# MINUTES

## MONTANA HOUSE OF REPRESENTATIVES
## 52nd LEGISLATURE - REGULAR SESSION

## SUBCOMMITTEE ON HUMAN SERVICES & AGING

**Call to Order:** By **CHAIRMAN DOROTHY BRADLEY**, on February 7, 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**

**CHAIRMAN BRADLEY** distributed **REP. WILLIAM BOHARSKI's** draft language on the transfer of funds from Medicaid nursing care to the Home and Community-Based Waiver Program. **EXHIBIT 1**

**Nancy Ellery, Medicaid Services Division Administrator,** distributed Department testimony on the State Medical Program. **EXHIBIT 2**

### EXECUTIVE ACTION ON INSTITUTIONAL REIMBURSEMENT, INDIAN HEALTH AND MEDICARE BUY-IN

**Carroll South, Legislative Fiscal Analyst,** referred to Institutional Reimbursement budget figures in **EXHIBIT 1 from Feb. 5, 1991, minutes.** He said the dollars are all federal funds. The General Fund match for state institutions is appropriated to the institutions. The budget drops in the second year of the biennium to reflect Medicaid reimbursement reductions from the downsizing of the Montana Developmental Center (MDC) at Boulder.

Indian Health is 100 percent federally funded. The budget reflects a large increase. Details are available if desired.

The Medicare Buy-In reflects a 10 percent funding increase in each year of the biennium because the program has been growing and is expected to continue to grow at that rate. It includes some General Fund matching money.

**MOTION:** **REP. JOHNSON** moved approval of the Institutional Reimbursement budget.

**VOTE:** The motion **PASSED** unanimously.

**SEN. KEATING** asked if Indian Health involves prenatal care. **Ms. Ellery** said Indian Health is the payer of last resort. As Medicaid eligibility for pregnant women has increased, more are being paid for by Medicaid and at lower rates than what Indian Health used to pay.

**SEN. KEATING** asked how the money is spent. **Ms. Ellery** said the money comes through as a pass-through from the federal Bureau of Indian Affairs. SRS passes the money on through contracts with Indian Health Service facilities statewide. SRS has a Medicaid staff person who responds to questions and manages the contract but does not get administrative money for the position. All the money goes to reservations for health services.

**SEN. WATERMAN** asked if the budget reflects an increase in funding. **Ms. Ellery** said yes. **SEN. WATERMAN** asked if programs like the Helena Indian Alliance come under this. **Ms. Ellery** said she wasn't sure. All the money goes to reservation clinics.

**MOTION:** **REP. JOHNSON** moved approval of the Indian Health budget.

**VOTE:** The motion **PASSED** unanimously.

**MOTION:** **SEN. KEATING** moved approval of the Medicare Buy-In budget.

**VOTE:** The motion **PASSED** unanimously.

## HEARING ON THE STATE MEDICAL PROGRAM

**Julia Robinson, SRS Director,** said the Department is proposing a major redesign of the State Medical Program.

**Ms. Ellery** distributed a fact sheet on the State Medical Program, **EXHIBIT 3**, and cost differences for state-assumed counties as requested by **SEN. KEATING. EXHIBIT 4**

**Ms. Robinson** read Pages 1-4 of **EXHIBIT 2.**

**SEN. KEATING** said it appears by looking at Chart 23 in **EXHIBIT 3** that there is no tie between General Assistance cases and Medical

cases. **Ms. Robinson** said there should be a tie. There was a flaw in the program's design.

**SEN. KEATING** asked how many people are being served. **Ms. Robinson** said about 3,000. **SEN. KEATING** asked what criteria determine eligibility. **Ms. Robinson** said people who are eligible for General Assistance are automatically eligible for the State Medical program. So are people who earns up to $330 per month and have a medical problem. **SEN. KEATING** asked about the age group. **Ms. Robinson** referred to Chart 22 in **EXHIBIT 3.** She continued reading from **EXHIBIT 2.**

**Ms. Ellery** discussed the Department's proposed redesign of the program. She read Pages 5-8 of **EXHIBIT 2.** The goal of managed care is to reduce costs by decreasing unnecessary and inappropriate use of services. SRS plans to contract with a private company to provide managed care. Blue Cross-Blue Shield data shows $9 is saved for each dollar spent on managed care.

**Ms. Robinson** distributed details on State Medical Program funding, **EXHIBIT 5**, and draft language on the General Relief Medical Assistance Program, **EXHIBIT 6.**

**SEN. NATHE** asked if emergency room use is limited under this program. **Ms. Ellery** said no. **Ms. Robinson** said that is why the Department wants to institute managed care. **Ms. Ellery** said the Medicaid Program has one restriction. The Department refers to it as a lock-in program. A computer tracking system identifies people who use emergency rooms or pharmacy services in excess of what is considered normal. The Department arranges through the county to have the person "locked" into one doctor, who then acts as that person's case manager. The patient can choose only one physician and one pharmacy. If the person goes elsewhere for services, the bill is not paid.

**SEN. WATERMAN** said outreach and education is needed to teach people about the program and how to use it. She asked if the Department's plans include outreach and education. **Ms. Robinson** said SRS staff will receive extensive training and all manuals will be rewritten. The Department will have to determine how to explain the program to people. **SEN. WATERMAN** suggested the Department work with advocacy groups. **Ms. Robinson** said the key to the program is to get clients on Supplemental Security Income (SSI). This bill would require them to be on SSI and the Department needs to make resources available to them. A recent change in federal law makes it much easier. The federal government will start paying as soon as the state determines potential eligibility.

**SEN. KEATING** asked if clients had to go to more than one place for services. **Ms. Robinson** said this group goes to the welfare office, which determines eligibility. The State Medical program is available in only state-assumed counties.

**SEN. KEATING** said Yellowstone County is not state-assumed. He asked if the budget would be dramatically impacted if Yellowstone County becomes state-assumed. **Ms. Robinson** said costs would be above $3 per capita. If Yellowstone County were to become state-assumed, it would probably cost the state some money.

**SEN. KEATING** said the program should be controlled so that it is not beneficial for non-assumed counties to become state-assumed. The program doesn't need to expand if non-assumed counties are serving needs. Some counties generate only three to four mills for these medical services and wouldn't benefit from becoming state-assumed. But at some point, if the Legislature allows the program to expand, other counties will want to become state-assumed to benefit from the money. **Ms. Robinson** said that is why the Department has redesigned the program so that it isn't an expansion. It's a reduction. Experience indicates counties want to remain non-assumed despite the financial attractiveness.

**SEN. KEATING** said people migrated from non-assumed counties when General Assistance became available in state-assumed counties. He asked if there was a similar migration with medical benefits. **Ms. Robinson** said the Department hasn't been collecting that kind of data. Movement from county to county lessened when the Department began computer tracking in the General Assistance program. The Department hopes to design a program that is reasonable for state-assumed counties but not so broad that people abuse it.

**SEN. KEATING** said it may help to know what mill-levy assessments would be if the counties weren't state-assumed. **Ms. Robinson** said the Department capped state-assumed counties at 12 mills. She asked **SEN. KEATING** if he wants to know what those counties would have to pay in addition to the 12 mills if they were not state-assumed. **SEN. KEATING** said yes. **Ms. Robinson** said she would get the information. **SEN. KEATING** asked for the number of mills levied by each of the non-assumed counties.

**Mr. South** said that before counties became state-assumed, they were authorized to levy up to a certain level. If expenses exceeded that level, counties could request a grant-in-aid from the state. Non-assumed counties still have that option. A grant-in-aid is financed with General Fund money.

**SEN. NATHE** asked about the per-capita cost for Gallatin County. **Mr. South** said the report compiled last summer examined per-capita costs for the State Medical Program in the 12 state-assumed counties in fiscal year (FY) 1990 or FY 1989, and per-capita costs for the same year in Gallatin and Yellowstone counties, the two largest non-assumed counties. The difference was $14.59 per capita in the 12 state-assumed counties and $2.75 in the two non-assumed counties.

Those figures reflected only a single time period. It may have been an exceptionally low year for Gallatin and Yellowstone counties, though it was a fairly normal year for state-assumed

counties. Yellowstone County's costs have risen significantly this year. The comparison probably should be averaged over a longer period of time.

**CHAIRMAN BRADLEY** said statistics showed minimal migration into state-assumed counties. It was thought that the State Medical Program would lure people from other counties with a lower level of medical options. The General Assistance population is down because of employability requirements and certain cutoffs, but utilization is rising. There is concern about abuse of medical options.

**Tape 1B**

**Ms. Robinson** said the state wouldn't pay for medical services unless they were necessary. The state pays for any major medical problem, but not every problem a person has. The Department hopes managed care will address abuse. The other concern is that people are not applying for SSI. It is optional, but difficult to get onto.

**REP. COBB** asked if the Department has sufficient legal assistance. **Ms. Robinson** said the Department had been worrying about how to get people onto SSI. With Omnibus Budget Reconciliation Act (OBRA) mandates of 1990, it is much easier. As soon as the state determines eligibility, clients become Medicaid-eligible and the federal government starts paying. **Norman Waterman, Family Services Division Administrator,** said the Division contracts with the Legal Services Division, which indicated it can handle the caseload. The caseload isn't expected to increase significantly. Independent disability determination will be done by a contractor. Legal Services will spend its time on the appeals process involving SSI applications. Once clients are on Medicaid, there is no rush to get them on SSI.

**SEN. NATHE** said it appears the State Medical Program costs about $1,830 per person per year. In Program No. 1 and No. 3 on Page 2 of **EXHIBIT 4**, the state is spending about the same amount of money for administration. He asked why it costs so much. The cost is only 3-4 percent in other programs. **Ms. Robinson** said it is a result of the chart. It reflects the total cost of welfare programs in state-assumed counties. Family Assistance figures reflect the entire AFDC program. In state-assumed counties, the state is spending $21 million in AFDC, including $4 million in General Fund money. The figures for Program 3 reflect administration costs. **SEN. NATHE** asked if those are the costs for 3,000 people in 12 counties. **Ms. Robinson** said no. Those 3,000 people are in the State Medical Program only. The state serves 70,000 Medicaid clients. There are a few more in state-assumed counties than non-assumed counties. Possibly 37,000 Medicaid recipients are reflected in the $4.5 million administrative cost. The chart is misleading. A county-by-county breakdown will be distributed at the next hearing.

## EXECUTIVE ACTION ON BUDGET MODIFICATIONS

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

**Mr. South** said the OBRA 1990 modification is not in the executive budget. He corrected budget figures in **EXHIBIT 13 from Feb. 4, 1991, minutes.** Under modification No. 13, OBRA 1987, nursing home residents diagnosed as developmentally disabled can choose to leave the nursing home and receive state-financed services in a community setting, or they can remain in the nursing home and receive active treatment, which is fully financed by General Fund money. Under OBRA 1990, the state can postpone offering active treatment until 1994. The executive budget modification would take $348,084 out of the OBRA 1987 modification, which is the General Fund portion dedicated to active treatment in nursing homes in the last year of the biennium. If the subcommittee does not take that money out, it will have to be added to the OBRA 1990 modification. If the subcommittee wants to accept the executive budget modification package as it now exists, the subcommittee would move modification No. 13, less $348,084 General Fund. The General Fund figure would be $296,516. The "other funds" category comprises federal funds that are matched when individuals leave nursing homes and go into matchable community services.

**SEN. WATERMAN** asked if the state delays implementation until 1994, active treatment for people who have chosen to remain in nursing homes will not begin until then. **Ms. Robinson** said yes. One reason to delay implementation is that there are no federal rules or regulations for active treatment. It isn't clear what the state will be required to do. Costs for the next biennium will be at least what was projected. Costs will double, starting in 1993.

**SEN. NATHE** asked if costs will drop by 1993 to coincide with a natural drop in population through death and screenings, and if inflation will be the only factor pushing costs. **Ms. Robinson** said that is the Department's hope.

**MOTION: SEN. KEATING** moved approval of the OBRA 1987, Developmental Disabilities Treatment budget modification, less $348,084.

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

**Ms. Ellery** distributed a budget summary for OBRA 1990. **EXHIBIT 7** She said OBRA 1990 became law on Nov. 5. The lateness forced the Department to seek a budget modification because impacts weren't known when the budget was being developed. The Department has only limited interpretation and analysis of the federal mandates. Figures have changed and reflect the Department's best guess.

OBRA 1990 will mean savings in some areas. The state will get about a 10 percent discount in drug prices through rebate agreements drug manufacturers will have to sign to be reimbursed under Medicaid. State savings will be almost $300,000 per year.

The purchase of group health insurance will save the state money. Medicaid will pay premiums for people with group health coverage, if it's cheaper to pay the insurance premium than to pay Medicaid benefits.

COBRA provides continued insurance coverage for up to two years when a person leaves employment in certain situations. A federal match is available for people who would not normally be Medicaid-eligible.

Hospital outpatient reimbursement will be reduced by 5.8 percent. This was a Medicare provision. Because the state of Montana uses Medicare's upper limits to set the Medicaid rate, a savings also will result in the Medicaid program.

Areas that will cost the state money include phase-in coverage for children below 100 percent of poverty, up to age 18. The state will phase in this coverage over a 12-year period.

Drug utilization review will require a client to be counseled by a pharmacist before a prescription is issued. It also involves a retrospective review to identify inappropriate use of pharmacy services.

Expanded coverage for qualified Medicare beneficiaries affects Medicare clients who are also eligible for Medicaid, which pays their out-of-pocket Medicare expenses. OBRA 1990 expanded coverage of people whose income is 100 percent of poverty. It goes to 110 percent of poverty next year, then up to 120 percent.

Veteran pension payments will be reduced to $90 per month for individuals in nursing homes who are also eligible for Medicaid. The law says the $90 cannot be applied to the cost of care. It won't apply to veterans who are widows, or have a spouse or dependent in a nursing home.

OBRA 1990 requires continued benefits throughout a woman's pregnancy and the baby's first year of life, regardless of changes in income level.

The law requires the state to provide rehabilitation services to all children. It ties into OBRA 1989, which says the state must provide treatment for a child whose problem is detected in the screening process, regardless of whether it is an allowable Medicaid service. Some therapeutic foster-home and group-home services will be covered that were not covered before. Some increased federal matching money will be provided for services that the General Fund finances now.

The state will be able to pick up on some outpatient alcohol and drug treatment programs. Rehabilitation services can be provided at home and do not have to be directed by a physician. Services must be provided to children with special needs, such as those on ventilators who need 12- to 24-hour nursing care each day. The Department identified two children whose services will cost more than $100,000 per year. Under this federal mandate, the state must provide those nursing services. Some of these children are currently served under the Medicaid Waiver program.

To meet these mandates, the Department needs resources. The Department is seeking 3 FTEs, one to work with the drug rebate program, one to work with the Federal Qualified Health Center Program and new Medicare groups, and a third to design and implement new rehabilitation services. The Department also will need a pharmacy consultant and medical consultant. When OBRA 1989 was passed last year, SRS absorbed the costs of program expansions without increases.

The health insurance program will pay for itself quickly. The Department is seeking contract money to provide services to pay premiums and track costs.

**REP. COBB** asked for additional information on the purchase of health insurance. **Ms. Ellery** said the Department anticipates paying insurance premiums for 300 people in the first year and saving $1,700 per case. **Ms. Robinson** said the Department will have a better estimate after the first year.

**SEN. WATERMAN** asked if the reduction in hospital outpatient reimbursements is an attempt to decrease incentive to use those services. **Ms. Ellery** said the reduction is a flat 5.8 percent off outpatient cost. She doesn't know how the percentage was calculated. The law mandates the percentage. **SEN. WATERMAN** said she is concerned that the cost is being shifted to private-pay patients. She asked if managed care can be used to control use of rehabilitation services. **Ms. Ellery** said yes. That is one of the reasons the Department is seeking authorization for additional medical consultant hours. The consultant can help SRS decide the most cost-effective, least restrictive care for children.

**SEN. KEATING** asked **Bob Olsen, Montana Hospital Association representative,** for additional information on the hospital outpatient issue. **Mr. Olsen** said the rollback of 5.8 percent is on Medicare Part B, which does not include all outpatient hospital services. He doesn't know how it will translate to Medicaid, which covers a broader spectrum of outpatient services than Medicare. The 5.8 percent exempts sole community hospitals. There are 46 in Montana. They are primarily small and rural hospitals. Hospitals subjected to the rollback would be those in Missoula, Great Falls, Billings and some of the other large hospitals.

**SEN. WATERMAN** said there would be $2 million saved over the biennium. It appears to be a large savings from a limited number of hospitals. **Ms. Ellery** said that was discussed with the Health Care Financing Administration's regional office in Denver to ensure Medicare provisions in the law applied to Medicaid. This can change. SRS received verbal confirmation that this would apply to Medicaid so the Department made the adjustments. New information comes out all the time on who is affected.

**SEN. KEATING** asked if rehabilitation services include emotional and mental rehabilitation, not just physical rehabilitation, for children under 18. He asked if these funds would apply if the Department of Family Services (DFS) develops treatment programs for youth and parents are involved in the process. **Ms. Robinson** said the Medicaid Services Division has been working with DFS to ensure the best use of Medicaid funds in rural community programs. The Department hopes to match some of their General Fund money and some of the new money. **Ms. Ellery** noted that services are provided up to age 21.

**MOTION:** **SEN. KEATING** moved approval of the OBRA 1990 executive budget modification with corrected figures.

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

**Mr. South** explained the cost-containment budget modification, No. 16, in **EXHIBIT 13 from Feb. 4, 1991, minutes.** He said the modification is the managed care contract for the State Medical Program.

**Ms. Ellery** distributed an explanation of the State Medical Managed Care modification, **EXHIBIT 8**, and Nursing Home Audit funds, **EXHIBIT 9.** She said the managed care modification is in the executive budget under the Hospital Rate Study. It has been separated out so that figures match those in the LFA budget. The modification will allow SRS to contract for managed care for State Medical clients. Cost is estimated at $150,000 per year. Savings of up to one-third in inpatient hospital costs are anticipated.

**SEN. NATHE** asked if a person would be locked into one doctor, and where the extra money goes. **Ms. Ellery** said managed care is a term used to describe a lot of things. **SEN. KEATING's** bill will allow SRS to develop managed care for Medicaid and State Medical populations. Under the State Medical Program, SRS would contract with an agency that would have medical staff review inpatient hospital admissions to ensure they were necessary. SRS is considering managed care for the Medicaid population. SRS wants Medicaid clients to be assigned one physician to manage their care.

**REP. COBB** asked if the state will save 30 percent in the Medicaid program also. **Ms. Ellery** said no. SRS already has a contract with the Montana/Wyoming Foundation to review hospital admissions for medical necessity. The contract is built into the Medicaid program. SRS wants to expand managed care in Medicaid to have primary care physicians be case managers.

**Tape 2A**

**SEN. NATHE** asked how SRS planned to handle other managed care concepts without imposing a lot of paperwork on hospitals. **Ms. Ellery** said physicians aren't going to want more paperwork, particularly with the existing reimbursement structure of the state. SRS hopes to reduce paperwork in the managed care program for the Medicaid population and provide incentives to participate.

**CHAIRMAN BRADLEY** said the cost-containment budget modification in **EXHIBIT 13 from Feb. 4, 1991, minutes,** includes the $30,000 request for additional nursing home audits, which is explained in **EXHIBIT 9.**

**SEN. KEATING** asked if the audit request involves federal money. **Ms. Ellery** said it is 50 percent federal money and 50 percent state money.

**Marcia Dias, Montana Low-Income Coalition representative,** asked if managed care by a primary physician will preclude a second opinion on a person's medical condition, and if it will open up the agency or contractor to a lawsuit if the referral is inappropriate. She asked if people will be open to lawsuits and workers' compensation claims if a client is placed in a high-risk job without special glasses, hearing aids, etc, that may not be needed for the job, but working without them would endanger the worker. She asked if job interviews will be difficult for clients without teeth, hearing aids or glasses, even if those things are not needed for the job.

**Ms. Robinson** said managed care is not something being imposed on low-income people. Everyone with insurance experiences it. Managed care is a second opinion. SRS probably would pay for a second opinion if a client has a major problem. In terms of Project Work, SRS will pay for specific services based on an individualized plan. The intent is to reduce costs and better meet individual needs by moving away from an entitlement program toward individualized services. SRS wants to encourage people to participate in Project Work. Under the existing model, all these services are paid for whether the client is willing to work or not.

**MOTION: SEN. KEATING** moved approval of the cost-containment budget modification.

**VOTE:** The motion **PASSED** unanimously.

**Roger Tippy, Montana State Pharmaceutical Association representative,** said he proposed language that suggests SRS adopt a rule for the second half of the biennium to add $1 per prescription for OBRA-mandated counseling services at the time of drug dispensing. The fee would be added to the $4.08 reimbursement rate, which apparently will not be increased. The cost would be about $50,000 per month. The Department will see some savings through the Drug Utilization Review Board. It may not cost as much to run the board as anticipated.

**Ms. Ellery** said SRS currently provides $4.08 reimbursement per prescription. The Department projects it will pay for 660,000 prescriptions; therefore, a $1 increase in the dispenser fee would cost approximately $660,000. A survey showed the $4.08 dispensing fee meets about 75 percent of a pharmacy's cost. At nursing homes, with unit dosages, the fee meets 88 percent of cost. The Department didn't include additional money in the budget for this. The additional $1 per prescription is a legitimate request, in terms of the added responsibility on pharmacists to provide counseling. The number of prescriptions is anticipated to grow from 660,000 to about 915,000 in FY 92.

**SEN. NATHE** asked what the Drug Utilization Review Board will do. **Ms. Ellery** said OBRA mandates require a prospective drug review, which is the counseling provided before a prescription is dispensed. A retrospective review is the monitoring of use. The board will be composed of physicians, pharmacists and SRS staff. They will review the program and try to determine if there is inappropriate use of the drug program, and work with physicians and pharmacists to control it.

**Mr. Tippy** said congressional record pages indicated eight areas of prospective counseling. If the client is a Medicaid patient, a druggist must counsel the person about such things as potential side effects of the drugs being taken, whether other drugs being taken are compatible with the one being dispensed and whether the drugs need to be taken with food.

**SEN. NATHE** said he doesn't understand why a pharmacist has to repeat what has already been done by a doctor. **Ms. Ellery** said a patient may be seeing more than one doctor and may be prescribed more than one drug. Doctors wouldn't necessarily know if a patient is getting something that may interact with something else. Unless the person is going to the same pharmacy all the time, there is no way to monitor it.

**SEN. WATERMAN** said it can be very confusing for patients. Some people are hesitant to say anything to their doctors about medication they are prescribed. When they hear about side effects and other information from the pharmacist, it can seem like the pharmacist is saying the doctor doesn't know what he is doing. Patients don't necessarily know pharmacists have been instructed to provide counseling. It can lead to a lot of misunderstandings.

**SEN. KEATING** said a $1 dispensing fee on 900,000 prescriptions would wipe out any financial benefit from drug rebates. **CHAIRMAN BRADLEY** said the question is whether the subcommittee feels concerned enough about this to look at a lesser amount.

**REP. COBB** suggested the rebates be given to pharmacists. It could be an incentive for them to try to find ways to save the state money. As it is now, the state takes money away from them and they have to find a way to get it back.

**SEN. KEATING** asked if the $4.08 reimbursement rate covers 75 percent of the cost of the drug. **Ms. Robinson** said it covers the cost of preparing the prescription, not the cost of the drug itself. SRS pays a portion of the cost of the drug, but it is separate from the dispensing fee.

**SEN. KEATING** asked **REP. COBB** if he was suggesting the additional money be rebated in the base, rather than for each prescription. **REP. COBB** said the money should be put up front.

**SEN. WATERMAN** said there is a proposal to require use of generic drugs with Workers' Compensation cases. She asked if that would be the case here. **Ms. Ellery** said SRS has been requiring use of generic drugs in Medicaid since the start of the pharmacy program. The only time a generic drug would not used is if a doctor indicates a brand name is necessary.

**SEN. NATHE** asked if the dollar will reduce dispensing costs. **Mr. Tippy** said federal mandates slow the number of prescriptions that can be filled in a day, so the average dispensing fee will increase. **Ms. Robinson** said SRS pays $4.08 per prescription, which is 75 percent of cost. Pharmacists are asking for $1 to be added, which would bring the reimbursement to $5.08 per prescription. SRS studies indicate they are charging $5.43 per prescription to the general public. If the dollar is added, pharmacists would be getting 93 percent of cost.

**SEN. WATERMAN** asked what it would cost in General Fund if the subcommittee increased the rate by 10 percent. **Ms. Robinson** said her staff would calculate the figures. **SEN. WATERMAN** asked if it were reasonable to increase the reimbursement rather than grant a flat fee. In other areas, the subcommittee has increased provider rates. **SEN. KEATING** asked if she were talking about increasing it from 75 percent to 85 percent of cost. **SEN. WATERMAN** said yes. **Ms. Ellery** said the federal government is going to take its portion of the drug rebates up front and drug manufacturers are increasing prices before rebate agreements are signed. How much will be saved through rebates will depend on how high prices go up.

**CHAIRMAN BRADLEY** suggested action be postponed until after discussion of the provider-rate increase issue. She directed the subcommittee to budget modification No. 10, elderly waiver expansion, on **EXHIBIT 13 from Feb. 4, 1991, minutes.**

**Ms. Robinson** said the modification is for an additional 50 slots. She referred to Page 55 of **EXHIBIT 19 from Feb. 1, 1991, minutes.**

**CHAIRMAN BRADLEY** asked how this would affect Glendive. **Mr. Robinson** said the 50 slots are not designated for a specific area. There is a team in Miles City that can expand into Dawson County, which is at the top of the list of rural areas. The initial proposal was to begin taking care of the waiting list.

**SEN. KEATING** asked if the program allows people to stay in their homes longer, if nursing home money is paid to in-home patients and if it is an alternative to nursing home care. **Ms. Robinson** said yes.

**Mr. South** said **REP. BOHARSKI's** proposal would expand the waiver program beyond what is in the executive budget. Individuals who would qualify under the expanded program would be those who would otherwise go into a nursing home. He said **REP. BOHARSKI** discussed the possibility of expanding waiver slots for patients who are already in nursing homes. His proposal would put language in the bill to allow nursing care money to be transferred under the waiver program if Medicaid recipients in nursing homes could be served by the waiver program.

If money is taken out of the nursing home budget and the population did not decrease, a supplemental appropriation may be needed. A supplemental may be needed anyway because projections are based on 2 percent growth. If it grows more than that, a supplemental will be needed.

Nursing homes are held harmless. Because it is an entitlement program, they get paid for every Medicaid recipient in their facility. In cases where the waiver program removes a Medicaid patient from a nursing home and the bed will not be filled, the nursing home would be short one bed. That would be the maximum impact on any one nursing home.

**SEN. NATHE** asked if people are going to be told they have to take their relatives out of nursing homes because they're not eligible for services. **Mr. South** said no. No one would be taken out who didn't wish to leave. The concept is to take individuals out who may have gone in before waiver slots were available. **Mr. Robinson** said waivers have traditionally been capped. If clients are allowed to return to their communities, money is available for that. The entitlement is behind patients who will remain in nursing homes. **CHAIRMAN BRADLEY** noted that **REP. BOHARSKI's** proposal would be for a maximum of 50 additional slots.

**SEN. KEATING** asked if there are 100 people eligible for waiver payments for in-home care if the money is available. **Ms. Robinson** said yes. **SEN. KEATING** asked if they are nursing home-eligible as well. **Mike Hanshew, Long-Term Care Bureau Chief,** said all 107 people have been screened and require the level of care of a

nursing home. Twelve of them are in a nursing home and would like to move out, if a waiver slot becomes available. They are not being pressured to move out. They want to return home if they can.

**SEN. KEATING** said **REP. BOHARSKI's** plan would enable those 12 to return home and receive in-home care. But there is a waiting list for nursing home beds. Nothing is being taken away from nursing homes. Those slots would fill up quickly.

**SEN. NATHE** asked what the difference is between the Elderly Waiver Program and the statewide contract with West Mont, which provides nursing home services at a client's home. **Ms. Ellery** said the waiver program exists in only 30 counties statewide. One waiver service is personal care. People eligible for the waiver are individuals at risk of going into a nursing home. In addition to that, Montana has a statewide personal care program. West Mont provides personal care services to people in the waiver program and others. Not all of them are at risk of going into a nursing home.

**MOTION:** **REP. JOHNSON** moved acceptance of the Elderly Waiver Expansion budget modification, including the Department's apparent priority of Dawson and Hill counties.

**DISCUSSION:** **SEN. KEATING** asked about the county priorities. **Ms. Robinson** said Hill and Dawson counties are at the top of the list for outreach in rural areas. Some of the 50 slots would be used to expand to those two counties.

**SEN. WATERMAN** referred to background information on the waiver expansion modification on Page 55 of **EXHIBIT 19 from Feb. 1, 1991, minutes.** She asked if this proposal is above and beyond the proposal for a personal-care pilot program. **Ms. Robinson** said yes. It is a different issue. There are a number of personal-care facilities statewide. SRS funds personal-care individuals. There is a different level of care below a nursing home. It is like a retirement home. People want Montana to get involved in paying for that. The federal government will not make that an entitlement program until 1994. SRS wants to experiment with a pilot program before then. The theory is that the state will save money. **Mr. Hanshew** said a problem with using the waiver for licensed personal care facilities is that the level of care provided in a nursing home cannot be required. It has to be required to be in the waiver.

**Ms. Robinson** noted that existing teams will be used for outreach in Dawson and Hill counties. Additional money for this is not in the budget.

**SEN. KEATING** asked if the motion addresses **REP. BOHARSKI's** proposal. **CHAIRMAN BRADLEY** said no. She will have language brought to the subcommittee regarding his proposal. **SEN. KEATING** asked if his proposal will cost more money. **Ms. Robinson** said SRS

believes it will because beds will be filled behind individuals moved out for the waiver program. SRS isn't sure a supplemental appropriation won't be needed anyway. There may be savings in the long run, but she can't guarantee savings in the first two years.

**Tape 2B**

**VOTE:** The motion **PASSED** unanimously.

**CHAIRMAN BRADLEY** suggested **Mr. South** draft language for an additional 25 waiver slots. She said there is a good chance nursing home beds will be filled as individuals leave. Two years from now, the subcommittee can reassess the situation. She asked if anyone has strong feelings about this issue. **SEN. KEATING** said the Department identified 12 nursing home patients who would like to be on the waiver program, which is half of the 25. It is worth a try. **CHAIRMAN BRADLEY** said a motion isn't needed. The subcommittee can consider language **Mr. South** will draft.

**SEN. NATHE** asked if more money will have to be added as nursing home beds fill up. **CHAIRMAN BRADLEY** said she is not proposing that. She proposes growth in the budget accommodate that. So much fluctuation is possible anyway. This is a small part of it. **SEN. NATHE** asked if this is a one-time deal. **Mr. South** said he would call it a pilot program to see how it works. Tentative language could require some kind of a report to the next Legislature on how it went.

**CHAIRMAN BRADLEY** asked the subcommittee after its break whether language by **REP. BOHARSKI** would be acceptable with modification to reflect an additional 25 slots instead of 50. **SEN. NATHE** asked who would decide to move the 25 individuals. **Ms. Robinson** said SRS teams would screen individuals and offer them the option to move. It would be strictly optional.

## EXECUTIVE ACTION ON THE STATE MEDICAL PROGRAM BUDGET

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

**Mr. South** said there is a significant difference between the LFA and executive budgets for the State Medical Program. A bill is going through the Legislature to reduce the scope of the State Medical Program. **Ms. Robinson** said that if the bill fails, SRS could make some savings because of OBRA, but maybe not the amount previously indicated. Case management savings would have to be recalculated. The budget is dependent on the bill passing.

**Mr. South** said OBRA 1990 permits a transfer of people paid under State Medical to Medicaid. A federal match is required in the appropriation. The LFA number is General Fund as is the executive's $2 million. The federal match for FY 92 is $1,810,649 and $1,857,892 for FY 93. Any motion to adopt the executive amount for State Medical should include General Fund and federal amounts.

**SEN. KEATING** said he thought it was all state money. **Ms. Robinson** said it used to be. A way to save money is to get more people eligible for Medicaid. The Medicaid match is needed to make the program work. All the money has been put in State Medical so the subcommittee can see what it is allocating. The Department has drafted language to have the money follow the client to other programs. **CHAIRMAN BRADLEY** said the language looks good. It will be included with other language to be approved later.

**MOTION:** **SEN. KEATING** moved approval of the executive budget for the State Medical Program, including federal funds of $1.8 million plus per year.

**VOTE:** The motion **PASSED** unanimously 5-0. **REP. COBB** was absent.

## EXECUTIVE ACTION ON A MEDICAID PROVIDER-RATE INCREASE

The vote was taken on discussion item No. 5 in **EXHIBIT 1 from Feb. 5, 1991, minutes.**

**CHAIRMAN BRADLEY** said she asked **Mr. South** to calculate costs for a 2 percent increase. **Mr. South** distributed the cost analysis. **EXHIBIT 10.** He said he tried to break out costs for the major provider groups in Primary Care. Total General Fund cost for a 2 percent Medicaid provider-rate increase is $3.5 million. Total cost is $12.7 million. He believes the 2 percent provider-rate increase would raise the drug dispensing fee by 2 percent. **Ms. Ellery** said the dispensing fee was increased by 2 percent in the last biennium. **Mr. South** said it does not apply to the purchase of drugs. The actual cost for the drugs and the cost of the increase over three years is built into projections. The 2 percent would cover the dispensing fee and part of the additional cost of the drugs, but how much will depend on how much drug prices increase. Amounts in **EXHIBIT 10** are tentative and based on projections. If the subcommittee approves a provider-rate increase in the Medicaid program, it will not necessarily be approving a dollar value. Whatever percentage is approved will be built into the budget. Rebasing for any of the modifications is not included in the figures, which assume percentages are being applied to the 1991 rate. If percentage increases are added on top of rebasing for hospitals and nursing homes, these figures will increase significantly.

**SEN. WATERMAN** asked if there would still be providers who haven't received increases. **Ms. Robinson** said there would be a slight problem if the subcommittee grants 2 percent in some of these programs. Five percent has been granted in others and some of the people are on the same facility's staff. With the Medicaid Waiver, they are the same people. **Ms. Ellery** said a 2 percent increase in this area would cover providers who did not get increases from previous subcommittee actions.

**SEN. WATERMAN** asked if language is needed to ensure everyone receives at least 2 percent and that the higher percentage would be granted if there is a duplicate population. **Ms. Robinson** said she would work on the language with **Mr. South. CHAIRMAN BRADLEY** said the subcommittee can clarify the intent.

**SEN. KEATING** asked who received a 5 percent increase. **CHAIRMAN BRADLEY** said community group homes, developmental disabilities (DD) providers, and vocational rehabilitation providers. Those workers rely solely on the state for their support. These providers have a variety of income sources, one of which is the state.

**SEN. KEATING** asked how much the subcommittee has exceeded the budget in these areas. **Bill Furois, Office of Budget and Program Planning,** said he believes it is $3.4 million, including DD providers, vocational rehabilitation and visual services.

**SEN. KEATING** said the subcommittee is talking about another $3.6 million. **CHAIRMAN BRADLEY** said 5 percent would provide a 3 percent increase in salaries, and help cover inflationary and other costs.

**SEN. KEATING** said the 2 percent for this group includes nursing homes and hospitals. He asked if that takes care of all the remaining providers. **Ms. Robinson** said yes.

**MOTION:** **SEN. WATERMAN** moved approval of a 2 percent Medicaid provider-rate increase.

**DISCUSSION:** **SEN. WATERMAN** said it appears the cost of these programs is rising and the Legislature exacerbates the cost when it doesn't provide an increase.

**Ms. Robinson** corrected an earlier statement. She said the 2 percent does not cover State Medical. It covers all Medicaid providers. **CHAIRMAN BRADLEY** said the subcommittee will make an exemption with the waiver.

**AMENDMENT:** **SEN. WATERMAN** said her motion will include language that indicates waiver figures will be adjusted.

**DISCUSSION:** **SEN. KEATING** asked if the motion includes the $900,000 for pharmacists. **SEN. WATERMAN** said no. This is in lieu of that.

**SEN. KEATING** asked how much General Fund money is included in all the provider program increases. **CHAIRMAN BRADLEY** said the total will have to be calculated. **SEN. KEATING** said he didn't know where the money will come from, but if providers aren't there to offer services, the state will be in deeper trouble than it already is. The subcommittee is buying a little assurance that services will be delivered.

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

**CHAIRMAN BRADLEY** referred to discussion item No. 8, the use of child support enforcement money as a state Medicaid match, in **EXHIBIT 1 from Feb. 5, 1991, minutes.**

**Mr. South** said anything over $500,000 in the Child Support Enforcement fund balance at the end of the current biennium reverts to the General Fund. A motion was made in the subcommittee to continue the fund balance at that level. It wasn't totally clear if the subcommittee wanted the money to revert to the General Fund or be spent in an area that is identifiable.

The executive budget applies some of the money in excess of the $500,000 balance in lieu of General Fund match in the Medicaid program. The LFA budget does not. The subcommittee needs to decide what to do with the excess money. If some of it is going to be applied to Medicaid in lieu of General Fund, it may be more practical to apply it all. The other option is to continue to revert it to the General Fund. He noted that **SEN. KEATING** is concerned the money will lose its identity if it reverts to the General Fund and SRS staff will not be rewarded for generating the money.

**CHAIRMAN BRADLEY** asked which is preferable in terms of ease in accounting. **Mr. South** said that when the excess is used for the Medicaid program, the General Fund appropriation is reduced by the same amount. If the Department overestimates revenue from that source, the shortfall would have to be covered with General Fund money, which would exacerbate any supplemental problem. The excess currently reverts to the General Fund and loses its identity, as does all money that goes into the General Fund.

**SEN. NATHE** asked where the money is coming from. **Mr. South** said the 1989 Legislature expanded the Child Support Enforcement program, moved it from the Department of Revenue to SRS and required it to be cost-effective. The money comes from enforcement activities from several different sources. It is placed in an enterprise account. At the end of the year, anything over $500,000 reverts to the General Fund.

**Ms. Robinson** said the Child Support Enforcement program is supposed to be a revenue source for women and children, not the state. The state wants to emphasize as many non-public assistance cases as possible. Over time, cost-effectiveness drops because an increasing number of staff end up collecting from non-welfare clients.

**Mr. South** said a motion is needed to adopt either the executive funding, which uses a portion of the surplus, or continue existing language, which would revert the money to the General Fund and require an increase in General Fund in the executive

budget. The use of that money is the only difference between the LFA and executive budgets for the Medicaid program. It's a revenue issue only. The net effect on the General Fund is zero.

**MOTION:** **REP. COBB** moved approval of the executive budget recommendation for the state Medicaid match.

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

**Mr. South** referred to discussion item No. 7 in **EXHIBIT 1 from Feb. 5, 1991, minutes,** which addresses whether the 12-mill welfare levy covers costs incurred by the state in state-assumed counties. He said he was asked last spring to examine revenue generated by state-assumed counties compared with expenses. At that time, costs exceeded revenue. Based on what is happening in General Assistance and what may happen in State Medical, and given adoption of the executive budget, the balance may be closer than it is now. The year reviewed was an exceptionally high year. **SEN. KEATING** said he appreciates SRS' plan for State Medical. The needy will be served. There won't be the waste that there was in the General Assistance program. It is starting to balance out.

**Mr. South** referred to discussion item No. 9, language to permit transfers between benefit programs, in **EXHIBIT 1 from Feb. 5, 1991, minutes.** He said the Budget Office, SRS and LFA Office will draft language to determine the amount of flexibility the Department should have to transfer money between major entitlement programs. The Department must have flexibility in benefit areas, where it is difficult to project. **CHAIRMAN BRADLEY** asked if any subcommittee members had sentiments to reflect in the language. When there was no response, she said the subcommittee will trust **Mr. South** and the Department to work it out.

**SEN. KEATING** said he would like to reconsider previous action on licensed professional counselors. Some language is still needed in the appropriations bill to permit the Department to engage those services even if the bill goes through.

**Ms. Robinson** said the Department doesn't normally open options unless it has clear direction from the Appropriations Committee. The Department can put in the amount of new money it will cost to open the option, or the subcommittee can take the argument of the licensed professional counselors, which is that it won't cost any money because there will be savings in other parts of SRS, the Department of Family Services or the Department of Institutions. Institutions and Family Services would like to see General Fund money used for this program. The cost is $89,000.

**CHAIRMAN BRADLEY** asked **SEN. KEATING** if it were acceptable to him for **Mr. South** to review expansion language with him before it is presented to the subcommittee. **SEN. KEATING** said yes.

**MOTION:** **SEN. KEATING** moved to reconsider previous action regarding licensed professional counselors.

**VOTE:** The motion **PASSED** unanimously.

**MOTION:** **SEN. KEATING** moved to appropriate $89,000 in General Fund money with federal match for licensed professional counselors and to develop language to include them in the budget.

**VOTE:** The motion **PASSED** unanimously.

**MOTION:** **SEN. NATHE** moved to reconsider the Medically Needy issue.

**VOTE:** The motion **PASSED** unanimously.

**SEN. NATHE** said medical coverage for caretaker relatives should be put back into the budget. The extension of medical assistance may help keep the caretaker relative off AFDC.

**Penny Robbe, Program and Policy Bureau Chief,** said the Department's proposal would eliminate coverage for caretaker relatives under the Medically Needy Program. The child would still be covered. Family income would be considered in determining how much of the child's medical bill the family has to pay. Anything over the family's responsibility would be paid by Medicaid. As it is now, once the family's responsibility is met, Medicaid coverage is available for the child and the caretaker relative.

**REP. JOHNSON** asked how a grandparent would be cared for if not covered by this program.

**Tape 3A**

**Ms. Robbe** said grandparents could qualify for medical assistance if they are aged, blind or disabled. Assistance would be related to another program. As it is now, eligibility is related to the AFDC program because the person is caring for the child.

**REP. JOHNSON** asked how many people would be affected by the change. **Ms. Robinson** said 859.

**SEN. WATERMAN** said caretaker relatives may just end up on another program if they are cut off this one.

**SEN. KEATING** asked if the program is monitored closely. **Ms. Robinson** said the Medically Needy Program is very large, costs the state about $39 million and is the most difficult to administer. People have to spend money before they are eligible. Case management is not provided in this program because case management is a service. SRS just determines if they're eligible.

**SEN. KEATING** asked if these people are really needy or if they can take advantage of the program. **Ms. Robinson** said they definitely have medical bills or they wouldn't be spending down to this program. Someone in the family has a major medical problem. The bills should be accrued by the child. The other person becomes eligible because of the child's medical costs.

**CHAIRMAN BRADLEY** asked if the Department can come back in two years with a report on the impact of this, or if it would be too cumbersome. **Ms. Robinson** said her staff believe it may be too difficult to follow. She needs to talk to her staff to see what can be done.

**CHAIRMAN BRADLEY** said the biggest concern seems to be about grandparents being cut off from services. She asked if many would be impacted. **Ms. Robinson** said the majority of caretaker relatives are single parents. More information can be provided.

**CHAIRMAN BRADLEY** said this issue is something that can be revisited at the end of the subcommittee's work. She asked the subcommittee to postpone action for now. The subcommittee has made few tough decisions to take to the full Appropriations Committee. An effort must be made regarding some of these issues and the Department is recommending this change.

**SEN. NATHE** said he would be willing to wait. But the family unit is deteriorating and this is one program that attempts to hold it together. It would cost more money to have these children in foster homes or to have the caretaker on AFDC.

**Ms. Robinson** said the Department will provide demographic information for the subcommittee's review.

**CHAIRMAN BRADLEY** said the record will reflect that the issue is not resolved and will be brought back for further discussion.

**Ms. Dias** reiterated **SEN. NATHE's** comments. She said working people are not collecting AFDC. This could be the final straw for people who are caring for someone else's children. **CHAIRMAN BRADLEY** said the subcommittee will make sure she is present when the issue is revisited.

**REP. COBB** said he wanted to amend the SRS budget to add more slots in the Elderly Medicaid Waiver program, fund all or part of the DD waiting list, and change AFDC funding. He asked if **CHAIRMAN BRADLEY** wanted him to wait until the end of the subcommittee's work. **CHAIRMAN BRADLEY** said no, make the motions now.

**MOTION: REP. COBB** moved to add 50 more slots to the Medicaid Waiver program, 38 in FY 92 and 12 in FY 93. The cost will be $74,888 in General Fund for the first year and $100,000 in the second year.

**DISCUSSION:** **REP. COBB** said the subcommittee would be doubling what it did with **REP. JOHNSON's** previous motion.

**SEN. WATERMAN** said the subcommittee added 50, then another 25 through **REP. BOHARSKI's** amendment. There is a proposal going through for a pilot program for personal-care facilities, which would impact a number of beds. **Ms. Ellery** said the pilot program proposal has nothing to do with this proposal.

**REP. JOHNSON** asked if this would make it 125 slots. **CHAIRMAN BRADLEY** said yes. **SEN. WATERMAN** said the waiting list is 100.

**VOTE:** The motion **FAILED** 1-4, with **REP. COBB** voting aye. **SEN. KEATING** was absent.

**REP. COBB** distributed language that calls for SRS and the Office of Public Instruction to jointly design a strategy for providing a transition from school to adult services for special education graduates. **EXHIBIT 11**

**CHAIRMAN BRADLEY** said she would give the language to **Mr. South.**

**REP. COBB** said 30 individuals are waiting for Specialized Family Care. It would cost $190,966 in General Fund money over the biennium to serve them. They are receiving other services. The issue is to decide who to serve, then the subcommittee can go to other committees and let them be the ones to say no. It isn't fair for this subcommittee to have to make the tough choices. If other committees want to fund this and all their programs, taxes will have to be raised.

**CHAIRMAN BRADLEY** told **REP. COBB** that she respects his perspective. The strength of this budget is that it is has been the least amended budget once it left the subcommittee. This subcommittee cannot work in a vacuum and pretend the rest of government doesn't exist. Other subcommittees are coming up with reasonable budgets that don't have huge amounts of money that can be transferred to this area. Once this budget becomes known as a fat budget or one that cannot stand on its own, it will not only lose the small pieces being added now, it will be open game and everything this subcommittee has tried to do will go down the drain. Every piece will be re-examined. Right now this budget is going forward with a lot of respect. There haven't been a lot of complaints.

**REP. COBB** apologized. He said he is concerned about that too. But there is $400,000 in one-time money that eventually will revert to the General Fund. SRS says it is $120,000. This money is what would fund the 30 slots. **CHAIRMAN BRADLEY** said it's nice to snatch a few hundred-thousand out, but the SRS budget is millions and millions ahead of where it was when it came to the subcommittee.

**SEN. KEATING** said he empathizes with **REP. COBB**, but the subcommittee cannot argue over taking money from one group of needy people to give it to another group of needy people. The subcommittee doesn't get into that. It tries to follow the budget and provide where possible. It's a good idea to look at the budget as a whole and see if it isn't possible to get money from another subcommittee to supplement what this subcommittee wants to do. These programs should be given more priority than other programs. But this can't be done when each subcommittee is segregated and focusing on its own work. Subcommittees get possessive about what they do and they take pride in it. The best place to make such a move is in the full Appropriations Committee where everyone goes through the same process again. That's the place to start arguing about shifting dollars from one subcommittee to another. If this subcommittee puts a lot of extra money in these programs and announces a plan to attack other subcommittees, that will prompt a defensive wall that this subcommittee will never get through.

**REP. COBB** said he will just give the subcommittee his amendments to look over. **CHAIRMAN BRADLEY** said they deserve a vote. **REP. COBB** told **CHAIRMAN BRADLEY** he isn't going after her and doesn't want to put her in a position where she has to defend everything and get shot to pieces. This subcommittee could have put together a better budget and is doing all the work that the governor's office should have done. **CHAIRMAN BRADLEY** told **REP. COBB** that his motions deserve votes and that he is a committed subcommittee member.

**SEN. WATERMAN** said she shares the same frustration. Agencies have been told they have only so much money, then everyone talks about need. This subcommittee is put in the position of having to make decisions that someone else has chosen to avoid. She would like to wipe out the Specialized Family Care waiting list too. But **REP. COBB** made a good argument when she wanted to add the salary enhancement. He said the issue should be done as an amendment on the House floor to force everybody to vote on it. Maybe that is a better way to address this issue too.

**REP. COBB** said he wants to make sure the issue is addressed. He doesn't want to put **CHAIRMAN BRADLEY** on the spot. He can do this in the full committee if preferred. **CHAIRMAN BRADLEY** said she will fight for whatever the subcommittee decides to put into the budget.

**MOTION:** **REP. COBB** moved to add 30 Specialized Family slots at a cost of $190,966 in General Fund over the biennium.

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

**MOTION:** **REP. COBB** moved an additional 62 respite care slots for DD children and two slots for DD adults. The cost would be $518

per year, $64,232 for the 62 the children and $21,072 for the two adults, for a total of $66,304 for the biennium.

**DISCUSSION:** **CHAIRMAN BRADLEY** said she is being set up with a budget that is going to get clobbered. It will be open season. This should be considered when voting.

**VOTE:** The motion **FAILED** 1-5, with **REP. COBB** voting aye.

**REP. COBB** declined to make any other motions. He said he can see where things are going. He will submit the language on transition-to-work being tied to General Assistance. It won't cost any more money. Thirty contracted FTEs are needed for the Child Support Enforcement Bureau. It won't cost any more General Fund money and will take care of the backlog of cases.

**CHAIRMAN BRADLEY** said the subcommittee needs to leave for the day. It will take up supplementals first thing at the next hearing.

## 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** 2/7/91

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

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2-7-91

Exhibit #1
2/7/91
Human Services
Subcommittee

Beharski

The department may transfer funds appropriated for medicaid nursing care to the home and community based waiver program under the following conditions:

1) During the 1993 biennium, up to 50 residents may be moved from nursing facilities and funded under the waiver program

2) Per diem costs for each resident moved from nursing facilities may not exceed the state-wide average medicaid per diem cost of intermediate nursing care;

2) Records must be maintained of each resident transferred from nursing facilities to the home and community based waiver program; and

3) The department shall submit a report to the 1993 legislature specifying the number of nursing residents moved from nursing facilities to the waiver program and the total cost savings achieved by the transfers.

Let case manag. find them - pluck them out of N. homes.

Exhibit # 2

EXHIBIT 2
DATE 2-7-91
2/7/91 Human Services Subc.

Presentation Date: 2/6/91
SRS Page # 100
LFA Page # B-84
SRS Staff: Nancy Ellery, John Chappius, Norm Rostocki, Mary Dalton, Mike Hanshew

**Presentation on State Medical Program**

NOTE: This handout must be accompanied by Exhibit 3, which includes charts referred in the text

The State Medical Program was originally designed to pay for medical care for certain low-income Montanans who have nowhere else to go: they don't have health insurance and don't qualify for any other state or federally funded program such as Medicaid or Medicare. The services available are similar in amount, scope, and duration to the services available through Montana's Medicaid program. (Refer to chart 1 on a fact sheet on the State Medical Program)

The State Medical Program began in 1983. Montana state law requires all counties to provide financial and medical assistance to indigent residents. Some counties, however, were having difficulty meeting that legal mandate. As a result, the Legislature authorized the state to assume responsibility for the administration and funding of welfare and medical assistance programs in counties that asked for help. In return, the counties give the state revenue equal to 12 mills. The map in your handout shows the location of the 12 state-assumed counties. Refer to chart 2b

In 1990 there were just over 3,000 people on State Medical. There are two ways to become eligible: a) you have to receive General Assistance payments (which, for a single individual, means income

can't be over $220 a month); and b) you may become eligible for State Medical by making less than an average of $330 a month and need help with medical bills. Chart 22 provides demographic information about State Medical recipients. Then and mostly Single shows that 21% of GA recipients

The cost of the State Medical Program has increased dramatically since state assumption began in 1983. Chart 23 shows how costs have held steady despite a 65% drop in the General Assistance caseload. The cost of the program remained fairly constant at $2.7 million between 1984 and 1987, when costs jumped to $4.7 million -- a 74% increase. The projected cost for Fiscal Year 1991 is $5.1 million. Unlike the Medicaid program, where the federal government pays for 70% of the costs, the money for State Medical comes entirely from the General Fund.

Chart 24 Inpatient and outpatient hospitals accounts for 62% of the costs.

Problems

In order to gain a better perspective on State Medical, we compared it to similar programs in other states and the District of Columbia. We found that we were offering one of the most generous programs in the nation. Only 10 other states have programs as comprehensive as ours. In the other 40 states, 13 didn't offer <u>any</u> medical assistance to people not eligible for federal programs. Chart 25 26 summarizes programs in the surrounding states.

With this startling information as a background, we began analyzing who used the program and how they used it. We found to our dismay that what some might perceive as generosity in the program actually

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resulted in less than optimal care.

People who become eligible for State Medical get a monthly letter of authorization. This letter is what they show to doctors, pharmacies, and hospitals as proof of payment when they go to get some kind of medical service. Once we give the recipients a letter of authorization and explain what benefits State Medical covers, they may use the authorization like the rest of us could use a gold VISA card. Their medical credit is not restricted.

This lack of coordination and oversight of care means that we often treat the secondary symptoms without getting to the primary problem. Out of 728 inpatient hospital admissions for the State Medical Program last year, 254 or 35% were for conditions related to alcohol and drug abuse and mental disorders. Those hospitalizations took care of the severe complications of those conditions, but not the underlying problem itself.

Another consequence of this freedom is the potential for abuse. For example, one person got 196 prescriptions in a one year period. These prescriptions were for drugs such as sleeping pills, muscle relaxants, and pain killers, all prime candidates for addiction and abuse. These cost the program $1,710. Another person visited the outpatient department of the hospital 61 times in three months for backaches. That cost us $1,422. And another person not only uses the emergency room to avoid asking his doctor for prescription drugs, he uses the ambulance get there.

Redesigning the Program

Since I believe our goal is to provide medical care for low-income Montanans in a cost-effective and reasonable manner, it became clear to me from this information that we must restructure the program. I asked Mrs. Ellery and her staff to work with Norm Waterman and the Family Assistance staff to design a reasonable program of care. Mrs. Ellery is prepared to present their proposal.

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2-7-91
Hum Serv Sub

Presentation Date: 2/6/91
SRS Page # 127
LFA Page # B-57
SRS Staff: Nancy Ellery, John Chappius, Norm Rostocki, Mary Dalton, Mike Hanshew

**Presentation on State Medical Program**

Madam Chairperson, members of the subcommittee, my name is Nancy Ellery and I'm the Administrator the Medicaid Services Division of the Department of Social and Rehabilitation Services. I appreciate the opportunity to appear before you today to describe the improvements we have made in the State Medical Program so far, and to discuss our proposal to restructure it.

The State Medical Program was transferred to the Medicaid Services Division in July of 1990. Since then we have started to bring this program in line with our management of the Medicaid Program. A number of changes have been instituted in the manner in which services are delivered, including the fact that authorizations for medical services are only given on request rather than monthly in a carte blanche manner.

The initiatives we've undertaken so far have strengthened the management of the program. The next step is restructuring the program itself.

Basically, we propose to take a two-tiered approach to the State Medical Program: Acute Care Coverage and Chronic Care Coverage. The range of services available will still be comparable to

Medicaid. However, Acute Care Coverage will focus on services for immediate medical needs such as a broken leg. Chronic Care Coverage will be more comprehensive and include services needed to treat long-term medical problems or disabilities. Both will incorporate managed care, which is the oversight and coordination of health care delivery.

Chart 25 shows how this two-tiered system would work. When someone becomes eligible for State Medical, that person is immediately put on Acute Care Coverage. That means we'll pay for services to treat their immediate, short-term medical problems. Managed care will make sure that expensive services such as in-patient hospital admissions are medically necessary.

If the person has a chronic condition or disability that's expected to last 12 months or more, we have them apply for Supplemental Security Income -- called SSI for short -- a federal program that provides financial payments as well as Medicaid benefits for low-income aged, blind, and disabled people.

A new provision (OBRA 1990) in federal law allows states to do independent determinations of disability in order to qualify for Medicaid. Previously, states had to abide by the disability determination made in the SSI process. Only 29% of applicants in Montana pass the initial screen. Another 20% are later found eligible after going through the appeals process. ~~In order to take advantage of this federal change, we will be presenting a modification in the~~

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Medicaid budget.

If Montana's independent disability determination finds a person to be disabled, Medicaid can begin immediately, and continues until the final SSI appeal is exhausted. If the final SSI appeal still finds no disability, then Medicaid is closed and the client is put on Chronic Care Coverage in the State Medical program.

The Department will work aggressively to help people get SSI eligibility. We already have a contract with Montana Legal Services to help people initially denied SSI eligibility to appeal that denial.

The two exceptions to this new program would be children and people enrolled with the Project Work Program. Children will still be entitled to the full range of services similar to Medicaid. In other words, there will be no change in services for children. Those in the Project Work Program may receive some services not covered by State Medical if they're necessary for employment. The Project Work Program will pick up the costs of those extra services.

This two-tiered approach addresses the main problem of our current open-ended system. Our proposal insures that we address a person's underlying medical condition -- not just the symptoms. People with long-term problems will receive the benefit of a comprehensive treatment plan through managed care in the Chronic Coverage

Program. We won't just treat the medical crises -- we'll work to prevent them.

But our proposal has other benefits as well. By insuring that people in Acute Care Coverage use medical services wisely, we reduce abuses by recipients who see a State Medical letter of authorization as a kind of "blank check" for health care.

Finally, this proposal will help contain costs. Reducing the unnecessary use of services will reduce costs. Identifying those who may be eligible for SSI and conducting independent disability determinations to get Medicaid started earlier will mean we get federal assistance in meeting their needs.

We need to make sure the State Medical Program reaches the people who need it. This bill will help us do that, and I urge the subcommittee to approve it.

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HB

# FACTSHEET ON STATE MEDICAL PROGRAM

**Description:** State law requires all counties to provide financial and medical assistance for indigent residents. Counties having trouble fulfilling the mandate can ask the state to assume that responsibility in return for providing revenue equal to 12 mills. State Medical pays for medical care for certain low-income Montanans in the 12 state-assumed counties (Cascade, Deer Lodge, Flathead, Lake, Lewis and Clark, Lincoln, Mineral, Missoula, Park, Powell, Ravalli, and Silver Bow). The amount, scope, and duration of benefits are comparable to services in Montana's Medicaid program.

**Who It Serves:** The program serves a little over 3,000 low-income Montanans not eligible for any federally-funded program such as Medicaid or Medicare. 85% get State Medical because they receive General Assistance payments. The other 15% are eligible because their incomes are below $330 a month (for a single person) and they have high medical bills.

**Cost:** The cost of the State Medical Program has increased dramatically since state assumption began in 1984. From $2.7 million in 1984, it remained fairly constant until 1987, when costs jumped to $4.7 million -- a 74% increase. The projected cost for 1991 is $5.1 million. State Medical funds come solely from the General Fund.

**Problems:** Recipients get a monthly letter of authorization, and then it's up to them to decide what services to get. While some might call the open-ended nature of the program generous, it's actually is an invitation for abuse and less than optimal care.

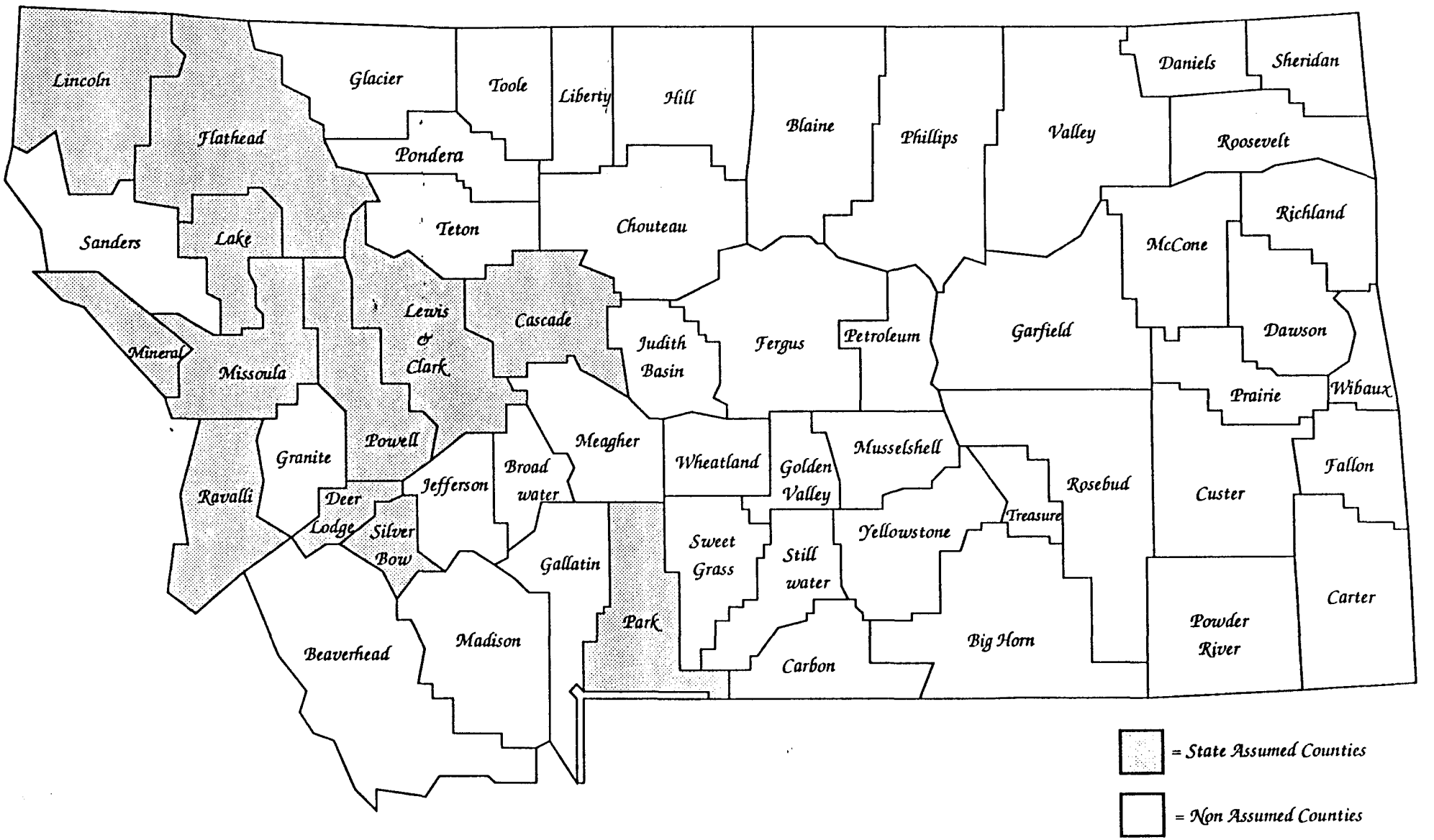
**Proposed Changes:** The Department proposes to keep eligibility criteria the same, but take a two-tiered approach to services:

Acute Care Coverage. Cover treatment of short-term, immediate medical problems. If another medical need developed later, they could get reauthorized for coverage of that problem.

Chronic Care Coverage. We would assist people with long-term conditions or disabilities in applying for Supplemental Security Income or SSI, a federal program that makes people eligible for Medicaid. A new provision in federal law allows people who pass the initial screen for SSI to get on Medicaid while they await the final word on their SSI eligibility. Those who are eventually denied SSI would get Chronic Care Coverage, where we would used managed care to develop a comprehensive treatment plan.

CHART 21

# State Assumed Counties



# State Medical Age Distribution
## FY 1990

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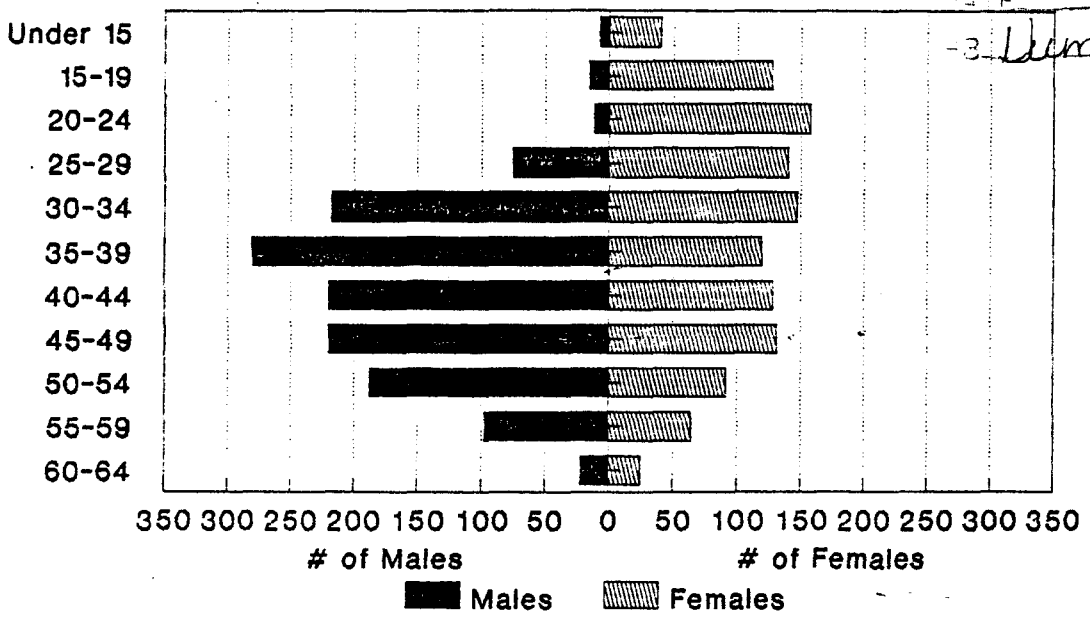
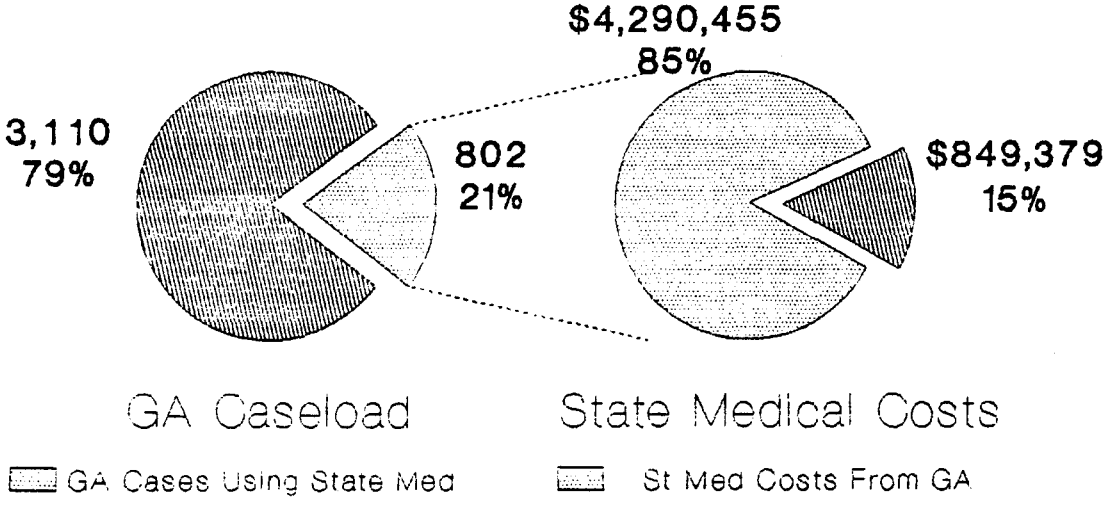



# GA Usage of State Medical
## FY 1990




**Conclusion: 21% of GA recipients use State Medical program and account for 85% of State Medical costs.**

CHART 23

3
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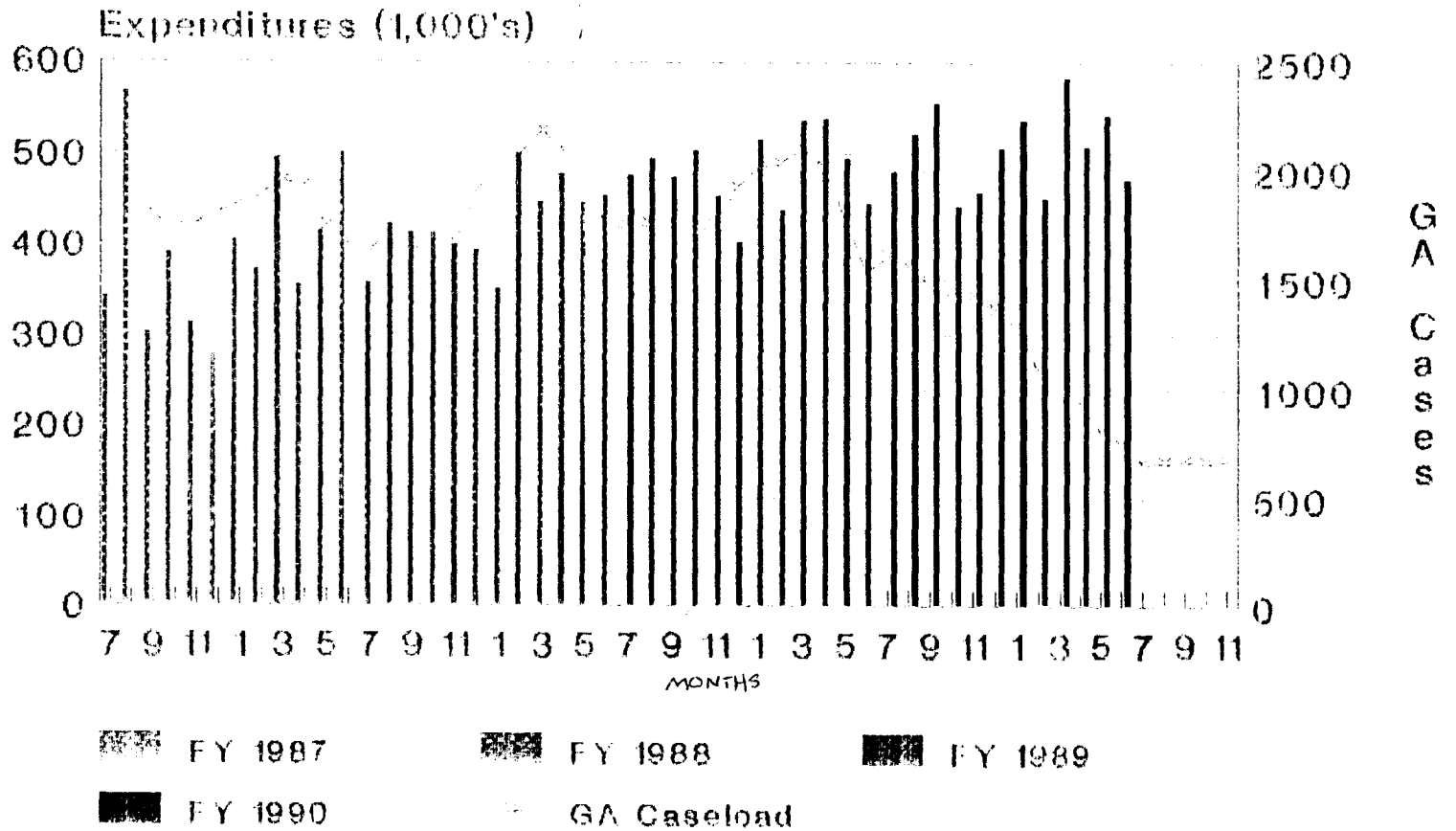
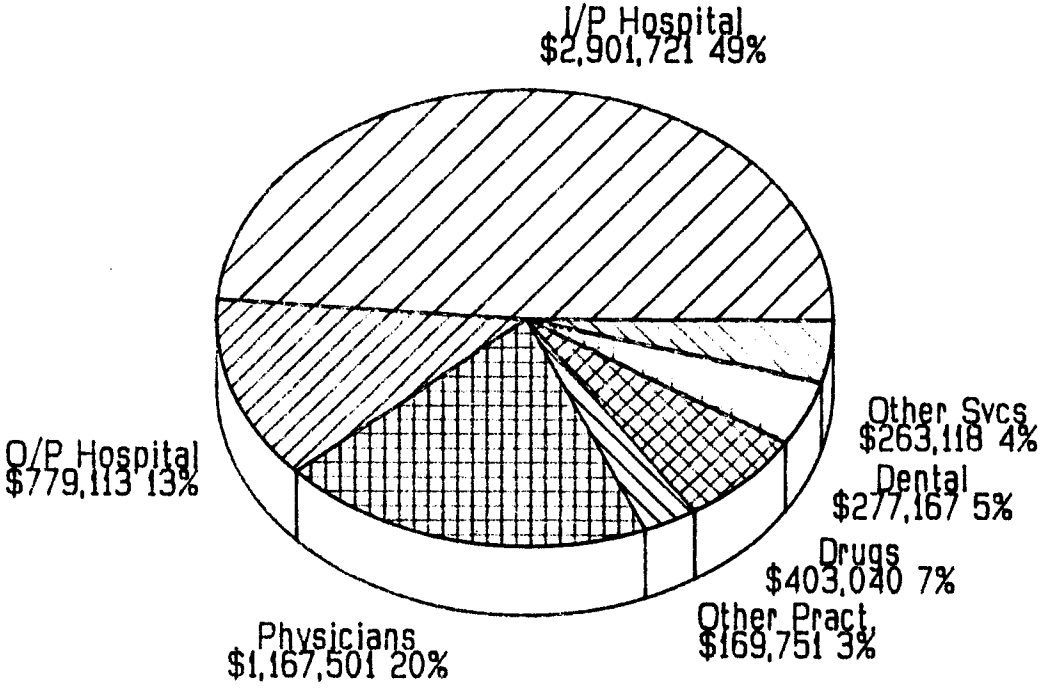
# State Med Costs vs GA Cases
## FY 1987-90




FY 1990 cost data not yet complete.

CHART 24

# State Medical Costs
## FY 1990




Costs as of 11/1/90 and prior to Medicaid refunds.

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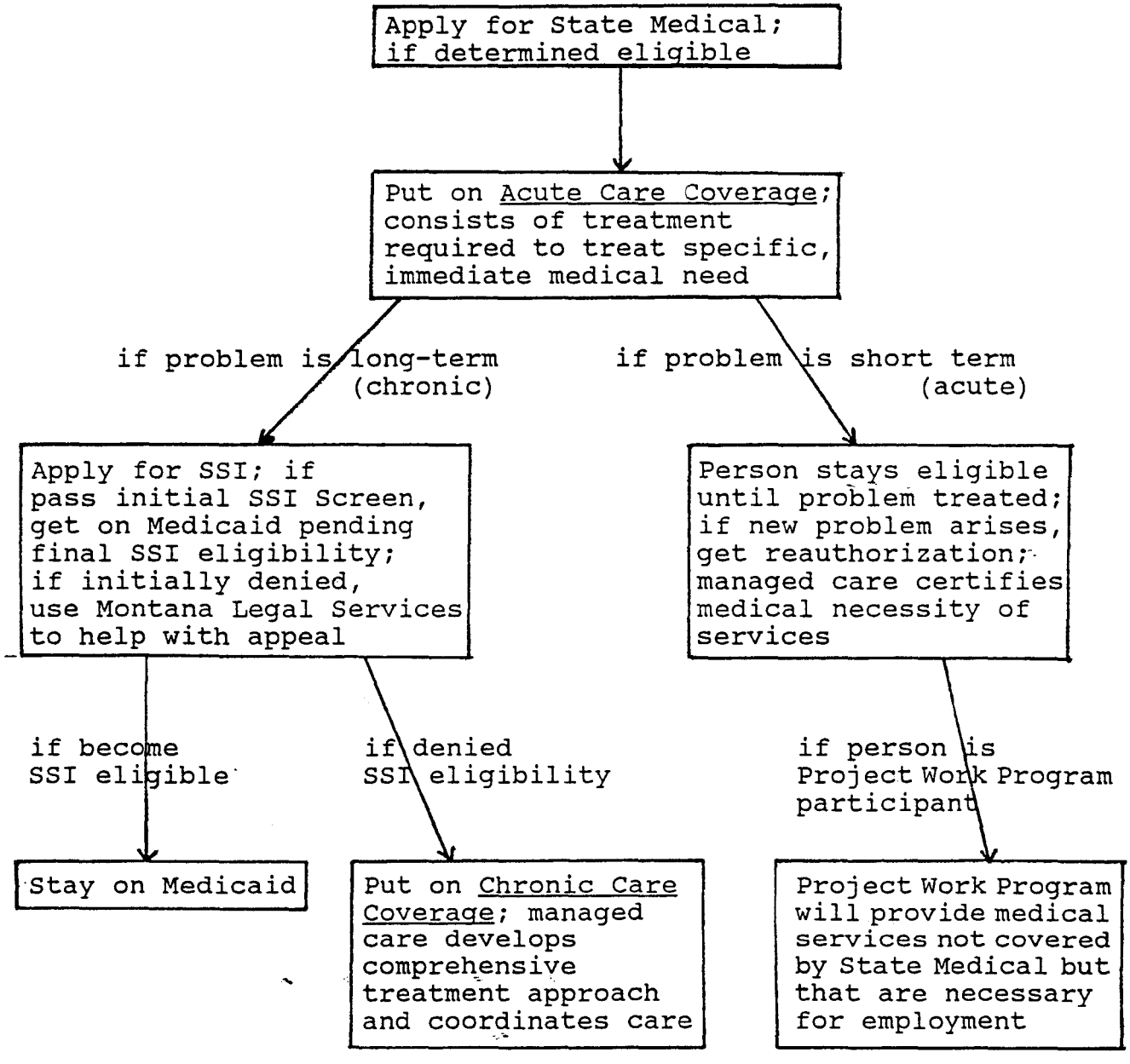
SB Dum. Dev. Sub.

## HOW PROPOSED TWO-TIERED SYSTEM WILL WORK:




Note: Eligibility criteria will remain the same. Benefits will still be limited to amount, scope, and duration of services available under Medicaid. Children are exempt from above changes. SSI is a federal program to provide financial assistance to low-income aged, blind, and disabled; includes Medicaid benefits.

CHART 26

# Comparison of Montana Indigent Medical Program To Surrounding States

Colorado: No County or State funded Indigent Program

Idaho: State mandates counties to provide emergency services.
County sets eligibility standards.

Nevada: State mandates all counties provide indigent medical svs.
Benefits similar to Medicaid benefit level.

North Dakota: Only offered in some counties;
Only Emergency medical costs covered.

South Dakota: County Administered program; Benefits vary by county.

Utah: State Administered program.
Care for acute, life-threatening, or infectious diseases

Wyoming: State administered program;
Benefits less comprehensive than Medicaid.

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4
DATE 2-7-91

February 5, 1991

Department of Family Services state General Fund share of costs incurred and paid in FY 1990 in the state-assumed counties:

| | |
|---|---|
| Foster Care | $1,600,000 |
| Administration | 315,000 |
| Total | $1,915,000 |

FY 90 STATE ASSUMPTION

| STATE ASSUMPTION | Total Amount | G.F. Amount |
|---|---|---|
| REVENUE FROM STATE ASSUMED COUNTIES | | |
| County Mill Levy Revenue Estimated | | $6,907,000 |
| TOTAL MILL REVENUE ESTIMATED | | $6,907,000 |
| PRORGAM 01 - FAMILY ASSISTANCE | | |
| Workfare | $1,497,021 | $1,497,021 |
| N. W. Workfare | $322,922 | $322,922 |
| AFDC Regular | $17,757,004 | $1,151,974 |
| Emergency AFDC | $144,960 | $72,482 |
| General Assistance | $970,711 | $970,711 |
| AFDC Grant Diversion | $5,250 | $341 |
| AFDC Regular U.P. | $487,497 | $31,592 |
| Burials | $148,433 | $148,433 |
| TOTAL PROGRAM 01 | $21,333,798 | $4,195,476 |
| PRORGAM 03 - ELIGIBILITY DETERMINATION | | |
| Eligibility Technicians | $2,863,922 | $1,460,384 |
| County Directors and Clerical | $1,377,319 | $702,305 |
| Training Travel | $1,530 | $766 |
| Front End Investigators | $259,195 | $64,800 |
| TOTAL PROGRAM 03 | $4,501,966 | $2,228,205 |
| PRORGAM 06 - STATE ADMINISTRATION | | |
| Food Stamps | $182,705 | $91,354 |
| GA Data Processing | $85 | $85 |
| St/Co Administration FA | $702,448 | $358,184 |
| MIMS Data Processing | $6,050 | $3,028 |
| State Administration | $171,343 | $168,269 |
| TOTAL PROGRAM 06 | $1,062,631 | $620,914 |
| PRORGAM 07 - MEDICAID SERVICES | | |
| State Medical | $5,519,801 | $5,519,801 |
| Doctors | $3,289 | $3,289 |
| TOTAL PROGRAM 07 | $5,523,090 | $5,523,090 |
| TOTAL SRS EXPENDITURES | $32,421,485 | $12,567,685 |
| REVENUE MINUS EXPENDITURES | | ($5,660,685) |

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Human Service Sub

EXHIBIT 5
2-7-91

# Derivation of the Amounts and Funding Allocations for the State Medical Program for FY 1992 and FY 1993

**Assumptions:**

[1] The base cost (current level) of the state medical program is $5,020,000.

[2] Current level costs are divided between unemployable and employable clients according to the following percentages: employable 40%; unemployable 60%.

[3] Under the department proposal, the employable clients would be covered under the "acute coverage" provisions of the state medical program, and costs for these clients would be borne entirely by the state general fund.

[4] Under the department proposal, the unemployable clients would be covered under the "chronic illness" provisions of the state medical program, and costs for these clients would be allowable for medicaid reimbursement. For the purposes of this presentation, we are proposing that the state match for these costs be included in the state medical appropriation.

[5] All state medical clients, both employable and unemployable, will be covered by the department's managed care program for state medical clients.

[6] Based upon department studies, 49% of all costs in the state medical program are incurred for inpatient care. These costs are susceptible to reduction under the managed care program.

[7] The managed care program will reduce inpatient costs for state medical cases by an average of 33% in FY92 and 29% in FY93.

[8] New SRS administrative procedures will reduce costs by 10%-20% below the costs incurred under the managed care levels for the employable category.

**Calculations:**
Based on the above assumptions, the table below summarizes the costs associated with the state medical program for FY92 and FY93:

| | | FY92 | FY93 |
|---|---|---|---|
| I. | Base cost of state medical program (all GF) | $5,020,000 | $5,020,000 |
| II. | Amount of base allocated to employable clients | 2,008,000 | 2,008,000 |
| | Less reduction due to managed care (33% of 49% in FY92; 29% of 49% in FY93) | -324,693 | -285,337 |
| | Less reduction due to new administrative procedures | -337,024 | -339,388 |
| | Equals net GF cost for employables | $1,346,283 | $1,383,275 |
| III. | Amount of base allocated to unemployables | $3,012,000 | $3,012,000 |
| | Less reduction due to managed care (33% of 49% in FY92; 29% of 49% in FY93) | -487,040 | -428,005 |
| | Equals net total cost for unemployables | 2,524,960 | 2,583,995 |
| | General fund share to be included in state medical appropriation for unemployables | $ 714,311 | $ 726,103 |
| IV. | Total general fund appropriations for state medical | $2,060,594 | $2,109,378 |
| V. | Total federal appropriations to state medical program to cover the unemployables | $1,810,649 | $1,857,892 |

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

Appropriations Subcommittee on Human Services
Modifications to House Bill #2

Subject: General relief medical

The Department of Social & Rehabilitation Services is authorized to transfer monies appropriated in the general relief medical assistance program in order to facilitate fiscal management and to insure that the expenditures of money follows the needs of the client receiving the services.

GRM.fm

RC

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 (OBRA 90) SUMMARY FOR THE BIENNIUM

| | EY92 TOTAL | EY92 FEDERAL | EY92 STATE | EY93 TOTAL | EY93 FEDERAL | EY93 STATE |
|---|---|---|---|---|---|---|
| **BENEFITS** | | | | | | |
| *REBATES FROM DRUG MANUFACTURERS | ($1,000,000) | ($ 717,100) | ($282,900) | ($1,100,000) | ($ 790,900) | ($ 309,100) |
| *PURCHASE OF GROUP HEALTH INSURANCE | ($ 675,000) | ($ 484,043) | ($190,958) | ($ 675,000) | ($ 485,325) | ($ 189,675) |
| *REDUCE HOSPITAL OUTPATIENT REIMBURSEMENT | ($ 923,638) | ($ 662,341) | ($261,297) | ($1,220,411) | ($ 883,227) | ($ 345,183) |
| *FEDERAL FINANCIAL PARTICIPATION FOR COBRA COVERAGE PAYMENTS | ($ 187,500) | ($ 134,456) | ($ 53,044) | ($ 187,500) | ($ 134,813) | ($ 52,688) |
| *PHASE-IN COVERAGE OF ALL CHILDREN BELOW 100% OF POVERTY UP TO AGE 18 | $1,170,000 | $ 839,007 | $330,993 | $1,560,000 | $1,121,640 | $ 438,360 |
| *PROSPECTIVE AND RETROSPECTIVE DRUG UTILIZATION REVIEW INCLUDING DRUG REVIEW BOARD | $ 165,000 | $ 123,750 | $ 41,250 | $ 330,000 | $ 247,500 | $ 82,500 |
| *EXPANDED COVERAGE OF QUALIFIED MEDICARE BENEFICIARIES | $ 242,700 | $ 174,040 | $ 68,660 | $1,180,328 | $ 708,946 | $ 471,382 |
| *VETERANS PENSION CHANGES | $ 744,120 | $ 533,608 | $210,512 | $ 744,120 | $ 535,022 | $ 209,098 |
| *MANDATORY CONTINUATION OF BENEFITS THROUGH PREGNANCY AND FIRST YEAR OF LIFE | $ 219,200 | $ 157,188 | $ 62,012 | $ 219,200 | $ 157,605 | $ 61,595 |
| *REHABILITATION SERVICES | $2,195,199 | $1,574,177 | $621,022 | $4,382,341 | $3,150,903 | $1,231,438 |
| *OTHER CHANGES | $ 102,890 | $ 78,136 | $ 24,754 | $ 102,890 | $ 78,303 | $ 24,588 |
| TOTAL BENEFITS | $2,052,971 | $1,481,966 | $571,004 | $5,327,968 | $3,705,654 | $1,622,315 |
| **ADMINISTRATION** | | | | | | |
| *PERSONAL SERVICES | $ 84,206 | | | $ 84,111 | | |
| *CONTRACT SERVICES PHARMACY, REHABILITATION AND HEALTH INSURANCE | $ 147,103 | | | $ 122,203 | | |
| *TRAVEL | $ 2,700 | | | $ 2,700 | | |
| *REPAIR | $ 3,000 | | | $ 3,000 | | |
| *EQUIPMENT | $ 12,000 | | | $ 12,000 | | |
| TOTAL ADMINISTRATION | $ 249,109 | | | $ 211,914 | | |
| TOTAL COST | $ 2,302,080 | | | $5,539,882 | | |

| PERSONAL SERVICES FTE | GRADE | STEP | FTE |
|---|---|---|---|
| DRUG REFORM | 12 | 2 | 1 |
| FDHC, OMB, DSA | 15 | 2 | 1 |
| REHABILITATION | 15 | 2 | 1 |

Exhibit # 7
2-7-91
Human Serv. Subc.

DATE 2-7-91
SB

Exhibit #8
2/7/91
Human Serv
Subc.

**STATE OF MONTANA - MEDICAID PROGRAM**
**DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES**
**STATE MEDICAL MANAGED CARE**

This modification includes funding for a managed care system for the State Medical Program. Managed care would provide guidance to clients concerning proper cost effective medical care and it would require prior approval before certain services could be provided. Managed Care is an integral part of the projected cost savings for the State Medical Program. This program is estimated to cost approximately $150,000 per year. It is expected to save the state medical program an estimated 30 percent of its inpatient hospital costs.

Exhibit #9
2/7/91
Human Serv. Subc.

EXHIBIT 9
DATE 2-7-91
HB

**STATE OF MONTANA - MEDICAID PROGRAM**
**DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES**
**ADDITIONAL NURSING HOME AUDITS**

The executive budget includes a request for funds in order to rebase nursing home reimbursement rates. The rebase will update nursing home rates to an appropriate level. Additional nursing home audits will be required in order to keep nursing rates updated and reasonable.

The Department is requesting funds in order to perform additional audits of nursing homes. This is estimated to cost $30,600 per year.

| | 1992 Total | 1992 General Fund | 1993 Total | 1993 General Fund | Biennium Total | Biennium General Fund |
|---|---|---|---|---|---|---|
| | 2% Medicaid Provider Rate Increases | | | | | |
| Inpatient Hospital | 1,139,143 | 322,263 | 2,351,222 | 660,693 | 3,490,364 | 982,957 |
| Inpatient Psychiatric | 176,735 | 49,998 | 367,064 | 103,145 | 543,799 | 153,143 |
| Outpatient Hospital | 264,317 | 74,775 | 549,623 | 154,444 | 813,940 | 229,219 |
| Physicians | 423,802 | 119,894 | 871,630 | 244,928 | 1,295,432 | 364,822 |
| Other Practitioners | 69,709 | 19,721 | 144,061 | 40,481 | 213,770 | 60,202 |
| Drugs | 343,083 | 97,058 | 724,818 | 203,674 | 1,067,900 | 300,732 |
| Dental | 75,120 | 21,251 | 152,285 | 42,792 | 227,404 | 64,043 |
| Other | 391,100 | 110,642 | 807,447 | 226,893 | 1,198,547 | 337,535 |
| Nursing | 1,199,153 | 339,240 | 2,446,272 | 687,402 | 3,645,425 | 1,026,643 |
| Waiver | 99,449 | 28,134 | 200,887 | 56,449 | 300,336 | 84,583 |
| State Institutions | 36,748 | 0 | 74,479 | 0 | 111,227 | 0 |
| Total Medicaid Costs | 4,218,358 | 1,182,977 | 8,689,787 | 2,420,902 | 12,908,145 | 3,603,879 |
| Less Cost Savings | (108,672) | (30,743) | (120,453) | (33,847) | (229,126) | (64,591) |
| Total | 4,109,686 | 1,152,234 | 8,569,334 | 2,387,054 | 12,679,020 | 3,539,288 |

Exhibit #10
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Human Services
Subc.

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2-7-91

Exhibit 17
11
2-7-91 2/7/91
Human Services Subc.

# TRANSITION FROM SCHOOL TO ADULT SERVICES

Each year, approximately 60 students graduate from special education. These students have a variety of service needs that will best be met through a coordinated planning effort that begins upon entry into high school.

A transition planning process involving representatives of the family, the school system, and the adult service system needs to be developed. A plan for an individual should establish instructional objectives that will provide the student with skills needed in his/her adult life and address activities required for a smooth transition into adult services.

Close coordination between the two systems will result in better planning to meet individual needs and better planning at the agency level to assure availability of needed services.

In order to accomplish the coordination necessary the Departments involved in providing services should work together to present to the 1993 Legislature a proposal that will assure continuity of services.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services SUBCOMMITTEE DATE 2/4/91

DEPARTMENT(S) SRS DIVISION

**PLEASE PRINT** **PLEASE PRINT**

| NAME | REPRESENTING | |
|---|---|---|
| John Downen | SRS | |
| Roger Tippy | M+S Pharmaceutical | |
| Rose Hughes | MT. Health Care Assn | |
| Chris Volinkaty | DD Lobbyist | |
| Nancy Ellery | SRS | |
| Julie Robinson | SRS | |
| John Chappuis | SRS | |
| John E. Thompson | SRS | |
| Penny Robbe | SRS | |
| Norm Waterman | SRS | |
| Terry Kratz | SRS | |
| MIKE HANSHEW | SRS | |
| HANK Hudson | Gov office | |
| Greg Olsen | DDPSC | |
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