MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN DOROTHY BRADLEY**, on February 6, 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)

Tape 1A

Julia Robinson, SRS Director, distributed an analysis of a 5 percent obstetrical and gynecological rate increase compared with increases granted by the subcommittee. **EXHIBIT 1**

CHAIRMAN BRADLEY asked the subcommittee if it wanted to reconsider its action. When there was no response, she thanked **Ms. Robinson** for the information and introduced **REP. WILLIAM BOHARSKI,** who discussed his Medicaid Waiver proposal.

He said the modification would add an additional 50 slots, but between 80 and 100 people are on the waiting list. If 50 slots are added, they will be filled by people on the waiting list. Some people on the Waiver program can get by without it. His proposal is for 50 slots above the 50 slots in the budget modification. (Is this right?? That's what it sounds like on the tape.)

Case management teams would remove certain people from nursing homes and put them on the waiver program. The idea is to have as many senior citizens as possible remain at home with their families and be served at the same cost.

There are safeguards to prevent the plan from getting out of hand. If the individuals have already gone into a nursing home, they have been determined eligible for services. There should be no impact on the budget. Fifty more slots are available to Montana before the state reaches its nursing home bed limit under federal guidelines.

The Department would be given the authority to shift money from the nursing home budget to the Medicaid Waiver budget for people who meet criteria. He doesn't know what the impact would be on the number of nursing home beds if there were a change in nursing home funding.

SEN. WATERMAN asked what would prevent people on the waiting list from filling the 50 slots opened up in the nursing homes when residents are placed on the waiver program. **REP. BOHARSKI** said eligibility criteria would prevent it. If the money comes from the nursing home budget, the only people who would qualify would be those currently in a nursing home. People on the waiting list would not qualify, unless they were in a nursing home.

SEN. WATERMAN asked what would keep people on the waiting list from filling the nursing home slots and becoming Medicaid-eligible. **REP. BOHARSKI** said if that was going to happen, it already would have. Nursing homes are not full. The occupancy rate is only 92-93 percent. **Nancy Ellery, Medicaid Services Division Administrator,** said half of Montana's nursing homes have waiting lists. There is nothing to prevent someone who is Medicaid-eligible from filling newly opened nursing home beds. Sixty-two percent of the beds in nursing homes are Medicaid beds.

SEN. NATHE asked what the average length of stay is in a nursing home. **Ms. Ellery** said about eight months.

INPATIENT PSYCHIATRIC SERVICES

CHAIRMAN BRADLEY said the first and possibly the most difficult issue to resolve is the Department's proposal to transfer inpatient hospital and residential psychiatric Medicaid match money to the Department of Family Services (DFS). She asked **Tom Olsen, DFS Director,** to summarize his plan for a continuum of care and the costs.

Mr. Olsen distributed a report on DFS' response to HB 100 mandates and an explanation of the Department's plans for the $3.5 million in residential treatment money proposed for transfer from SRS to DFS. **EXHIBIT 2-3**

He noted that the HB 100 executive summary identifies resources needed to bring the state's program in line with national standards. He reviewed **EXHIBIT 3** and said $1.3 million of the $3.5 million will be reserved to fund existing services. DFS also has a supplemental budget request of about $900,000 for foster-care needs that weren't met this year. The governor's budget does

not add the supplemental appropriation into DFS' base for next year. It comes out of the $3.5 million.

A continuum of care includes services to strengthen families and prevent a child's removal from home. Many children are being sent to out-of-state facilities that need long-term care in a therapeutic environment. He wants to develop those services in Montana.

The $2.2 million will meet the needs of about 40-50 percent of the children identified in the HB 100 study. An immediate effort will be made to return children from out-of-state placements. Approximately 68 children are in out-of-state facilities.

CHAIRMAN BRADLEY asked if the money set aside for developing pilot programs is $2.2 million, and if DFS intends to keep $1.3 million in reserve for existing services. **Mr. Olsen** said yes.

CHAIRMAN BRADLEY referred to discussion item No. 3, the transfer of inpatient psychiatric responsibilities, in **EXHIBIT 1 from Feb. 5, 1991, minutes.** She said **Mr. Olsen's** information indicates the Medicaid match transfer for the residential psychiatric treatment program provides sufficient room to maneuver, plus carry-over. **Mr. Olsen** said it will allow DFS to meet approximately 40-50 percent of the identified need and allow DFS to carry over the money needed from the supplemental appropriation into the base program.

CHAIRMAN BRADLEY referred to the residential psychiatric treatment budget modification on Page 2 of **EXHIBIT 13 from Feb. 4, 1991, minutes.** She said she reviewed DFS figures and couldn't find any justification for the transfer of the entire Medicaid match.

Mr. South said it appears DFS would use only part of the budget modification, $3.5 million, to develop a continuum of care. The executive also proposes to transfer the $5 million that is in the executive and LFA base for inpatient hospitalization. If DFS isn't going to use the $5 million, there may be no reason to transfer it. It may just complicate the accounting system. SRS is the Medicaid agency for all these programs. As a compromise, the subcommittee could transfer $3.5 million to DFS as part of the budget modification and continue to appropriate the match for inpatient hospitalization to SRS.

Ms. Robinson said she opposed the suggestion. There needs to be a single agency in charge of services for children. If a piece is left with SRS, the idea of a comprehensive system for children is moot. A piece is already left with the Department of Institutions. The long-term goal is to have a strong Family Services department in charge of services for children to ensure appropriate placements.

CHAIRMAN BRADLEY said a problem she sees is that parents take their children in directly. **Ms. Robinson** said SRS is trying to correct that through utilization review. Assertions that Montana runs its program differently from other states are incorrect. She read a letter from Mental Health Management of America and referred to attached materials. **EXHIBIT 4**

CHAIRMAN BRADLEY said she is concerned that DFS is not in a position to be a gatekeeper either. If children are eligible, they can enter the program. DFS had not been given the tools to develop services. Now DFS has put together a respectable continuum of services through a pilot project. She doesn't want to overwhelm the Department so that it can't function. The tracking system should be left the way it is. It can be reviewed in two years and further action can be taken then. The agency has not been allowed to do what it originally was designed to do.

SEN. WATERMAN said she doesn't understand **CHAIRMAN BRADLEY's** concern about the transfer of the $9 million to DFS. The Institutions Subcommittee is dealing with money for youth services. She asked where that fits in and why it is in Institutions. **CHAIRMAN BRADLEY** said DFS indicated in its outline that the $5 million isn't needed. She asked why it cannot be left with SRS, the Medicaid agency.

SEN. KEATING said he needs a flow chart to show the movement of money. **CHAIRMAN BRADLEY** said one can be provided at the next hearing. She asked **Mr. South** to explain the two Medicaid programs and the controversy.

SEN. KEATING asked if DFS has base funding for FTEs, operating expenses, etc., and if the subcommittee is considering a transfer of General Fund and Medicaid money from SRS in addition to what DFS already has. **Mr. South** said the DFS budget will be heard later. The budget includes modifications for additional FTEs. The $3.5 million is the Medicaid match for residential psychiatric treatment. It is a budget modification in the governor's budget. **CHAIRMAN BRADLEY** said it is for the Yellowstone Treatment Center. **Mr. South** said the proposal is to leave the federal matching money at SRS and transfer the $3.5 million in General Fund money to DFS, where it will be used to expand community-based programs and Medicaid match for the Yellowstone Treatment Center. The other part of the transfer is the inpatient hospitalization program, which is ongoing. The proposal is to leave the federal match with SRS and send the $5 million in General Fund money to DFS. The question is what DFS would do with the $5 million if it gets it. DFS has already described its plan for the $3.5 million. Moving the $5 million for the inpatient hospitalization program to DFS doesn't move the program to DFS. The program is an optional Medicaid service the state has chosen to provide. The transfer to DFS will make the money available for other purposes.

SEN. NATHE asked how the $9 million will be used. **Mr. South** said the $9 million is the maximum needed to match the $3.5 million.

DFS is saying it will reserve $1.3 million for matching purposes. A commensurate amount of the $9 million will be used to match the $1.3 million. The $1.3 million would be used for the Yellowstone Treatment Center. It would be matched with the federal money the subcommittee approves in SRS. It is a maximum match on the federal side. The matching ratio is approximately 28 percent to 72 percent.

SEN. KEATING asked why SRS wants to give the money away. **Ms. Robinson** said this is not unusual. SRS matches the Department of Institutions' General Fund money. SRS has the authority to match with federal money. The actual design of the program lies with Institutions. The way to improve children's services is to ensure DFS has the responsibility for the program's design and financing. Psychiatric hospitalization is a small piece of a comprehensive children's services system.

If SRS keeps the money, she will present a bill to severely limit expansion of these programs and change eligibility. Her job is to control Medicaid costs, not to have comprehensive services for children. It is possible under the Early Periodic Screening program to fund these programs without legislation. It is not possible to stop the growth. **Mr. Olsen** can. He wants to assign staff to assess needs and work with providers on determining needed services. He would oppose a bill to limit the size of the Medicaid program.

SRS agrees DFS is the lead agency in children's services. If the psychiatric budget is left at SRS, an attempt will be made to reduce eligibility and the number of psychiatric hospitals. Montana's placement rate in psychiatric hospitals far exceeds other states in which Mental Health Management of America operates. The way to get the best services for children is to have them all together.

SEN. KEATING asked if DFS has a plan for eligibility, care and disbursement of clientele if it gets $5 million in Medicaid money for psychiatric hospital care. **Mr. Olsen** said the goal would be to evaluate all children to see if they can benefit from a lower level of care. Children must be placed appropriately, not just because a bed and funding is available. Not every Medicaid-eligible child needs psychiatric hospital treatment. He would propose a bill to require any program seeking Medicaid money to be approved by an agency such as DFS. He wants the authority to require assessment of children before Medicaid money is expended to ensure appropriate treatment and prevent parents from inappropriately placing their children in costly treatment.

SEN. KEATING asked if the plan entails a shift of personnel. **Ms. Robinson** said one position is being shifted from the Medicaid program in SRS and **Mr. Olsen** is in the process of filling it. A contractor will do the screening.

CHAIRMAN BRADLEY said DFS doesn't need the revenue from that program because there are no plans for it.

Tape 1B

Mr. Olsen said that if the money is transferred, the first priority would be to review placements to ensure a lower level of care would not be more appropriate. The Department's intent is to develop intermediate levels of care, which may result in a drop in the number of children going into psychiatric hospitalization.

CHAIRMAN BRADLEY asked if SRS and DFS would work jointly on utilization rules. **Mr. Olsen** said yes. The two departments coordinate carefully. It is a matter of philosophy. The question is whether all services for children should be in one agency. DFS was created for that purpose and that is why the transfer was anticipated. **Ms. Robinson** said funding should be put together first, so that when options are created, there is access to necessary resources. Costs can be reduced with development of less restrictive programs. DFS won't have access to the money to reduce costs unless all the money is transferred from SRS.

CHAIRMAN BRADLEY said the state wants to build for the long term but it can't be done overnight. DFS is just beginning to respond to directives from the 1989 Legislature. There is concern about accountability over the next two years. The Legislature has to be able to track where the money goes.

SEN. WATERMAN said she still isn't sure where the best place for the $5 million would be. Programs are so fragmented that children don't get the best services. The agencies must work together. She asked if DFS will be overwhelmed if the $5 million is transferred or if the money will create more options. **Mr. Olsen** said DFS is a small, young agency. This is more money than the agency has ever had before. What is done with it will depend on how well the agency can manage it. There are nothing but opportunities. Either way, it will work out for the best. At the beginning, the transfer will be a record-keeping exercise. For the first two years, DFS will be in the process of developing a system of care, putting in intermediate care programs to see which work. After the initial pilot period, costs can be lowered by providing more alternatives. He is not afraid of managing the money. It's just more zeros. The question is whether the Legislature wants all the resources in one agency to meet the needs of children.

CHAIRMAN BRADLEY asked if DFS' intention was to remain within the $2.2 million to broaden services. **Mr. Olsen** said that is the money identified for developing new services. **CHAIRMAN BRADLEY** said his hands would be full developing five new options. **Mr. Olsen** said yes. It will be exciting.

SEN. KEATING said he initially opposed having a separate department. Since then, he reluctantly participated in the development of family services. The whole family has to be served to serve children. DFS has developed well. There is no place to send graduates from intensive care facilities. There are no half-

way houses for transition into society. A whole system needs to be developed. Family services is about moving people into a greater degree of self-reliance. He wants to give DFS the opportunity to do the job and supports the transfer of $3.5 million, plus $5 million, or whatever it takes.

REP. JOHNSON said he senses a reluctance to catch the $5 million at DFS. **Mr. Olsen** said he doesn't want anyone to think DFS will take the $9 million being spent on psychiatric hospitalization and see large cuts in the first two years. Lower level resources will have to be developed first. No savings will result in the first two years. He is not reluctant to take the $9 million. DFS can impact the number of children being inappropriately placed. It will take two years to make that change.

Jim Smith, Montana Residential Child Care Association representative, said the association's membership includes about 25 organizations that provide a wide range of out-of-home care. There is no philosophical difference between SRS and DFS. The concern is the capacity of DFS to manage and administer a large, complex component of the Medicaid program, which is itself the largest, most complex line-item in state government.

He didn't realize there was a large backlog of unresolved fiscal issues between the state and Rivendell that date back to 1987. He asked who would inherit those problems. The future of this part of the Medicaid program holds promise of more and similar issues. There are a number of budget modifications for DFS that are needed, but modifications won't get the agency to where it needs to be.

Administration of the $5 million in the inpatient psychiatric budget has been described as an accounting function. He worked on the HB 100 report. The agency's accounting capacity is very limited. DFS has virtually no management information system, no on-line computer system to track where children are, what services they are getting and whether the services are appropriate.

There is a modification for about $100,000 to begin development of an information management system. DFS originally requested $700,000 for system development. He intends to recommend the modification be increased substantially. If the subcommittee wants to go along with the transfer, it should look seriously at increasing the agency's capacity to administer the money. The agency is woefully understaffed and lacks equipment. The modification for staff calls for an additional 21 FTEs for DFS, including 13 social workers and eight support staff. DFS had asked for 65 FTEs in its executive budget request. The HB 100 study showed DFS needed 108 new FTEs to get a ratio of social workers-to-clients that meets national standards. If the subcommittee is willing to make the transfer, then it ought to think about going far beyond the modifications recommended in the executive budget.

Many association members who represent the low end of the continuum of care feel strongly that they want to work with DFS to develop services. This development will require management, planning and coordination with communities and existing providers. It must be done quickly. Association members want to see these programs on line by July 1, 1991. Inpatient psychiatric hospitalization should be with DFS, as should the programs within the Department of Institutions for severely emotionally disturbed youth. He wonders if DFS is being given too much, too soon.

Pat Melby, Rivendell Operations Vice President, said he initially thought the transfer of funds to DFS was a bad idea and would cause problems. He thinks he has changed his mind; but he believes there is a difference in philosophy between DFS and SRS. DFS wants to ensure there are appropriate services at all levels to prevent children from being placed in inappropriate higher-level services. DFS also recognizes there is a place in the spectrum of services for inpatient psychiatric services. The SRS philosophy, if the program stays with SRS, is to intensify utilization review and begin to eliminate inpatient psychiatric beds in Montana. Rivendell supports the transfer of these funds to DFS.

REP. COBB asked if DFS has the resources and staff to handle the extra money. **Mr. Olsen** said there is a competent accounting system in place. **Doug Matthies, DFS Administrative Support Division Administrator,** said Medicaid payments would still be run through SRS. DFS would have the match money to reimburse SRS. The payment system would be done in conjunction with SRS.

REP. COBB asked if DFS has specific deadlines for how it will use the money and if it is known how many children will be served. **Mr. Olsen** said DFS intends to develop a plan with its 10 youth advisory councils statewide to meet the needs of children regionally. There is no plan yet.

CHAIRMAN BRADLEY said the subcommittee could approve $3.3 million and postpone the final vote on the second amount until the subcommittee reviews the DFS budget. That would allow DFS time to modify its proposal or present whatever is necessary for the additional duty. She asked if that approach makes sense. The subcommittee fully endorses the first set of programs but needs to know the cost and what DFS would need to take on that function. **Mr. Olsen** said he would be glad to present additional information.

EXECUTIVE ACTION ON THE INPATIENT PSYCHIATRIC FUNDING TRANSFER

MOTION: **SEN. WATERMAN** moved to adopt the executive budget modification to transfer $3.5 million to DFS and hold open the remainder of the decision.

DISCUSSION: **CHAIRMAN BRADLEY** said there are two sides to the issue. There has been no final decision. **SEN. WATERMAN** said she

would like to reserve judgment on the additional transfer until the subcommittee deals with DFS' budget.

Mr. South said that if the subcommittee adopts the modification in SRS, it needs to adopt the same modification in DFS. By this vote, in principal, the subcommittee would be saying it wants to do that.

SEN. NATHE asked if the money being voted upon is General Fund money. **Mr. South** said yes. **SEN. KEATING** said the subcommittee, in essence, is giving SRS zero General Fund. **CHAIRMAN BRADLEY** said yes.

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

RESIDENTIAL INPATIENT PSYCHIATRIC TREATMENT MEDICAID REIMBURSEMENT

CHAIRMAN BRADLEY referred to discussion item No. 2 on **EXHIBIT 1 from Feb. 5 1991, minutes.** She said an effort was made last session to include residential treatment as a Medicaid service with certain restrictions that got thrown out along the way. It was to be self-terminating at the end of a trial period. Money is being appropriated to something in which statutory authority expires July 1. The subcommittee needs to decide what to do about it. No bill or bill request exists to extend the program. If the subcommittee decides a bill is needed, it would have to be a committee bill.

Mr. Melby said Shodair Children's Hospital in Helena requested a bill that will be introduced soon. **CHAIRMAN BRADLEY** requested the subcommittee get copies of the bill when available.

Ms. Robinson said SRS did not request a bill because federal law changed since the original bill was passed. A reason for a bill would be to limit the growth of programs. Shodair is suing SRS because the Legislature chose to limit the residential treatment program to Yellowstone Treatment Center only. There are two to three other places that can offer long-term beds. The program could expand very quickly unless there are limits. **CHAIRMAN BRADLEY** said clarification is needed. The Legislature ought to be aware of the implications and possible limitations.

SEN. WATERMAN said she is troubled that the Legislature authorized a certain number of beds at a certain facility. She sees a need to limit the number of beds, but she is troubled that a facility was given exclusivity. She asked if it could be limited, but not to a particular facility. **Mr. Olsen** said yes. He doesn't believe the intent was to make a special deal with Yellowstone Treatment Center. It was the only facility in the state at the time that met the needs of Medicaid residential treatment. It was a test to see how the new law would work. Montana's mistake has been to allow providers to determine what

they will offer. The state has not said what is needed and what should be developed. Language is needed to allow DFS to approve programs for which the state will expend Medicaid funds. It would be much like the certificate-of-need process, but moves it from the Department of Health to the department that would be responsible for developing the system of services. DFS also would like to see language that requires children to be assessed for proper placement before any Medicaid dollars are spent. That would prevent parents from placing a slightly unruly child in psychiatric hospitalization. **CHAIRMAN BRADLEY** asked **Mr. Olsen** to draft his concerns in bill form.

SEN. WATERMAN asked if families can be required to undergo an evaluation before a child is placed in treatment, or if that conflicts with the philosophy to not limit Medicaid services. **Mr. Olsen** said he doesn't think so. The state has the authority to develop a Medicaid plan that works best for Montana. DFS is working on a Medicaid Waiver under the rehabilitation option that may make some services available at lower levels of care, such as therapeutic group care and possibly family-based services. If the state can access those funds, it would open up a new market to providers that would be partially paid by Medicaid.

SEN. WATERMAN said she would like DFS' overview to include information on what the Department of Institutions is doing. **Mr. Olsen** said it is being worked on.

REP. COBB asked when the Medicaid Waiver will be ready. **Ms. Ellery** said it really isn't a waiver. Rehabilitation Services is a service available under the Medicaid State Plan. SRS has the authority to do that but hasn't exercised the authority yet. The option allows more flexibility in where services are provided and who provides them.

Tape 2A

Mr. Melby suggested the subcommittee not create a separate certificate-of-need process for residential treatment services but allow the current process, administered by the Department of Health, to work. DFS could determine need and provide information, rather than create a duplicate service. The state already has a competent Health Planning Bureau.

EXECUTIVE ACTION ON LICENSED PROFESSIONAL COUNSELORS MEDICAID REIMBURSEMENT

CHAIRMAN BRADLEY referred to discussion item No. 4, licensed professional counselors, in **EXHIBIT 1 from Feb. 5, 1991, minutes.**

Mr. South said reimbursement is available for licensed professional counselors under the State Medicaid Plan, but only if a specific appropriation is made. LFA and executive bases in Primary Care do not include such an appropriation.

SEN. KEATING said he drafted a bill that would eliminate specific appropriation language so that licensed professional counselors

would be listed in the codes with social workers, clinical psychologists and others.

MOTION: **SEN. KEATING** moved to include language in the appropriations bill that licensed professional counselors be included as a part of the appropriation for treatment.

DISCUSSION: **SEN. NATHE** asked what licensed professional counselors do. **SEN. KEATING** said they deal with sub-acute emotional disturbances and mental problems. They have the same training as social workers but specialize in sexual abuse, incest, etc. More licensed professional counselors work in rural areas than clinical psychologists and social workers. That is where the need is. People have been turning to more costly services because they could not get Medicaid reimbursement for services provided by licensed professional counselors.

SEN. NATHE asked where regional mental health centers fit in. **SEN. KEATING** said licensed professional counselors on staff at a licensed center receive Medicaid reimbursement. Private licensed professional counselors cannot. Social workers can receive Medicaid reimbursement because they are qualified under the codes. Licensed professional counselors are restricted because the Legislature chose to leave them off the list.

CHAIRMAN BRADLEY asked for a cost estimate. **Ms. Robinson** referred to Page 41 of **EXHIBIT 19 from Feb. 1, 1991, minutes.** She said the cost to the General Fund would be $89,805. It is not in the governor's budget because SRS tried to halt expansion of the Medicaid program.

SEN. WATERMAN said licensed professional counselors may be the only ones available in rural areas. She asked if services would rapidly expand in urban areas with Medicaid eligibility. **Ms. Ellery** said there aren't enough psychologists and social workers participating in urban areas for everyone to have the access to the counseling they need. Waiting lists exist at many community health centers. By adding licensed professional counselors as a Medicaid-reimbursed service, the waiting list would be reduced.

SEN. WATERMAN asked **Mr. Olsen** to respond to the question and asked if the governor's office recommends this. **Mr. Olsen** said the system of care he envisions would be rural in nature with the capacity to develop therapeutic homes across the state in areas that don't have access to regional mental health centers. Licensed professional counselors are needed and should be Medicaid-reimbursable.

REP. COBB asked if there would be a savings. **Mr. Olsen** said he can't say what the savings would be because the system of care isn't in place. There would be some.

SEN. KEATING said SRS indicated there probably wouldn't be a savings as such, but money could be transferred around. People

are using substitute services from professionals who are Medicaid-reimbursable but more expensive than licensed professional counselors. By making licensed professional counselors Medicaid-eligible, people will receive the appropriate service at less cost.

CHAIRMAN BRADLEY said **SEN. KEATING's** motion is to have language that would include licensed professional counselors. He also has a bill to do the same thing. **SEN. KEATING** said his bill would delete the phrase in the codes that says there must be a specific appropriation for licensed professional counselors. The subcommittee must specifically appropriate monies necessary to pay these licensed professional counselors. **CHAIRMAN BRADLEY** said the budget would be adjusted accordingly.

SEN. KEATING asked how much money would be needed. **Ms. Robinson** said $90,000.

AMENDMENT: **SEN. KEATING** amended his motion to include $90,000 in the budget to reimburse licensed professional counselors under the Medicaid budget.

DISCUSSION: **Mr. South** asked if that was just the General Fund amount. **Ms. Robinson** said yes. **Mr. South** said the best motion may be to allow fiscal officers to work out the proper funding level. It has to have a federal match with it. **CHAIRMAN BRADLEY** said the figures will be adjusted by the Budget Office, the Department and **Mr. South.**

SEN. WATERMAN asked if the governor's office considered this or had a position on it. **Mr. Furois** said it was considered when the Budget Office began looking at issues. It was not in the base budget. It was presented as a cost savings. The Budget Office doesn't see a cost savings. **SEN. WATERMAN** said the governor then chose not to recommend it. **Mr. Furois** said yes.

VOTE: The motion **FAILED** 2-4, with **CHAIRMAN BRADLEY** and **SEN. KEATING** voting yes.

SEN. WATERMAN said she would rather wait for the issue to come through the bill process.

EXECUTIVE ACTION ON MEDICALLY NEEDY ELIGIBILITY

CHAIRMAN BRADLEY referred to discussion item No. 1, the Medically Needy issue, on **EXHIBIT 1 from Feb. 5, 1991, minutes.**

Mr. South said the Medically Needy issue is seen in the differences for Primary Care. The federal government allows states flexibility in how lenient or restrictive they are in this category. He distributed a breakdown of cost savings, refunds and other items that account for the difference between the LFA and executive budgets for Primary Care. **EXHIBIT 5**

Ms. Ellery distributed details of Primary Care cost-containment projections. **EXHIBIT 6**

Mike Billings, Office of Management, Analysis and Systems Director, said TEAMS savings were projected by an outside study. He reviewed **EXHIBIT 6.**

SEN. NATHE asked for an explanation of the V.A. Aid and Attendance cost-containment category. **Ms. Ellery** said pensions for veterans in nursing homes will be used to offset Medicaid costs. Veterans are not being moved from nursing homes.

Ms. Robinson said costs are escalating because an increasing number of people are eligible for Medicaid. SRS projected a 5 percent reduction in eligibility in the Medically Needy program. It will be less than 2 percent to meet the $1.7 million in projected savings from eligibility changes.

Penny Robbe, Program and Policy Bureau Chief, distributed an explanation of the caretaker relative reduction in the Medically Needy Program. **EXHIBIT 7.** She said the Medically Needy program is optional in Montana. The program must cover at least pregnant women and children. States then have the option to cover the elderly, blind, disabled and AFDC-related caretaker relatives who are rearing a dependent child. In most cases, a caretaker relative is a single parent.

Most AFDC caretaker relatives who qualify for the Medically Needy program are part of the state's working poor. The family earns too much income to qualify for AFDC cash assistance but may not earn enough to pay for all necessary medical services.

The Department's goal is to ensure necessary medical services are provided to children. The Department recommends elimination of the coverage for caretaker relatives of dependent children. It is the Department's hope that low-cost health insurance will be made available by their employers to meet their needs. A $1.7 million savings is anticipated each year of the biennium with this change.

SEN. WATERMAN asked when caretaker relative's would be eliminated from the program and when low-cost insurance is expected to be available. She said she is hesitant to eliminate these people from the program before insurance is available. **Ms. Robinson** said there is a potential gap. Caretaker relatives could be without insurance if their employers choose to not offer it. Caretaker relatives would be eliminated from the program July 1.

SEN. WATERMAN asked if employers will have low-cost insurance to implement by July 1. **Ms. Robinson** said Blue Cross-Blue Shield is ready to make the insurance available to employers if the Legislature passes the bill recommended by the governor. Whenever services are reduced, someone potentially gets hurt.

SEN. WATERMAN asked if it would be better to postpone action on the proposed cut to see if the low-cost insurance plan passes. **CHAIRMAN BRADLEY** said she wants the subcommittee to take some action. It can always be changed later as the bill goes through. The subcommittee can choose to not use the savings. If the bill passes, some appropriations committee or the Senate Finance Committee can adjust it later. A decision is needed as to whether the savings will be included in the Primary Care budget. LFA calculations do not include the savings.

Mr. South said the simplest way to handle the matter is to accept LFA figures for Primary Care and choose the number of deductions.

MOTION: **REP. COBB** moved to calculate the savings in the Medically Needy program.

VOTE: The motion **PASSED** 4-2, with **CHAIRMAN BRADLEY** and **SEN. WATERMAN** voting no.

CHAIRMAN BRADLEY clarified that all savings will be part of the calculations.

Marcia Dias, Montana Low-Income Coalition representative, asked if the Department knows whether people providing for AFDC children are working. She said she is concerned that more children could be forced into foster care if this coverage is eliminated. Foster care would be more costly. **Ms. Robinson** said she will have staff work with **Ms. Dias** to answer her questions.

EXECUTIVE ACTION ON THE HOSPITAL RATE REBASE BUDGET MODIFICATION

CHAIRMAN BRADLEY referred to budget modifications on Page 2 of **EXHIBIT 13 from Feb. 4, 1991, minutes.** She said votes are needed on the hospital rate rebase, ambulance rate increase and health clinic expansion. The subcommittee has already adopted the hospital rate study.

Ms. Robinson referred to background information on the hospital rate rebase budget modification on Page 48 of **EXHIBIT 19 from Feb. 1, 1991, minutes.** She said this modification is the follow-up piece to the hospital rate study. The Department is recommending the rates be implemented in the second year of the biennium, once the study is completed. It is the same issue with nursing homes. Once those rates are studied, adjustments would be made if needed. Funds have been estimated because the study has not been completed. **Ms. Ellery** said the increase was based on a national index of 5.63 percent.

CHAIRMAN BRADLEY asked if the Department's recommendation is for nursing homes to have an increase in the first year of the biennium. **Ms. Robinson** said yes. **CHAIRMAN BRADLEY** asked why the executive decided to postpone any hospital increases until the second year of the biennium. **Ms. Robinson** said it was because the

rate rebase study hadn't been done. **Ms. Ellery** said the Department analyzed the base year when DRGs were implemented in 1987. The DRG rate was within 5 percent of hospital cost. After the rate study is completed in the first fiscal year, rates should be increased based on study results and inflation factors.

Bob Olsen, Montana Hospital Association representative, said the association agrees that the 1987 base year is close to actual cost. It was part of the agreement between the association, hospitals and the Department when DRGs were implemented. In the first year of DRGs, payments were to equal the amount that would have been paid if the state remained on a cost-base system. The study in process now should be completed sometime this spring. The association estimates payments are 5 percent below costs now. Payments will be 10 percent behind after rates are rebased because of inflationary increases, unless a rate increase is granted this year.

MOTION: SEN. KEATING moved approval of the hospital rate rebase budget modification.

DISCUSSION: REP. COBB asked if a supplemental appropriation would be sought to cover the 10 percent. **Ms. Robinson** said the state must provide reasonable rates but does not have to pay 100 percent of cost. The purpose of the 5 percent is to rebase the rates, not to give an inflationary increase. This is not a percentage increase; it's a rate readjustment. There is no guarantee they won't sue. The Hospital Association does not like the state's rate structure and will be asking for a change. The Department will argue that the structure is correct.

VOTE: The motion **PASSED** unanimously.

EXECUTIVE ACTION ON THE AMBULANCE RATE INCREASE BUDGET MODIFICATION

Ms. Robinson referred to background information on the ambulance rate increase budget modification on Page 56 of **EXHIBIT 19 from Feb. 1, 1991, minutes.** She said the Department is recommending the increase because rural areas lack sufficient emergency care.

Ms. Ellery said ambulance rates were increased 2 percent last session, which was the first increase since 1982.

Tape 2B

Volunteer ambulance services lose money when they provide care to a Medicaid recipient. The modification would allow SRS to finance advanced life-support services, bring the ambulance base rate up to 90 percent of charges and offer the same milage rate as Medicare. The cost is $493,918 for each year of the biennium, including $278,520 in General Fund money.

MOTION: SEN. KEATING moved approval of the ambulance rate increase budget modification.

DISCUSSION: **SEN. WATERMAN** asked why Medicaid does not recognize these services. **Ms. Ellery** said the Department hasn't had the money to pay for it. **Ms. Robinson** said there have been hospital closures. These services need to be provided.

SEN. NATHE asked if this involved private ambulances. **Ms. Ellery** said some are private and some are volunteer services. Ambulance companies by law must provide these services. If the person is on Medicaid, the ambulance company gets reimbursed for less than half the cost. They get nothing if it is an air ambulance.

VOTE: The motion **PASSED** unanimously.

EXECUTIVE ACTION ON THE HEALTH CLINIC EXPANSION BUDGET MODIFICATION

Ms. Ellery referred to background information on the health clinic expansion budget modification on Page 47 of **EXHIBIT 19 from Feb. 1, 1991, minutes.** She said the modification is in response to a federal mandate from the Omnibus Budget Reconciliation Act (OBRA) 1989. It would provide Medicaid reimbursement to community health clinics funded under the Public Health Service Act. It represents a cost shift from the federal government to states. It is a valuable service in rural areas. Three Montana clinics currently qualify for the federal funding, if it is approved: the Butte Community Health Center, and the Deering Community Health Center and the migrant farm worker health center in Billings. States must reimburse clinics for 100 percent of their costs. The modification will cost $65,000 in each year of the biennium. The amount will change as more clinics qualify. This will be a mandated Medicaid service.

MOTION: **REP. COBB** moved approval of the health clinic expansion budget modification.

DISCUSSION: **SEN. WATERMAN** asked how the clinics differ from the Helena Indian Alliance, which provides services to people not covered by Medicaid or Medicare. **Ms. Ellery** said those are clinics funded with federal Indian Health Services money. SRS reimburses such clinics under the state's Indian Health Services program. This is a new category. Similar services are provided. They can be provided by a nurse practitioner or physician assistant. It is a different funding mechanism.

SEN. WATERMAN said she thought Indian Health Service wasn't funding this and it was being picked up under Medicaid. **Ms. Robinson** said that is correct. New eligibility requirements expanded the program. Pregnant women and children who used to be covered by Indian Health Service will be covered by Medicaid.

REP. COBB asked if more clinics will qualify. **Ms. Robinson** said this is federal mandate to shift costs to states. The more programs the federal government chooses to file under this

category, the more it will cost Montana. So far only three clinics qualify. **REP. COBB** asked if costs will escalate as more clinics qualify. **Ms. Ellery** said it is possible. Medicaid currently pays for some services provided under the Physician Services Program. Because the state must provide 100 percent of cost, more clinics will want to come under this category.

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

MOTION: **SEN. NATHE** moved to reconsider eligibility changes for caretaker relatives under the Medically Needy program.

VOTE: The motion **PASSED** unanimously.

MOTION: **SEN. NATHE** moved to not try to make savings in this area.

DISCUSSION: **SEN. KEATING** asked if it makes a difference if a caretaker relative has the money to pay for the medical needs of the child. **Ms. Robinson** said eligibility staff need to answer the question.

SEN. KEATING asked if the children lost eligibility by the subcommittee's previous action. **Ms. Robinson** said no. Children will remain eligible. The child's caretaker will not be eligible. These people are potentially the working poor and may not have other insurance.

SEN. WATERMAN asked how a child could be Medicaid-eligible and not the parent, and how the child's eligibility is determined if it isn't based on the family's income. **Ms. Robinson** said Medically Needy eligibility is based on medical need and the inability to pay for medical services. Under the Department's proposal, which is to save money, the caretaker relative would no longer qualify for Medicaid; the child receiving the care would still qualify.

SEN. WATERMAN said a family is determined to be medically needy if a large portion of the family's budget is being used for medical expenses. If a caretaker relative uses a large portion of the family budget to pay for a child's medical care and the caretaker becomes ill, the caretaker's need is no less than the child; but the caretaker may not be eligible because of employment. It is difficult to understand why a child can be needy and the child's parent can't be.

SEN. KEATING said the child is being taken care of. The parent doesn't have to pay for it. **SEN. WATERMAN** said the child is eligible because the family doesn't have money. **SEN. KEATING** said that isn't always the case. **Ms. Robinson** said a family would have to spend down resources because of medical needs to be eligible for the Medically Needy Program. **SEN. WATERMAN** said a child wouldn't be eligible for this program unless family resources had

been considered. **Ms. Robinson** said she believes that is correct, but she is uncomfortable providing information because she is not an eligibility expert.

CHAIRMAN BRADLEY suggested this be examined further and the vote be taken at the next hearing. **SEN. NATHE** said he will remake his motion in accordance with **CHAIRMAN BRADLEY's** wishes.

CHAIRMAN BRADLEY said the subcommittee is on record voting for the hospital rebase increase. She asked if anyone wanted to make a motion on a provider-rate increase for the first year of the biennium, since none is built into the budget.

MOTION: **REP. JOHNSON** moved approval of a 5 percent provider-rate increase.

DISCUSSION: **SEN. WATERMAN** said she wants to know the cost, and the governor's and SRS' recommendation and reasoning for not providing it in the first year. **Ms. Robinson** said the adjustments SRS is making between nursing homes and hospitals are not inflationary increases. There were no inflationary increases. SRS could have suggested rate increases for everyone. It is an effort to change rates so they are in compliance with federal law.

CHAIRMAN BRADLEY said she was frustrated that the budgets did not reflect inflationary increases for providers. They have in the past. The subcommittee knew it was setting a precedent by approving a 5-and-5 increase. The question is whether the subcommittee wants to be consistent. The Department's proposals have all been rebasing, not inflationary. But there should be some recognition of the reality of inflation. The question is whether this should be done in the first year of the hospital budget.

SEN. KEATING asked if there were increases in payments for these services. **Ms. Robinson** said the state gave 2 percent across-the-board increases in each year of the last biennium. **SEN. KEATING** asked if that means the Department is starting with a zero-based budget, where the 2-and-2 left off, and no cost increases are in the budget. **Bill Furois, Office of Budget and Program Planning,** said the 2 percent increases over the last biennium brought payments up. He didn't know to what percentage of costs. The rebasing will move the payment up to 85 percent of costs for nursing homes and hospitals. It doesn't cover inflation.

SEN. KEATING asked **Rose Hughes, Montana Health Care Association representative,** if nursing homes raised their costs so that the 2 percent increase involved more money. **Ms. Hughes** said costs have increased. The rebase amount is trying to get nursing homes to current costs. Future costs will be higher. At the end of the biennium, nursing homes will have gained little ground even with the increase.

Mr. South said the appropriation report from the 1989 Legislature shows nursing homes received 3 percent increases. Hospital-based services received 3.9 percent increases. Fee-based providers received 2 percent increases.

Mr. Olsen said the Montana Hospital Association supports the rebase. Different hospitals have had different experiences with DRGs, depending on procedures for making payments. The payment system needs to be evaluated. Administrative changes are needed to improve the claim process. The association would like to see a 5 percent rate increase for the first year so hospitals can remain in place until the study is completed. Hospitals receive 95 percent of actual costs to provide care. If hospitals have to wait until the second year for an increase, they will slip to 85 percent.

SEN. NATHE asked if the rate rebase would be needed if hospitals receive a 5 percent increase this year to go to 100 percent of costs. **Mr. Olsen** said medical inflation will be somewhere between 8 percent and 12 percent. If a 5 percent increase is approved, hospitals will be somewhere between 90-95 percent in the next fiscal year. The following year, if it is presumed inflation will continue at its current pace, hospitals will be rebased at that 90-95 percent cost-to-payment level. Even after the rebase study, payments will be below full cost. The state doesn't have to pay hospitals 100 percent of cost. Payments must be reasonable.

SEN. NATHE asked if hospitals can write off the difference. **Mr. Olsen** said no.

Ms. Robinson distributed a cost analysis for 5 percent increases in all Medicaid programs. **EXHIBIT 8.** She warned that figures were calculated quickly and costs shift rapidly.

SEN. WATERMAN asked if a 5 percent increase this year and a 5 percent rebase next year would amount to a 10 percent increase next year. **Ms. Robinson** said everyone would get a 5 percent increase with an across-the-board increase. With rebasing, some get nothing and others get more than 5 percent. SRS isn't saying they will get a 5 percent increase in the second year.

SEN. KEATING asked if the figures include federal and General Fund dollars. **Ms. Robinson** said yes. **SEN. KEATING** asked if it would cost $3 million in General Fund money in fiscal year (FY) 92. **Ms. Robinson** said it would be about $9.3 million in General Fund money for the biennium for all programs.

CHAIRMAN BRADLEY asked **REP. JOHNSON** if his motion is to go with 5 percent for the first year and the rebase for the second year, which would be $3 million instead of $9 million. **REP. JOHNSON** said yes. **Ms. Robinson** said the $3 million is all Medicaid cost. The cost for Primary Care for the first year would be $7.2 million. The amount would be 70 percent of that.

CHAIRMAN BRADLEY suggested the subcommittee postpone action on the increases until discussion is completed on this part of the budget. The subcommittee can take action once the figures are reviewed and verified by the Department, Budget Office and LFA.

HEARING ON NURSING HOME AND COMMUNITY-BASED PROGRAMS

MEDICARE BUY-IN AND MEDICAID WAIVER

Ms. Robinson said this is the area of the budget referred to by the Department as Long-Term Care. Two major pieces are nursing home programs and community-based programs. She distributed and read Pages 1-8 of **EXHIBIT 10.** She referred to Page 2 of **EXHIBIT 9.**

Tape 3A

Hank Hudson, the Governor's Office on Aging representative, said the utilization fee for nursing home beds was reviewed by the Governor's Advisory Council on Aging and the long-term care study group for the Health Care for Montanans project. The amount paid for long-term care by private-pay residents in nursing homes continues to rise considerably faster than Medicaid rates. Private-pay residents believe they are carrying the load for the state. The council and study group decided the utilization fee wouldn't be so objectionable if it were a way to ensure training and proper staffing at facilities, and a reduction in cost shifting. Seniors feel that improved care and a reduction in cost shifting is worth $1 per day. Something needs to be done about Medicaid reimbursement rates.

Joan Taylor, Chairwoman of the Montana Case Management Association and a social worker for the Lewis and Clark City-County Health Department, said she represents 11 case-management teams in the Home and Community Services program, also known as the Medicaid Waiver Program. She reviewed **EXHIBIT 11.**

She said case-management teams put together the most cost-effective, comprehensive plan of care that meets individual needs. They provide a single access point for all services.

She urged support for the governor's recommendation to expand the program by 50 additional slots, plus another 57 slots to eliminate the waiting list. The association also recommends existing teams be used for any expansion of the program.

The average cost in Lewis and Clark, and Jefferson counties for one year is about $11,500 per person, which is significantly less costly than a more restrictive environment.

Dennis Taylor, former Developmental Disabilities Division Administrator, reviewed a long-term care budget modification related to OBRA 1987 mandates. He said the mandates will directly impact individuals with developmental disabilities who are in or referred to nursing homes. **EXHIBIT 12**

The state of Montana assured the Health Care Financing Administration that inappropriately placed people who prefer community placement will have those alternative placements by the end of this biennium. The budget modification for $644,600 will enable the state to develop 85 alternative placements and provide active treatment, or specialized services, to the 125 people who chose to remain in nursing homes.

The state can postpone for one year the provision of specialized services to the 125 nursing home residents. The Department is seeking authority to amend the alternative disposition plan, which indicated specialized services would be provided in nursing homes beginning in FY 93. The amendment would change that to the beginning of FY 94 for nursing home residents affected by OBRA. If the subcommittee approves that approach, the budget request will drop from $644,600 to $296,516. The state will save about $348,000 in General Fund money. **Ms. Robinson** said this has not been reduced in the budget. It is a subcommittee option. **Mr. Taylor** said SRS will provide both alternative placements for 85 people and special services for the 125 nursing home residents if the subcommittee approves the $644,600. It will be a mandate in the 1993 Legislature.

Brody Mall, Mission Mountain Enterprises Executive Director, said Mission Mountain is a community-based provider of developmental disabilities services. He testified in support of OBRA recommendations and said many people would benefit. Mission Mountain currently serves 13 of these people in its work activity program in Polson. Nineteen of the 85 people live in the Polson area and have chosen alternative placements. Mission Mountain is ready and willing to provide these services.

SEN. WATERMAN asked who pays for the individuals in the nursing homes and if there will be a savings. **Mr. Mall** said his understanding is that these individuals would receive alternative placements in group homes or supportive living arrangements. There would be some savings by moving them out of nursing homes.

SEN. WATERMAN asked if the savings was built into the budget. **Ms. Robinson** said no. Savings are figured into the OBRA 90 budget, which will be reviewed at the next hearing.

EXECUTIVE ACTION ON MEDICAL BENEFITS

Votes were taken on issues in **EXHIBIT 1 from Feb. 5, 1991, minutes.**

CHAIRMAN BRADLEY said there is no difference in the base budget for Nursing Care.

SEN. KEATING asked if it included the user fee. **CHAIRMAN BRADLEY** said no. LFA and executive figures are identical.

MOTION: **REP. JOHNSON** moved approval of the nursing care budget.

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

CHAIRMAN BRADLEY said budget figures are identical for the Medicaid Waiver base budget.

REP. JOHNSON reviewed a letter from the Glendive Medical Center that requests Dawson County be included in the Medicaid Waiver program. **EXHIBIT 13**

MOTION: **REP. COBB** moved approval of the Medicaid Waiver base budget.

VOTE: The motion **PASSED** unanimously.

CHAIRMAN BRADLEY referred to the nursing home rate rebase and nursing home fee adjustment budget modifications on Page 2 of **EXHIBIT 13 from Feb. 4, 1991, minutes.**

Ms. Robinson said that if the nursing home fee increase does not go through, SRS will need $2.6 million in new General Fund money. **Mr. Taylor** corrected the figures. He said the fee raises $2.2 million, but the net effect is $1.8 million. **Ms. Robinson** said that if the fee doesn't go, SRS will have to make a number of adjustments to the budget. **CHAIRMAN BRADLEY** said the subcommittee can take whatever action it feels is appropriate since the utilization fee is going through bill form.

SEN. WATERMAN asked if the fee is needed to fund the rebase. **CHAIRMAN BRADLEY** said no, not if the subcommittee puts the money into the budget.

SEN. KEATING asked if the rebase is tied to the utilization fee. **SEN. WATERMAN** asked if the governor uses the fee to fund part of the developmentally disabled. **Mr. South** said there are two separate modifications to isolate the fee issue. Part of the rebasing is contingent on the fee. **Mike Hanshew, Long-Term Care Bureau Chief,** said the rebasing stands by itself. If it is funded with revenue from the fee, the second modification must be approved. That would fund the Department's payment of a portion of the fee. If the fee is rejected, the second modification isn't needed.

SEN. WATERMAN asked if the subcommittee must either approve the fee or come up with another source for the $1.8 million if it approves the rebase. **Mr. Hanshew** said yes. If the subcommittee passes the rebase and not the fee, the subcommittee will have to make up approximately $1.8 million in General Fund from another source. It is the net revenue from the fee.

SEN. WATERMAN said she understands that senior citizens favor the fee if it ensures improved care. She asked if there is another way to raise the money and still get the federal match. **Mr. Hanshew** said revenue can be raised in a number of ways beyond passing charges onto the facilities, but they are outside the scope of the Medicaid program. There are a limited number of ways to take advantage of the federal match. This is one the Department suggested.

SEN. KEATING said the state gets a 72 percent match with its 28-cent investment. The match goes to the facility, which gives part of it back to the state. The state is then using federal money to leverage more federal money. The user fee provides a double whammy. If Medicaid payments are increased, the facility can shift the cost from the private-pay resident and give them better services. The state benefits overall because it is getting nearly double the match amount. **Mr. Hanshew** said the $4.5 million budget modification to rebase nursing homes rates assumes the $1.8 million would come from the utilization fee. The subcommittee won't have to add $1.8 million onto the $4.5 million. If the fee doesn't pass, all the revenue will have to come from the General Fund.

SEN. WATERMAN asked why additional fees paid by private-pay residents can't be used for the match. **Mr. Hanshew** said the state doesn't get that revenue. It is the difference between a flat charge for a day of nursing home care and extra fees they may pay for special services, like a television in their room. Those fees aren't included in the rate and are paid to the facility.

SEN. WATERMAN referred to **EXHIBIT 9**. She said it suggests private-pay residents will get reimbursed through an income tax credit. She asked where that is in the plan and how long it will take to implement. **Mr. Hudson** said two proposals in the Health Care for Montanans project provide incentives for people to pay for their own long-term care. One involves the elderly care credits law, which would be amended to provide tax credit eligibility to the family member who pays for the long-term care of a parent. That bill has not been introduced yet. The other would provide a 100 percent tax credit for nursing home insurance premiums. That may not impact the utilization fee.

CHAIRMAN BRADLEY suggested the subcommittee take action on the nursing home rate rebase budget modification. The utilization-fee bill will fare on its own merits.

MOTION: **SEN. KEATING** moved approval of the nursing home rate rebase budget modification.

SUBSTITUTE MOTION: **REP. COBB** moved to approve the rate rebase contingent upon passage of the utilization fee bill.

DISCUSSION: **SEN. KEATING** said the subcommittee can always reconsider its action later. He wants to get things going. If the

bill fails, the Legislature has a budget buster and the subcommittee will have to come back and deal with it.

REP. COBB said it isn't a budget buster. It involves $2 million. Once the money is put in, there is less incentive to pass the bill. **CHAIRMAN BRADLEY** asked **REP. COBB** if the purpose behind his motion is to add incentive to get the bill through. **REP. COBB** said yes. **CHAIRMAN BRADLEY** said that if the bill fails and the subcommittee feels nursing homes have to be taken care of in the rebase, it would force an amendment. If the bill fails, and the subcommittee passes **SEN. KEATING's** motion, the adjustment could be automatic. **REP. COBB** said that is true.

VOTE ON THE SUBSTITUTE MOTION: The motion **FAILED** on a tie vote, 3-3, with **CHAIRMAN BRADLEY, SEN. WATERMAN** and **REP. JOHNSON** voting no.

DISCUSSION: **SEN. KEATING** said he sensed some members of the subcommittee do not believe it is wise to use the user fee to leverage more federal money. **CHAIRMAN BRADLEY** said she opposes it for a number of reasons. She believes the issue should be debated over the bill, not in the subcommittee.

Tape 3B

SEN. WATERMAN said senior citizens resent the fact that the Legislature is not dealing with tax reform and that they are being asked to shoulder the cost of improved services for everyone in nursing homes. Sixty percent will not be paying this cost.

CHAIRMAN BRADLEY said the question she wants the subcommittee to deal with is whether the rebasing modification is justified. The vehicle for the other debate has been introduced in the form of a bill and is before a committee.

VOTE ON THE ORIGINAL MOTION: The motion **PASSED** 4-2, with **SEN. KEATING** and **REP. COBB** voting no.

Ms. Ellery distributed background information on the HB 100 mandate, **EXHIBIT 14,** and overview material for the Medicaid long-term care budget modification, **EXHIBIT 15.**

ADJOURNMENT

Adjournment: 12 p.m.

Dorothy Bradley
REP. DOROTHY BRADLEY, Chairman

Faith Conroy
FAITH CONROY, Secretary

DB/fc

HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUBCOMMITTEE

ROLL CALL **DATE** 2/6/91

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

2/6/91
Human Serv. Subc.

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

STAN STEPHENS
GOVERNOR

JULIA E. ROBINSON
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210
(406) 444-5622
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EXHIBIT 1
DATE 2-6-91
HB

February 1, 1990

Representative Dorothy Bradley, Chairman
Human Services Subcommittee
Capitol Station
Helena, Montana 59604

Dear Representative Bradley:

We have calculated the percentage increase in provider reimbursement pursuant to the ob/gyn provider rate increase approved in your committee on February 5, 1990. The following table shows only the increase for ob/gyn grouped procedures. It does not reflect the pediatric portions of the mod. Pediatrics is not grouped like ob/gyn. The pediatric increase would have to be shown over a large number of procedures and because of the complexity would take a great deal of time and effort.

Table 1, Increase in OB/GYN Provider Rates at 5%

Service Description	Current Rates	5% Increase	Proposed Rates
Global Care	$ 755	$ 38	$ 793
Vaginal Delivery	$ 427	$ 21	$ 448
C-Sections	$ 806	$ 40	$ 846

Table 2, Increase in OB/GYN per Committee Action

Service Description	Current Rates	Proposed Increase	Proposed Rates	Percent Increase
Global Care	$ 755	$ 480	$ 1,235	63.58 %
Vaginal Delivery	$ 427	$ 374	$ 801	87.59 %
C-Sections	$ 806	$ 306	$ 1,112	37.97 %

I hope this will answer all of your questions on these services. Please let me know if I may be of further help.

Sincerely,

Nancy Ellery

Nancy Ellery, Administrator
Medicaid Services Division

EXHIBIT 2
DATE 2-6-91
SB

BUILDING AN ADEQUATE SERVICE SYSTEM FOR CHILDREN AND FAMILIES:

Montana's Opportunity to Effectively Protect Children and Strengthen Families

♦♦ A Report to the Montana Legislature in Response to HB100 ♦♦

♦♦ Prepared by the Montana Department of Family Services ♦♦

♦♦ **EXECUTIVE SUMMARY** ♦♦

♦♦ December, 1990 ♦♦

EXECUTIVE SUMMARY

HB100'S MANDATE TO THE DEPARTMENT OF FAMILY SERVICES

In HB100, the Montana Legislature instructed the Department of Family Services (DFS) to prepare a report for the 1991 Legislature concerning the implementation of a continuum of services to children and youth that addresses the identified needs of children who are in the custody of the department or for whom DFS has a legal mandate to provide services.

The Legislature requested DFS to:

(1) quantify the numbers of children served by DFS and the numbers of children unserved or underserved,
(2) identify what is needed for a complete and adequate continuum of services that meets the needs of children served by DFS, and
(3) describe DFS efforts to stabilize the foster care provider rate system.

The Legislature specifically instructed DFS to identify the additional resources needed to develop services in the following areas: preventive services, family-based services and in-home services for families in crisis, and intermediate-level services such as specialized foster care, therapeutic foster care and therapeutic group home care.

HB100 also asked DFS to identify services needed to meet the needs of DFS-served children in certain special populations: juvenile sex offenders, dually-diagnosed children (developmentally disabled and emotionally disturbed), juvenile delinquents in need of community juvenile corrections programs, chronically mentally ill children, and severely emotionally disturbed children.

The Legislature stressed that the planning process for developing the DFS children and family service system should be done in conjunction with the ten DFS Local Youth Services Advisory Councils.

DFS METHODS OF RESPONDING TO THE HB100 MANDATE

It is important to understand that the HB100 task of quantifying the numbers of children served, underserved, and unserved was strictly limited to youth either in the custody of DFS or for whom DFS has a legal mandate to provide services.

To quantify the numbers of children involved and identify what is needed for a complete and adequate continuum of services, DFS used two basic resources: (1) DFS' current data sources, the Protective Services Information System and the Foster Care Payments System (Client Database), and (2) special DFS surveys and research concerning the needs of DFS-served children.

Since the information available through the department's current data collection is very limited, additional surveys of children receiving DFS services at a certain point in time during

FY90 were necessary. By combining this point-in-time data with caseload trends over the past five years, the department arrived at estimates and projections for the FY92-FY93 period.

The department used data on historical trends wherever possible, but shortcomings in the data collection system shared with SRS clearly revealed the need for a comprehensive management information system (MIS).

The department's process for identifying and calculating additional resources needed for FY92 and FY93 did not include a consideration of possible rate increases or cost-of-living increases that would affect the costs involved. Instead, since the HB100 report is not a budget request but rather an estimate or indication of the additional resources needed for FY92 and FY93, the department used FY90 average costs for services in calculating estimates.

Since projected caseload increases are crucial to providing estimates of the needs for FY92 and FY93, anticipated caseload growth based on trends over the past six years was included in DFS' calculation of estimates of additional resources needed.

The department identified and quantified the needs of children served by DFS, including children and youth in each of the four special population categories requested by the Legislature. The service needs of children in the four special populations are included as part of the overall service needs rather than being separated out as an isolated set of needs for the special populations.

The Legislature suggested that the planning process for the development of the children's services system should be tied to the local level and involve local advisory council participation in the planning process. In response, the department designed and implemented a DFS Local Youth Services Advisory Council planning process during 1989 and 1990 that directly focused these grassroots councils' efforts on HB100's issues and concerns. The department then utilized the results and recommendations that emerged from the ten local youth services advisory councils' efforts in conducting HB100 research and in preparing this HB100 report.

The department also consulted regularly with a HB100 Subcommittee established by the State Youth Services Advisory Council (SYSAC) in designing the department's activities for meeting the HB100 mandate. The department provided a draft of this HB100 report for review and comment to all members of the state and local youth services advisory councils.

SUMMARY OF KEY FINDINGS

*** **DFS identified a need for a Management Information System (MIS).** The data collection system now used by DFS is not adequate to meet DFS needs.

Additional resources needed for the MIS:

FY92:	$ 418,149	Completion of the system requirements analysis; software design and development; hardware acquisition and installation
FY93:	$ 487,733	System development; hardware acquisition and installation
FY94:	$1,035,642	System development; hardware acquisition and installation
FY95 and beyond:	$ 569,510	System maintenance and operation

*** **DFS identified a need for additional staff to accomplish essential DFS service mandates.** DFS identified a need for a total of 190.84 additional FTEs:

- -- 108.1 CPS social worker FTEs and 32.4 supervisor FTEs
- -- 10 family resource specialist FTEs
- -- 13.4 social worker FTEs and 2.7 social worker supervisor FTEs for required services to Native American children living on reservations.
- -- 15.38 FTEs for services at the Pine Hills School for Boys
- -- 4.86 FTEs for services at the Mountain View School for Girls
- -- 3 aftercare counselor FTEs and 1 aftercare supervisor FTE

Additional resources needed:	**FY92**	**FY93**
Salaries, operating expenses and training:	$7,101,891	$7,101,891

*** **DFS identified how well the needs of children served by the department are currently being met.** The great majority of children being served by DFS were found to be adequately served, with the services provided being sufficient to meet the children's needs, as summarized below:

- -- 80.4% of the children served by DFS in out-of-care;
- -- 65.8% of the children served by DFS in abuse and neglect investigations and protective services.

*** **DFS identified how well the needs of children in the four special populations highlighted by the Legislature are being met.** The great majority in the special populations who are being served by DFS were found to be adequately served, as summarized below:

- -- 77.8% of those who are both developmentally disabled and emotionally disturbed;
- -- 75.0% of those who are juvenile delinquents needing community-based corrections services;
- -- 75.4% of the children with severe emotional disturbances or chronic mental illness;
- -- 58.3% of those who are juvenile sex offenders.

*** **DFS identified a need for additional In-Home Services.** The department's HB100 research found that DFS-served children had extensive unmet needs for In-Home Services.

Inadequately served children who will need In-Home Services:

	FY92	FY93
In-Home Family Support Services:	852	914
Family or Individual Therapy and Mental Health Services:	975	1046
Child Protective Day Care:	191	205
Family-Based Services to prevent imminent out-of-home placements:	635	678
Additional resources needed:	$4,431,600	$4,835,200

*** **DFS identified a need for additional Out-of-Home Services.** The department's research found that DFS-served children had extensive unmet needs for Out-of-Home Services.

Inadequately served children who will need Out-of-Home Services:

	FY92	FY93
Family Foster Care:	145	152
Group Home Care:	14	15
Specialized Foster Care:	59	62
Therapeutic Foster Care:	28	29
Therapeutic Group Home Care:	45	47
Independent Living Services:	15	15
Residential Treatment Services:	45	47
Additional resources needed:	$2,307,079	$2,320,387

RECOMMENDATIONS OF THE STATE YOUTH SERVICES ADVISORY COUNCIL

At its December, 1990 meeting, the State Youth Services Advisory Council recommended that DFS should: (1) place high priority on the development of a new DFS Management Information System; (2) work toward increasing DFS' Child Protective Services (CPS) social worker staff by 108 employees; (3) initiate a Family-Based Services (FBS) program statewide to meet the identified need for FBS services and make FBS a key component of DFS' basic response to child abuse and neglect; and (4) phase in the three recommendations above over a three-year period, FY92-FY93-FY94.

THE DFS ACTION PLAN

DFS will take the following steps to achieve the recommendations of the State Youth Services Advisory Council and meet the needs identified in the department's HB100 research.

*** **DFS will work with representatives of the public and private sectors in a policy advisory group to design a system of care for out-of-home services and develop standards for when a child will be placed in a certain level of out-of-home care. DFS will:**

1. develop an evaluation methodology for assessing children's needs and identifying appropriate placement options;
2. develop a common application form for statewide use with children being considered for out-of-home placements; and
3. resolve the issue of the cost of services in the continuum and develop payment rates for the levels of care that are identified.

*** **DFS will pilot a continuum of services system in each of the five regions. DFS will:**

1. design and initiate a plan for the full continuum of services, starting with regional pilot projects;
2. identify services needs for the continuum regionally;
3. develop and implement Requests for Proposals (RFPs) for needed services and award contracts by July 1, 1991; and
4. expand the agreements with the Indian tribes and explore the option of contracting with the Tribes for provision of basic child protection services.

*** **DFS will use the following resources to begin development of the continuum of care:**

- DFS will use Medicaid residential treatment funds transferred to the department by SRS to develop services designed to reduce the numbers of children inappropriately placed in in-patient psychiatric care and to dramatically increase in-state treatment options. The funds will be allocated as follows:
  - approximately $500,000 to pilot projects for family-based services and in-home family support services in each region, to reduce the number of out-of-home placements;
  - approximately $200,000 to expand family foster care and group home care services;
  - approximately $800,000 to develop and expand therapeutic foster care and therapeutic group home care services;
  - approximately $200,000 to develop specialized group care alternatives for medically needy children; and
  - approximately $500,000 to develop residential treatment programs statewide.

- DFS will use approximately $1.3 million of the funds transferred by SRS to DFS from Medicaid residential treatment services to meet current treatment obligations.

*** **In addition, to increase the resources available to meet the needs of children served by the department, DFS will:**

1. pursue funding under Medicaid for less intensive out-of-home care services;
2. more fully utilize the SRS "Kids Count" program (EPSDT, Early Periodic Screening, Diagnosis and Treatment) program to screen children in foster care for medical needs;
3. use the SRS Kids Count/EPSDT program for identifying and meeting the medical needs of children receiving CPS services from DFS who are IV-E eligible; and
4. develop an interagency agreement with the Department of Institutions regarding emotionally disturbed and severely emotionally disturbed children, clarifying the two departments' respective roles and responsibilities.

See Section V of the HB100 report for a more detailed summary of the key findings of this report.

A copy of the complete Department of Family Services HB100 report, **BUILDING AN ADEQUATE SERVICE SYSTEM FOR CHILDREN AND FAMILIES: Montana's Opportunity to Effectively Protect Children and Strengthen Families**, is available upon request.

EXHIBIT 2
DATE 2-6-91
SB Jud. Serv. Sub

EXHIBIT 3
DATE 2-6-91
HB

Exhibit #3
2/6/91
Human Serv
Subc.

Pursuant to a memorandum of understanding between the Department of Social and Rehabilitative Services and the Department of Family Services, DFS will receive the general fund matching portion for the federal Medicaid funding for inpatient psychiatric hospitalization and residential treatment services. The general fund match for inpatient psychiatric services for youth under 21 years of age has been added to the DFS base budget for out-of-home care services. This amounts to $2,454,310 for FY92 and $2,586,360 for FY93. Additionally, an amounts of $1,771,365 for FY92 and $1,765,061 for FY93 has been added for the general fund match for residential treatment services.

The intent of the funding transfer is to enable DFS to begin the process of developing an appropriate continuum of care for the youth of Montana. The Department will utilize the funds to initiate development of community-based treatment and care alternatives for children and youth who can be appropriately served in a less restrictive environment. To accomplish this, DFS will allocate a portion of these funds for the development of new services; co-ordinate with the medicaid program to ensure that all eligible costs are appropriately claimed to medicaid; and review with SRS the eligibility standards to make them coincide with the services available.

In developing a plan to create alternatives, the department will not only consider the findings of the study mandated by HB 100 but also consider input from regional Youth Advisory Councils, affected state agencies, and private care providers. The department anticipates that the provision of a true "continuum of care" will result in a reduction in the numbers of placements into high cost care and a corresponding reduction in the cost of care.

This will be accomplished in the 1992-93 biennium through the following plan of action: a) DFS will reserve for the biennium approximately $1.3 million of the funds transferred from medicaid residential treatment services to meet current treatment obligations. The remainder will be allocated in the development of a "continuum of care" designed to reduce the numbers of children inappropriately placed in inpatient psychiatric care and to dramatically increase in-state treatment options.

* Approximately $500,000 will be allocated to development of pilot projects in each region for family-based services and in-home support to reduce the numbers of out-of-home placements.

* Approximately $200,000 will be allocated to expand family foster care and group home care.

* Approximately $800,000 will be allocated to develop and expand therapeutic foster and therapeutic group homes.

* Approximately $200,000 will be allocated to develop specialized group care alternatives for children with special medical needs.

* Approximately $500,000 will be allocated for development of residential treatment programs statewide.

b) DFS will work with SRS and the state's utilization review contractor to carefully define eligibility criteria for placement in inpatient psychiatric hospitalization. This will ensure that only those children who cannot be appropriately served in a less restrictive environment will be placed psychiatric care; c) DFS will develop resources to assist in screening children referred for placement in order to more accurately assess their care needs. This will ensure placement in the least restrictive environment; and DFS will develop a system to fairly and accurately assess the cost of care within each level of care.

	FY 92	FY 93
Base Budget Adjustment		
Benefits and Claims	2,454,310	2,586,360
General Fund	2,454,310	2,586,360
Base Budget Increase		
Benefits and Claims	1,771,365	1,765,061
General Fund	1,771,365	1,775,061

EXHIBIT 4
DATE 2-6-91
HB

Exhibit #4
2/6/91
Human Services
Subc.

2200 21st Avenue, South, Suite 201
Post Office Box 120309
Nashville, Tennessee 37212
(615) 269-7001
FAX (615) 269-7174

February 5, 1991

Ms. Nancy Ellery, Administrator
Medicaid Services Division
Department of Social and Rehabilitation Services
State of Montana
Box 4210
Helena, Montana 59604

Dear Ms. Ellery:

Mental Health Management of America has utilization review contracts with Medicaid agencies in Arkansas, Kentucky, Montana, North Carolina and Tennessee. The medical necessity criteria are the same for each state contract and are applied consistently across states. These criteria have been approved by the Health Care Financing Administration and are consistent with Federal regulations governing utilization control in the Medicaid Under 21 program.

The same team of psychiatric review nurses and psychiatrists conduct reviews in each of these states and are regularly supervised and evaluated in order to maintain consistency in conducting reviews. The Medicaid Services Division in Montana has not instructed MHMA to apply the medical necessity criteria in any way that is inconsistent with standard procedures. A comparison of Montana's denial rates, changes in census and changes in average length of stay with other states we are working with does not indicate a differential impact of the review process on Montana facilities.

Sincerely,

Rick Sivley

Richard D. Sivley
President

RDS:rbb

INPATIENT PSYCHIATRIC SERVICES PROGRAM

ISSUE: Department delays in disputed cases

RESPONSE: There are currently 31 requests for Departmental Review of disputed cases from three facilities (11 - Rivendell Butte; 12 - Rivendell Billings; 8 - YTC). The oldest pending request was received 10/23/90. In order to deal more quickly with these requests, the Department has amended the UR contract to have MHMA issue the formal determination following the denial/informal reconsideration. The facilities may then request an Administrative Review/Conference which will be conducted within ARM 46.12.1210 guidelines. This change was effective 02/01/91. MHMA has received a list of the outstanding cases will begin issuing formal determination within the next two weeks. Previously requested Administrative Reviews by YTC have been scheduled for 02/11-13/91.

Rivendell of Butte has 113 days that are pending formal determination (113 x $350/day = $39,550). Rivendell of Billings has 289 Medicaid eligible days pending formal determination ($101,150).

ISSUE: MHMA has told Montana providers that we have the most stringent UR criteria in the nation.

RESPONSE: Nancy Ellery has received a letter confirming that the criteria being utilized is used in 5 states, has been approved by HCFA and is consistent with Federal regulations governing utilization control in the Medicaid Under 21 program.

ISSUE: What does the ALOS of 39.8 days for adolescents mean?

RESPONSE: The National Association of Private Psychiatric Hospitals has demonstrated that between FY 84 and FY 87, the ALOS for adolescents decreased from 56.8 days to 42.3 days and the ALOS for children under 13 decreased from 74.3 days to 46.7 days. Since FY 87, the ALOS has continued to decline. According to our contractor, MHMA, Montana's ALOS of 39.8 days is consistent with the national recommendation of ALOS of 40 days for adolescents. "Most children and adolescents requiring hospitalization will require inpatient treatment for relatively **brief** stays." (NAPPH). According to Dr. Robin Kirk, MHMA Vice President, there is no evidence in the scientific literature that longer lengths of stay correlate with better outcomes.

IN PERSPECTIVE

Child & Adolescent Psychiatric Hospitalization

FROM THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

Children's Mental Health Needs

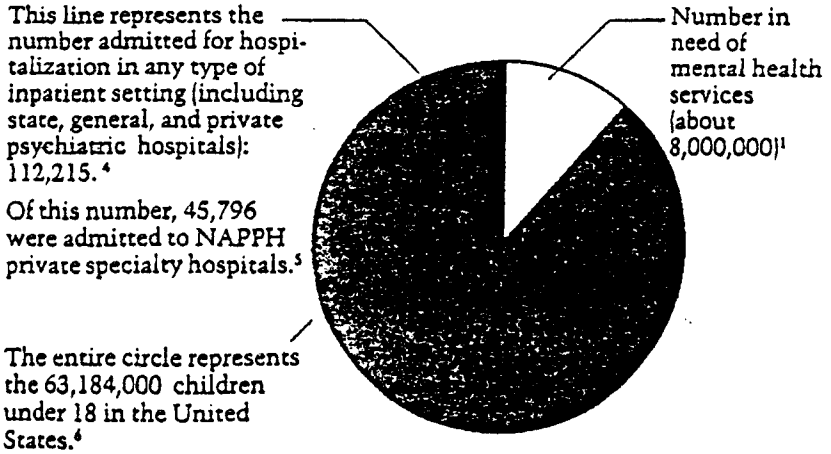
Conservative estimates indicate that about 12 percent of the nation's children (or nearly 8 million) under the age of 18 are in need of mental health services.[1] The number may be as high as 22 percent (or 14 million).[2]

At least 3 million children are *seriously mentally ill*, according to a study for the Children's Defense Fund. Serious mental illness is defined as having a duration of over one year, known to more than two agencies.[3]

Private psychiatric hospitals have played an important role in helping the most seriously disturbed of these youngsters by providing both inpatient treatment and a range of hospital-based alternatives to inpatient care.

Child and Adolescent Hospitalization in NAPPH Hospitals

The number of children and adolescents hospitalized in NAPPH hospitals in a single year is less than one-tenth of one percent of the U.S. population of this age. The number of young people under the age of 18 who were admitted for hospitalization in *any* type of inpatient setting (including state hospitals, general hospitals with psychiatric units, multi-service institutions, and private psychiatric hospitals) is less than *two-tenths of one percent* (0.17%) of the total population of that age (in 1986 a total of 112,215 inpatient admissions out of 63,184,000 young people).



[1] *Children's Mental Health: Problems and Services*, U.S. Office of Technology Assessment, Duke University Press, 1986

[2] *Research on Children and Adolescents with Mental, Behavioral and Developmental Disorders*, Institute of Medicine, 1989

[3] Knitzer, J.: *Unclaimed Children*. Washington, D.C., 1982

[4] National Institute of Mental Health, 1986 data

[5] NAPPH 1988 *Annual Survey, Final Report*

[6] Bureau of Census, 1986

More young people are receiving help for serious mental illnesses, and private psychiatric hospitals and units in general hospitals have opened during recent years to serve many communities. However, the number of admissions of children and adolescents from 1980 to 1986 in all types of inpatient settings (including state, private, multi-facility, and general hospitals) has increased only 38% according to NIMH data (from 81,532 admissions in 1980 to 112,215 admissions in 1986). This equals—on average—a little more than a *six percent* increase per year.

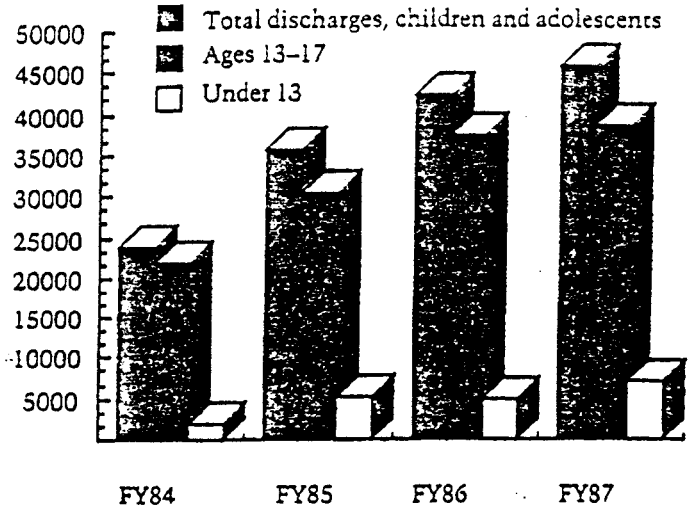
Inpatient Services

The private sector has been working to develop services to meet the pressing needs of America's children struggling with serious mental illness. More resources are now available to children and adolescents.

Discharges in NAPPH Hospitals by Age Group

	FY84	FY85	FY86	FY87
Under 13	2,104	5,188	4,863	7,258
Ages 13–17	21,982	30,473	37,187	38,538
Total Discharges	23,986	35,656	42,050	45,796

The graph below illustrates the number of reported discharges by age group.



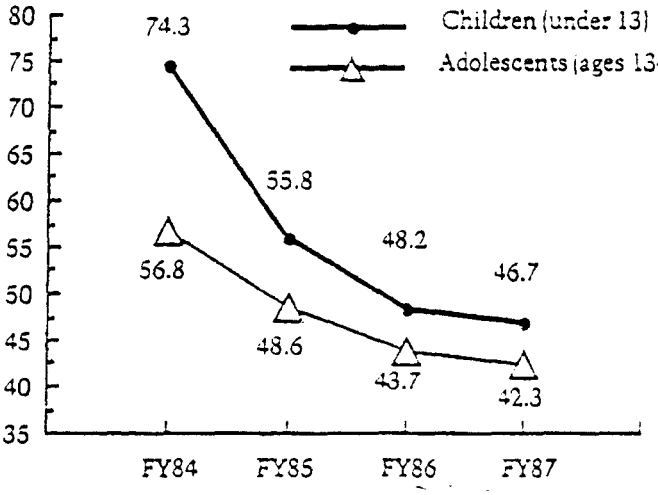
Source: *1988 NAPPH Annual Survey, Final Report*

Length of Stay

EXHIBIT 4
DATE 2-6-91
HB Hum. Serv. Sub.

Most children and adolescents requiring hospitalization will require inpatient treatment for relatively brief stays. Improvements in medication management and technologies of treatment have reduced lengths of stay. However, for the severely psychiatrically ill child or adolescent, some NAPPH hospitals provide highly specialized, intensive services that often require a longer length of stay than the national average.

National Average Length of Stay in Days, 1984–1987

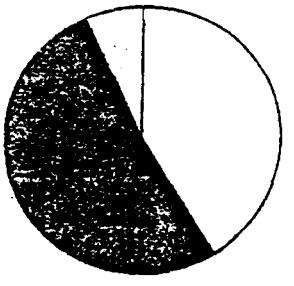


Source: *1988 NAPPH Annual Survey, Final Report*

The Mental Health Delivery System

Private psychiatric hospitals are an important part of the mental health delivery system for children and adolescents.

Numerical and Percent Distribution of Admissions under Age 18 to Selected Inpatient Psychiatric Services: United States, 1986



Non-federal general hospitals	45,587	41%
Private psychiatric hospitals	42,502	38%
State and county mental hospitals	15,953	14%
"Other" or multi-service facilities	8,173	7%
Total	112,215	100%

Source: National Institute of Mental Health (compiled data)

Children under 18 account for only 7.7% of all inpatient admissions, of all ages, treated in any inpatient setting. In other words, the 112,215 young people admitted for hospitalization in 1986 represented 7.7% of the 1,596,063 psychiatric inpatient admissions (of all ages) who received treatment in 1986.

Of the total number of all inpatients of all ages, young people under 18 who were hospitalized in private psychiatric hospitals represented only 2.7%.

Outpatient Treatment

For outpatient psychiatric care, children under 18 represented 24.9% of all outpatient admissions. They accounted for 561,845 outpatient admissions out of a total of 2,259,976 outpatient admissions of patients of all ages.[1]

Of the 561,845 young outpatient admissions seen in 1986, private psychiatric hospitals provided care for 41,653 of them, or nearly 8 percent.[1]

As a total of all outpatient care provided to all age groups, children and adolescents receiving outpatient counseling from private psychiatric hospitals accounted for 1.8% of all outpatient admissions of all age groups.[1]

It is important to note that the 41,653 outpatient admissions seen by private psychiatric hospitals received *only* outpatient services. They are not part of the inpatient count.[1]

Population Trends

The need for child and adolescent mental health services can be forecast in census data. For the years 1980 to 1986, the population aged 10 to 18 declined 11 percent (from 30,707,000 in 1980 to 27,420,000 in 1986). The population aged 15 to 18 declined 10.3% from 12,465,000 in 1980 to 11,181,000 in 1986.

However, the population aged 1 to 10 years increased 8.2% (from 33,048,000 in 1980 to 35,764,000 in 1986).[2]

Projecting this data six years ahead, it would appear that the population aged 1 to 10 in 1986, now entering their teen years, will lead to a continuing—and perhaps growing—need for health services for adolescents.

[1] National Institute of Mental Health (compiled data), 1986

[2] Bureau of Census, 1986

MENTAL HEALTH MANAGMENT OF AMERICA, INC.

MONTANA MEDICAID <21

DISCHARGE LENGTH OF STAY REPORT

OCTOBER - DECEMBER 1990

FACILITY	PROV #	NUMBER OF CASES	TOTAL DAYS	AVERAGE LENGTH OF STAY
NORTHWEST PASSAGES	4103606			0.00
RIVENDELL BILLINGS	4102865	36	1417	39.36
RIVENDELL BUTTE	4103827	62	2294	37.00
RIVENDELL OF UTAH	4102774			0.00
SHODAIR CHILDREN'S	4103138	19	945	49.74
YELLOWSTONE	0000000	12	3270	272.50
OVERALL AVERAGE LENGTH OF STAY		129	7,926	61.44

MENTAL HEALTH MANAGMENT OF AMERICA, INC.

NORTH CAROLINA MEDICAID < 21

DISCHARGE LENGTH OF STAY REPORT

AUGUST - OCTOBER 1990

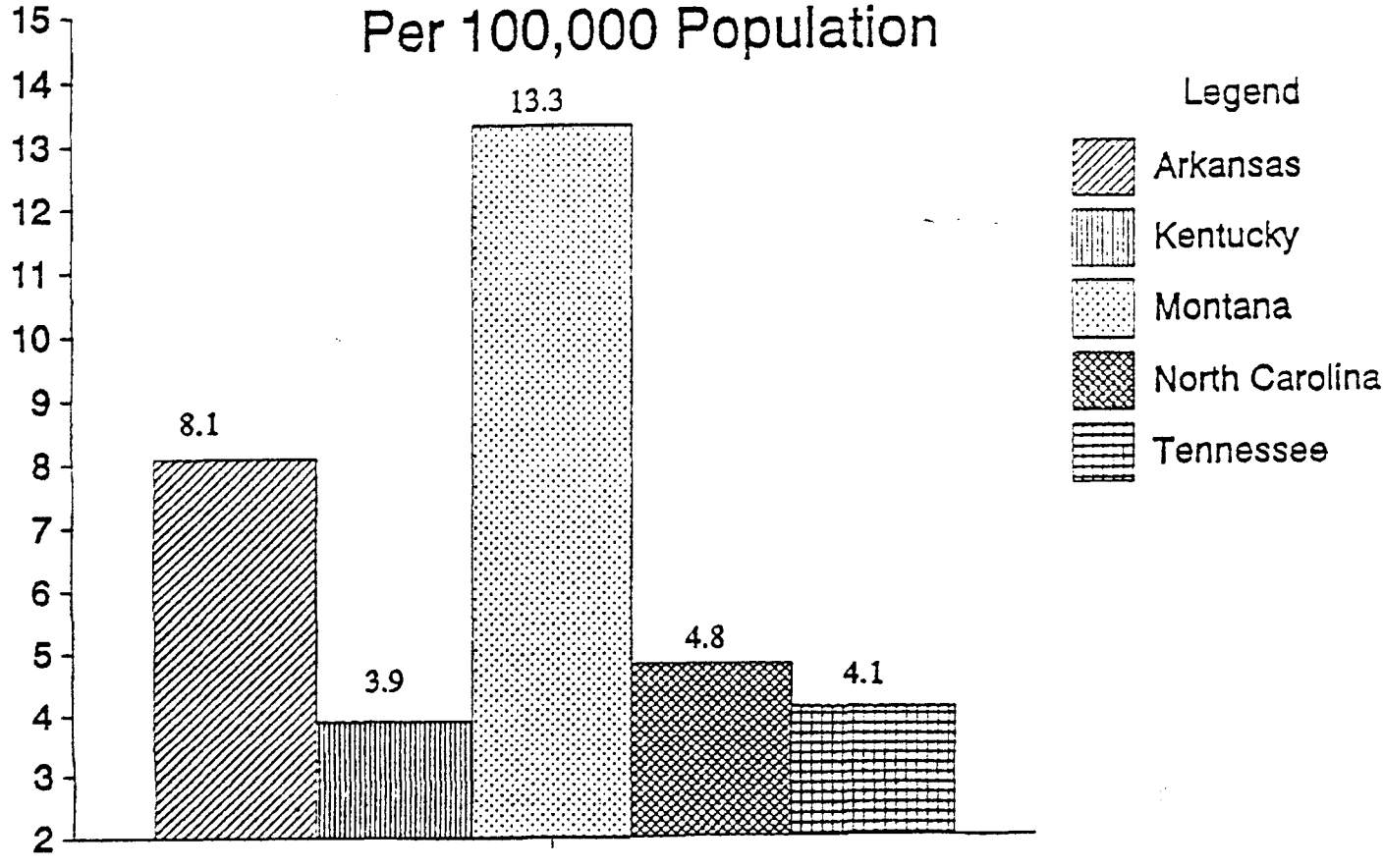
11/19/90

FACILITY	PROV #	NUMBER OF CASES	TOTAL DAYS	AVERAGE LENGTH OF STAY
AMOS	3400500	2	61	30.50
APPLACHIAN HALL	3404005	11	1128	102.55
BROUGHTON (State - short term)	3404002	38	1970	51.84
BRYNN MARR	3404016	32	1840	57.50
BRUNSWICK	3400158	12	1146	95.50
CHARTER GREENSBORO	3404015	13	626	48.15
CHARTER WINSTON-SALEM	3404006	11	312	28.36
CHARTER NORTHRIDGE	3404018	18	601	33.39
CHARTER PINES	3404019	3	150	50.00
CHERRY (State - Long term)	3404003	53	3381	63.79
CHESTNUT HILL (Out-of-state RTC)	4204007	17	3779	222.29
CPC CEDAR SPRING	3404020	14	1024	73.14
CUMBERLAND	3404010	47	1951	41.51
DOROTHEA DIX (State hosp.)	3404001	15	3145	209.67
DUKE	3400030	13	761	58.54
FORSYTH-STOKES	3404013	4	310	77.50
HIGHLAND	3404000	5	817	163.40
HCA HOLLY HILL	3404014	22	1132	51.45
JOHN UMSTEAD (State hosp.)	3404004	36	4940	137.22
PARK RIDGE	3400023	16	1143	71.44
PENINSULA VILLAGE (Out-of-state RTC)	4404989	25	2954	118.16
TEN BROECK	3404017	48	2212	46.08
YOUTH CARE	3400501	13	848	65.23
OVERALL AVERAGE LENGTH OF STAY		468	36,231	77.42

EXHIBIT 4
2-6-91
Hum. Serv. Sub-

Medicaid Inpatients

Per 100,000 Population



MENTAL HEALTH MANAGEMENT OF AMERICA, INC.

KENTUCKY MEDICAID <21

DISCHARGE LENGTH OF STAY REPORT

OCTOBER - DECEMBER 1990

FACILITY	PROV #	NUMBER OF CASES	TOTAL DAYS	AVERAGE LENGTH OF STAY
BROOKLAWN TREATMENT CENTER	2021194	0	0	0.00
CENTRAL STATE HOSPITAL	2021293	30	734	24.47
CHARTER OF LOUISVILLE	2021277	11	441	40.09
CHARTER OF PADUCAH	2021228	10	303	30.30
CHARTER RIDGE	2021186	66	2973	45.05
CHILDREN'S PSYCH NORTHERN KY.	2021160	71	3525	49.65
CUMBERLAND HALL	2021269	58	1848	31.86
EASTERN STATE HOSPITAL	2021285	11	226	20.55
JEFFERSON HOSPITAL	2020030	54	1711	31.69
LINCOLN TRAIL	2021244	17	352	20.71
OUR LADY OF PEACE	2021236	112	3586	32.02
OWENDELL PSYCHIATRIC CENTER	2021210	63	2751	43.67
TEN BROECK	2021251	66	2483	37.62
VALLEY INSTITUTE OF PSYCHIATRY	2020022	83	4980	60.00
WESTERN STATE HOSPITAL	2021996	11	579	52.64
OVERALL AVERAGE LENGTH OF STAY		663	26,492	39.96

Arkansas Medicaid < 21
Length of Stay Report for Short Term Facilities
July - December, 1990

	Discharge Length of Stays			Static Length of Stays		
Facility Name	Episodes	Total Days	Avg. LOS	Episodes	Total Days	Avg. LOS
Arkansas State Hospital	42	2743	65.31	6	270	45.00
Bridgeway Hospital	11	667	60.64	3	90	30.00
Charter Vista Fayett	63	5705	90.56	17	947	55.71
Charter Vista L/R	12	420	35.00	6	225	37.50
George W. Jackson (State Hosp)	2	9	4.50	1	17	17.00
Greenleaf	11	755	68.64			
Harbor View Mercy	35	2538	72.51	16	1280	80.00
Pinewood Hospital	73	3818	52.30	18	660	36.67
Rivendell Psych. Ctr.	108	8266	76.54	33	3512	106.42
Shadow Mountain, OK	1	226	226.00			
Totals	358	25147	70.24	100	7001	70.01

NOTE: This report reflects reviews completed before 12/31/90

4
2-6-91
Thurs. Sec. Sub.

Exhibit #5
2/6/91
Human Services
Subc.

	FY 92	FY 93	01-Feb-91 06:04 PM
CV #771 Total	($5,433,608)	($6,022,672)	
Components:			
St Med Transfers	$450,000	$450,000	
Refunds	($1,200,000)	($1,200,000)	Carroll
TEAMS savings	($868,212)	($1,463,401)	
Eligibility Chnges	($1,721,516)	($1,715,391)	
Add Cost Cntnmnt	($2,093,880)	($2,093,880)	

EXHIBIT 5
DATE 2-6-91

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

DEPARTMENT OF SRS
COST CONTAINMENT PROPOSED IN PRIMARY CARE

02/05/91
02:00 PM

	FY92	FY93
Agreed to by LFA:		
1. State Medical to Medicaid Transfers	$450,000	$450,000
2. Refunds	($1,200,000)	($1,200,000)
Subtotal	($750,000)	($750,000)
Other Proposed Cost Containment:		
TEAMS - Over Payment Reduction	($425,565)	($714,947)
TEAMS - Recoupment/Overpayment	($133,137)	($224,621)
TEAMS - Improved Closure Time	($90,840)	($156,613)
TEAMS - Increased TPL Collections	($205,183)	($344,710)
TEAMS - Medicaid Decrease-IVD Interface	($13,487)	($22,510)
Subtotal - TEAMS	($868,212)	($1,463,401)
Eligibility Changes	($1,721,516)	($1,715,391)
Additional Cost Containment:		
V.A. Aid & Attendance	($671,400)	($671,400)
TPL Training	($92,000)	($92,000)
Medical Support Enforcement	($672,980)	($672,980)
New TPL Staff	($600,000)	($600,000)
DEERS Data Match	($57,500)	($57,500)
Subtotal - Addnl Cost Cont.	($2,093,880)	($2,093,880)
GRAND TOTAL - COST CONTAINMENT	($5,433,608)	($6,022,672)

TEAMS SAVINGS

1. Overpayment Reduction

   SRS has an enviable error rate already, but TEAMS will improve this rate. TEAMS will reduce error rates, through improved accuracy of calculations, reduction of errors.

2. Increased TPL Collections

   This is the result of increased information available to TPL staff who pursue insurance claims, child support enforcement and any other third party liability.

3. Recoupment of Overpayments

   In addition to above, also includes more accurate determination of eligibility.

4. Timely Closure

   By timely closing case can prevent charges to Medicaid Program of expenditures that should be borne by individual. Currently will provide individual with Medicaid card for one month. If can close out case at appropriate time will save.

5. IV-D Interface

   With interface with Child Support Enforcement (IV-E) can identify parents with insurance who could be billed for Medicaid cost to children; or parents (spouses) who are paying child support that could offset Medicaid payments.

EXHIBIT 6
DATE 2-6-91
SB Dem. Soc. Sub.

ELIGIBILITY COST CONTAINMENT

Coverage of caretaker relatives is an option under the Medically Needy Program. That is, parents (and occasionally a grandparent, aunt, uncle, etc.) who would be eligible for AFDC benefits except their income exceeds the AFDC standard would not be eligible for Medicaid benefits under the Medically Needy Program.

When determining Medically Needy eligibility for the children, the caretaker relative's income would be counted and their medical bills would be applied toward the children's incurment requirement. However, only the children would be eligible for Medicaid coverage.

There are approximately 859 caretaker relatives currently receiving Medically Needy coverage. The estimated savings for elimination of this coverage group is $1,700,000 (based on FFY90).

Individuals in this coverage group are typically the "working poor". If the coverage group is eliminated and the Governor's health insurance for low income Montanans is adopted, the caretaker relative's medical needs would be met using health insurance provided through their employer.

ADDITIONAL COST CONTAINMENT

1. VA Aid and Attendance: Increased referrals to the VA office for VA pension aid and attendance benefits. It is estimated that 150 Medicaid recipients in nursing homes will receive VA benefits of $4,476 to reduce Medicaid costs.

2. Third Party Liability (TPL) Training: Training of eligibility technicians has resulted in a 3% growth in third party collections. It is estimated that an additional 84.5 cases have been identified at $1,090 per case.

3. Medical Support Enforcement: The Child Support Enforcement Division estimates as of December 1, 1990, 223 children have been identified as having insurance through absent parents. Annual savings average to $1,522 per child.

4. Two FTE's added to the TPL staff have recovered over $300,000 in cash and another $300,000 in cost avoidance.

5. DEERS Data Match: The Department has been able to charge CHAMPUS with over $230,000 in medical bills. It is assumed that 25% of these bills will be paid.

		Savings Estimated as of 1/31/91
1.	VA Aid and Attendance	$ 671,400
2.	TPL Training	92,000
3.	Medical Support Enforcement	672,980
4.	New TPL Staff	600,000
5.	DEERS Data Match	57,500
	TOTAL Estimated Savings	$2,093,880

Exhibit #7
DATE 2-6-91 2/6/91
Human Services Subc.

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

STAN STEPHENS
GOVERNOR

JULIA E. ROBINSON
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210
(406) 444-5622
FAX (406) 444-1970

February 4, 1991

The Honorable Dorothy Bradley, Chairperson
Human Services Subcommittee
House of Representatives
Capitol Station
Helena, MT 59601

SUBJECT: Caretaker Relative Reduction in Medically Needy Program Costs

Dear Representative Bradley:

Coverage of caretaker relatives is an option under the Medically Needy Program. That is, parents (and occasionally a grandparent, aunt, uncle, etc.) who would be eligible for AFDC benefits except their income exceeds the AFDC standard would not be eligible for Medicaid benefits under the Medically Needy Program.

When determining Medically Needy eligibility for the children, the caretaker relative's income would be counted and their medical bills would be applied toward the children's incurment requirement. However, only the children would be eligible for Medicaid coverage.

There are approximately 859 caretaker relatives currently receiving Medically Needy coverage. The estimated savings for elimination of this coverage group is $1,700,000 (Based on FFY 90).

Individuals in this coverage group are typically the "working poor". If the coverage group is eliminated and the Governor's health insurance for low income Montanans is adopted, the caretaker relative's medical needs would be met using health insurance provided through their employer.

Sincerely,

Julia E. Robinson

Julia E. Robinson
Director

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EXHIBIT 8
DATE 2-6-91
HB

Exhibit #8
2/6/91
Human Services Subc.

Medicaid Services Division
Budget years 1992 and 1993
04-Feb-91
07:16 PM
Filename: ABUDG93

CV #	Description	FY 1992	FY 1993	FY 1992 Cost of a 5% Increase	FY 1992 with a 5 percent Increase	FY 1993 Cost of a 5% Increase	FY 1993 with a 5 percent Increase
00700	Administration	$4,191,560	$4,187,976		$4,191,560		$4,187,976
MODS							
92700	Hospital Rate Study etc	$434,160	$232,600		$434,160		$232,600
92701	Baby Your Baby	$268,000	$0		$268,000		$0
92702	Nurse Aid Testing	$172,800	$172,800		$172,800		$172,800
	Total Admin.	$5,066,520	$4,593,376	$0	$5,066,520	$0	$4,593,376
	Long Term Care						
00744	Nursing Homes	$59,957,640	$61,156,793	$2,997,882	$62,955,522	$6,265,573	$67,422,366
00746	Elder Waiver	$2,815,451	$2,815,451	$140,773	$2,956,224	$288,584	$3,104,035
00748	Disabled Waiver	$2,157,007	$2,157,007	$107,850	$2,264,857	$221,093	$2,378,100
00747	Institutions	$10,666,425	$9,899,939	$533,321	$11,199,746	$1,016,660	$10,916,599
	LTC Base	$75,596,523	$76,029,190	$3,779,826	$79,376,349	$7,791,910	$83,821,100
MODS							
92724	OBRA DD Treatment	$0	$1,407,070		$0		$1,407,070
92734	Nursing Home Fee Adjustment	$0	$1,392,704		$0		$1,392,704
92744	NH Rebase	$5,153,957	$10,742,204		$5,153,957		$10,742,204
92746	Waiver Expansion	$264,715	$264,715		$264,715		$264,715
	LTC Mod	$5,418,672	$13,806,693	$0	$5,418,672	$0	$13,806,693
	LTC Total	$81,015,195	$89,835,883	$3,779,826	$84,795,021	$7,791,910	$97,627,793

Medicaid Services Division
Budget years 1992 and 1993
04-Feb-91
07:16 PM
Filename: ABUDG93

CV #	Description	FY 1992	FY 1993	FY 1992 Cost of a 5% Increase	FY 1992 with a 5 percent Increase	FY 1993 Cost of a 5% Increase	FY 1993 with a 5 percent Increase
Primary Care							
	Base per Furois & South	$145,574,213	$152,852,924	$7,278,711	$152,852,924	$15,649,228	$168,502,152
00771	Med Adjust.	($5,433,608)	($6,022,672)		($5,433,608)		($6,022,672)
	Transfers out to DFS	($2,454,310)	($2,586,360)		($2,454,310)		($2,586,360)
	Expected Savings - Psych U/R	($1,413,927)	($1,423,488)		($1,413,927)		($1,423,488)
	Primary care per Exec.	$136,272,368	$142,820,404	$7,278,711	$143,551,079	$15,649,228	$158,469,632
MODS							
92758	Childrens Dental	$217,488	$217,486		$217,488		$217,486
92760	Residential Psych	$4,516,295	$4,516,295		$4,516,295		$4,516,295
92761	OB/GYN/PEDS	$4,842,751	$4,842,750		$4,842,751		$4,842,750
92763	Health Clinics	$65,000	$65,000		$65,000		$65,000
92863	Ambulance	$493,918	$493,918		$493,918		$493,918
92764	Hospital Rebase	$0	$4,368,271		$0		$4,368,271
92861	EPSDT Case Mgmt/screens	$289,783	$350,057		$289,783		$350,057
92865	TCM Preg Women	$493,050	$493,146		$493,050		$493,146
		$10,918,285	$15,346,923	$0	$10,918,285	$0	$15,346,923
Per Exec	Prim Care before IHS & Buy in	$147,190,653	$158,167,327	$7,278,711	$154,469,364	$15,649,228	$173,816,555
00754	Buy In	$5,178,800	$5,697,000		$5,178,800		$5,697,000
00755	IHS	$4,000,000	$4,000,000		$4,000,000		$4,000,000
Total	Primary care plus IHS/Buy in	$156,369,453	$167,864,327	$7,278,711	$163,648,164	$15,649,228	$183,513,555
	State Medical						
00770	State Medical	$2,060,594	$2,109,378	$103,030	$2,163,624	$216,089	$2,325,467
	Other Items						
	OBRA 1990	OBRA 1990 is subject to change and is not included here.					
	Total without OBRA 1990	$244,511,762	$264,402,964	$11,161,567	$255,673,329	$23,657,228	$288,060,192
	General Fund Increase			$3,006,731		$6,361,999	
	Federal Fund Increase			$8,154,836		$17,295,228	
				$11,161,567		$23,657,228	

DATE 2-6-91 Exhibit # 18
2/6/91
HB Human Services
Srebc -

NURSING FACILITY UTILIZATION FEE

In order to provide a way to help finance rapidly increasing Medicaid costs for nursing home services, the Department of Social and Rehabilitation Services (SRS) proposed a nursing home utilization fee. The following are answers to some of the questions frequently asked about the proposed fee.

How would the fee work? Beginning in July of 1992, nursing homes would be assessed a flat one dollar per day charge for each day a nursing home bed is occupied.

How much money would the fee raise? A total of about 2.3 million dollars in additional revenue per year would be raised by the fee. About one million dollars of the total revenue from the fee would come from federal sources.

Can nursing homes make residents pay the fee? People whose nursing home care is funded by Medicaid or Medicare, over two-thirds of the people in nursing homes, cannot be made to pay the fee. Facilities could decide to charge the cost of the fee to the 31% of nursing homes residents who pay for their own care.

Who are the people who pay for their own care? People who pay for their own nursing home care, or "private payers," do not meet the Medicaid or Medicare nursing home eligibility requirements, or have chosen not to apply for either of these two programs.

Who are the people funded through Medicaid? Medicaid eligibility is somewhat complicated, but under most circumstances people may be eligible and still retain a number of resources, including: their home, a car, personal effects and household goods, life insurance with a face value of under $1,500 and a burial plot. Individuals in nursing homes may keep up to $2,000 in cash or other resources. Since October of 1989 the married spouse of a Medicaid nursing home resident, referred to as the"community spouse," can keep a minimum of $13,296 in resources. If the couple has more than this amount, the spouse at home can keep half of the resources, up to a maximum of $66,480. In combination with his or her own income, the community spouse may keep a minimum of $933 per month of the nursing home spouse's income. Single people may be eligible for Medicaid funded nursing home care if their monthly income is less than the monthly cost of the nursing home they are entering, currently about $2,000 per month.

How would the revenue from the fee be spent? Revenue from the fee would be used to finance a portion of the almost 16 million dollar increase in nursing home rates called for in the Governor's budget for the next biennium.

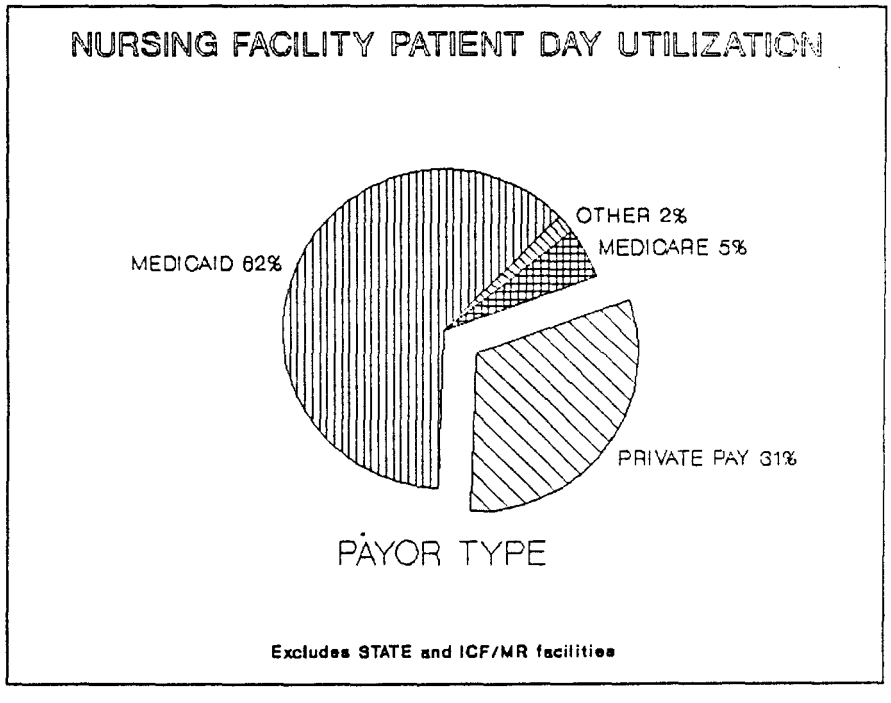
Why such a large nursing home rate increase? An independent assessment of Montana's Medicaid nursing home reimbursement system confirms that payments to nursing homes have not kept pace with increases in the cost of providing nursing home services as required by federal law.

How will persons paying for their own care benefit from higher Medicaid rates? When Medicaid doesn't pay its share of the cost of care, nursing homes shift these costs to private payers. In a sense this is a hidden tax already included in private pay rates. Low Medicaid reimbursement rates also mean lower quality care for all residents due to shortages of staff and scarcity of services. When Medicaid rates are adequate, the need for shifting costs to private pay residents is eliminated and the quality of care offered to all residents, regardless of payment source, will increase.

Is anything being done to cushion the impact of the fee on some of the people paying for their own care? The Governor's Health Care for Montanan's initiative includes a proposal that would expand the kind of services qualifying for the current Montana Elderly Care Tax Credit to include nursing home care. If the proposal is adopted by the legislature, many persons purchasing nursing home services for a spouse or blood relative would be eligible for state income tax credits.

What if the proposed fee is not adopted? If the fee is not enacted an additional 1.85 million general fund dollars would be required to fund the nursing home rate increase called for in the Executive Budget.

The graph below displays a breakdown of the sources of payment for nursing home services. As you can see, person's paying for their own care, the only people who could be charged the fee, make up less than one-third of the nursing home population.



The graphs on the next page provide further information on the proposed nursing home utilization fee.

EXHIBIT 9
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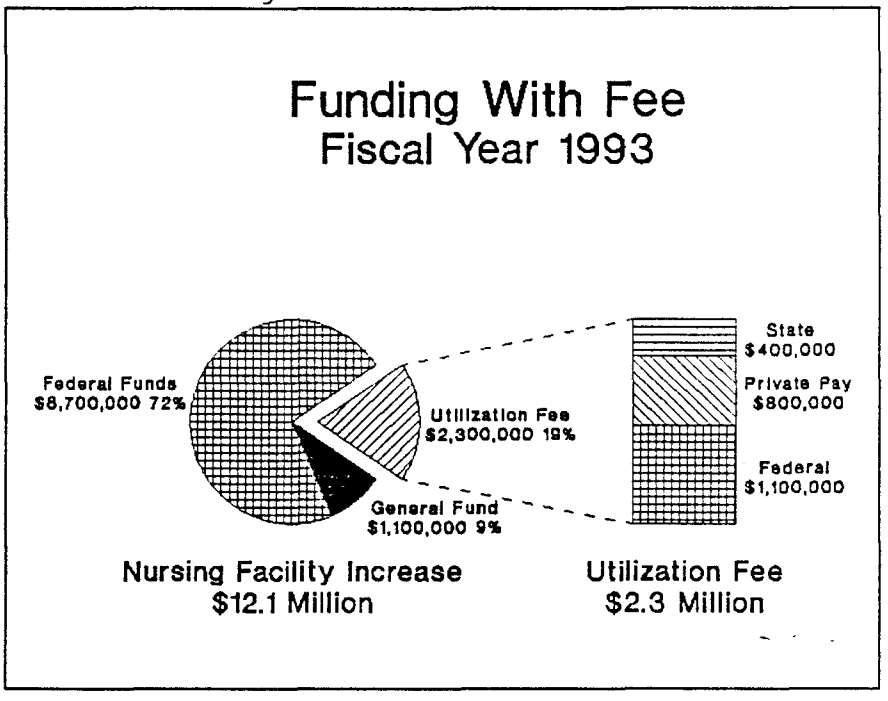
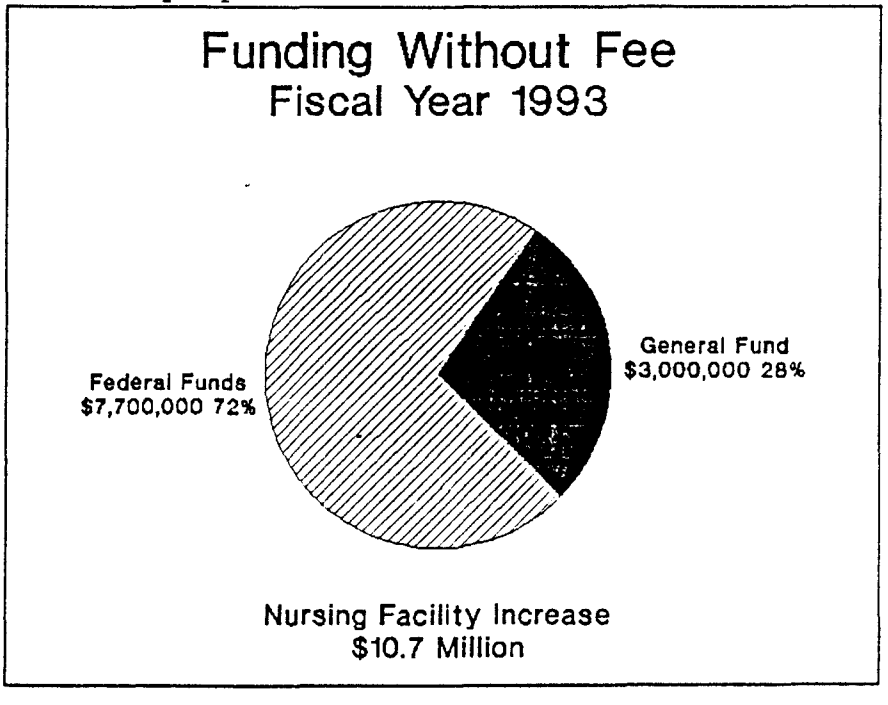
Graph #1 shows the amount of revenue raised by the fee and how it is spent. This graphs also provides a breakdown of who is paying the fee. As you can see, the majority of the revenue from the fee is paid by the federal government.



Graph #2 shows the cost of the proposed nursing home increase without the revenue from the fee. In the absence of the fee the state's share of the rate increase must come entirely from the state general fund. This is a 1.85 million dollar general fund increase over the proposal that includes the utilization fee.



ACTUAL AND PROJECTED INCREASE IN POPULATION 85 YEARS AND OLDER 1900 - 2050

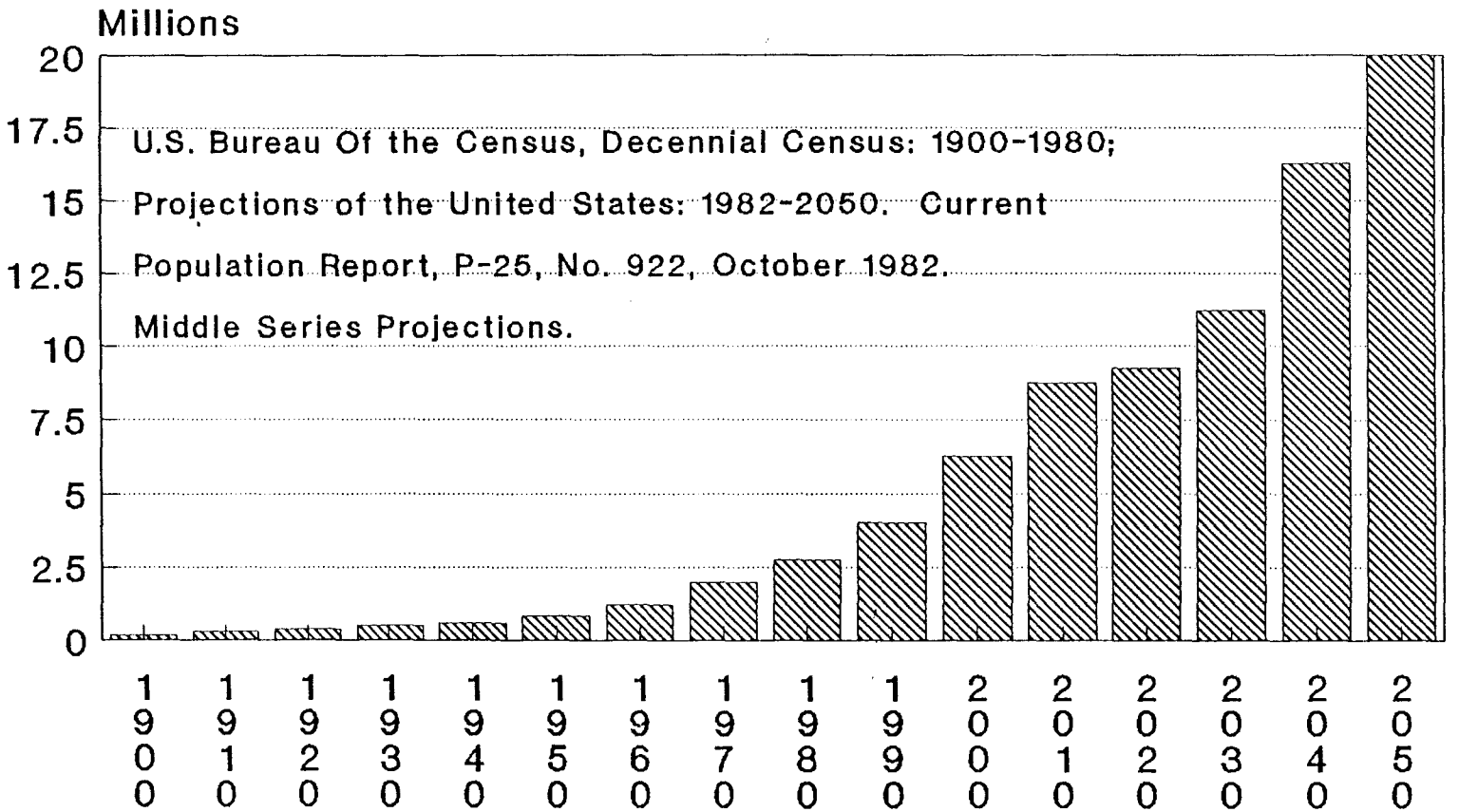


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Exhibit # 10
2/6/91
Human Serv. Subc.

Presentation Date: 2/6/91
SRS Page Number: 59
LFA Page Number: B-81
SRS Staff: Nancy Ellery, John Chappius, Norm Rostocki, Mary Dalton, Mike Hanshew

Presentation on Nursing Home and Community Based Programs

Chairman Bradley, members of the committee, for the record my name is Julia Robinson, Director of the Department of Social and Rehabilitation Services. I am here to talk to you today about the long term care programs of the Medicaid Services Division.

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

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

In the past, the two major factors affecting nursing home costs have been the growth in the number of licensed nursing home beds, and the level of reimbursement provided to facilities. Over the past five years the number of licensed nursing home beds has increased at about 2% per year.

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

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

After the last legislature, the nursing home providers met with me and asserted that Medicaid reimbursement rates for nursing facilities were inadequate and did not meet the criteria established by the Boren Amendment. Specifically, nursing homes

contended that the rate increases over the past several years have failed to keep pace with the rising costs of providing care.

I researched my options at length. After such research, it became clear to me that states that had been sued and lost in court, have had to spend considerably more money on back payments, etc. than would have been spent at tax payers expense had the state chosen a more direct method of addressing the problem. This does not take into consideration the costs of the lawsuit to the public or the wear and tear on agency staff of being in an adversarial role with the very agencies they are supposed to be working with. States that have recently lost Boren Amendment law suits include Pennsylvania, Michigan, Colorado and Virginia. In the Virginia case, providers established the right to sue states over the Boren Amendment in federal court.

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

1. Are we providing adequate state funding to insure ongoing quality care by quality staff?
2. Is the state's failure to adequately fund facilities resulting in an onerous cost shift to private pay residents or to county governments which operate 20% of

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

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

SRS is proposing a nursing home rate increase that complies with the federal requirements, but more importantly will enable nursing facilities to provide quality care. In fiscal year 1992 average Medicaid reimbursement would go from $56.00 to about $60.00 dollars per day. The following year, rates would rise an additional $4.00 per day. This represents a nearly seven percent increase in reimbursement rates for each of the next two years. The total cost

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to the general fund of this initiative is about 4.5 million dollars for the biennium.

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

Given that I felt we had to meet our commitment to providers but at the same time I felt it was unconscionable not to fund other needs in the SRS budget, I asked my staff to research how other states were trying to meet the ever increasing costs of Medicaid. They came back with a variation of a creative financing approach currently used in California, Florida, Georgia, Ohio, Tennessee and Texas. The approach is to assess $1.00 per day on every occupied nursing home bed in order to raise a large portion of the state funds required for the nursing home reimbursement increase. As you can see from the charts in handout # 18 (Exhibit #9), the state and federal government would be the primary payers of such a fee. When we developed this proposal last summer we included funds in the SRS

budget to raise nursing home rates an additional $1.00 per day to pay the utilization fee. Because the federal government pays 72% of each dollar spent, there are obvious advantages to the state to include the payment of the fee in facilities' reimbursement rates. Modifications to federal law in the past several months have changed the mechanics of the way the funds will be delivered, but the amount of money providers will receive remains the same. The fee is expected to raise 2.3 million dollars per year in revenue for the state to use as matching funds in the nursing home program. The federal government will be the source of over 1 million of the 2.3 million dollars, or 45% of the revenue from the fee. The 2.3 million dollars will be used as state matching funds to secure more federal dollars. The revenue from this fee will pay two-thirds of the cost of maintaining the rate increase in the proposed executive budget.

Medicaid recipients, in other words, low income individuals, will not pay the fee from their own funds, nor will people those nursing home care is paid for by Medicare, a group of people who do not necessarily have low incomes. By law the cost cannot be passed on to these individuals. For private pay persons, it is up to the facility to decide whether or not to pass along the cost. It is our hope with the substantial new funds in state money, this cost would not be passed on. We have been told by facilities, however, they probably will pass the cost on. Even in this case there should be a long term cost savings to private pay through reduced

cost shifting of Medicaid costs. An additional benefit to persons paying for their own care is the improvement in services the additional Medicaid dollars should bring. This proposal has been presented in full to another legislative committee, so I will not belabor it here.

~~(NANCY HERE)~~

While nursing home care is the most visible long term care service funded through Medicaid, it is by no means the only service option available. Medicaid funds several home and community services that enable some people who require long term care to remain in their homes and avoid placement in an institutional setting.

The Medicaid Home and Community Services (HCS) waiver, available in 31 of Montana's 56 counties, is a critical component of our state's long term care system. The HCS waiver provides a variety of home and community services that are not ordinarily funded through Medicaid to physically disabled and elderly individuals who require the level of care provided in a nursing home, but choose to remain at home. Some important HCS waiver services include: nursing, adult day care, respite care, personal care, Medical Alert and home modifications. Waiver services are coordinated by a network of eleven private case management teams made up of a nurse and a social worker. Case management is the glue that holds the waiver program together. Case managers ensure that waiver services meet each person's needs in as cost effective a way as is possible. At the direction of the 1989 Legislature, the department commissioned

an independent assessment of the cost effectiveness of Montana's waiver program. The results of the study confirm our belief that the waiver program is a cost effective alternative to nursing home care. Unfortunately, as is the case with many valuable programs, the demand for HCS services exceeds the supply available. There are currently over 100 people waiting for HCS services across the state. These people are by definition at risk of placement in a nursing home. In order to maintain our commitment to a balanced long term care system, the executive budget contains a proposal to provide HCS waiver services to an additional 50 people from the waiting list during the coming biennium.

Another important long term care service is the personal care program. Personal care services are provided to Medicaid eligible individuals who require assistance with the activities of daily living such as bathing, grooming and dressing. These services, which must be prescribed by doctor, are delivered in each person's home by personal care attendants working under the supervision of a registered nurse. Until the mid 1980's the department contracted directly with each personal care attendant who provided services. In 1986 the state department of labor ruled that personal care attendants did not meet the legal requirements necessary for independent contractor status. In response to that ruling the department issued a request for proposals for private agencies interested in providing personal care services. Since that time, Westmont Home Management Services Corporation of Helena, has

operated Montana's personal care program on a statewide basis. Last year, personal care services were provided to a total of 1,400 people in 39 counties across the state. The group of people who receive personal care is primarily made up of elderly persons and people with physical disabilities. While the services are important to everyone who receives them, people with severe physical disabilities are especially dependant on the day-to-day assistance provided by attendants. More and more people who receive personal care, especially the disabled, are demanding a greater degree of control over the services they receive. With the approval of the 1989 legislature, the department is conducting a pilot project to develop a system of self-directed personal care services that provides more opportunities for consumer participation in planning for and meeting their own needs. The study is part of SRS's continuing effort to work to improve personal care services in this state. In an effort to secure greater public involvement in planning services, the department for the first time has asked representatives from long term care provider and consumer groups to help draft the personal care services contract request for proposals that will define the personal care program for the coming biennium.

Recently, there has been a good deal of interest expanding Medicaid funding for personal care to include services provided in licensed personal care facilities. Advocates of such a policy believe that it would help reduce the cost of long term care to the state and fill a gap in Montana's long term care services continuum. While

such an option may be possible in the future, it is currently not available because of federal restrictions on where personal care may be provided. Despite the current restrictions, I believe the idea may have merit and I am very supportive of the concept of seeking federal approval for a pilot project to test the impact of such a policy on a limited basis. Staff from the Medicaid Services Division are working with a number of legislators, including Senator Waterman of this committee, to develop an acceptable pilot project proposal for consideration by the legislature.

(NANCY HERE)

While it is clear we are now doing a good deal to meet the long term care needs of many of Montana's citizens, I believe it is important that we begin now to prepare for the future. The money we are spending today to provide long term care services represents just the tip of the iceberg in potential public costs as we look towards the future. We are experiencing a dramatic increase in the number of seniors in the United States, especially in the over 85 age group(chart #19). This is occurring at a time when the number of working taxpayers is going down. When the babyboom generation retires early in the next century there will be more senior citizens than working tax payers. It is imperative that we begin to look for creative ways to both meet the ever increasing demand for services and at the same time act to control expenditures. I believe we can begin to address the challenge that the future holds by working now to develop a continuum of long term care in this

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state that provides quality nursing home services to those who require them, but also assures an array of home and community service alternatives to those who are able to remain in their homes.

(Hank Hudson and Joan Taylor here)

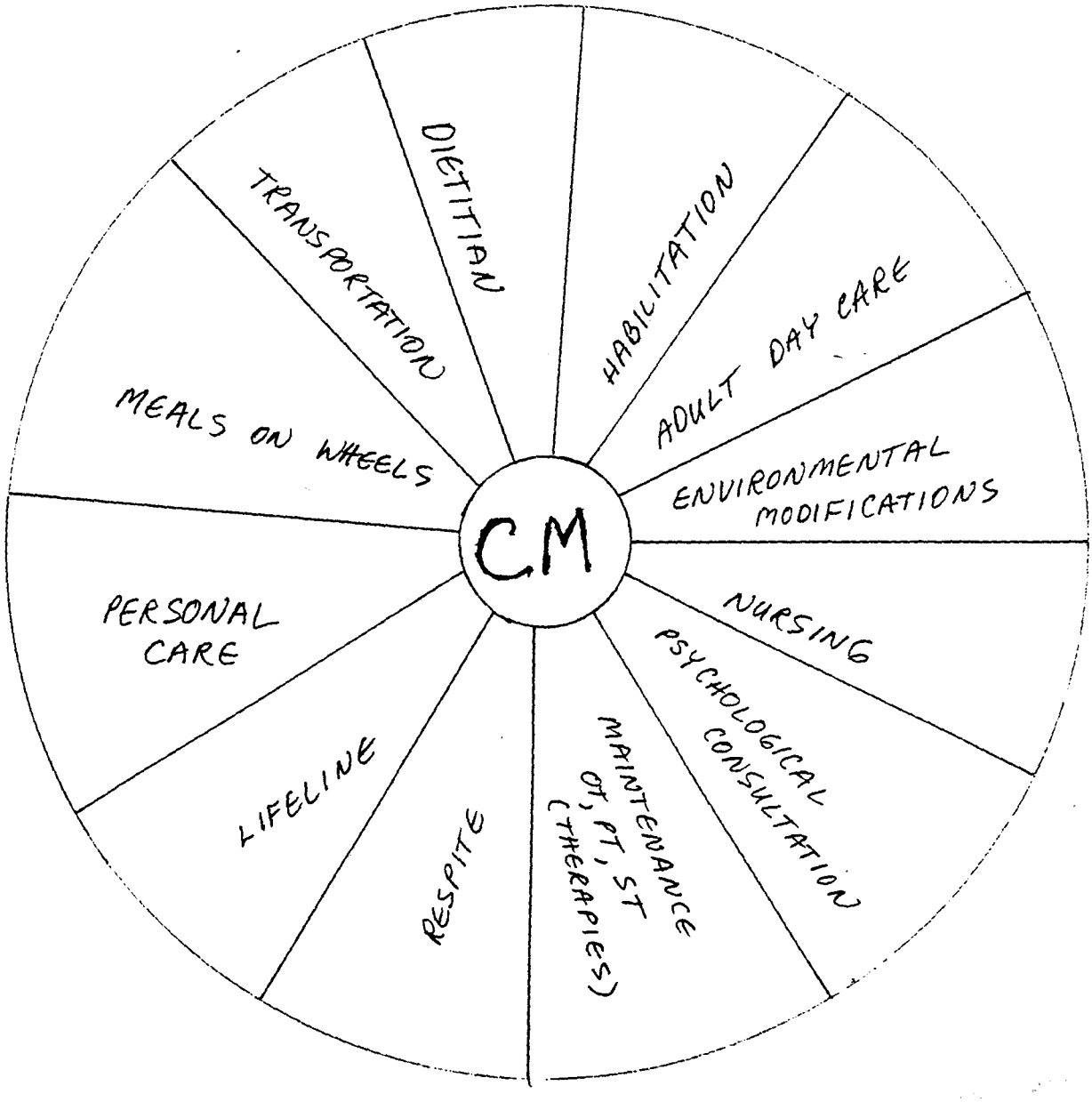
Realistically, government will continue to play a key role in financing long term services in the future. If, however, we hope to be able afford the kind of care all people want and deserve, we must provide incentives that encourage people to plan for their own long term care needs. Consistent with that philosophy, Governor Stephen's Health Care for Montana's package includes initiatives that provide tax incentives to support privately funded long term care. One proposal would expand the existing Montana Elderly Care Tax Credit to include a wider variety of long term care services, including nursing homes. Another proposal would qualify some costs for long term care insurance as a state income tax deduction. I believe both proposals will help focus the attention of each of us on the need to plan for a future that may include long term care services for ourselves or a loved one.

Thank You.

Exhibit #11
2/6/91
Human Serv. Subc.

EXHIBIT 11
DATE 2-6-91

MEDICAID WAIVER
CASE MANAGEMENT



MONTANA CASE MANAGEMENT ASSOCIATION

MEDICAID WAIVER CASE MANAGEMENT

CASE MANAGEMENT:

DEFINITION--Case management is a process which coordinates multiple services for individuals through assessment, planning, arranging for and monitoring services.

CASE MANAGEMENT ACTIVITIES--Case management includes the following activities:

Assessment--A comprehensive evaluation of the person's health, social, environmental and financial needs.

Care Planning--The development of a realistic and cost effective plan of care which involves the Case Management Team, the person, the attending physician and family members. Refer to HCS 808 for discussion of Plan of Care requirements.

Coordination--The arranging for necessary services by agencies, family members or volunteers.

Monitoring--The monitoring of services being delivered and changes in the person's situation.

MONTANA CASE MANAGEMENT ASSOCIATION

EXHIBIT 11
DATE 2-6-91
Hum. Sen. Svc.

MONTANA CASE MANAGEMENT ASSOCIATION
HOME AND COMMUNITY SERVICES
(MEDICAID WAIVER PROGRAM)

The Case Management Association consists of 11 Social Worker, RN Teams, who manage the delivery of services known as the Home and Community Services (Medicaid Waiver Program). The Department of Social and Rehabilitation Services of the State of Montana offers the Home and Community Services Program (Medicaid Waiver) to certain Medicaid eligible elderly and physically disabled individuals who require long term care. The program offers a valuable choice for elderly and physically disabled persons and contains health care costs by providing long term care services in the home rather than in an institution. The cases are managed by teams consisting of a registered nurse and a medical social worker and their agency is under contract with the department of Social and Rehabilitation Services. The Home and Community Service Program is available to individuals who are: elderly or physically disabled, on Medicaid, require intermediate or skilled nursing facility level of care and live in an approved service area. Current counties the Home and Community Services are available to include: Big Horn, Carbon, Cascade, Custer, Deer Lodge, Fallon, Fergus, Flathead, Gallatin, Golden Valley, Jefferson, Judith Basin, Lake, Lewis and Clark, Lincoln, Madison, Mineral, Missoula, Musselshell, Park, Petroleum, Ravalli, Richland, Roosevelt, Silver Bow, Stillwater, Sweetgrass, Teton, Wheatland, and Yellowstone.

This program is one choice of several in a continuum of care of services for elderly and physically disabled persons in the state of Montana. Since the onset of the Medicaid Waiver program in 1983, Case Managers have seen a tremendous improvement in the quality of life for elderly and physically disabled recipients. As documented in a recent survey, we have seen an increase in independence, less risk for persons choosing to live at home and a general overall sense of well being for elderly and physically disabled persons. Prior to the program many elderly and disabled persons who are now on the program, were living in institutions or surviving marginally in at risk home situations. This program enhances the recipients existing resources of family and friends with community services in an overall plan of care developed by the Case Management Team, the recipient and their physician.

Currently, there are approximately 439 opened cases, which includes a capacity to serve 330 elderly persons, and 174 physically disabled and 7 heavy care slots on a state wide basis. There is a waiting list of 27 elderly and 80 disabled persons and 25 Group Home. We would recommend that consideration for expansion include opening additional slots to cover those waiting and/or to expand existing team service delivery areas to include other counties.

The results of a recent statewide client satisfaction survey of all persons on the program show:

* ***90% of elderly clients felt they would NOT be able to remain at home without waiver services.***

* ***70% of physically disabled clients responded they would***

NOT be able to remain at home without medicaid waiver services.

* *82% of elderly clients stated their relationships with their family had improved because of the program.*

* *79% of physically disabled clients responded their relationships with family had improved because of the program.*

When asked "Where would you be without in home services?"

* *63% responded they would be in a nursing home.*

other responses were:

* *dead,*

* *up a creek without a paddle,*

* *unsafe, unhappy, relatives overburdened,*

* *out in the street.*

When asked how they felt about receiving Medicaid Waiver services, people responded:

* *"I'm happy living alone, I don't have to share my belongings with another person."*

* *"I'm so very fortunate to have services to stay in my own home."*

* *"I rejoice in being home".*

* *"I can keep a little bit of independence staying in my home, even though I need alot of help."*

* *"I couldn't manage without the program."*

* *"I believe this is the best thing that has happened for older people."*

* *"It's good to have these services for us old people, to stay home and be happy."*

* *"It's wonderful to stay home and do the things I enjoy."*

* *"There's no place like home."*

The Montana Case Management Association Home and Community Services Program clearly offers a choice that means improved quality of life for elderly and physically disabled persons living in Montana. (*This report was prepared by the Montana Case Management Association).

2/6/91 Human Serv. Subc. 12

January 21, 1991

OBRA 87

Persons with Mental Retardation Inappropriately Placed in Nursing Homes

2-6-91

POPULATION

Montana has 240 persons with mental retardation living in nursing homes. Most of these individuals are inappropriately placed because they do not need nursing services. Some of these persons were placed in nursing homes from institutions and many went to nursing homes because specialized services for developmentally disabled persons were not readily available in their communities.

OBRA LAW

Congress passed the Omnibus Budget Reconciliation Act (OBRA) 1987, which went into effect January, 1989. The law requires States to prevent further inappropriate placements into nursing homes. States were also required to conduct assessments of all individuals with retardation residing in nursing homes and must provide specialized services to these persons. The law allowed these individuals to make a choice to remain in the nursing home or have alternative placements developed for them in the community.

PLACEMENT NEEDS

There are 85 persons who need and want to leave nursing homes to community placements. These individuals and their families have documented their requests for alternative placements and are waiting for these services to be available.

- The mean age of the persons needing placement is 47 years old.
- More than half of these persons are now receiving DD day services.
- Almost half use wheelchairs and need barrier-free residences.
- Twenty percent have "mental retardation related conditions" of cerebral palsy, brain injuries and seizures and were placed in nursing homes because of the scarce residential resources that can provide the personal care services they need.
- Persons needing placements live in many towns, but the largest groups are living in nursing homes in Big Sandy, Butte, Billings and Polson.

PLACEMENT PLAN

The Developmental Disabilities Division (DDD) has developed plans to meet the specific needs for the 85 persons needing placements out of nursing homes. The types of placements developed will include group homes (intensive, standard and senior), foster homes and individualized supported living arrangements. The Division plans to make placement services available during fiscal year 1993, with all persons placed by June, 1993. The DDD will develop services for individuals remaining in nursing homes late in 1993 or early in 1994.

FUNDING

The DDD has submitted a Home and Community Based Waiver (HCB) specifically to meet the placement needs of persons inappropriately placed in nursing homes. Approval of the waiver is expected by January 31, 1991. This waiver will provide federal medicaid funding to meet 71% of the costs of developing needed placement services. The costs of providing specialized services for persons continuing to reside in nursing homes must be 100% state general funds.

January, 1991

NURSING FACILITY POPULATION WITH DEVELOPMENTAL DISABILITIES

AGE	NEED ALTERNATIVE PLACEMENT	REMAIN IN NF WITH SPECIALIZED SERVICES	REMAIN IN NF SPECIALIZED SERVICES
4		X	
6			
8		X	
10		X	
12		XX 1	
14			
16		X	
18		1	
20		X	
22			
24	X	X 111	
26	X 1	X 1	
28	1	1	
30	1		
32	X	11	
34	X 1	11	
36	XX 11111		
38	XXX 11		
40	XXX 1111	X 1	
42	X 1	X 11	
44	XXXX 11	X 111	
46	XXXX 1		
48	XX 1	111	
50	XX 111	111	
52	XX	X 1	
54	X 1111	X 1	
56	X	XX 111	
58	XX 11	XX 11	
60	XX 11	XX 1	1
62	X 1	XX 1111111	1
64	1	X X 111	1
66	XXX 1	X 11111	1
68	XX	XX 11	
70	XX 1	XXX 1111	1
72	XX	X X 1111111	
74	X X 11	XX 111111111	11
76		XX 11111	11111111
78	X	X 11	
80	X	11111	111
82		X X 11	111
84		11	1111
86		X 1	11
88		X	1
90		X X	1

TOTAL PERSONS = 85	TOTAL PERSONS = 125	TOTAL PERSONS = 30
MEDIAN AGE = 47	MEDIAN AGE = 67	MEAN AGE = 76
IN DD DAY = 48	IN DD DAY = 40	IN DD DAY = 0
NO DD DAY = 37	NO DD DAY = 85	NO DD DAY = 24

KEY: X = RECEIVING DD FUNDED SERVICES
1 = NOT RECEIVING DD SERVICES

January, 1991

NURSING HOME POPULATION
CHOICES FOR PLACEMENT AND SPECIALIZED SERVICES

REGION I	TOTAL	PLACEMENT CHOICE	NURSING HOME SPECIALIZED SERVICES	NURSING HOME ONLY (ELDERLY)
Circle	1		1	
Glasgow	2		2	
Malta	1		1	
Plentywood	1	1		
Sidney	1		1	
Wolf Point	2		2	
Baker	2		2	
Broadus	1		1	
Forsyth	2		2	
Glendive	3	1	1	1
Miles City	10	4	6	
	26	6	19	1

REGION II	TOTAL	PLACEMENT CHOICE	NURSING HOME SPECIALIZED SERVICES	NURSING HOME ONLY (ELDERLY)
Harlem	8	3	4	1
Big Sandy	18	11	7	
Browning	1		1	
Choteau	3	1		2
Fort Benton	2		2	
Shelby	1		1	
Great Falls	11	1	7	3
Havre	3		2	1
Chester	4	1		3
Conrad	1			1
Cut Bank	1		1	
	53	17	25	11

REGION III	TOTAL	PLACEMENT CHOICE	NURSING HOME SPECIALIZED SERVICES	NURSING HOME ONLY (ELDERLY)
Hardin	2		2	
Columbus	13	2	11	
Billings	15	6	9	
Lewistown	19	5	13	1
Roundup	1	1		
Big Timber	1		1	
Red Lodge	5	3	1	1
Harlowton	1		1	
	57	17	38	2

January, 1991

NURSING HOME POPULATION
CHOICES FOR PLACEMENT AND SPECIALIZED SERVICES

REGION IV	TOTAL	PLACEMENT CHOICE	NURSING HOME SPECIALIZED SERVICES	NURSING HOME ONLY (ELDERLY)
Helena	6	2	4	
Clancy	5		3	2
Butte	14	5	8	1
Deer Lodge	1		1	
Dillon	1			1
Galen	6		2	4
Sheridan	1			1
Bozeman	5	2	3	
White Sulpher	2		1	1
Warm Springs	3	2	1	
Livingston	2		1	1
Anaconda	1		1	
TOTAL:	47	11	25	11

REGION V	TOTAL	PLACEMENT CHOICE	NURSING HOME SPECIALIZED SERVICES	NURSING HOME ONLY (ELDERLY)
Big Fork	1	1		
Eureka	3	1	2	
Hot Springs	3		3	
Kalispell	3	1	2	
Libby	6	3	1	2
Stevensville	3	1	2	
Plains	2	1	1	
Polson	23	19	3	1
Ronan	2		1	1
Whitefish	4	2	2	
Hamilton	1		1	
Missoula	6	5		1
TOTAL:	57	34	18	5

STATEWIDE	240	85	125	30

1d
2-6-91
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MONTANA OBRA PLACEMENT NEEDS
FOR PERSONS WITH RETARDATION INAPPROPRIATELY PLACED IN NURSING HOMES

Montana has 240 persons with mental retardation living in nursing homes. Most of these individuals are inappropriately placed because they do not need nursing services. Some of these persons were placed in nursing homes from institutions and many went to nursing homes because specialized services were not readily available in their communities. The federal OBRA law allows these individuals to choose to leave nursing homes and requires the state to develop the services they need to be placed in the community. Some of the 85 individuals who have chosen to leave nursing homes and are waiting for placement are:

WILLIS - Willis is 46 years old, wears a beard and speaks with difficulty due to cerebral palsy. He has mild mental retardation. He has a good sense of humor. Willis was placed in the institution at age 16 and lived there for 15 years. For the past 15 years he has lived in a nursing home. He needs help for all self-care because of his cerebral palsy, but he is in good health. He enjoys listening to recorded books and watching educational programs on TV. He budgets his money for recreational activities and is fully capable of choosing his own activities. He attends a DD day program. Willis wants very much to leave the nursing home to live in his own place where he can make more of his own choices and have more social activities. His parents support this decision.

JANET - Janet is 41 years old, has Down's Syndrome, is deaf and blind, and she cannot speak. She lived with her parents until she was placed in a foster home, where she lived for 15 years. She was then placed in a nursing home five years ago. Janet can walk but prefers to hold on to walls since she cannot see. She can feed herself with her fingers but needs help using a spoon. She needs help with all her self-care. Janet like to interact with persons, particularly if she can touch them, but will occasionally pinch. She has no medical or nursing needs and the only medication she receives is mellaril to control behavior problems. She will hit herself and will throw or tear things. She is often physically restrained in a geri chair. The staff at the nursing home feel she is inappropriately placed because they do not have the ability to work on communication, self-care training or behavioral management. She has shown some ability to learn skills in working with puzzles and stringing beads. Janet has never had an opportunity for appropriate training. She could greatly benefit from placement in an intensive training DD group home and day program.

FRED - Fred is 36 years old, is in a wheelchair with paralyzed legs due to spina bifida. He has a shunt in his arm to receive dialysis since he has had his kidneys removed. Fred has mild mental retardation. He speaks in complete sentences, can shave, brush his teeth and operate the TV. Fred was placed in an institution at 4 months old and lived there for 22 years. He was then placed in a nursing home where he has lived for the past 15 years. Two years ago he was treated for depression when he requested the dialysis be discontinued so he could "go to heaven". Now Fred wants to live in an apartment with a roommate. He wants to have his own room, he wants to be taken to basketball games and rock concerts and shop for his own personal needs.

JOANNE - Joanne is a 60 year old woman who is friendly and like to help others. She uses a walker and she has mild mental retardation. Joanne is totally verbal and is very capable of expressing her needs and choices. She lived with her mother until 5 years ago when her mother died. Since that time she has lived in the nursing home and enjoys attending a senior DD day program. Joanne wants to live in a senior group home and do some cooking, and have more privacy than is available at the nursing home. She mentioned that recently she has had several different roommates at the nursing home because they were very ill and died and all of the relatives were in her room day and night.

Angie Drennan, a skills trainer, prepares dinner from a menu the women planned themselves.

Sideman said there's been no opposition locally to moving persons who have developmental disabilities into city neighborhoods. Larger group homes with eight to 15 residents have often met zoning obstacles and neighborhood resistance.

"We haven't had a problem because we are doing it quietly. We go in and meet the landlord, pay the rent and once we are there, we meet the neighbors. In some neighborhoods, neighbors extend a hand and say call us if you need anything. Our houses don't look like an agency program. There's no van with a label sitting in the driveway. The only thing that would possibly look different from the rest of the neighborhood is a wheelchair ramp and that's not uncommon today," she said.

Anna and Mary's north side neighbors made curtains for the house and children from nearby St. Agnes grade school planted flowers before Mary and Anna moved in.

Sideman said reaching out into the community is difficult for nursing homes because the staff is so busy making sure that residents get the physical and medical care they require.

"They are worried about whether everyone is showered and fed and gets their medication. They don't have time to say 'Anna, would you like to volunteer at the hospital?' Our staff works on getting people involved in the community."

The staff helps participants find ways to develop their own interests and skills.

"One of our participants, who is blind and uses a cane or a walker to walk, now volunteers at a day-care center one hour a day and tells stories to the kids," Sideman said.

Mary, an avid baseball fan, hopes someday to work at a ballpark concession stand. From the back porch of her house, she can see games from a neighborhood baseball diamond.

Anna has her own interests. Arrangements are being made for Anna to work in a hospital mailroom.

"She just loves being around people," Sideman said.

Anna's new battery-powered wheelchair lets her be even more independent. The new wheelchair made it possible for an attendant to take Mary and Anna on excursions into the city together. Between them this summer they hit the city's main events—LincolnFest, the Carillon Festival, the Illinois State Fair, along with blockbuster movies and church picnics.

"I assist them with whatever they want to do. These guys can communicate a lot," says Kendra Guernsey, a skills trainer for Mary and Anna, who previously worked in a group home for delinquent kids.

"Mary and Anna don't argue with me. They want to sit down to their meal, take a bath and go to bed," Guernsey said. "Doing normal things in life is just thrilling to them."

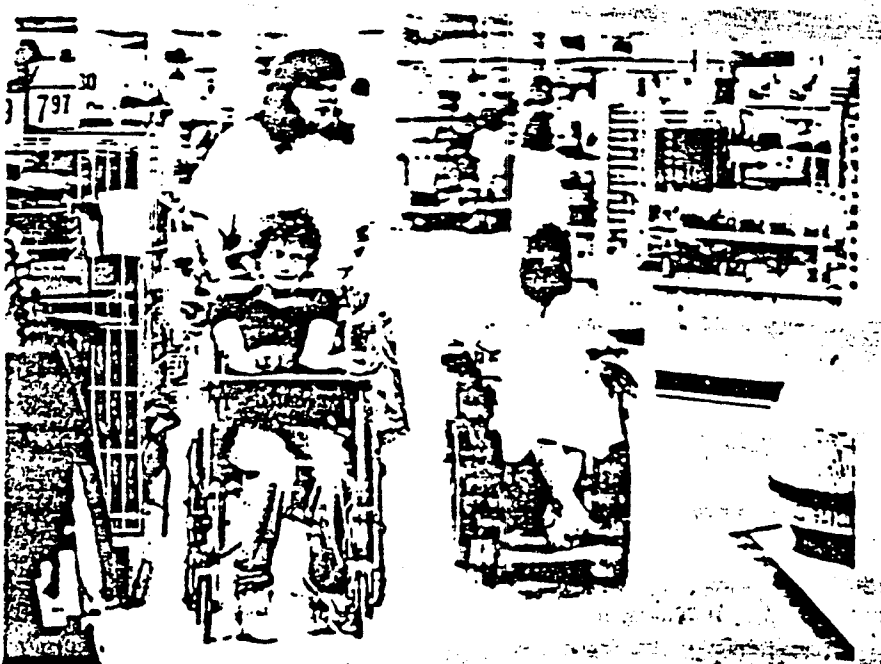
Anna adds, "I had to fight with them to give me a bath in the nursing home."

"To go to the bathroom you'd have to wait an hour for them to help you," she says. Mary points in agreement with Anna.

Guernsey reads to Mary and Anna in the evening. This week's selection from the library includes "His Gentle Voice," a Christian romance, and the autobiography of Amy Grant, the Christian pop singer. Anna and Mary share favorite music—rock n'roll—and soap operas.

The only conflict they have is over what baseball game to watch.

Anna likes the Cardinals and Mary likes the Cubs.



UCP skills trainer Kendra Gumsey accompanies Mary and Anna on a shopping trip for a stereo.

Exhibit #13
2/6/91
ltw

EXHIBIT 13
DATE 2-6-91
SB

Glendive Medical Center

February 4, 1991

The Honorable John Johnson
Helena, Mt. 59620

Dear John:

I am writing you in regards to Glendive Medical Center's request that Dawson County be designated for the Medicaid Waiver Program. I am attaching a list of the counties throughout the State that have the Medicaid Waiver Program. Please note that Custer and Richland Counties have the Waiver Program. Because Dawson County has similar population statistics, we feel there is a real need for the Waiver Program and we would like to urge the Appropriations Committee to designate Dawson County for this program. We are requesting approximately 40 slots for the program.

I have spoken with Lori Brengle, Area Agency Director and Sue Howe, Long Term Care Specialist for the local Medicaid Division and they are both in support of the attempts by Glendive Medical Center to get the Waiver Program.

As you know, Glendive Medical Center is considering the possibility of building a 26 bed nursing home addition to meet the long term care need in Dawson County. This addition has received Certificate of Need approval from the State and the Board of Directors is debating whether to build it. As you know, building beds is extremely expensive and we would like to utilize any community based programs first. However, because Dawson County is not designated in the Waiver Program, we can not even utilize this option. If there is still a need existing for the new nursing home beds after using the Waiver Program, we would pursue it at that time.

GMC has approximately 56 people on its nursing home waiting list and the nursing home has run 100% occupied for the last five years. In addition, the hospital has also designated 17 swing beds which have operated also at 100% occupancy.

The waiver could also be used for other people in addition to adults. There have been several people in Dawson County that have called me regarding the possibility of expanding the Waiver Program for developmentally disabled people.

Here are the population statistics for Dawson County based on July 1, 1988 figures from the Bureau of Census information. We received this information from the National Planning Association Data Services, Inc. which was released in January of 1990.

Age	Total Population
55-59	370
60-64	380
65-69	370
70-74	260
75 & above	470

Total SSI eligible people in Dawson County: 55

Total Number of people on Medicaid: 475 (unlimited potential because of new changes in the system)

I have spoken to the Jane Korin, Program Director for Case Management of the Medicaid Division of Montana. She is well aware of the attempts by Glendive Medical Center to designate Dawson County for the Medicaid Waiver Program. She recommended that I contact you and Dorothy Bradley to get Dawson County designated.

We urge your consideration and assistance in getting Dawson County designated for the Medicaid Waiver Program. I think it will fill a real need that exists in Dawson County and promote a cost effective alternative than admission to a nursing home.

Thank you again for your support and assistance. If you have any questions, please feel free to contact me.

Sincerely,

John H. Solheim (fs)
Chief Executive Officer

JHS:pz

cc: Dorothy Bradley, Chairman
Appropriations Committee

Jane Korin
Program Director

EXECUTIVE SUMMARY

HB100'S MANDATE TO THE DEPARTMENT OF FAMILY SERVICES

In HB100, the Montana Legislature instructed the Department of Family Services (DFS) to prepare a report for the 1991 Legislature concerning the implementation of a continuum of services to children and youth that addresses the identified needs of children who are in the custody of the department or for whom DFS has a legal mandate to provide services.

The Legislature requested DFS to:

(1) quantify the numbers of children served by DFS and the numbers of children unserved or underserved,
(2) identify what is needed for a complete and adequate continuum of services that meets the needs of children served by DFS, and
(3) describe DFS efforts to stabilize the foster care provider rate system.

The Legislature specifically instructed DFS to identify the additional resources needed to develop services in the following areas: preventive services, family-based services and in-home services for families in crisis, and intermediate-level services such as specialized foster care, therapeutic foster care and therapeutic group home care.

HB100 also asked DFS to identify services needed to meet the needs of DFS-served children in certain special populations: juvenile sex offenders, dually-diagnosed children (developmentally disabled and emotionally disturbed), juvenile delinquents in need of community juvenile corrections programs, chronically mentally ill children, and severely emotionally disturbed children.

The Legislature stressed that the planning process for developing the DFS children and family service system should be done in conjunction with the ten DFS Local Youth Services Advisory Councils.

DFS METHODS OF RESPONDING TO THE HB100 MANDATE

It is important to understand that the HB100 task of quantifying the numbers of children served, underserved, and unserved was strictly limited to youth either in the custody of DFS or for whom DFS has a legal mandate to provide services.

To quantify the numbers of children involved and identify what is needed for a complete and adequate continuum of services, DFS used two basic resources: (1) DFS' current data sources, the Protective Services Information System and the Foster Care Payments System (Client Database), and (2) special DFS surveys and research concerning the needs of DFS-served children.

Since the information available through the department's current data collection is very limited, additional surveys of children receiving DFS services at a certain point in time during

FY90 were necessary. By combining this point-in-time data with caseload trends over the past five years, the department arrived at estimates and projections for the FY92-FY93 period.

The department used data on historical trends wherever possible, but shortcomings in the data collection system shared with SRS clearly revealed the need for a comprehensive management information system (MIS).

The department's process for identifying and calculating additional resources needed for FY92 and FY93 did not include a consideration of possible rate increases or cost-of-living increases that would affect the costs involved. Instead, since the HB100 report is not a budget request but rather an estimate or indication of the additional resources needed for FY92 and FY93, the department used FY90 average costs for services in calculating estimates.

Since projected caseload increases are crucial to providing estimates of the needs for FY92 and FY93, anticipated caseload growth based on trends over the past six years was included in DFS' calculation of estimates of additional resources needed.

The department identified and quantified the needs of children served by DFS, including children and youth in each of the four special population categories requested by the Legislature. The service needs of children in the four special populations are included as part of the overall service needs rather than being separated out as an isolated set of needs for the special populations.

The Legislature suggested that the planning process for the development of the children's services system should be tied to the local level and involve local advisory council participation in the planning process. In response, the department designed and implemented a DFS Local Youth Services Advisory Council planning process during 1989 and 1990 that directly focused these grassroots councils' efforts on HB100's issues and concerns. The department then utilized the results and recommendations that emerged from the ten local youth services advisory councils' efforts in conducting HB100 research and in preparing this HB100 report.

The department also consulted regularly with a HB100 Subcommittee established by the State Youth Services Advisory Council (SYSAC) in designing the department's activities for meeting the HB100 mandate. The department provided a draft of this HB100 report for review and comment to all members of the state and local youth services advisory councils.

SUMMARY OF KEY FINDINGS

*** **DFS identified a need for a Management Information System (MIS).** The data collection system now used by DFS is not adequate to meet DFS needs.

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Additional resources needed for the MIS:		
FY92:	$ 418,149	Completion of the system requirements analysis; software design and development; hardware acquisition and installation
FY93:	$ 487,733	System development; hardware acquisition and installation
FY94:	$1,035,642	System development; hardware acquisition and installation
FY95 and beyond:	$ 569,510	System maintenance and operation

*** DFS identified a need for additional staff to accomplish essential DFS service mandates. DFS identified a need for a total of 190.84 additional FTEs:

- -- 108.1 CPS social worker FTEs and 32.4 supervisor FTEs
- -- 10 family resource specialist FTEs
- -- 13.4 social worker FTEs and 2.7 social worker supervisor FTEs for required services to Native American children living on reservations.
- -- 15.38 FTEs for services at the Pine Hills School for Boys
- -- 4.86 FTEs for services at the Mountain View School for Girls
- -- 3 aftercare counselor FTEs and 1 aftercare supervisor FTE

Additional resources needed:	FY92	FY93
Salaries, operating expenses and training:	$7,101,891	$7,101,891

*** DFS identified how well the needs of children served by the department are currently being met. The great majority of children being served by DFS were found to be adequately served, with the services provided being sufficient to meet the children's needs, as summarized below:

- -- 80.4% of the children served by DFS in out-of-care;
- -- 65.8% of the children served by DFS in abuse and neglect investigations and protective services.

*** DFS identified how well the needs of children in the four special populations highlighted by the Legislature are being met. The great majority in the special populations who are being served by DFS were found to be adequately served, as summarized below:

- -- 77.8% of those who are both developmentally disabled and emotionally disturbed;
- -- 75.0% of those who are juvenile delinquents needing community-based corrections services;
- -- 75.4% of the children with severe emotional disturbances or chronic mental illness;
- -- 58.3% of those who are juvenile sex offenders.

*** DFS identified a need for additional In-Home Services. The department's HB100 research found that DFS-served children had extensive unmet needs for In-Home Services.

Inadequately served children who will need In-Home Services:

	FY92	FY93
In-Home Family Support Services:	852	914
Family or Individual Therapy and Mental Health Services:	975	1046
Child Protective Day Care:	191	205
Family-Based Services to prevent imminent out-of-home placements:	635	678
Additional resources needed:	$4,431,600	$4,835,200

*** DFS identified a need for additional Out-of-Home Services. The department's research found that DFS-served children had extensive unmet needs for Out-of-Home Services.

Inadequately served children who will need Out-of-Home Services:

	FY92	FY93
Family Foster Care:	145	152
Group Home Care:	14	15
Specialized Foster Care:	59	62
Therapeutic Foster Care:	28	29
Therapeutic Group Home Care:	45	47
Independent Living Services:	15	15
Residential Treatment Services:	45	47
Additional resources needed:	$2,307,079	$2,320,387

RECOMMENDATIONS OF THE STATE YOUTH SERVICES ADVISORY COUNCIL

At its December, 1990 meeting, the State Youth Services Advisory Council recommended that DFS should: (1) place high priority on the development of a new DFS Management Information System; (2) work toward increasing DFS' Child Protective Services (CPS) social worker staff by 108 employees; (3) initiate a Family-Based Services (FBS) program statewide to meet the identified need for FBS services and make FBS a key component of DFS' basic response to child abuse and neglect; and (4) phase in the three recommendations above over a three-year period, FY92-FY93-FY94.

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THE DFS ACTION PLAN

DFS will take the following steps to achieve the recommendations of the State Youth Services Advisory Council and meet the needs identified in the department's HB100 research.

*** **DFS will work with representatives of the public and private sectors in a policy advisory group to design a system of care for out-of-home services and develop standards for when a child will be placed in a certain level of out-of-home care. DFS will:**

1. develop an evaluation methodology for assessing children's needs and identifying appropriate placement options;
2. develop a common application form for statewide use with children being considered for out-of-home placements; and
3. resolve the issue of the cost of services in the continuum and develop payment rates for the levels of care that are identified.

*** **DFS will pilot a continuum of services system in each of the five regions. DFS will:**

1. design and initiate a plan for the full continuum of services, starting with regional pilot projects;
2. identify services needs for the continuum regionally;
3. develop and implement Requests for Proposals (RFPs) for needed services and award contracts by July 1, 1991; and
4. expand the agreements with the Indian tribes and explore the option of contracting with the Tribes for provision of basic child protection services.

*** **DFS will use the following resources to begin development of the continuum of care:**

- DFS will use Medicaid residential treatment funds transferred to the department by SRS to develop services designed to reduce the numbers of children inappropriately placed in in-patient psychiatric care and to dramatically increase in-state treatment options. The funds will be allocated as follows:
  - -- approximately $500,000 to pilot projects for family-based services and in-home family support services in each region, to reduce the number of out-of-home placements;
  - -- approximately $200,000 to expand family foster care and group home care services;
  - -- approximately $800,000 to develop and expand therapeutic foster care and therapeutic group home care services;
  - -- approximately $200,000 to develop specialized group care alternatives for medically needy children; and
  - -- approximately $500,000 to develop residential treatment programs statewide.

- DFS will use approximately $1.3 million of the funds transferred by SRS to DFS from Medicaid residential treatment services to meet current treatment obligations.

*** **In addition, to increase the resources available to meet the needs of children served by the department, DFS will:**

1. pursue funding under Medicaid for less intensive out-of-home care services;
2. more fully utilize the SRS "Kids Count" program (EPSDT, Early Periodic Screening, Diagnosis and Treatment) program to screen children in foster care for medical needs;
3. use the SRS Kids Count/EPSDT program for identifying and meeting the medical needs of children receiving CPS services from DFS who are IV-E eligible; and
4. develop an interagency agreement with the Department of Institutions regarding emotionally disturbed and severely emotionally disturbed children, clarifying the two departments' respective roles and responsibilities.

See Section V of the HB100 report for a more detailed summary of the key findings of this report.

A copy of the complete Department of Family Services HB100 report, BUILDING AN ADEQUATE SERVICE SYSTEM FOR CHILDREN AND FAMILIES: Montana's Opportunity to Effectively Protect Children and Strengthen Families, is available upon request.

EXHIBIT 15
DATE 2-6-91
HB

Exhibit #15
2/6/91
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Chairman Bradley, members of the committee, I'd like to briefly review the budget modifications in the Medicaid long term care area, most of which Julie touched upon in her presentation. In addition, I'd also like to take some time to mention several other long term care issues which are being discussed during this legislative session.

The largest budget modification in the area of long term care, which Julie has already discussed at length, is to re-base nursing home reimbursement rates. The proposal would raise the Medicaid rate paid to nursing homes from about $56.00 per day to almost $64.00 per day at the end of the biennium, at a total cost of almost 16 million dollars.

In order to help finance the increase, SRS proposed a nursing facility utilization fee of one dollar per day. If implemented the fee would raise about 2.3 million dollars per year. The budget contains a modification that would reimburse nursing facilities in an amount equal to the $1.00 per day cost of paying the fee for Medicaid residents. The need for this budget modification is contingent on the passage of the proposed fee by the legislature. Should the utilization fee proposal be rejected, this modification would no longer be necessary.

Another budget modification would add home and community services funded through the Medicaid Waiver for an additional 50 people over

the next two years. Thirty-eight people would be served in the first year and an additional 12 people in the second year. Waiver services provide a cost effective alternative to the nursing facility for people who wish to remain in their own homes. In December, a total of 107 people were on the waiting list for waiver services in the 31 counties where the waiver is available.

The remaining long term care budget modification deals with the OBRA requirements relating to persons with developmental disabilities who live in nursing homes. Here to speak to you about this issue is Dennis Taylor the former administrator of the Developmental Disabilities Division.

Before I conclude this portion of the presentation, I'd like to make you aware of two other long term care issues.

Last session, the legislature increased the salaries of developmental disabilities service providers. A similar increase was not included in the budget for the two group homes operated for people with physical disabilities that are funded under Medicaid waiver. Since the Medicaid waiver group home services are provided by an agency that also operates DD group homes, a problem was created. The provider couldn't justify two different salary structures for virtually identical types of work. Since I now understand that you have before you a proposal to again increase developmental disabilities service provider salaries, I wanted you to be aware of this issue.

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Finally, the 1989 legislature adopted legislation to make Hospice Care a Medicaid reimbursable service. That legislation is scheduled to sunset at the end of this year. SRS supports House Bill 545 which will extend the authorization for Medicaid funded Hospice services. The program is in its infancy and Medicaid utilization has remained low. While there is a limited amount of data on the program, we believe in the future Hospice care will prove to be a valuable alternative to the institutional placement of persons who have a terminal illness.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services SUBCOMMITTEE DATE 2/6/91

DEPARTMENT(S) SRS DIVISION

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Mike Billings	SRS	
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Nancy Ellery	SRS	
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