that programs are often fragmented and people don't know where to go for services. **Ms. Costello** said Medicaid is in the same building. **SEN. NATHE** said Missoula is on the right track.

CHAIRMAN BRADLEY referred to the first five budget modifications in **EXHIBIT 13 from Feb. 4, 1991, minutes,** and the primary care issue in **EXHIBIT 1.**

Mr. South said the executive's intent is for the modifications to be limited to dollar figures, even if percentages have to be recalculated. To accomplish that, the subcommittee will have to approve language that directs the Department to recalculate projections and assure percentages are within available dollars.

The physician rate increase would be impacted. Once the state sets Medicaid parameters and conditions are met, there is little control over what happens to the Medicaid budget. Percentage increases change as costs escalate. The only way to control it is to ask the agency to recalculate the percentage right before each fiscal year begins.

CHAIRMAN BRADLEY said **Mr. South** was addressing No. 10 under the items for committee discussion in **EXHIBIT 1.** No. 10 relates to budget modifications 1-5 on **EXHIBIT 13 from Feb. 4, 1991, minutes.**

Ms. Robinson agreed that language is needed if the subcommittee wants to stay within budgeted dollars.

SEN. NATHE asked how much money is spent for obstetrician and pediatrician reimbursements. **Ms. Ellery** said physicians receive $755 to cover costs of a normal delivery and prenatal care. If the rate was 90 percent of charges, reimbursement would go as high as $1,200.

SEN. KEATING asked if the rate increase is covered by the budget modification. **Ms. Ellery** said obstetric and pediatric fee increases are included. **Ms. Robinson** said obstetricians are requesting reimbursement at 90 percent of charges. Pediatricians are seeking 80 percent. Obstetricians pay higher insurance rates.

CHAIRMAN BRADLEY asked what happened after the 1989 Legislature raised provider rates by 2 percent and approved an additional amount. **Ms. Ellery** said the Legislature approved a 2 percent provider-rate increase in FY 90 and FY 91, and appropriated $100,000 for physicians in rural areas. The Department said all of Montana is rural, so all physicians received the 2 percent increases and a portion of the $100,000.

CHAIRMAN BRADLEY reminded the subcommittee that it approved 5 percent increases for other providers. She asked what it would cost to provide a similar increase to physicians in each year of the biennium. **Ms. Ellery** said the figures would have to be calculated. **Ms. Robinson** said the proposed physician fee increase would be significantly higher than the 5-and-5 increase granted to other providers.

SEN. NATHE asked how much has been spent in the past. **Ms. Robinson** said the information will have to be calculated. **SEN. NATHE** said that was OK. **Ms. Robinson** said rates must be increased substantially to qualify for and retain State Medicaid Plan approval. If the dollar amount is locked in, percentage increases will be lower. Volume has increased because of eligibility expansion. **Ms. Ellery** said the Department based the budget on what usual and customary charges were in late 1989. Charges have risen since the survey was done.

EXECUTIVE ACTION ON THE KIDS COUNT! PROGRAM

Votes were taken on issues in **EXHIBIT 13 from Feb. 4, 1991.**

CHAIRMAN BRADLEY said background information on the Case Management/Screening budget modification is on Page 49 of **EXHIBIT 19 of Feb. 1, 1991, minutes.**

SEN. KEATING asked how caseloads were calculated. **Ms. Ellery** said the Department used a historical model based on the past number of cases and an estimate of what will occur in the future based on changes.

SEN. KEATING asked if there is an increase in low-income, unwed mothers. **Ms. Robinson** said the Department is having a difficult time calculating how many people will be using Medicaid because the federal government continues to expand eligibility. **Ms. Ellery** said Medicaid standards were increased for pregnant women and children up to age 6 with income of less than 133 percent of poverty. Children in families without a pregnant woman can now become eligible.

SEN. NATHE asked how the program fits into the Department of Health's immunization program.

Tape 2A

Ms. Robinson said the program provides comprehensive screening of children and is broader than the Health Department's immunization program. If the child doesn't get immunized through public health, SRS pays for it.

CHAIRMAN BRADLEY asked if non-Medicaid families receive as much screening and extensive care as Medicaid families. **Dr. Strickler** said screening levels are based on a scale created by the American Academy of Pediatrics. The scale specifies the appropriate number of screenings for children as recommended by federal Medicaid. Few insurance companies pay for well-child care. The same number of visits are recommended for Medicaid patients as full-pay patients.

MOTION: **SEN. KEATING** moved approval of the EPSDT Case Management/Screening budget modification.

VOTE: The motion **PASSED** 3-2, with **REP. COBB** and **SEN. NATHE** voting no. **SEN. WATERMAN** was absent.

CHAIRMAN BRADLEY said background information on the Case Management for Pregnant Women budget modification is on Page 50 of **EXHIBIT 19 from Feb. 1, 1991, minutes.**

SEN. NATHE asked if the program links existing nutritional programs in the Health Department and providers of Medicaid services. **Ms. Ellery** said yes. It will provide federal Medicaid

money to expand coordinated services. It will be a Medicaid-covered service so more money will be available to expand services in other areas.

SEN. NATHE said there should be one-stop care for these people. He expressed concern about duplication of services. **Ms. Robinson** said this client group won't come in for services at all. Case management helps ensure these people keep their doctor appointments and that they take care of themselves.

SEN. KEATING said he is concerned about relieving people of the responsibility to take care of themselves. If they don't, the state ends up paying enormous costs for innocent babies born with terrible problems. He asked why the state supplements people who won't care for themselves or accept responsibility for their actions. He has to vote for this for the baby's sake. He wants to put pressure on the people who bring these problems to the state.

REP. JOHNSON asked if the modification is included in the executive budget. **Ms. Robinson** said all Kids Count! initiatives are in the executive budget.

CHAIRMAN BRADLEY said she doesn't see an alternative but also is concerned that the state is creating a program that may encourage less responsibility. **Ms. Robinson** said the hope is that case managers will help these people develop skills for self-improvement. The Department is advocating the program because of its responsibility to children. More needs to be done to assist in the family. It is possible to change how a family deals with its problems.

MOTION: **SEN. KEATING** moved approval of the Case Management for Pregnant Women budget modification.

DISCUSSION: **SEN. NATHE** asked if information on Page 50, which indicates that $493,000 is being spent per year to serve 3,100 babies, is correct. **Ms. Ellery** said **Dr. Nelson** referred to 1,341 people served through the low birth-weight project last year. They are Medicaid- and non-Medicaid-eligible people. This modification will allow Medicaid to pay for some of the case management already being provided to Medicaid-eligible women. She doesn't know how many Medicaid-eligible women are served by the low birth-weight project, but most are.

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

MOTION: **SEN. NATHE** moved approval of the Children's Dental Expansion budget modification.

DISCUSSION: **CHAIRMAN BRADLEY** said background information on the modification is on Page 46 of **EXHIBIT 19 from Feb. 1, 1991, minutes.**

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

CHAIRMAN BRADLEY said background information on the Obstetrician and Pediatrician Rate Increase budget modification is on Page 51 of **EXHIBIT 19 from Feb. 1, 1991, minutes.** She asked the Department to calculate the percentage increase provided by the modification and to present the figure to the subcommittee. **Ms. Robinson** said the amount is 40 percent more than what is being paid now. She will have the figures calculated for the subcommittee.

SEN. KEATING asked how many people are served. **Ms. Robinson** referred to Page 44 of **EXHIBIT 19 from Feb. 1, 1991, minutes. Ms. Ellery** said the number is roughly 30 percent of 60,000 recipients. Women and children represent almost two-thirds of the Medicaid caseload but only account for 30 percent of the expenditures.

MOTION: SEN. KEATING moved approval of the Obstetrician and Pediatrician Rate Increase budget modification.

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

SEN. KEATING asked if more doctors will deliver babies now. **Dr. Nelson** said yes. An increase in compensation of $400-$500 will make a difference.

HEARING ON INPATIENT PSYCHIATRIC CARE

CHAIRMAN BRADLEY referred to the Residential Psychiatric Treatment budget modification on Page 2 of **EXHIBIT 19 from Feb. 1, 1991, minutes,** and discussion items No. 2, residential inpatient psychiatric services, and No. 3, transfer of inpatient psychiatric responsibilities, from **EXHIBIT 1.**

Mr. South said that in the early 1980s, the total psychiatric inpatient program for youth in Montana was on the campus of Montana State Hospital. It was a small unit with a capacity of 30. It ran at capacity most of the time. The executive asked the Legislature to build a new facility for psychiatric treatment for youth. That facility was built in Billings and was operated by the state for about a year.

When the state decided to build and operate a new facility, the assumption was that the state would get Medicaid reimbursement and the federal government would subsidize operations. It was determined after more than a year that the facility would never become Medicaid certified if the state continued to operate it. The state could not recruit a psychiatrist or meet Medicaid standards.

During the 1986 Special Session, the Department of Institutions asked the Legislature to sell the facility to the private sector

on condition the facility would become Medicaid-certified and the federal government would provide 70 percent of the funding. It was sold to Rivendell of Billings.

Rivendell has since built a new facility in Butte, and Shodair Children's Hospital in Helena is offering psychiatric inpatient treatment. Medicaid reimbursement for the psychiatric inpatient program has increased significantly since 1986. The state spent $2.1 million in General Fund money in the last year it operated the facility. That amount should be compared with the program's state Medicaid match because they are one in the same.

The 1989 Legislature expanded the psychiatric inpatient treatment program to include residential facilities. A pilot program was established and $1.5 million in federal funds was appropriated each year of the biennium to fund it. It was to be matched by foster-care money in the Department of Family Services (DFS). The Department began paying retroactively under the program beginning in July of FY 91.

The executive now proposes that approximately $12 million be devoted to residential psychiatric treatment. The legislation authorizing that as part of the state Medicaid program expires in July. Before the subcommittee considers the $12 million, it should be determined whether the Legislature intends to expand the program to residential psychiatric treatment.

Part of the executive proposal is to move not only the residential portion of psychiatric inpatient treatment money to DFS, but also the General Fund match for hospitalization at Rivendell and Shodair. Once the money is in DFS, alternative services will be established that are less intensive and costly. Although the money may be spent for purposes other than Medicaid reimbursement, there is no guarantee Medicaid reimbursement costs will drop for the psychiatric inpatient program. Parents can still take their children to these facilities. If the children are Medicaid-eligible, the state will pay.

If DFS spends the General Fund money on community programs that don't decrease Medicaid use of the facilities, there will have to be a supplemental appropriation for the psychiatric inpatient program.

Ms. Robinson said use doesn't have to decrease. It must only be maintained at the current level. If the current level is maintained, there will be $3.5 million in new money in the DFS budget. Otherwise, a supplemental appropriation will be needed.

REP. FRANCIS BARDANOUVE, CHAIRMAN OF THE APPROPRIATIONS COMMITTEE, asked what the $12 million includes. **Mr. South** said approximately $9 million in federal funds and $3 million from the General Fund.

SEN. NATHE asked if the money approved last session to reimburse the Yellowstone Treatment Center is in this budget. **CHAIRMAN BRADLEY** said yes. **Mr. South** said that was a pilot program and the residential part of it expires in July, but the money is in the executive budget. The $9 million is in SRS and the $3.5 million is in DFS.

PUBLIC COMMENT

Pat Melby, Rivendell representative, said he previously served as SRS director. What everyone hears about is the 1,000 percent increase in the program between FY 87 and FY 90. What isn't mentioned is that Medicaid reimbursement was available for only six months in FY 87. Rivendell of Billings was the only facility that was Medicaid-certified during that fiscal year, and it did not become certified until March 15, 1987. Rivendell received only a few months of Medicaid reimbursement that year. Rivendell knew then that it would not get reimbursed for more than 2,000 days of service.

When Rivendell took over the facility, it was full of children placed by the Department of Institutions and Montana courts. Shodair did not become Medicaid-certified until September 1987. Rivendell of Butte did not become certified until August 1988. It should be noted that the Medicaid expenditure was zero on Jan. 1, 1987, so the tremendous increase is logical and explainable when that is considered.

In 1986, the state spent $2.1 million in General Fund money to operate the Youth Treatment Center for 43 to 46 children. More children are being treated now and with better services at possibly less General Fund cost than the state spent in 1986.

Rivendell supports the governor's initiative to develop alternative services. However, the administration is suggesting that the money for inpatient psychiatric services for youth be appropriated to DFS, regardless of whether the children being served are DFS' responsibility. The executive wants to use the Medicaid match to develop alternative services. DFS is being set up and will have to ask for a supplemental appropriation in 1993. It is an important program. A separate appropriation should be made to develop alternative services. If the plan works the way the administration expects it to work, Medicaid costs will drop.

The sale of the Youth Treatment Center to Rivendell two years ago was hailed as the model of privatization. But in 1991, it became evident the sale was a dismal failure. In the first year that Rivendell ran the facility, Medicaid determined that a number of days of service for youth did not meet medical necessity requirements. The cost approached $500,000.

An agreement was reached in February 1988 between Rivendell, DFS, SRS, the Department of Institutions and the governor's office to pay Rivendell an unspecified amount for the expenses. No amount

was put in writing, but the state acknowledged its liability and stated that some payment should be made. Rivendell has repeatedly asked about the payment, but no payment or response to inquiries has been received.

After Rivendell took over the facility, SRS began to tighten utilization review. Reviews are needed in a third-party payment system, including the Medicaid program, but the purpose of doing the review should not be based on the idea of cutting program costs. It should be designed to ensure patients receive only needed services until less restrictive alternatives are possible. If utilization review is done properly, unnecessary costs will be avoided and patients will not be discharged prematurely, which is happening now.

In 1986, prior to the sale, the average length of stay was in excess of 180 days. Rivendell's proposal to the state indicated an average length of stay of 90 days for adolescents and 120 days for children. With utilization review done by the Montana/Wyoming Foundation for Medical Care, the average length of stay dropped to 60 days. Rivendell adjusted to the shortened stay and revamped its treatment program so that the average length of stay would be closer to 50 days.

Last July, SRS entered into a new utilization-review contract with Mental Health Management of America (MHMA). It is believed there were instructions to be more stringent than the Montana/Wyoming Foundation in applying the medical-necessity standard. As a result, the average length of stay is approaching 30 days. In December, it was 34 days and dropping. SRS says the current experience is consistent with national average lengths of stay. The national average is meaningless when trying to determine what is appropriate in a rural state like Montana. An average stay of 30-40 days is unrealistic. The average length of stay in facilities in other rural states is much longer.

MHMA officials have told Rivendell that Montana has the most restrictive medical-necessity standard of any state in which Rivendell operates. This is not a federal standard. SRS admitted Montana has the third most restrictive medical standard in the nation.

A memo from SRS suggests the agency should be directed by legislation to adopt a rule by July 1, 1992, that requires parent income and assets to be considered for purposes of determining eligibility for inpatient psychiatric services. That requirement would ensure many youth would not get needed services. They eventually would end up in the youth services system by some other means, most likely through the criminal justice system. The administration indicated two weeks ago that no attempt would be made to change the eligibility rule during the upcoming biennium. DFS felt it would be premature to do so.

The rules of the game have been changed so much since the sale, the screws have been tightened so tight, it doesn't appear Rivendell will be able to continue operating the facility. It is possible the state will be asked to buy the facility back.

Tape 2B

John Conroy, Operations Vice President for Rivendell, said financial viability of the inpatient hospital psychiatric program is in doubt. The philosophy of service also has changed. Only children who are a danger to themselves or others are admitted. They are stabilized, treated for the crisis phase and discharged as soon as they are able to be in a less restrictive environment, whether that environment is available or not.
One-thousand patient days have been saved by utilization reviews. But there is a backlog of claims awaiting Departmental review. These reviews need to be done. There is an increasing number of complaints by professionals about the decreasing length of stay. Children are not getting sufficient treatment and will be right back in the system. The transfer of too much money to other programs will shortchange children.

Ralph Yaney, a psychiatrist at Rivendell, said there is an attempt to put money from inpatient psychiatric care into other services. Children are being released without sufficient treatment and are returning to the system. Treatment criteria are too restrictive. Children whose conditions are not severe enough are being released. Medicaid money is being cut off. Discharges are being made that wouldn't ordinarily be made. He urged the subcommittee to continue support for services provided by such facilities as Rivendell.

Ms. Robinson said Medicaid is the payment system. SRS is not saying children must leave treatment. It is saying the medical need has ended and the state can no longer pay for the services. General Fund money can be used to continue a child's treatment. There may not be a medical need, but there may be a social need.

Jack Casey, Shodair Administrator, said Shodair hires competent psychiatrists and social workers who determine whether a child is in need of services. If Medicaid determines the child isn't in need of services under its strict medical criteria, it doesn't mean Shodair will discharge the child. Shodair this year spent more than $500,000 of its own money to treat those children. Shodair cannot continue doing this. It is a societal problem. These children need treatment.

Referral sources are complaining that children are being released too soon. By going to the shortest length of stay, more children will be returning to the system and money will be wasted. Facilities also face legal liability. If a child is discharged because there is no payment source and something bad happens, the facility is liable. A continuum of services is needed but there is a move to limit residential treatment services.

New funding and services are needed. Shodair supports community-based services. Providers will be back in two years to complain again if the money is taken from one end of the continuum to finance the other.

Robert Raymond, Executive Director of Rivendell, distributed a brochure that describes Rivendell's services. **EXHIBIT 6**

ADJOURNMENT

Adjournment: 11 a.m.

Dorothy Bradley
REP. DOROTHY BRADLEY, Chairman

Faith Conroy
FAITH CONROY, Secretary

DB/fc

HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUBCOMMITTEE

ROLL CALL **DATE** 2/5/21

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	✓		

6901 DEPT SOCIAL & REHAB SERVICES
07 MEDICAL BENEFITS

Budget Item	Actual Fiscal 1990	Executive Fiscal 1992	LFA Fiscal 1992	Difference Fiscal 1992	Executive Fiscal 1993	LFA Fiscal 1993	Difference Fiscal 1993
Primary Care	103,714,048	138,726,678*	145,574,213	(6,847,535)	145,406,764*	152,852,924	(7,446,160)
Nursing Care	53,955,000	59,957,640	59,957,640	0	61,156,793	61,156,793	0
Institutional Reimburs.	10,103,908	10,666,425	10,666,425	0	9,899,939	9,899,939	0
Indian Health	1,025,842	4,000,000	4,000,000	0	4,000,000	4,000,000	
Medicare Buy-In	4,337,485	5,178,800	5,178,800	0	5,697,000	5,697,000	0
Medicaid Waiver	4,912,626	4,972,458	4,972,458	0	4,972,458	4,972,458	0
State Medical	5,642,113	2,060,594	4,500,000	(2,439,406)	2,109,378	4,500,000	(2,390,622)
Total	183,691,022	225,562,595	234,849,536	(9,286,941)	233,242,332	243,079,114	(9,836,782)

* The Executive Budget transfers approximately $2.5 million each year to DFS as state match for psychiatric inpatient.

Items for Committee Discussion:

1) Medically Needy eligibility criteria:
   Federal regulations permit some flexibility in the establishment of eligibility for this group.
2) Residential inpatient psychiatric services:
   Legislation enacted by the 1989 legislature authorizing medicaid reimbursement for residential psychiatric treatment terminates July 1, 1991. The Executive Budget requests funding for residential psychiatric services but the executive has not requested the introduction of legislation to continue medicaid reimbursement for this service.
3) Transfer of inpatient psychiatric responsibilities:
   The Executive Budget proposes transferring all state medicaid match for inpatient hospital and residential psychiatric treatment to the Department of Family Services.
4) Licensed Professional Counselors:
   The 1989 legislature authorized medicaid reimbursement for licensed professional counselors if funds were specifically appropriated for this purpose. The 1989 legislature did not specifically appropriate the funds .
5) Provider rate increases:
   The Executive Budget includes fee increases for a few selected services and proposes some cost rebasing but does not provide general inflationary increases to medicaid providers.
6) State Medical Program:
   The Executive Budget proposes significant reductions in the scope of the state medical program.
7) Does the 12 mill welfare levy cover costs incurred by the state in state-assumed counties?
8) The use of Child Support Enforcement monies as state medicaid match?
   The Executive Budget includes funding from this source as state medicaid match
9) Language in the appropriation bill permitting transfers between benefit programs?
   Perhaps the executive could propose such language at the Thursday meeting.
10) Limit Executive Budget Modifications to the actual dollar amount requested?

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Presentation Date - 2/5/91
SRS Page 51
LFA Page B-81
SRS Staff Present - Nancy Ellery, John Chappuis, Norm Rostocki, Mary Dalton, Mike Hanshew, Terry Kinzz

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Presentation on Primary Care

Chairwoman Bradley, today the department is presenting on primary care,which includes hospital based services, physician, pharmacy, dental, psychiatric and residential treatment services for youth under age 21 and all other services that are not long term care in nature. Mrs. Ellery will be discussing specifics in these programs but before doing that, I would like to outline the conceptual model that led to our proposals - physician fee increase and psychiatric and residential treatment option for youth under age 21 which are part of the Kids Count Agenda.

As I made clear in my opening remarks, we at SRS believe that public efforts to improve children, youth and families must be premised upon the family. We all came from families and I believe no matter how dark some family roots, (incest, alcoholism, physical abuse,) we all try to remain in our families. In fact, John Bradshaw, noted family theorist, argues that the more dysfunctional the family, the stronger the linkages between family and child.

We don't talk about it much but I believe all families have moments of pain - times of trouble - but healthy families have mechanisms

to get through these periods and support each other. Unhealthy families spiral downward into addiction and abuse. I believe if we are going to change the future, by addressing long term social problems and societal dissolution, we have to address how our social policy deals with or impacts families.

In 1970 Alvin Toffler shook this country with his predictions of the future contained in his now famous book, "Future Shock". Writing about the family, Toffler described the family as the giant shock absorber of society - the place to which the bruised and battered individual returns... the one stable point in an increasingly flux-filled environment. He then proceeded on to describe options for the family of the future in which he characterized the fractured family where families break up, shatter, only to come together again in weird and novel ways. Twenty years later those of us working in human services and on family policy issues find his predictions about the family of the future to have become hauntingly true.

When in the past it was easy for anthropologists to draw simple schematics of the nuclear family, this is simply not true today. The complex web of divorces, remarriages, step-children, stepparents and live-in relationships has made it difficult to outline the structure that the Department of Family Services was designed to serve and the structure which all of us in the human services cabinet are committed to preserving through our public

policy initiatives. Experts predict that by 1995 only 30% of the children in this country will live with their natural father. From these figures, we can see that the traditional American family of parents and two kids is fast becoming a minority.

We may not like these changes, we may wish it were otherwise but public policy must be predicated upon reality and like it or not, we must be building public policy and public programs which address these changes.

We at SRS are proposing a number of changes in program design and philosophy in this budget which we think will improve our services to families. The design of these programs is predicated upon my belief and the belief of the staff at SRS that the philosophical heart of our programs should be what's good for the family is good public policy.

Today I have the privilege of presenting the steps we are taking to expand health care coverage of children. This is an area where we as a state can make a substantial difference improving the quality of life of our children while saving money for the state.

The first proposal expands the medicaid program and early intervention services for children. We have called funding proposals and the corresponding well child care services we are delivering in the field "Kids Count". Since we believe that children do count, we are putting our money where our mouth is. The Governor is recommending $3,311,869 in new general fund ~~and a~~ for Medicaid total of $11,746,511 in state and federal dollars to improve health care services to children. I see that as an investment in our future which is the children of today. (Refer to KIDS COUNT Program

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Component chart 15). Note: chart includes Part H.

For the past three years, SRS has undertaken studies of high cost deliveries. The results from these studies are consistent and startling. Four percent of the infants are responsible for over 50% of medicaid costs for infants in their 1st year of life. **[Show chart** 16]. For example, in 1988 129 babies cost an average of $33,000 or a total of 4.2 million in their 1st year of life. They made up 51% of medicaid's expenditures in this area while the remaining 3119 or 96% of the babies delivered used 49% of the dollars. Fifty percent of these high-cost infants received little or no prenatal care. In Montana a low birth weight baby is born every twelve hours. The Kids Count package is designed to help improve these statistics by providing better fees to family physicians and Ob/Gyns and providing case management services and education for high risk mothers-to-be. These costs only represent the costs of medical care in the child's first year of life. Lifetime medical costs for a very low birth weight cost infant can exceed $400,000.

Our program goes beyond birth. Every 3 days a child under the age of 1 dies in this state from health and accident related causes. As of 1987, this made Montana the worst in the country. We think we can and should do better. In Montana 25,000 children are currently on medicaid. As part of the "Kids Count Screening Proposal", we are aggressively doing outreach and trying to

encourage medicaid families to get regular ongoing health care. This approach should help improve health but it also results in cost-effective services. Children who have regular screens cost government 1/3 less than children without screens.

The other program which directly affects families and where we are proposing major changes is the medicaid psychiatric and residential treatment option for children under age 21. The Governor's budget includes the transfer of this program from SRS to DFS in its entirety. That transfer includes $3.5 million in new general funds. These funds can potentially be matched with federal funds for ~~more than~~ almost more than 9 million in new program dollars. In other words, if Family Services is able to just maintain current placements (I'm not talking about cuts), there are substantial new dollars available for alternative services. At the present time I am pleased to say that through a managed care contract, we at SRS have been able to insure that the child is appropriately placed and contain rapidly escalating costs. ~~Mrs. Ellery will be discussing the contract in more detail later.~~ By giving DFS all of the funding for residential psychiatric care for youth, it will be possible for Tom Olsen and his staff, with your input, to develop a complete continuum of care for children and families in Montana. It also insures that budget authority and responsibility are together. The Medicaid Division, through its contractor, will continue to be responsible for determining the medical necessity of Medicaid eligible children placed in care.

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It is my contention that every social worker, every time they come in contact with a child, is indirectly establishing a family policy direction for Montana. In other words, all those individual decisions make up the aggregate course and direction that is our child welfare system. Those individual choices can be to develop foster homes and build a stronger foster home system. Or they can be choices to place and have a larger placement system. Choices to commit dollars to developing in home services will help insure a quality in home service system. In the past, when all the psychiatric residential treatment funds were at SRS and yet DFS workers had responsibility for the child, the choice not to place did not mean additional dollars for DFS services. In other words, the relationship between those individual choices and state policy was very indirect. Because it was so indirect, we find DFS strangling for funds and SRS with an automatic pay category in the area of psychiatric hospitalization growing from $910,000 in fiscal year 1987 to $9.2 million in fiscal year 1990 [**Show chart** 9]. This represents a 1000% increase since the program began in 1986. This is at a time when our espoused state policy is to keep children in the least restrictive environment, preferably the home, and when the legislature by creating Family Services is saying, this is a "special" need that we as a state want to have priority attention.

It is my fervent hope that once the psychiatric and residential monies are transferred from SRS to DFS that the decisions by

workers and the dollars will tilt towards providing services in the community and not placement. I hope when you meet again after 2 years that the new money has gone for new services and once the new services are in place, placement rates will not only stay the same but will go down.

With this transfer, the DFS social workers and you have the rare opportunity to directly impact family policy in this state by choosing home and community based services over placement. All of those individual choices will mean that Family Services will become the leader and nucleus of community child welfare services as the legislature originally intended.

Mrs. Ellery will now discuss ~~primary care~~ the MHIMA contract and other issues in more detail.

Pres.Primary

2-5-91

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
NURSES AIDE TESTING AND CERTIFICATION

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) requires that all nurses aides must be tested and certified as having the expertise to provide services in long term care facilities that participate in either the Medicaid or Medicare Programs. Per regulation an independent contractor must provide the testing. The nursing facility itself may not test its own aides. Administrative expenses associated with testing and certification must be paid in proportion to the Medicaid Program. These costs can be paid for with State and Federal funds at a 50/50 match rate.

The Department estimates that approximately 2,000 aides will have to be tested each year. The Department of Health and Environmental Sciences (DHES), who will be managing this program, estimates that it will cost $160 for each test. Medicaid will be responsible to pay for 54% of these costs. The remaining costs will be paid for by Medicare. The Medicaid Program will be responsible for costs totaling $172,800.

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
AMBULANCE PROVIDER INCREASE

Each ambulance provider has an individualized base rate. Provider fees were increased 2 percent each year of the biennium. Prior to these increases, the rates had been frozen since 1982. In addition, the industry has grown more sophisticated so that advanced life support services are now recognized by the state licensing body, offered by ambulances and reimbursed by Medicare. Medicaid does not recognize these different levels of service and continues to pay only for basic life support services.

Medicaid also does not pay for air ambulance services although this is a widely accepted and necessary medical service. Ambulance providers have indicated they cannot afford to continue providing service to Medicaid clients without fee increases. Currently, providers are receiving approximately 50 percent of their charges for basic life support services. Medicaid's flat reimbursement rate translates to a payment rate of only 10 percent of their charges for advanced life support and air ambulance services. Emergency services, such as ambulance, are vital to the health and well-being of Medicaid recipients in a state as large and geographically diverse as Montana.

Medicaid annually provides 4,600 ambulance services; 80 percent of these services have been for basic life support and 20 percent have involved advanced life support services. This modification would increase reimbursement to 90 percent of billed charges ($140 for basic life support and $178 for advanced life support. Medicaid would reimburse at the same mileage rate as Medicare ($2.50 per mile for ground transport and $1.70 per mile for air transport). These changes are estimated to cost $493,918 in each fiscal year.

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KIDS COUNT PROPOSAL

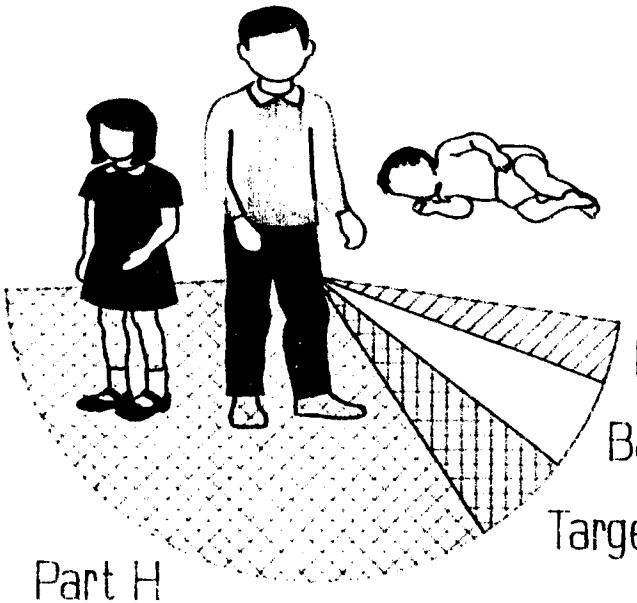
		Total Biennial General Fund Costs
1.	Increase Medicaid fees for obstetrical and pediatric providers.	$2,730,827
2.	Implement a targeted case management system for high risk pregnant women and children.	$ 278,058
3.	Implement case management for the Early Periodic Screening Diagnosis and Treatment Program and increase the number of well child screens.	$ 180,346
4.	Increase fees for children's dental services to 79% of charges.	$ 122,641
5.	Expand early intervention program for infants determined to be at risk of developmental delay (DD issue).	$1,794,118
6.	Continue education of pregnant women on the importance of prenatal care through the Baby Your Baby Project.	No general fund impact.
	Total	$5,105,990

A:KCP

CHART 15

Kids Count! Program Components
Biennial General Fund Costs

Total General Fund Cost: $5,105,990



General Fund Cost By Component:

OB/Peds Increase $2,730,827
Baby Your Baby $268,000 (donations)
Children's Dental $122,641

EPSDT Case Mgmt $180,346
Targeted Case Mgmt $278,058
Part H $1,794,118

CHART 16

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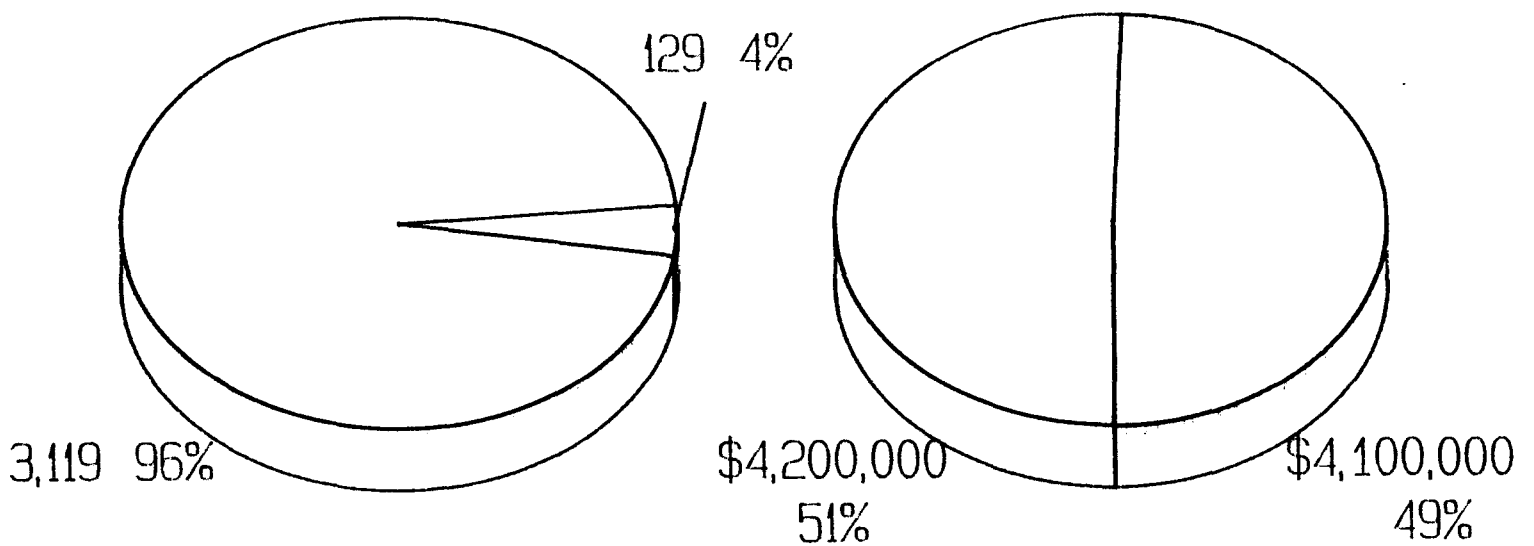
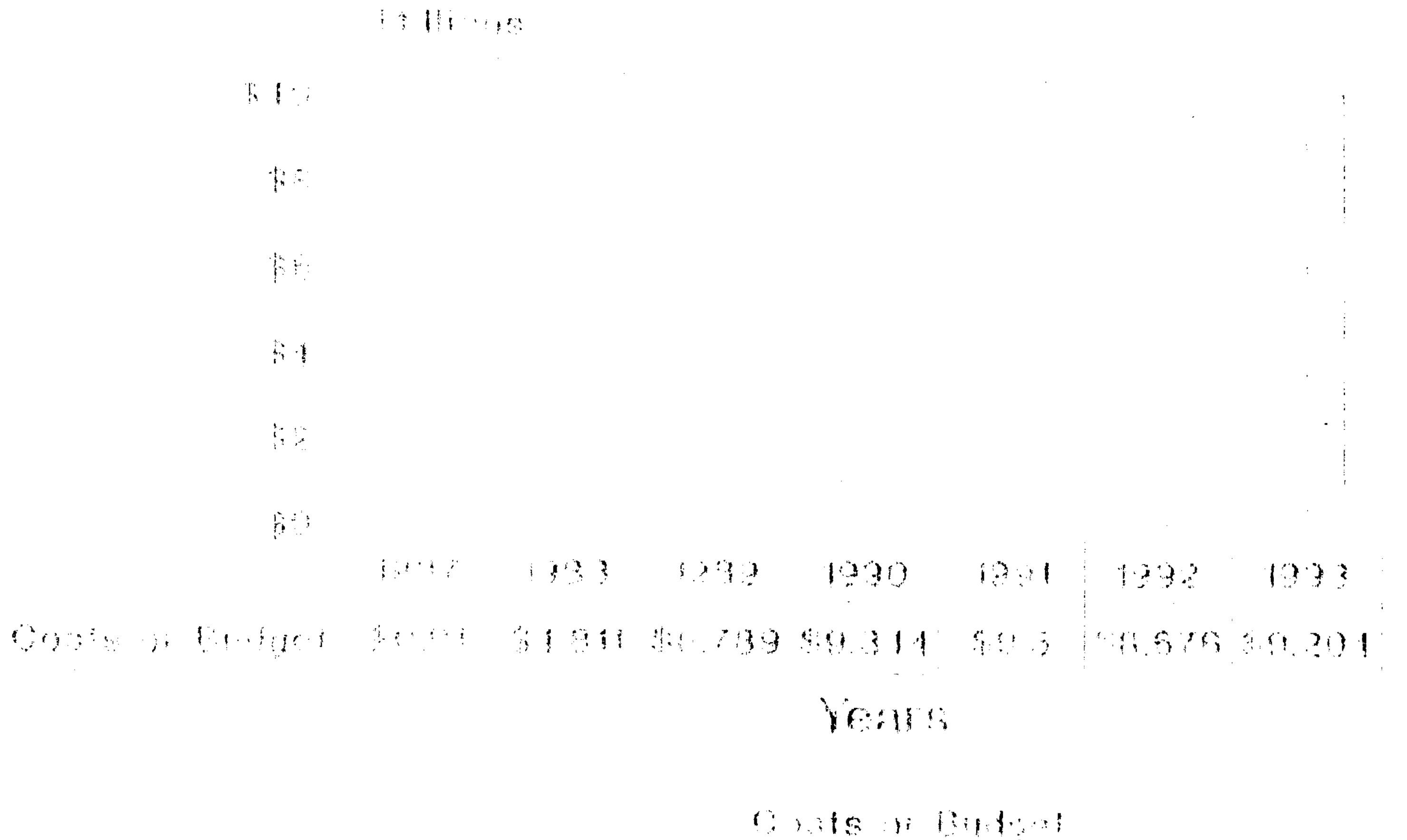
Total Infants On Medicaid
FY 1988

129 High Cost Infants Cost $4.2 million, 51% of Total Spent



Montana Medicaid Program

Youth Psychiatric Funding



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Amendments to House Bill 2
(General Appropriations Act)

"Funds appropriated in the medicaid program for inpatient psychiatric services for persons under 21 years of age may be transferred to the Department of Family Services for their youth foster care program. Funds appropriated for the youth foster care program may not be transferred to the medicaid program administered by the Department of Social and Rehabilitation Services.

The original Exhibit 5 booklet is available at the Montana Historical Society, 225 N. Roberts, Helena, MT. 59601. (Phone 406-444-4775).

EXHIBIT 5
DATE 2-5-91
HB

Exhibit #5
2/5/91
Human Servic
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REPORT AND RECOMMENDATIONS

THE GOVERNOR'S HEALTH CARE SERVICES AVAILABILITY ADVISORY COUNCIL

Submitted by members:

Sen. Paul F. Boylan, Bozeman
Sen. Loren Jenkins, Big Sandy
Charles Butler, Jr., Blue Cross/ Blue Shield, Helena
Larry E. Riley, Esq., Missoula
John Bartos, Hospital Admin., Hamilton
Mrs. Laura Grinde, Health Care Professional, Lewistown
Jim Hoyne, M.D., (Emergency Medicine), Clancy
Van Kirke Nelson, M.D. (Obstetrician), Kalispell,
Rep. Paula Darko, Libby
Rep. John A. Mercer, Polson
Leonard A. Kaufman, Ph.D., The Doctors Agency of Montana, Billings
Chadwick Smith, Esq., Helena
Mrs. Peggy Guthrie, Health Care Professional, Choteau
Jimmy L. Ashcraft, M.D., (Family Practice), Sidney
Gordon K. Phillips, M.D., (Obstetrician), Great Falls
Ex-officio member: Julia Robinson, Dir. Department of Social and Rehabilitation Services, Helena

Van Kirke Nelson, M.D., Chairman

RIVENDELL
PSYCHIATRIC CENTER

A specialty hospital.

Exhibit #6

Report to Our Communities

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services SUBCOMMITTEE DATE 2/5/91

DEPARTMENT(S) SRS DIVISION

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NAME	REPRESENTING	
JOHN DONWEN	SRS	
VAN KIRKE NELSON	PHYSICIAN	
Mary Costello	accessLinks Missoula Co Health Dept.	
TOM OLSEN	DFS	
Doug Matthias	"	
Penny Robbe	SRS	
Robert Raymond	Rivendell exec director	
John Conroy	Rivendell	
Ralph Yaney	Rivendell	
Pat Melby	Rivendell	
Jack Casey	Stodick	

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