MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN JOHN COBB**, on January 18, 1993, at 8:00 A:M.

ROLL CALL

Members Present:
Rep. John Cobb, Chairman (R)
Sen. Mignon Waterman, Vice Chairman (D)
Sen. Chris Christiaens (D)
Rep. Betty Lou Kasten (R)
Sen. Tom Keating (R)
Rep. David Wanzenried (D)

Members Excused: None

Members Absent: None

Staff Present: Lisa Smith, Legislative Fiscal Analyst
Lois Steinbeck, Legislative Fiscal Analyst
Connie Huckins, Office of Budget & Program Planning
John Huth, Office of Budget & Program Planning
Billie Jean Hill, Committee Secretary

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

Committee Business Summary:
Hearing: ASSUMED AND NON-ASSUMED COUNTIES BUDGET ITEMS AND MEDICAID SERVICES DIVISION
Executive Action: NONE

CHAIRMAN COBB outlined the morning's agenda.

HEARING ON ASSUMED AND NON-ASSUMED COUNTIES BUDGET ITEMS

Tape No. 1:Side 1

Ms. Lois Steinbeck explained the green budget sheets **(EXHIBIT 1)** and discussed the three issues before the committee for this meeting.

SEN. WATERMAN asked **Dr. Blouke** to share with the committee his perspective of the impact of the 5% personal services cuts. **Dr. Blouke** questioned the validity of eliminating well-trained people when the savings will have no impact on the general fund.

Dave DePew, Montana Public Employees Association, representing both the technicians in the assumed counties and non-assumed counties, reminded the committee that the technicians are front-line workers in the delivery of all SRS services.

Motion: **SEN. KEATING** moved to restore the non-general fund positions in both the 5% and the vacancy cuts motion to non-assumed counties.

Discussion:

REP. KASTEN said that the committee was going against the idea that this action was essential in order to produce a balanced budget.

SEN. KEATING said that to thin all programs just makes some programs unworkable; if the legislature is going to deal with the number of state employees, then certain programs have to be cut altogether. The state has to staff necessary programs as efficiently and effectively as possible.

Motion: **REP. KASTEN** made a motion to divide the question; to address separately the 5% and the December 1992 vacancy cuts.

REP. KASTEN withdrew her motion.

CHAIRMAN COBB stated that the committee would not take action.

SEN. WATERMAN asked for clarification of the motions and a legal opinion on the December 1992 vacancy cuts.

HEARING ON MEDICAID SERVICES DIVISION

Tape No. 1:Side 2

Ms. Nancy Ellery, Administrator, Medicaid Services Division, introduced her staff: **Mr. John Chappuis, Bureau Chief, Budget and Institutional Services Section; Ms. Mary Dalton, Bureau Chief, Primary Care Bureau; Mr. Norm Rostocki, Supervisor, Budget Section.** **EXHIBIT 2, EXHIBIT 3** and letter sent to all legislators on December 24, 1992, **EXHIBIT 4**).

Ms. Ellery discussed this issue and responded to questions from the committee.

CHAIRMAN COBB concluded the hearing.

ADJOURNMENT

ADJOURNMENT

Adjournment: 11:50 A:M

JOHN COBB, Chairman

BILLIE JEAN HILL, Secretary

JC/bjh

HOUSE OF REPRESENTATIVES

HUMAN SERVICES **SUB-COMMITTEE**

ROLL CALL **DATE** Jan 18, 1993

NAME	PRESENT	ABSENT	EXCUSED
REP. JOHN COBB, CHAIRMAN	✓		
SEN. MIGNON WATERMAN, VICE CHAIR	✓		
SEN. CHRIS CHRISTIAENS	✓		
SEN. TOM KEATING	✓		
REP. BETTY LOU KASTEN	✓		
REP. DAVID WANZENRIED	✓		

EXHIBIT 1
DATE 1-18-93
SB

6901 03 00000
DEPT SOCIAL & REHAB SERVICES — Eligibility Determination Pgm
Program Summary

Budget Item	Current Level Fiscal 1992	Current Level Fiscal 1993	Executive Fiscal 1994	LFA Fiscal 1994	Difference Fiscal 1994	Executive Fiscal 1995	LFA Fiscal 1995	Difference Fiscal 1995
FTE	194.80	403.40	184.55	194.80	(10.25)	184.55	194.80	(10.25)
Personal Services	5,049,270	10,205,380	5,174,540	5,407,505	(232,965)	5,186,867	5,420,378	(233,511)
Operating Expenses	60,288	175,985	115,374	115,374	0	118,492	118,492	0
Total Costs	$5,109,558	$10,381,365	$5,289,914	$5,522,879	($232,965)	$5,305,359	$5,538,870	($233,511)
Fund Sources								
General Fund	0	2,576,971	0	0	0	0	0	0
State Revenue Fund	2,610,464	2,728,028	2,704,189	2,823,296	(119,107)	2,713,605	2,833,132	(119,527)
Federal Revenue Fund	2,499,094	5,076,366	2,585,725	2,699,583	(113,858)	2,591,754	2,705,738	(113,984)
Total Funds	$5,109,558	$10,381,365	$5,289,914	$5,522,879	($232,965)	$5,305,359	$5,538,870	($233,511)

Page References

LFA Budget Analysis (Vol. II) p. B-67.
Stephens' Executive Budget p.p. B-35- B-36.

	Exec. Over(Under) LFA Fiscal 1994	Exec. Over(Under) LFA Fiscal 1995
Current Level Differences		
5% PERSONAL SERVICES REDUCTION - The joint House Appropriations and Senate Finance and Claims committees reduced personal services appropriations by 10.25 FTE and about $233,000 annually.	(232,965)	(233,511)
TOTAL CURRENT LEVEL DIFFERENCES	(232,965)	(233,511)
FUNDING - This program is funded 51% from state special revenue (county funds) and 49% from federal funds.		
Budget Modifications		
CONTINUE NON-ASSUMED CO. BA - This budget modification continues six eligibility technicians in non-assumed counties that were added by budget admendment during the 1993 biennium.	170,787	170,888
Language and Other Issues		
POSITIONS VACANT 12/29/92 - This program had 6.5 vacant FTE that were removed by the joint House Appropriations and Senate Finance and Claims committees. These positions are in the following counties: Big Horn, Gallatin, Glacier, Broadwater and Sanders.	144,373	144,503

EXHIBIT 1
DATE 1-18-93
SB

Positions Removed by Joint Committee Action
House Appropriations & Senate Finance and Claims
January 6, 1993

Position #	Position Description	Total Personal Services Fiscal 1994	Total Personal Services Fiscal 1995	FTE Removed by 5% Reduct.	FTE Removed by Being Vacant	Total FTE Removed	Non-Approp. FTE
All or Partial General Fund Positions							
	None					0.00	
Sub-Total		0	0	0	0	0	0.00
Non-General Fund Positions							
30021	Eligibility Examiner - Blaine	6,128	6,148	0.25		0.25	
30022	Eligibility Assistant - Blaine	6,097	6,102	0.25		0.25	
30025	Eligibility Assistant - Blaine	22,275	22,296	1.00		1.00	
30028	Typist II - Blaine	9,630	9,637	0.50		0.50	
30041	Eligibility Examiner - Broadwater	24,210	24,233	1.00		1.00	
30121	Eligibility Examiner - Choteau	4,778	4,782	0.25		0.25	
30122	Eligibility Examiner - Choteau	6,130	6,175	0.25		0.25	
30172	Eligibility Assistant - Fallon	24,161	24,184	1.00		1.00	
30278	Program Assistant I - Hill	21,793	21,814	1.00		1.00	
30280	Clerk Supervisor II - Hill	20,915	20,935	1.00		1.00	
30491	Secretary II - Phillips	10,693	10,693	0.50		0.50	
30501	Eligibility Examiner - Pondera	11,707	11,717	0.50		0.50	
30504*	Eligibility Assistant - Pondera	4,302	4,307	0.25		0.25	
30557*	Receptionist II - Richland	12,407	12,427	0.50		0.50	
30652	Eligibility Assistant - Sweetgrass	29,180	29,318	1.00		1.00	
30684	Administrative Assistant I - Valley	10,540	10,631	0.50		0.50	
30731	Eligibility Examiner - Yellowstone	11,395	11,404	0.50		0.50	
Adjustment	to tie to LFA/Exec. Difference	(3,374)	(3,291)				
	Subtotal - 5%	$232,965	$233,511	10.25	0.00	10.25	
30017	Eligibility Assistant - Big Horn	19,973	19,992		1.00	1.00	
30041	Eligibility Examiner - Broadwater	24,210	24,233		1.00	1.00	
30229	Eligibility Assistant - Gallatin	20,365	20,384		1.00	1.00	
30230	Eligibility Assistant - Gallatin	20,365	20,384		1.00	1.00	
30241	Program Assistant II - Glacier	25,084	25,103		1.00	1.00	
30246	Program Assistant I - Glacier	23,053	23,075		1.00	1.00	
30594	Eligibility Assistant - Sanders	11,323	11,332		0.50	0.50	
Subtotal - Vacant FTE		$144,373	$144,503	0.00	6.50	6.50	0.00
TOTAL		$377,338	$378,014	10.25	6.50	16.75	0.00

*FTE also included in action of joint subcommittees to remove positions vacant as of 12/29/92.

EXHIBIT 2
DATE 1-18-93
SB

6901 06 00000
DEPT SOCIAL & REHAB SERVICES
Program Summary
State Assumed County Admin.

Budget Item	Current Level Fiscal 1992	Current Level Fiscal 1993	Executive Fiscal 1994	LFA Fiscal 1994	Difference Fiscal 1994	Executive Fiscal 1995	LFA Fiscal 1995	Difference Fiscal 1995
FTE	203.10	0.00	192.10	203.10	(11.00)	192.10	203.10	(11.00)
Personal Services	5,166,079	0	5,405,876	5,669,519	(263,643)	5,418,602	5,682,480	(263,878)
Operating Expenses	1,012,918	1,080,928	1,010,926	1,015,266	(4,340)	1,024,416	1,015,354	9,062
Equipment	13,332	16,019	31,700	16,500	15,200	31,700	16,500	15,200
Total Costs	$6,192,331	$1,096,947	$6,448,502	$6,701,285	($252,783)	$6,474,718	$6,714,334	($239,616)
Fund Sources								
General Fund	3,161,245	596,195	3,288,671	3,354,663	(65,992)	3,302,044	3,362,538	(60,494)
Federal Revenue Fund	3,031,085	500,752	3,159,831	3,346,622	(186,791)	3,172,674	3,351,796	(179,122)
Total Funds	$6,192,331	$1,096,947	$6,448,502	$6,701,285	($252,783)	$6,474,718	$6,714,334	($239,616)

Page References

LFA Budget Analysis (Vol. II) p. B-70.
Stephens' Executive Budget pp. B-38 to B-39.

	Exec. Over(Under) LFA Fiscal 1994	Fiscal 1995
Current Level Differences		
5% PERSONAL SERVICES REDUCTION - The joint House Appropriations and Senate Finance and Claims committees removed 11.0 FTE and about $264,000 each year of the biennium.	(263,643)	(263,878)
POSTAGE AND RENT - The LFA current level includes a higher amount for postage in fiscal 1994 than the executive. The executive includes a higher amount for county office rent in fiscal 1995 than the LFA current level.	(4,340)	9,062
EQUIPMENT - The LFA and executive include the same level of funding for replacement office equipment for county offices. However, the executive includes funds for 13 personal computers and monitors each year and the LFA funds 5 personal computers and monitors.	15,200	15,200
TOTAL CURRENT LEVEL DIFFERENCES	(252,783)	(239,616)

FUNDING ISSUE - This LFA funded this program using the same percentages as the agency request: 50.06% from the general fund in fiscal 1994 and 50.08% in fiscal 1995 with the balance of funding from federal funds. The executive revised the funding mix to 51% general fund and 49% federal funds each year of the biennium.

Budget Modifications

Language and Other Issues

POSITIONS VACANT 12-29-92 - The joint House Appropriations and Senate Finance and Claims committees removed 2.50 FTE vacant as of 12-29-92. The positions are in the following counties: Lincoln, Park, and Ravalli.	61,442	61,645

EXHIBIT 2
DATE 1-18-93
SB

Positions Removed by Joint Committee Action
House Appropriations & Senate Finance and Claims
January 6, 1993

Position #	Position Description/County	Total Personal Services Fiscal 1994	Total Personal Services Fiscal 1995	FTE Removed by 5% Reduct.	FTE Removed by Being Vacant	Total FTE Removed	Non–Approp. FTE
All or Partial General Fund Positions							
30076	Eligibility Examiner – Cascade	23,345	23,363	1.00		1.00	
30081	Eligibility Examiner – Cascade	25,820	25,839	1.00		1.00	
30099	Eligibility Assistant – Cascade	21,836	21,857	1.00		1.00	
30105	Eligibility Assistant – Cascade	22,836	22,857	1.00		1.00	
30154*	Eligibility Examiner – Deer Lodge	27,407	27,433	1.00		1.00	
30158	Eligibility Assistant – Deer Lodge	9,909	9,925	0.50		0.50	
30320	Program Assistant I – Lake	5,401	5,407	0.25		0.25	
30333	Eligibility Examiner – Lewis and Clark	30,789	30,818	1.00		1.00	
30375*	Eligibility Examiner – Lincoln	12,812	12,821	0.50		0.50	
30435	Eligibility Examiner – Missoula	10,965	10,977	0.50		0.50	
30536	Eligibility Examiner – Ravalli	5,053	5,059	0.25		0.25	
30616	Eligibility Examiner – Silver Bow	26,475	26,495	1.00		1.00	
30628	Eligibility Assistant – Silver Bow	20,359	20,374	1.00		1.00	
30635	Eligibility Assistant – Silver Bow	23,824	23,846	1.00		1.00	
Adjustment	to tie to LFA/Exec. Difference	(3,188)	(3,192)				
	Sub–Total 5%	$263,643	$263,878	11.00	0.00	11.00	
30372	Eligibility Assistant – Lincoln	24,313	24,336		1.00	1.00	
30485	Eligibility Examiner – Park	12,383	12,392		0.50	0.50	
30537	Eligibility Examiner – Ravalli	24,746	24,917		1.00	1.00	
	Sub–Total Vacant	$61,442	$61,645	0.00	2.50	2.50	
Sub–Total All or Partial General Fund		$325,085	$325,523	11.00	2.50	13.50	0.00
Non–General Fund Positions							
	None						
Sub–Total		$0	$0	0.00	0.00	0.00	0.00
TOTAL		$325,085	$325,523	11.00	2.50	13.50	0.00

*FTE also included in action by joint appropriation committees to removed positions vacant as of 12/29/92.

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EXHIBIT 2
DATE 1-18-93
SB 9

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
NURSING HOMES (EXCLUDES STATE INSTITUTIONS)

There are 96 licensed nursing facilities in the state, (excluding state run facilities) with a total of about 6,700 beds. At any one time about 92% of nursing facility beds in the state are occupied. Nursing facilities are located in fifty-three of Montana's fifty-six counties, and range in size from 6 to 278 beds. Medicaid pays for about 62% of all nursing facility services, private payers 31% and Medicare/Other the remaining 7%. Medicaid funded nursing facility care for over 1.39 million bed days, with general fund expenditures exceeding $19 million in FY92. Nursing home expenditures now account for 27% of the total Medicaid budget.

RECIPIENTS AND FUNDING: Nursing Homes are a major portion of the Medicaid Program with FY92 costs of over $67 million dollars. This program is funded at approximately 71% Federal Funds and 29% State General Funds.

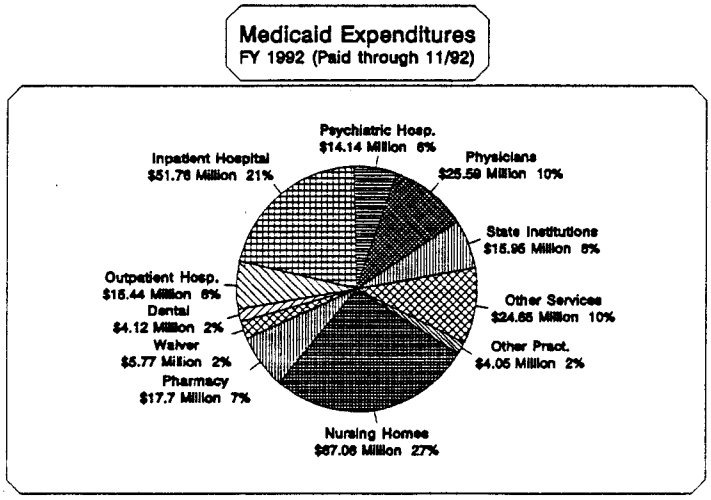


Figure 1

ISSUES: In fiscal year 1992 SRS implemented a new reimbursement system for nursing facilities which incorporates facility costs and an inflationary index. For fiscal year 1993 the department rebased the reimbursement formula using 1991 Medicaid cost reports to establish reimbursement levels. In 1993 the reimbursement formula projects the average cost of nursing facility care to be $75.43 per day while the average daily Medicaid reimbursement rate is $67.15 per day. The executive budget for 1994/1995 contains no new money to fund nursing facility reimbursement although the department requested approximately $ 16 million in additional funds to account for inflation and program enhancements. The projected cost of this request was $4.7 million in general fund. In addition, the Montana Health Care Association has informed the Department of its intent to file a Boren Amendment lawsuit against the state for fiscal year 1993, claiming that reimbursement rates are not reasonable and adequate to cover the costs which must be incurred by efficient and economically operated facilities.

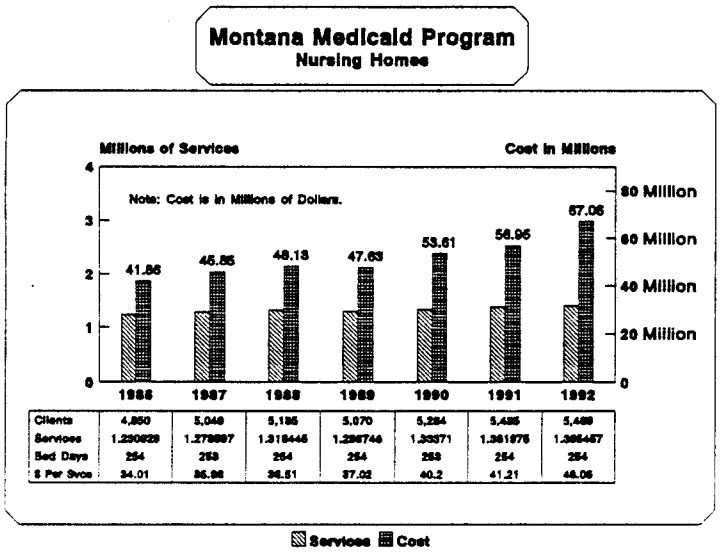


Figure 2

Utilization fee: The 1991 legislature passed HB 93, an act to impose a utilization fee on nursing facilities for bed days reimbursed by third party payers. The bed fee began in FY92 at $1.00 per bed day and increased to $2.00 per bed day in FY93. Modification to federal law in the past year has changed the mechanics of the way the bed fee may be assessed in the future. Starting in FY 1994 the fee must be imposed in a broad based manner to all payers. Currently the bed fee provides approximately $3.2 million in state revenue.

Department of Health and Environmental Sciences-OBRA

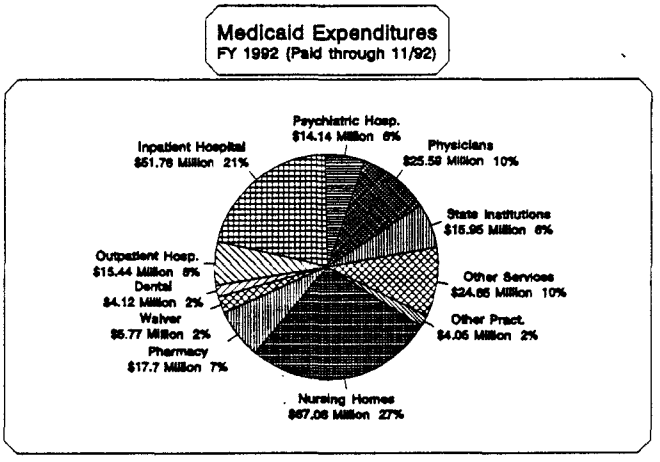
The Department of Health and Environmental Sciences receives reimbursement for performing activities pertaining to federal mandates under OBRA of 1987 and 1990. These activities include approval of training and testing programs for nurse aides, nurse aide certification registry maintenance, abuse registry and investigation activity. All funds related to this activity are located at SRS. The costs of these activities are considered administrative and are split 50% Medicaid and 50% Medicare. The Medicaid share is at a 50/50 match rate with total funds in fiscal year 1993 projected to be approximately $320,000. If these activities are not undertaken Health Care Financing Administration can pursue a compliance action which permits discontinuance of Medicaid payments.

EXHIBIT 2
DATE 1-18-93
SB

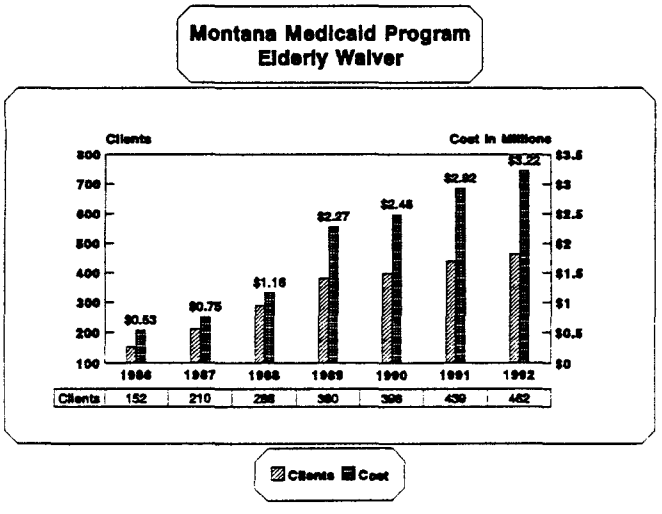
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
HOME AND COMMUNITY BASED SERVICES
(MEDICAID WAIVER)

The Home and Community Services Program provides services to Medicaid recipients in the community who require long term care. The recipient makes the choice to receive services in his home or in an institution. The program is also referred to as the Medicaid Waiver Program since the Federal Government granted the state a waiver of certain Medicaid regulations to pay for services in a recipient's home.

To be eligible for the waiver, an individual must be elderly or disabled, Medicaid eligible, require nursing facility level of care, have a plan of care approved by a physician, reside in specified counties, and be served in the community at a cost less than the cost of institutional care. The waiver also includes a population of up to seven recipients, who without the waiver, would be in a hospital. This group is referred to as the "heavy care" cases. The attachments depicting the graphs of the waiver are separated into clients/expenditures for the elderly waiver and the disabled waiver. The heavy care cases are included within the disabled waiver.



Home and Community Services are individually prescribed and arranged according to the needs of the recipient. An individual plan of care is developed by a case management team in conjunction with the recipient and the attending physician. The plan of care must be cost effective. The plan of care is reviewed at least every 6 months and revised anytime the recipient's condition changes.



The Department contracts with agencies to provide case management services. The case management team consists of a registered nurse and a social worker. The team is responsible for developing the recipient's plan of care; helping the recipient to use community and family resources; contracting with community agencies to provide needed services; and monitoring the delivery of services provided; and authorizing claims for waiver services.

Services available to recipients include case management, homemaker, personal care, adult day care, respite, habilitation, medical alert monitor, nutritional/dietitian,

EXHIBIT 2
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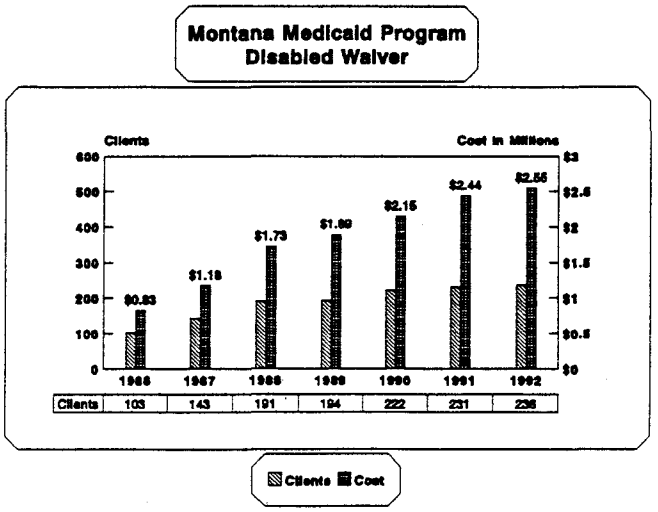
SB

transportation, environmental modification, respiratory therapy, and nursing services.

Waiver services are available in 32 counties. Case management teams are located in Missoula, Billings, Great Falls, Helena, Bozeman, Sidney, Miles City, Kalispell, Butte and Lewistown.



RECIPIENTS AND FUNDING: Home and Community Services are included in the Medicaid Program budget as 2 control variables entitled Elderly Waiver and Disabled Waiver. These services are funded at approximately 71% Federal Funds and 29% State General Funds. Since 1986, the number of clients served by the Home and Community Based Services Program has risen primarily due to the addition of new waiver sites. In 1986, Kalispell was established as a case management site. In 1990, Butte and Lewistown were established as case management sites.

ISSUES: The cost of services has risen since program onset in 1983, but budgeted per slot funding has not been increased proportionately. Reasons for increases in cost include: 1. severity of patient condition; 2. increases in the average length of stay in the program; 3. the actual cost of services has increased; 4. the changeover from independent contractors for in home care resulting in agency based service providers which are more expensive.

In June, 1992, the Department initiated a system change separating State plan personal care from the waiver plans of care. This change brought the Department in line with a Federal mandate that State plan services must not be reimbursed with waiver dollars. Personal care under the waiver is defined differently from State plan personal care. Waiver personal care includes socialization, social transportation with escort, and supervision.

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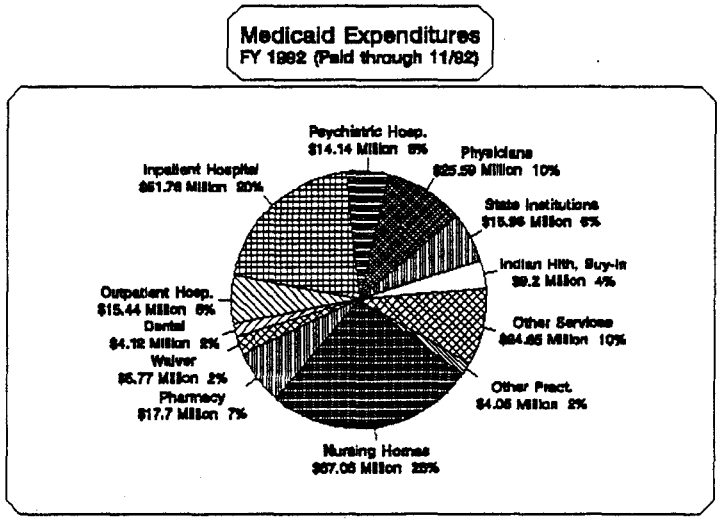
DATE 1-18-93
SB

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
INDIAN HEALTH AND MEDICARE BUY-IN PROGRAM

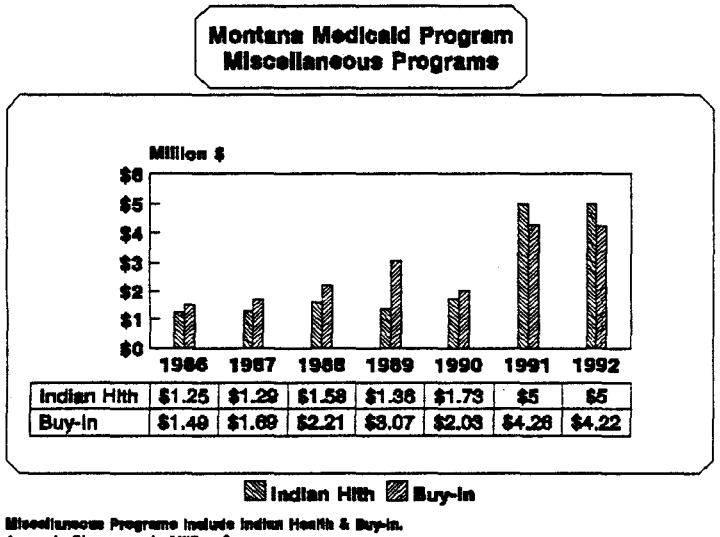
Indian Health: The Montana Medicaid Program provides reimbursement to the Indian Health Service within the state for medical services provided to eligible persons on the Flathead, Blackfeet, Rocky Boy, Fort Belknap, Crow, Northern Cheyenne, and Fort Peck Indian reservations.

Buy-In: The Montana Medicaid Program pays for the Medicare Part B Premium for Medicaid eligible persons who are disabled or 65 years or older. This program acquires Medicare coverage for this population and assures that Medicare will pay for 80% of their medical expenses leaving a liability of only 20% of these expenses for Medicaid.



Based on Medicaid Paid Claims through November 1992
Total 1992 Medicaid for these Benefits is $255.4 Million

RECIPIENTS AND FUNDING: Indian health is funded at 100% Federal Funds. The buy in program is funded at different federal matching percentage rates dependant on whether the client involved is receiving financial assistance or not and whether the client is considered to be medically needy. The Federal Omnibus Reconciliation Act of 1989 (OBRA 89) included certain factors which are causing a major increase in budgeted costs for 1992 and 1993. These factors include increased eligibility and premium cost.



Miscellaneous Programs include Indian Health & Buy-In.
Amounts Shown are in Million $.

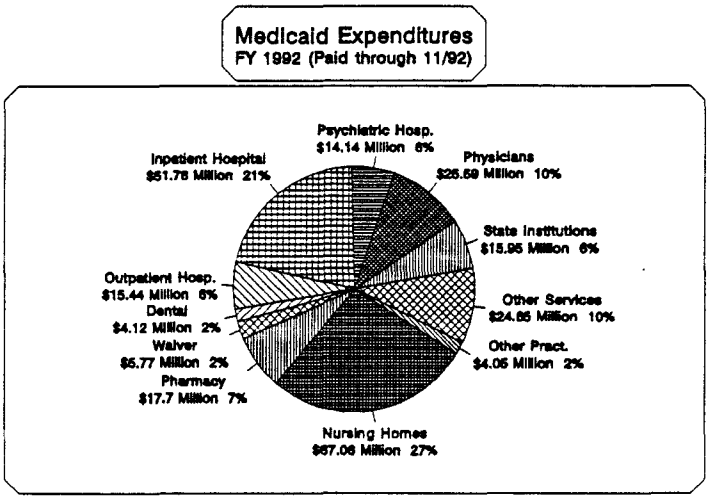
ISSUES: Indian Health expenditures have increased dramatically because IHS has developed new methods to determine eligibility. It is to the state's advantage that this program has increased because most of the people being served by the IHS would be eligible for Medicaid. However, when served by the IHS, their health care is funded totally by the Federal government.

EXHIBIT 2
DATE 1-18-93

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
DENTAL SERVICES

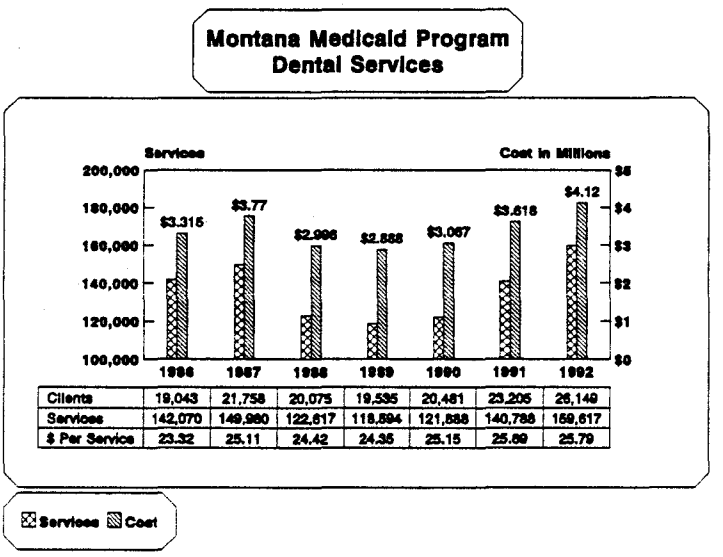
Dental Services are those services for the treatment of teeth and associated structures of the oral cavity and treatment of disease, injury or impairment which may affect the oral and general health of the individual. This service includes dentures. Dentures are artificial structures made by or under the direction of a dentist to replace a partial or full set of teeth. These services must be provided by licensed dentists or licensed dental hygienists under the supervision of a dentist. Dentures may be provided by a licensed denturist when they are prescribed by a licensed dentist. All services must be in the scope of professional practice as defined by law.

Medically necessary routine dental care including certain prophylactic procedures are available through the Medicaid Program. Certain services and procedures such as, crowns, bridges, endodontist procedures, periodontal procedures, dentures, and orthodontic procedures are available only after review and approval by the Medicaid dental consultant.



Based on Medicaid Paid Claims through November 1992
Total 1992 Medicaid for these Benefits is $246.2 Million
Excludes Indian Health and Medicare Buy In

RECIPIENTS AND FUNDING: Dental Services are included as a control variable in the Medicaid Primary Care Program. It is funded at approximately 71% Federal Funds and 29% State General Funds. Dental services represent 2% of the total Medicaid budget. Fees were increased 2% in SFY 90 & 91. There have been no increases since that time.



	1986	1987	1988	1989	1990	1991	1992
Clients	19,043	21,758	20,075	19,535	20,461	23,205	26,149
Services	142,070	149,980	122,617	118,594	121,888	140,788	159,617
$ Per Service	23.32	25.11	24.42	24.35	25.15	25.69	25.79

ISSUES: In SFY 89, coverage of dentures for adults was eliminated except in cases where the treating dentist certified that the patient's health would be seriously impaired if dentures were not provided. This policy was overturned by a district court decision. After the court decision, the department, through negotiations with the MDA, established more restrictive criteria for coverage of replacement dentures. At the same time, orthodontia and certain other dental services were eliminated or restricted. In SFY 90, orthodontia for adults was reestablished on a very limited basis and the criteria for coverage of dentures was made less restrictive. This was done in response to several fair hearings where the Department's limits were overturned. Under EPSDT, orthodontia and other services for children were reestablished per federal mandate.

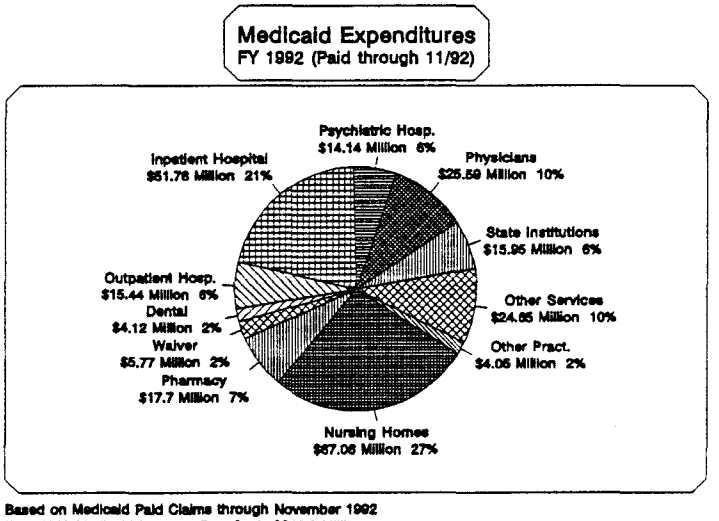
Currently, recipients are having difficulty finding dentists in certain areas who will accept Medicaid. Most are saying it is because payment rates are inadequate.

EXHIBIT 2
DATE 1-18-93
SB

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
PHYSICIAN SERVICES

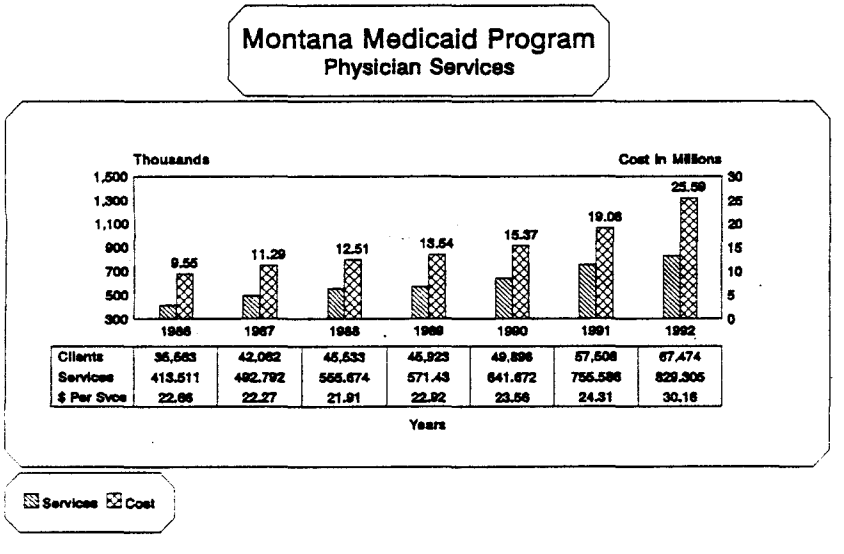
DESCRIPTION: Health care services provided by physicians include: primary health care and surgical treatment; diagnostic and evaluation services; psychiatric services; and, pain control and health maintenance care for terminally ill recipients. Physicians offer their services in a variety of settings: offices, surgical centers, clinics, outpatient or inpatient hospitals.

RECIPIENTS AND FUNDING: Physician Services are included as an individual control variable in the Medicaid Program Budget. They are funded with approximately 71% Federal Funds and 29% State General Funds. These services have seen a steady increase in costs from $9.55 million in 1986 to $25.59 million in 1992. Increased expenditures in physician services are attributed to: a larger caseload and greater utilization of the services; a change in the location where services are provided; a federally mandated change in coding and subsequently in reimbursement for certain limited services; and new, extensive diagnostic services and other technology. Similar expenditure increases have affected Medicare.



Based on Medicaid Paid Claims through November 1992
Total 1992 Medicaid for these Benefits is $246.2 Million
Excludes Indian Health and Medicare Buy In

ISSUES: Obstetrical and pediatric fee increases were given by the last legislature. As a result, the 1992 Medicaid State Plan for obstetrical and pediatric services was approved because equal access to services was demonstrated by a sufficient number of providers and an adequate level of payment. A significant number of providers began participating in the Medicaid program after this rate increase. The increase in provider numbers and level of reimbursement caused an increase in program payments and utilization. Requirements of OBRA '89 and OBRA '90 have also caused, and will continue to cause increased utilization of physician services in Medicaid: OBRA '89 expanded Medicaid eligibility for pregnant women and children under the age of 6 to 133% of poverty; and OBRA '90 expanded eligibility to children between the ages of 6 and 21 at 100% of poverty. The focus of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, to increase utilization of well child and preventative services for children has also increased utilization. These services are most often provided by physicians.



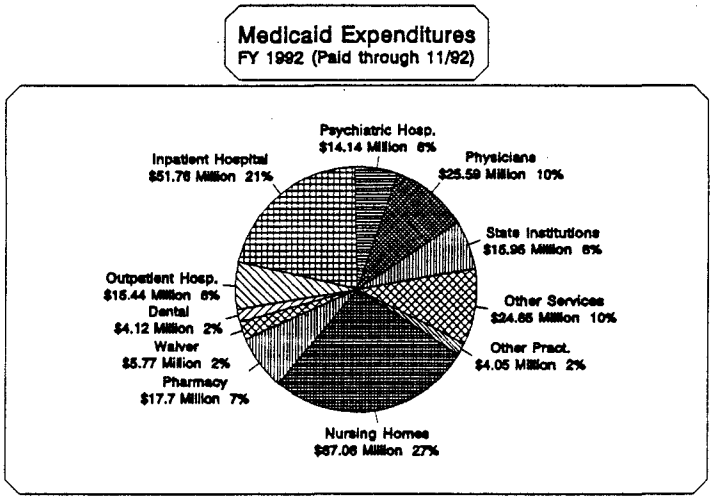
Although obstetrical and pediatric fees were increased during the last legislative session, fee increases were not given to other physician services. As a result, fees have fallen in some areas to 50% or less of charges. This creates an access problem for Medicaid clients.

EXHIBIT 2
DATE 1-18-93
SB

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
PHARMACY SERVICES

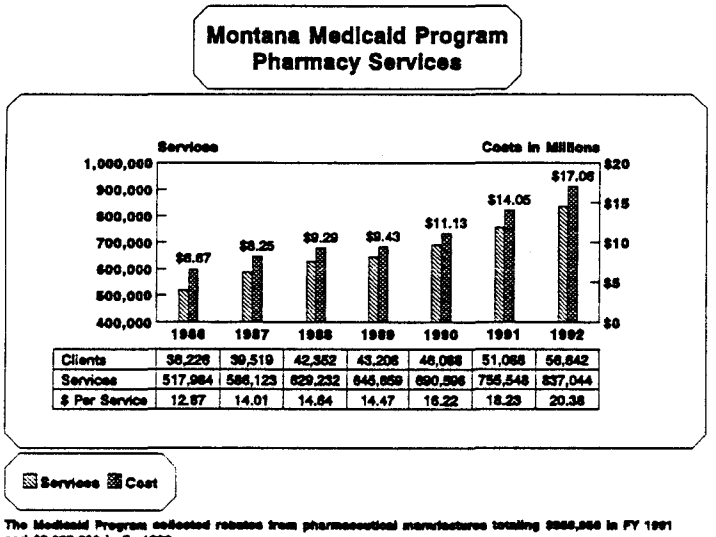
Drugs, or pharmacy services, are those medications prescribed by an authorized practitioner and dispensed by a registered pharmacist licensed by the State Board of Pharmacists. Treating illness with prescription drugs is usually much less expensive and often as effective as alternatives such as hospitalization or surgery. For this reason the pharmacy program represents one of the most cost effective Medicaid services.

RECIPIENTS AND FUNDING: Pharmacy Services is included as an individual control variable within the Medicaid Program Budget. It is funded with approximately 71% Federal Funds and 29% State General Funds.



Based on Medicaid Paid Claims through November 1992
Total 1992 Medicaid for these Benefits is $246.2 Million
Excludes Indian Health and Medicare Buy In

ISSUES: OBRA 90 mandated the states to participate in a manufacturer's rebate program beginning January 1, 1991. These rebates are returned to the State and Federal government and result in substantial cost savings to the program. In addition, OBRA 90 requires the Department, by January 1, 1993, to have an operational Drug Utilization Review (DUR) program. This function will improve the quality and cost effectiveness of drug therapy rendered to Medicaid recipients by examining drug interactions, usage patterns for recipients, and prescription patterns for providers. Pharmacy dispensers are required to offer to counsel patients as a part of DUR. This may increase the cost of dispensing drugs.



	1986	1987	1988	1989	1990	1991	1992
Clients	36,226	39,519	42,352	43,206	46,088	51,068	56,842
Services	517,984	586,123	629,232	645,859	690,596	756,548	837,044
$ Per Service	12.87	14.01	14.64	14.47	16.22	18.23	20.38

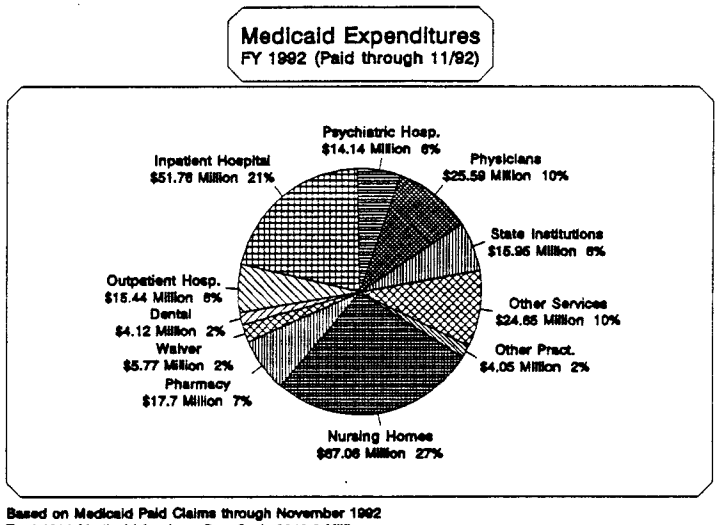
The Medicaid Program collected rebates from pharmaceutical manufacturers totaling $966,000 in FY 1991 and $3,635,000 in Fy 1992.

EXHIBIT 2
DATE 1-18-93
SB

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
INPATIENT PSYCHIATRIC SERVICES

DESCRIPTION: Medicaid covers Inpatient Psychiatric Services for individuals under age 21 provided in a hospital facility whose goals, purpose, and care are designed for and devoted exclusively to persons under age 21. Treatment is provided to youth who pose a significant danger to self, other, or to public safety, or who exhibit marked psychosocial dysfunction, or grave disability. The therapeutic intervention or evaluation must be designed to facilitate the individuals transfer to a less restrictive environment at the earliest possible time.

RECIPIENTS AND FUNDING: Inpatient psychiatric services are included as an individual control variable within the Medicaid Program budget. It is funded at approximately 71% Federal Funds and 29% State General Funds. The general fund portion is contained in the DFS budget. SRS maintains the federal match. This service has undergone a steady growth since it inception in 1987. Costs have increased from $910,388 in 1987 to $10,610,000 in 1992.



Based on Medicaid Paid Claims through November 1992
Total 1992 Medicaid for these Benefits is $246.2 Million
Excludes Indian Health and Medicare Buy In

ISSUES: Since July 1, 1990 the Department has contracted with Mental Health Management of America (MHMA) to provide preadmission and continued stay reviews to insure that all hospital and residential psychiatric placements are appropriate and medically necessary. In the first year of the contract, the annual cost for this service actually decreased as length of stay decreased. In 1992 the length of stay continued to decrease for each recipient, but the number of admissions rose. This is consistent with findings from other states who operate similar programs. The Department in a cooperative effort with the Department of Corrections and Human Services and the Department of Family Services is actively seeking to develop less costly alternative community services in lieu of inpatient psychiatric services.

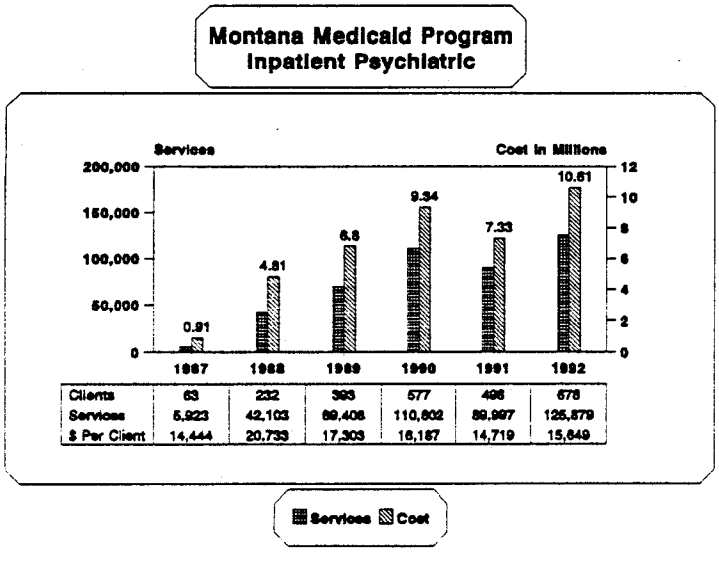
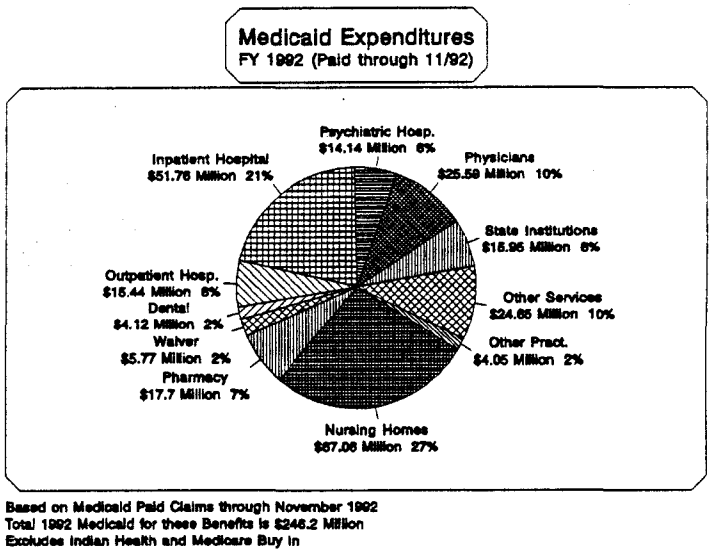


EXHIBIT 2
DATE 1-18-93
SB

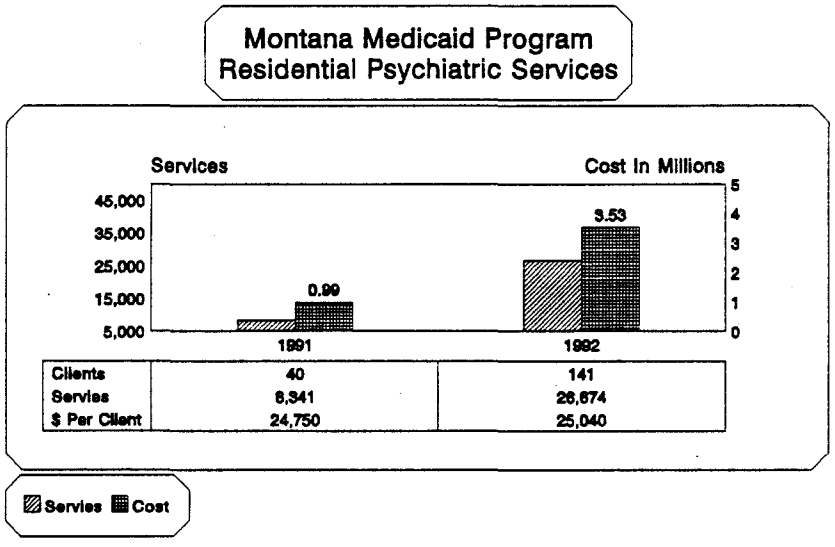
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
RESIDENTIAL PSYCHIATRIC SERVICES

DESCRIPTION: Medicaid covers Residential Psychiatric Services for individuals under age 21 provided in a facility whose goals, purpose, and care are designed for and devoted exclusively to persons under age 21. Treatment is provided to children who pose a significant danger to self, other, or to public safety, or who have marked psychosocial dysfunction, or grave disability. The therapeutic intervention or evaluation must be designed to facilitate the individuals transfer to a less restrictive environment at the earliest possible time.

RECIPIENTS AND FUNDING: Residential psychiatric services are included as an individual control variable within the Medicaid Program budget. It is funded at approximately 71% Federal Funds and 29% State General Funds. The general fund portion of the budget is contained in the DFS budget. SRS maintains the federal match. This service has undergone a steady growth since it inception in 1991. Costs have increased from $990,011 in 1991 to $3,530,581 in 1992.



ISSUES: Since July 1, 1990 the Department has contracted with Mental Health Management of America (MHMA) to provide preadmission and continued stay reviews to insure that all hospital and residential psychiatric placements are appropriate and medically necessary. The Department in a cooperative effort with the Department of Corrections and Human Services and the Department of Family Services is actively seeking to develop less costly alternative community services in lieu of residential psychiatric services.



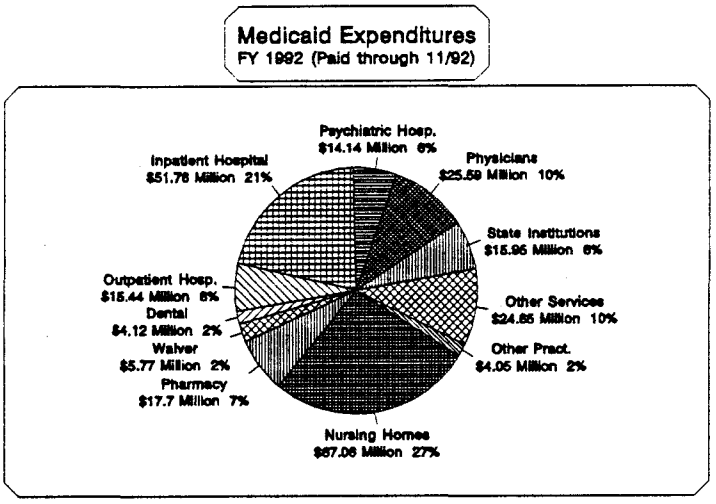
DATE 1-15-93

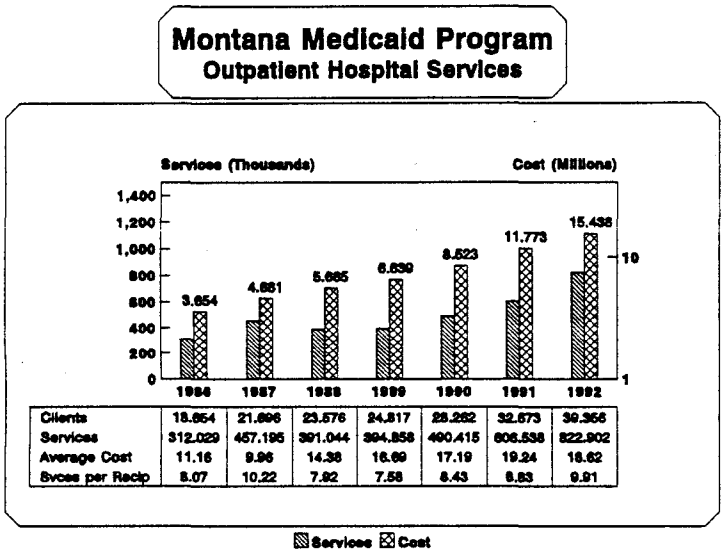
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES

OUTPATIENT HOSPITAL SERVICES

DESCRIPTION: Outpatient hospital services are provided under the direction of a physician or dentist and may be preventative, diagnostic, therapeutic, rehabilitative or palliative. Services are limited to emergency room services and services provided in a hospital that would also be covered by Medicaid in a non-hospital setting (i.e. outpatient surgery, physical therapy, etc.)

RECIPIENTS AND FUNDING: Outpatient Hospital Services are included as an individual control variable in the Medicaid Program budget. Services are funded at a match rate of approximately 71% Federal Funds and 29% State General Funds. A major goal of the Outpatient Hospital program is to encourage hospitals to provide services to "traditional" inpatients in the less restrictive/expensive outpatient setting. Reimbursement is on a retrospective provider specific, percentage of charge system based on cost reports filed with the Division.





ISSUES: 1) Utilization of outpatient services is increasing as medical technology and cost containment pressures increase. This increase appears to be consistent with the intent of the inpatient and outpatient hospital program to treat recipients in the least costly, safe environment. Nationwide for all insurers outpatient hospital costs are increasing. While it is the intent of the program to promote treatment in the least costly setting possible, it is also important to develop a reimbursement system that limits the growth in cost per service. The Department recommends a study of the outpatient hospital program to develop a reimbursement system that limits cost increases and encourages economic and efficient operation.

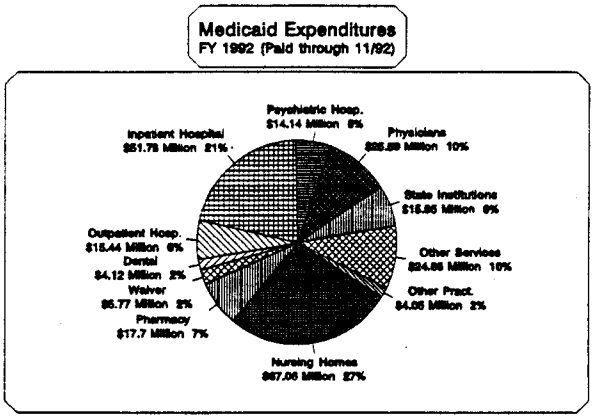
2) OBRA of 1990 contained provisions which could have a significant impact on outpatient hospital cost if they apply to Medicaid as well as Medicare: Section 4151 - reduces payments for federal fiscal years 1991 - 1995 as follows: a) Capital related costs for outpatient services by 15% for FY 1991 and by 10% for FY 1992-1995; b) Reasonable costs for outpatient hospital services by 5.8% in FY 1991-1995. A written interpretation of this section has been requested from HCFA to determine if we need to comply.

DATE 1-15-93

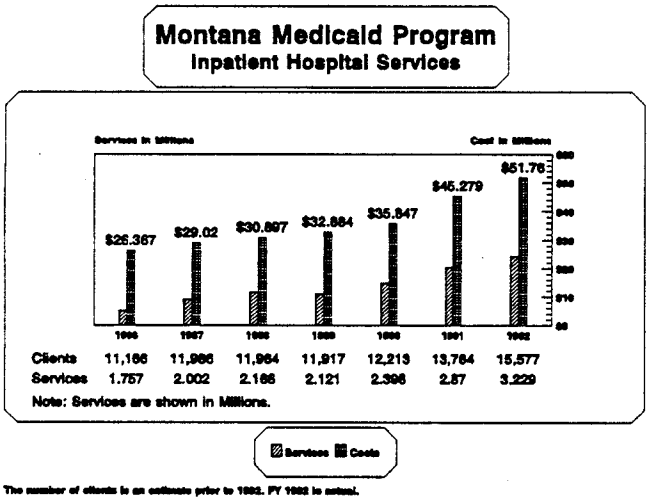
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
INPATIENT HOSPITAL SERVICES

Inpatient hospital services are medically necessary services furnished to Medicaid clients under the direction of a physician or dentist in an inpatient hospital setting. Payment for instate hospitals is made on the basis of a prospective payment system (PPS) developed by the state and is based on a diagnostic related group (DRG) system, which classifies each inpatient into a diagnostic group. Additional payments are made to four hospitals which serve a disproportionate share of Medicaid or low income patients.

Out of state hospitals and certain exempt units of in state hospitals (rehabilitation units) are reimbursed on a facility specific percentage of charges based on cost reports. Out of state services are generally utilized for services and levels of care that are not available in state.



RECIPIENTS AND FUNDING: Inpatient Hospital Services is included as an individual control variable in the Medicaid Program budget. It is funded at approximately 71% Federal Funds and 29% State General Funds. Costs for this program have increased steadily from $26 million dollars in 1986 to almost $52 million dollars in 1992. Further increases are projected in the upcoming biennium in both the executive and LFA budgets. This growth is largely due to two factors: increases in the number of Medicaid eligibiles due to new federal mandates, and steady growth in the number of categorically eligible recipients (AFDC, SSI, etc). The number of services received and the types of services available due to new technology have also increased the overall cost of providing services. Prospective reimbursement for in state hospital services was implemented in October of 1987. All increases have been approved by the legislature. Increases are limited by the federal limits on annual percentage increases.



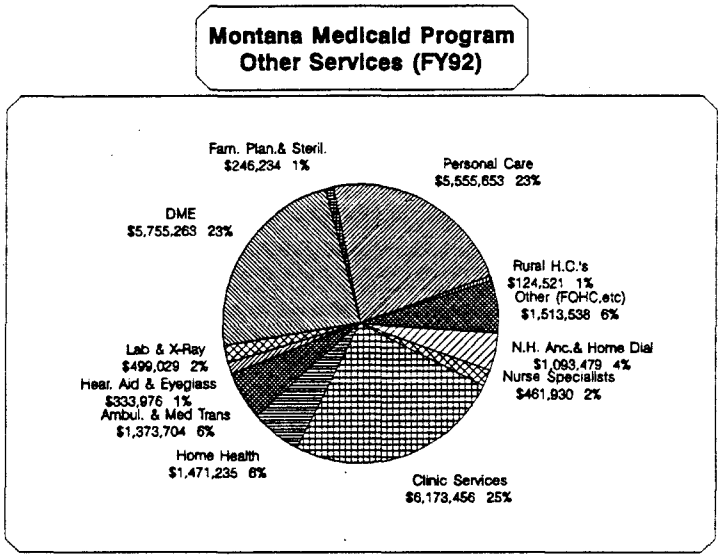
The number of clients is an estimate prior to 1992. FY 1992 is actual.

ISSUES: A study conducted in 1992 shows that a revision of the hospital reimbursement system is necessary, in order to protect the state from a Boren Amendment lawsuit; make the system more equitable among the hospitals; and maintain the system in compliance with the State Plan. The revisions include a rate increase to adequately fund the program as required by federal law, and system adjustments to enable the state to better control the rate of increase in costs of the program.

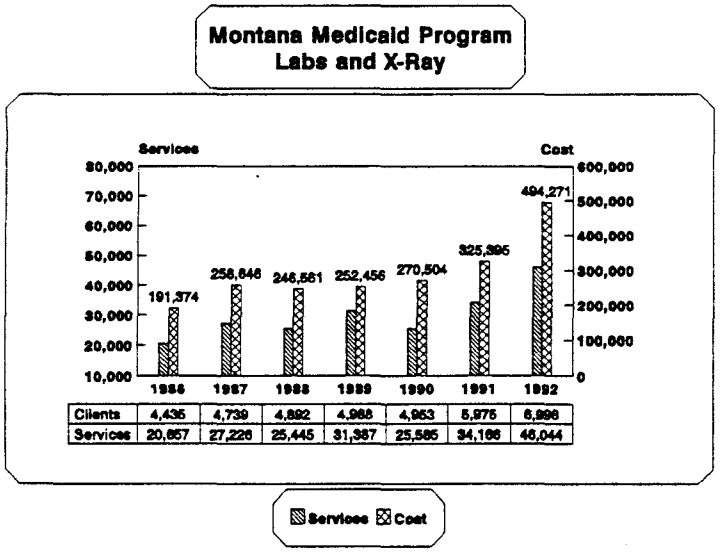
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL REHABILITATIVE SERVICES
LABORATORY AND X-RAY SERVICES

DESCRIPTION: Laboratory and X-ray Services are provided in outpatient hospital settings, and individual physician or medical clinic offices. These services are used to diagnose or monitor existing medical conditions under active treatment. These services may prevent more costly medical services if conditions remained undiagnosed or not properly managed by the physician. Included in the reimbursement of these services is the physician's analysis of a lab test, specialized radiation services for cancer treatment and newly developed diagnostic tests.

RECIPIENTS AND FUNDING: This program is budgeted under the "Other Services" section of the Medicaid Primary Care Program. It is funded at approximately 71% Federal Funds and 29% State General Funds. Program costs have increased from $191,374 in 1986 to $494,271 in 1992. This increase is due to several reasons:



1. The use of outpatient diagnostic tests and services prior to a hospital admission may have increased. The diagnostic services for a hospital admit are included in the DRG payment if performed within 24 hours of the admit. 2. The Medicaid fee schedule for many new radiation and other diagnostic services developed since 1986 is based on 65.2% of the billed charges. Once Medicaid has a specific number (50) of paid claims within a twelve month period, a specific fee is established. Any increased usage of the more advanced diagnostic tests will contribute to the spending increase. 3. There may be increased usage of diagnostic and laboratory services prior to confirming a diagnosis or referring a patient to a specialist. A related increase in usage of the lab and X-ray services relating to outpatient hospital services and ambulatory surgical center services may also contribute to the spending increase. As the number of surgeries and other services are no longer performed on an inpatient hospital basis, the separation of charges of the services occurs.

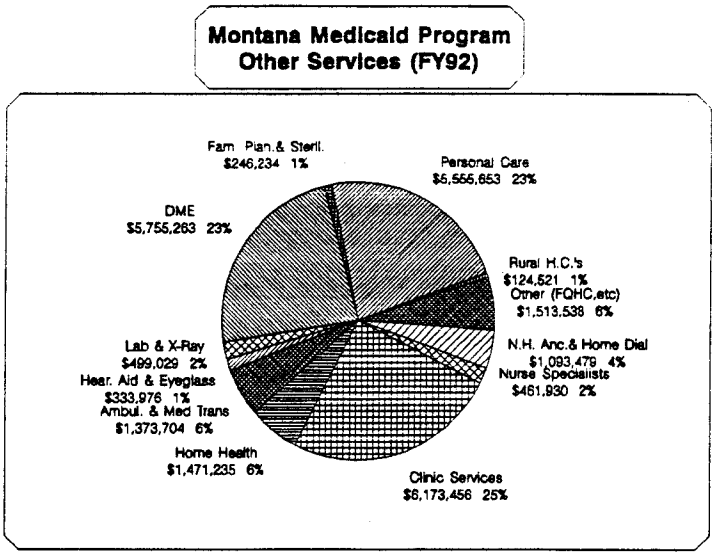


The number of clients using the service has increased from 4,435 in 1986 to 6,998 in 1992. This increase is representative of the increase in the overall Medicaid population in Montana.

DATE 1/19/93

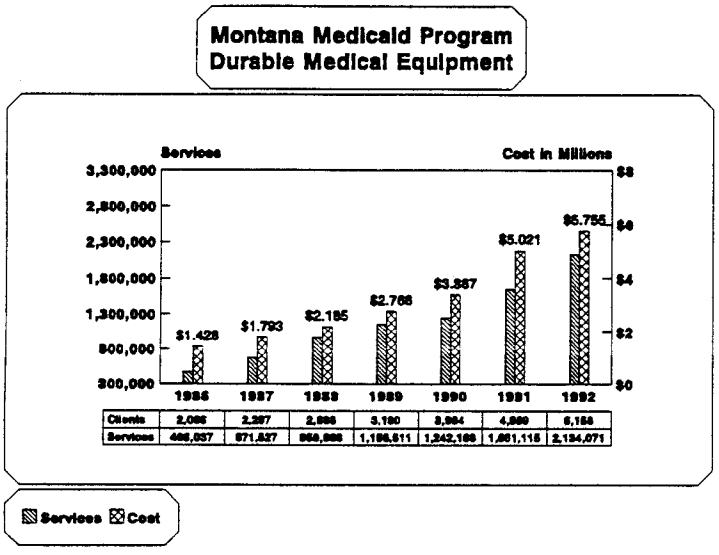
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
DURABLE MEDICAL EQUIPMENT

Durable medical equipment includes medical supplies and equipment suitable for use in the home. This category includes disposable supplies, enteral feeding supplies(tube feeding), minor equipment items (canes and walkers), and major equipment items such as wheelchairs, prosthetic devices, and oxygen.



Recipients and Funding: This program is included in the "Other Services" section the Medicaid Primary Care budget. It is funded at approximately 71% Federal Funds and 29% State General Funds. Over the period since 1986 DME Services has experienced steady growth in clients, services, and in cost.

Issues: Medicaid will implement a volume purchasing contract for wheelchairs in the spring of 1993. Clients will still receive needed equipment but it will all be supplied by one contractor. This should result in significant savings in this area.

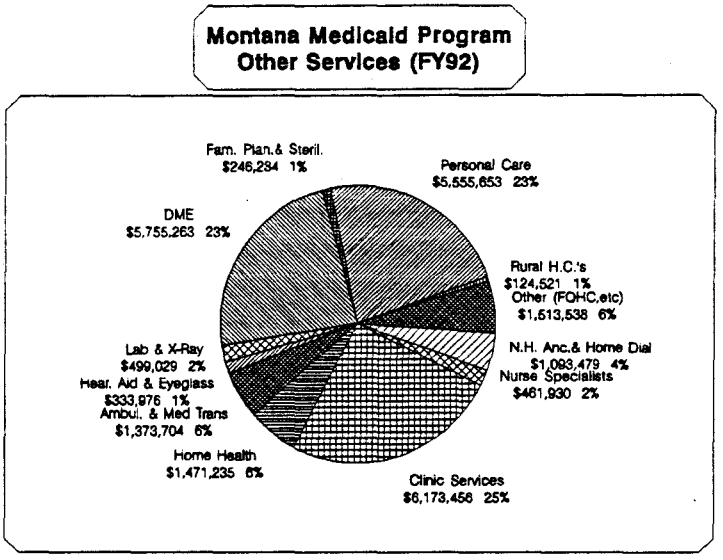


We are proposing to implement either a volume purchasing contract for oxygen or oxygen concentrators in the next biennium as a cost saving measure as well. Oxygen expenditures account for approximately 1/3 of all DME expenditures.

DATE 1-18-93

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
PERSONAL CARE

Personal care services are medically oriented in-home services provided to Medicaid recipients whose health problems cause them to be functionally limited in performing activities of daily living. These services include activities related to a recipient's physical health and personal hygiene, such as bathing, dressing, feeding, grooming, routine hair and skin care, toileting, help with self administered medications, limited homemaking tasks, and escort for medical related travel. The current contractor for personal care services statewide is West Mont Home Management Services, Inc.



Personal care services must be prescribed by a physician, supervised by a registered nurse and provided in the home setting. The nurse must complete home visits to review the plan of care, assess the quality of services provided, and provide training to the attendant. Personal care services are reimbursed as authorized by the supervising nurse and included in the individual plan of care.

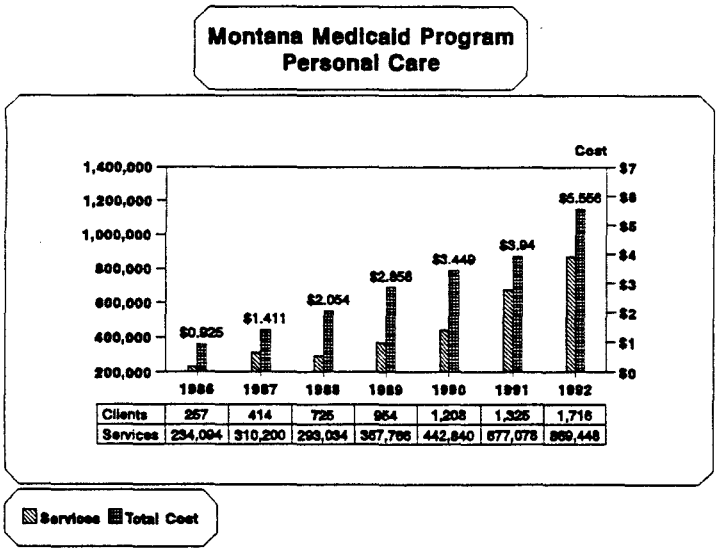
Recipients and Funding: Personal care services are included in the "Other Services" section of the Medicaid budget. These services are funded at approximately 71% Federal Funds and 29% State General Funds. The increase in expenditures for the personal care program is the result of increases in the number of clients served and the unit rate.

Issues: The current unit (hour) rate is $9.64. Here is the breakdown of expenses associated with the unit rate.

Worker's Comp	9.3%	$ .90
FICA & UI	6.8%	$ .66
Benefits*	8.0%	$ .77
Hepatitis B	.8%	$ .08
Administrative	7.1%	$ .68
Wages**	68.0%	$6.55
Total	100%	$9.64

*Benefits = retirement, health insurance, vacation

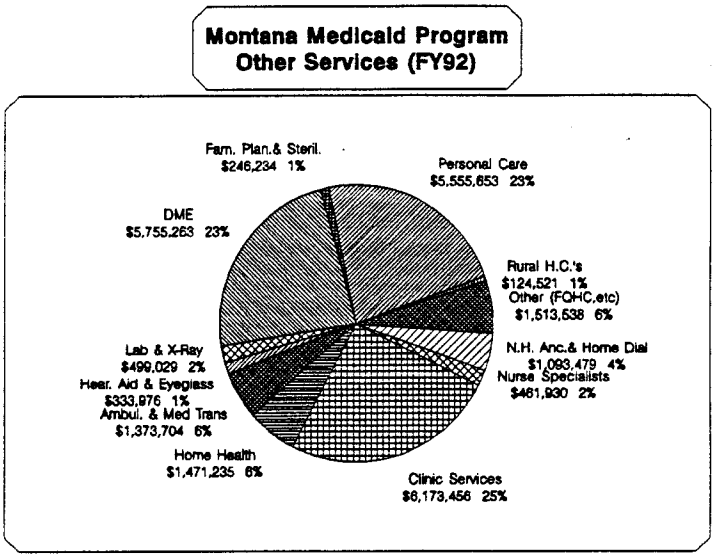
**76% of the wages are PCA and = $4.98



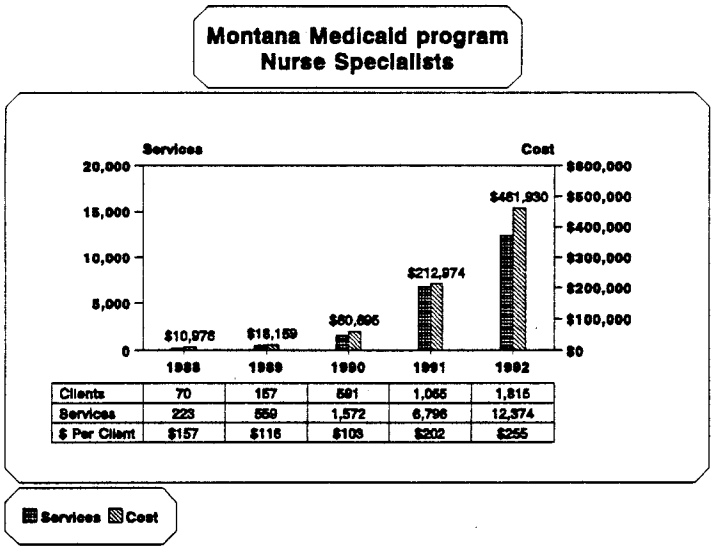
DATE 1-18-93

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
NURSE SPECIALISTS

Nurse specialists are nurse practitioners, certified nurse anesthetists, or certified nurse midwives. They are licensed to provide primary health care services. They work in collaboration with physicians and may be either independently employed or an employee of the physician. The level of service a nurse practitioner may provide is dependent upon their individual certification and the protocol developed with their collaborative physician. Certified nurse anesthetists work under the supervision of the attending physician as do certified nurse midwives.



Recipients and Funding: Nurse Specialists services are included in the "Other Services section of the Medicaid Primary Care Program. It is funded at approximately 71% Federal Funds and 29% State General Funds. Medicaid implemented coverage of nurse specialists on 10/1/87. Currently 182 nurse specialists participate in Medicaid. The increase in utilization of nurse specialist services shown on the graph is consistent with Medicaid's effort to expand the provider base covering primary health services. Nurse specialists are frequently employed in rural Montana communities and provide medically necessary services when a physician isn't available. Many rural based physicians would be limited in providing surgical services without the certified nurse anesthetists because a physician specializing in anesthesiology isn't available.

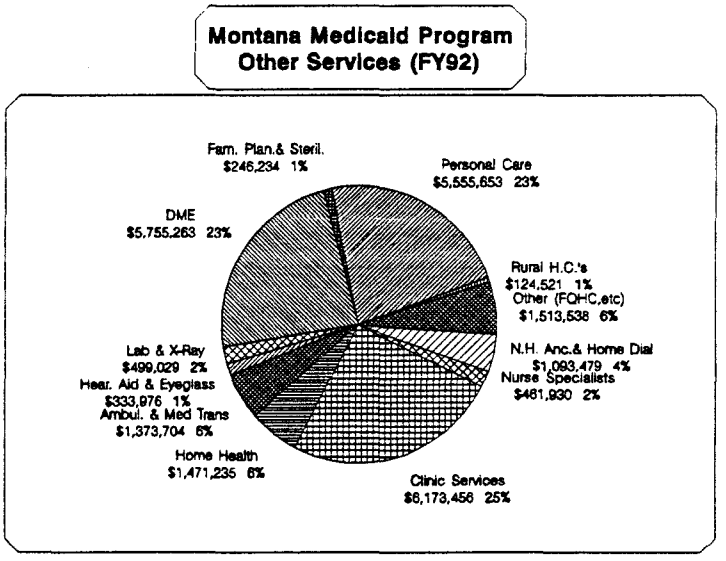


Issues: To increase access to well child care for participants in the Kids Count Program, the State rules were amended 12/90 to eliminate the requirement that nurse specialists be independently employed in order to participate in Medicaid; and nurse practitioners receive the same amount of payment for well child services as physicians. This has encouraged additional nurse practitioners to enroll as Medicaid providers, and to bill for services independent of physicians. This shift in billing is reflected as an increase in the Nurse Specialist program in the graph above. The utilization of certified nurse midwives to provide prenatal and delivery services is small due to the requirement that they be supervised by a physician and concerns over malpractice issues. "Lay" midwives are not Medicaid providers.

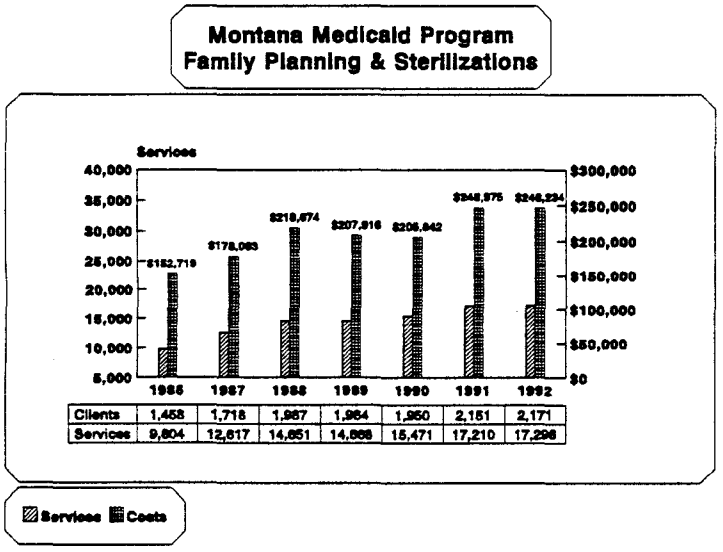
DATE 2-15-93
HB

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
FAMILY PLANNING AND STERILIZATIONS

Family Planning services are provided by physicians, physician's assistants, nurse practitioners, and family planning clinics enrolled in the family planning program of the Montana Department of Health and Environmental Services. Family Planning services include visits for physicals, medical counseling, contraceptive supplies and related laboratory services. Permanent sterilization services are also family planning services. Sterilizations are strictly controlled by the federal government. Informed consent must be obtained from the recipient at least 30 days prior to sterilization. Family Planning services are proven cost effective. A recent study shows that for every government dollar spent on family planning, an average of $4.40 is saved as a result of reduced expenditure on Medical, welfare and nutritional services.



RECIPIENTS AND FUNDING: Family Planning and Sterilizations are included in the "Other Services" section of the Medicaid Program. They are funded with 90% Federal Funds and 10% State General Funds. The higher federal match rate is available due to federal support of this program as a cost effective service. The number of clients has increased from 1458 in 1986 to 2171 in 1992. Costs have increased in a similar fashion from $152,719 in 1986 to $246,234 in 1992.

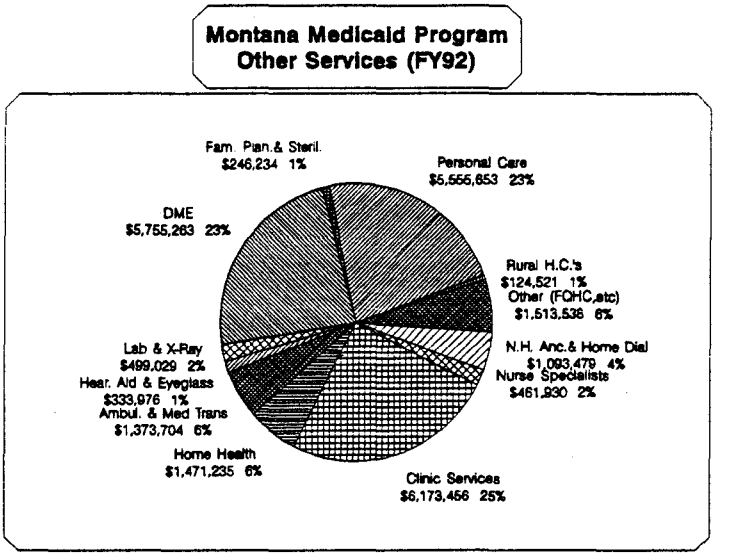


ISSUES: Medicaid has been working cooperatively with the Title X Family Planning Clinics to maximize federal reimbursement for covered services.

DATE 1-15-93

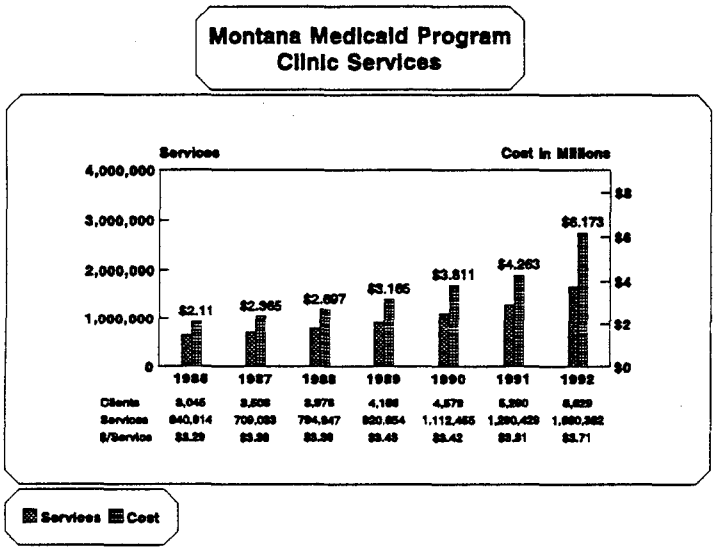
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
CLINIC SERVICES

Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided on an outpatient basis by a facility that is not part of a hospital, but is organized and operated to provide medical care to recipients. Clinic services may be provided in mental health centers, diagnostic centers, surgical centers and public health clinics.



Recipients and Funding: Clinic Services are included in the "Other Services" section the Medicaid Primary Care Program. It is funded at approximately 71% Federal Funds and 29% State General Funds.

Issues: Approximately 75% of the expenditures in clinic services occur in community mental health centers. Outpatient services are generally less costly than inpatient services.



Promotion of these clinic services and other clinic services such as surgical centers may contribute to fewer admissions to inpatient hospital services and at Montana State Hospital. These services remain important in the deinstitutionalization efforts of the state as a result of the Ihler lawsuit.

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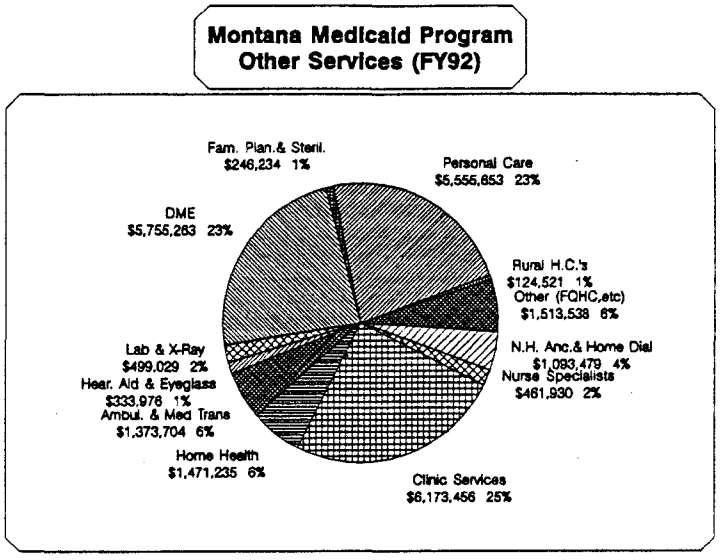
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
CLINIC SERVICES

Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided on an outpatient basis by a facility that is not part of a hospital, but is organized and operated to provide medical care to recipients. Clinic services may be provided in mental health centers, diagnostic centers, surgical centers and public health clinics.



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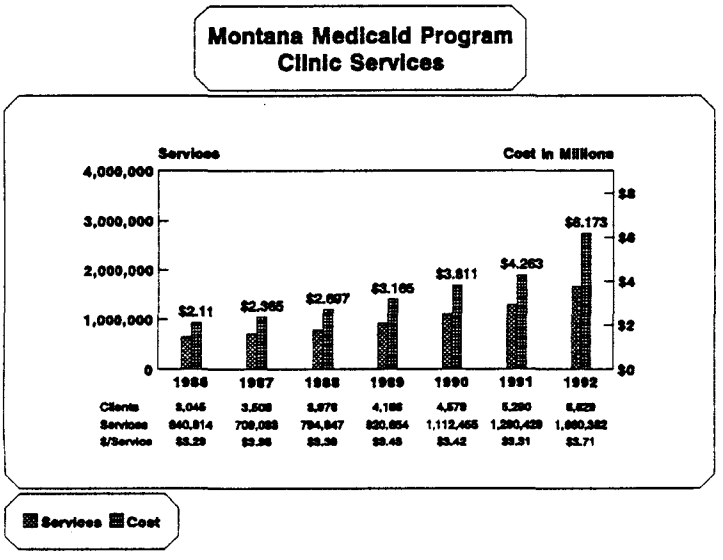

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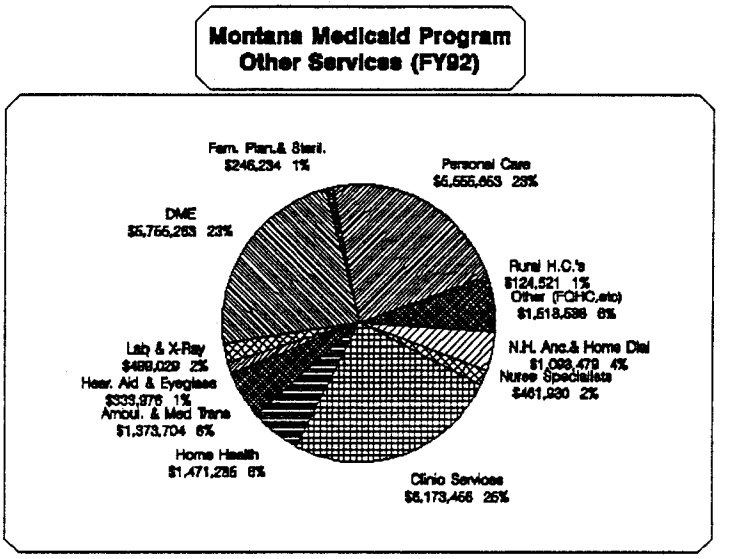
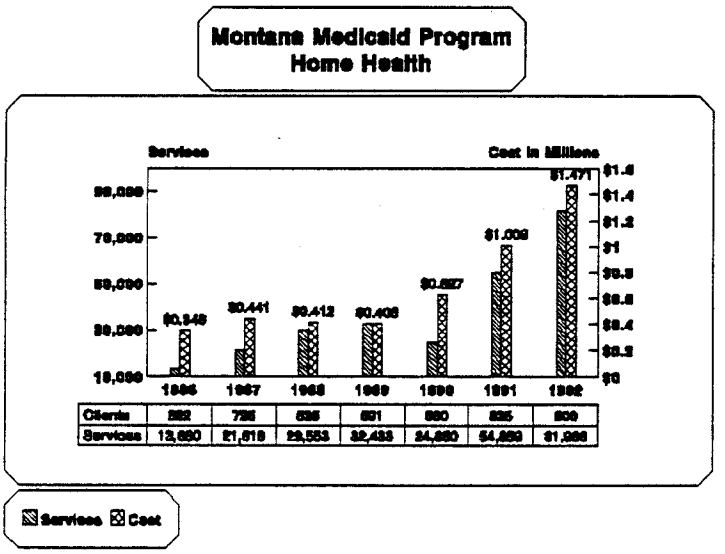
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
HOME HEALTH

Home health includes nursing, aide, physical therapy, occupational therapy, speech therapy, and medical equipment or supplies. These services are available within the client's home allowing the client to obtain services outside of a hospital or nursing facility. Home health services must be ordered by the client's attending physician, who must monitor the patient's progress toward recovery.



Recipients and Funding: Home health services are included in the "Other Services" section of the Medicaid Primary Care Program. It is funded at approximately 71% Federal Funds and 29% State General Funds. Reimbursement is based on allowable audited costs which are settled annually. Services for adults are limited to a combination of 200 visits for OT, PT, ST, and aide services and 365 nursing visits.

Issues: Home Health costs have increased for Medicaid, Medicare and other insurers in the past few years. This reflects the medical trend to treat people in their home whenever possible.



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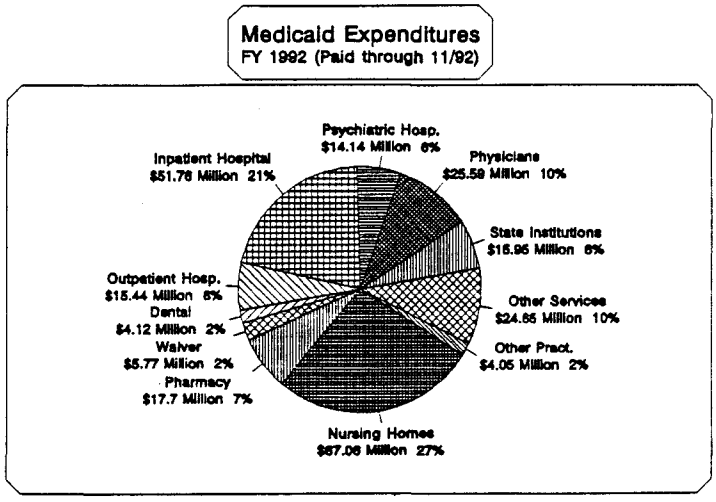
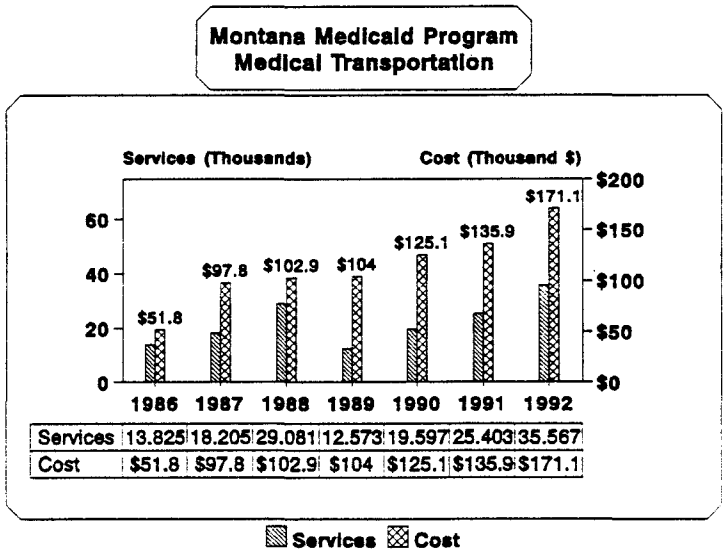
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
MEDICAL TRANSPORTATION

Medical transportation includes travel and per diem, furnished by a common carrier, private vehicle, air charter, or a non emergency specialized vehicle to secure medically necessary examination and treatment for a Medicaid recipient.

RECIPIENTS AND FUNDING: Medical transportation is included under the "Other services" section of the Medicaid Primary Care Program. It is funded at 71% Federal Funds and 29% State General Funds. Between 1986 and 1992 the number of people served has risen from 411 to 950.

ISSUES: Currently clients receive only $22.44 per day for meals and lodging. Some clients have expressed difficulty in finding adequate housing for this rate, especially when they must travel out-of-state for medical care.





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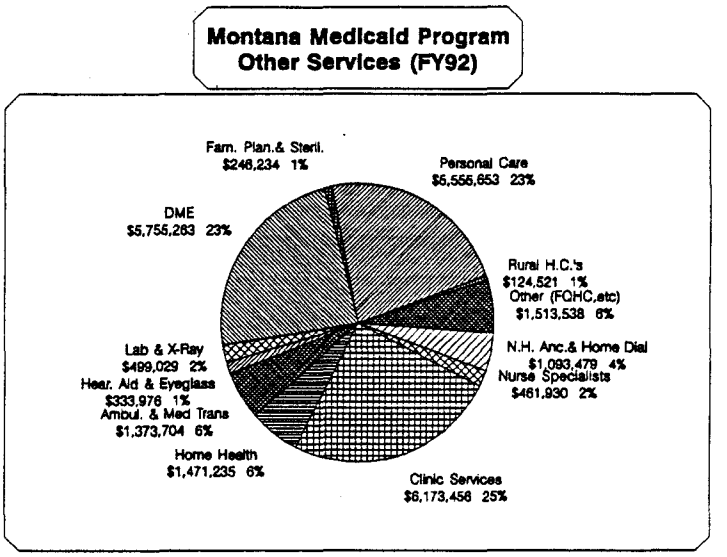
DATE 1-15-93

STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
AMBULANCE SERVICES

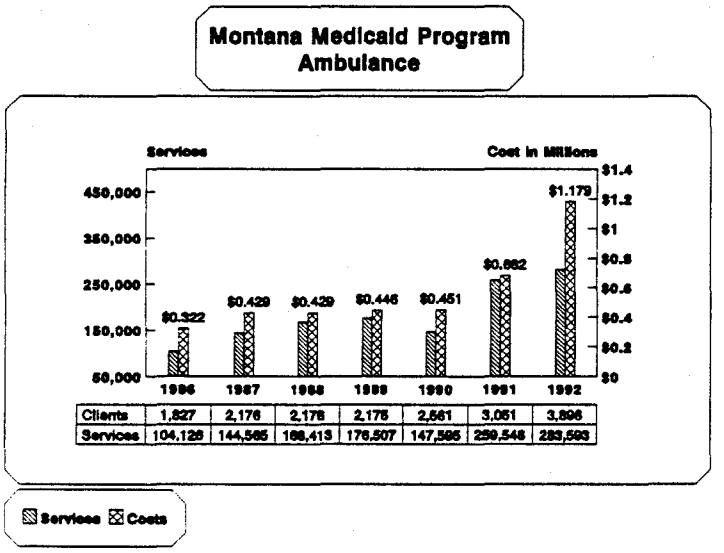
Emergency ambulance services are transport services provided for a sick or injured person who requires immediate medical attention by a licensed ambulance provider. Non-emergency ambulance services are those services provided by a licensed ambulance provider in the transportation of a sick or injured person who does not require immediate medical attention. For either service the vehicle must be specially designed and equipped in accordance with state law and be staffed by a trained ambulance attendant.



RECIPIENTS AND FUNDING: Ambulance services are included under the "Other Services" section of the Medicaid Primary Care Program. It is funded at approximately 71% Federal Funds and 29% State General Funds.

ISSUES: Ambulance provider rates were frozen from 1982 until 1989. In SFY 1990 rates were increased by 2% and by 2% percent again in SFY 1991. In 1992 ambulance providers were authorized a significant rate increase in which fees were set at 90% of Medicare reimbursement.

Providers of ambulance and hospital services indicate air ambulance rates remain underfunded by both Medicare and Medicaid making these services difficult to provide or obtain. This issue was raised in the out-of-state task force on hospitals as a major problem in transferring between hospitals.



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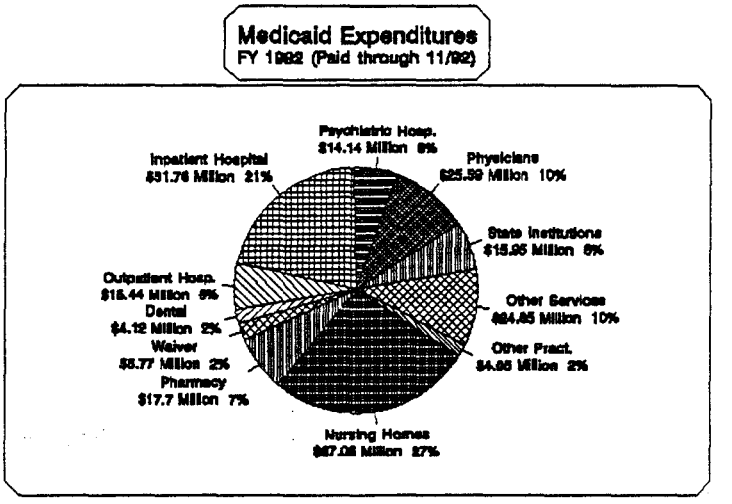
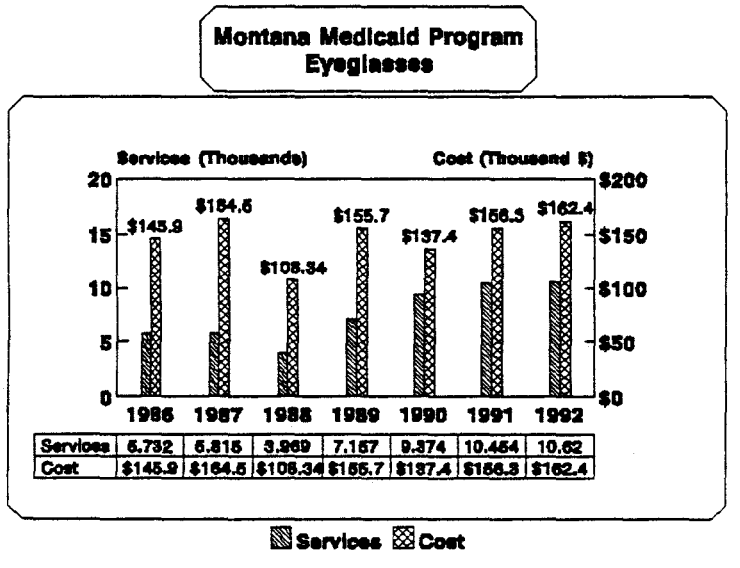
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
EYEGLASSES

Eyeglasses means complete lenses and frames dispensed by an ophthalmologist or optician. (Eyeglasses dispensed by optometrists are contained in the optometric services summary.)

RECIPIENTS AND FUNDING: Eyeglasses is a Medicaid Service which is included under the "Other Services" section of the Medicaid Primary Care Program. It is funded at approximately 71% Federal Funds and 29% State General Funds. Eyeglasses may be replaced once every two years for adults if the recipient's prescription does not change. In SFY 88, coverage of eyeglasses was eliminated for adults except in cases where the prescribing eyecare specialist certified in writing that the recipient's health would be seriously adversely affected if the glasses were not provided. This resulted in a reduction in services provided, dollars spent and recipients served. The reduction in coverage was reversed by a court decision.



ISSUES: The Medicaid Program will institute a volume purchasing contract for eyeglasses in February 1993. Medicaid recipients will continue to go to their optometric practitioner for eye exams and eyeglass fitting/adjustments, but a single lab will be used to make all eyeglasses. A reduction in Medicaid costs for eyeglasses is anticipated as well as a more consistent selection of good quality frames statewide. A subsequent increase in expenditures may be seen.



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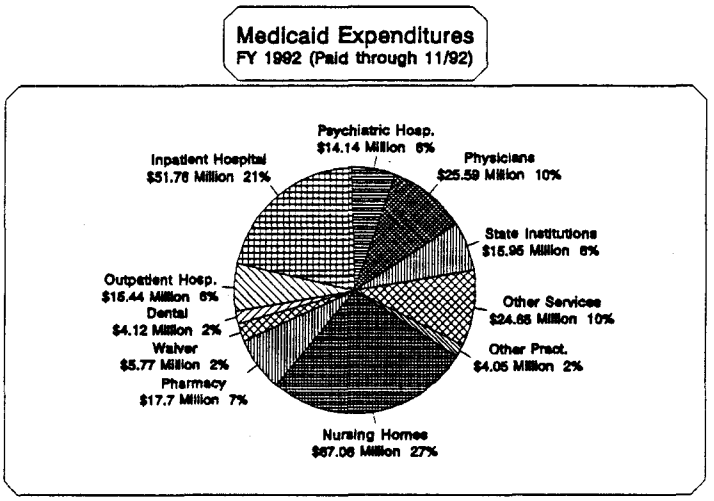
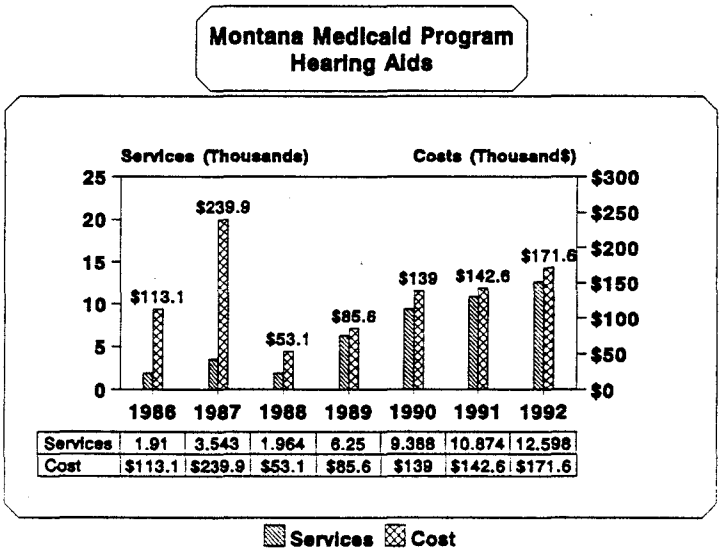
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
HEARING AIDS

Hearing aids are any wearable instrument or device designed for or offered for the purpose of aiding persons with impaired hearing. A hearing aid dispenser can be any person, partnership, corporation or association engaged in the sale, lease, or rental of hearing aids to a Medicaid recipient.

Recipients and Funding: Hearing aids is included under the "Other Services" section of the Medicaid Primary Care Program. It is funded at 71% Federal Funds and 29% State General Funds. Effective April 1, 1989 the program established minimum hearing requirements for adults who require hearing aids. Dispensing fees were reduced. An audiologist consultant was hired to review all requests for hearing aids. The consultant also assisted with the development of criteria for binaural aids (two aids). The program has eliminated the purchase of approximately 100 hearing aids per year which were not medically necessary through the use of the consultant at an estimated savings of $30,000.





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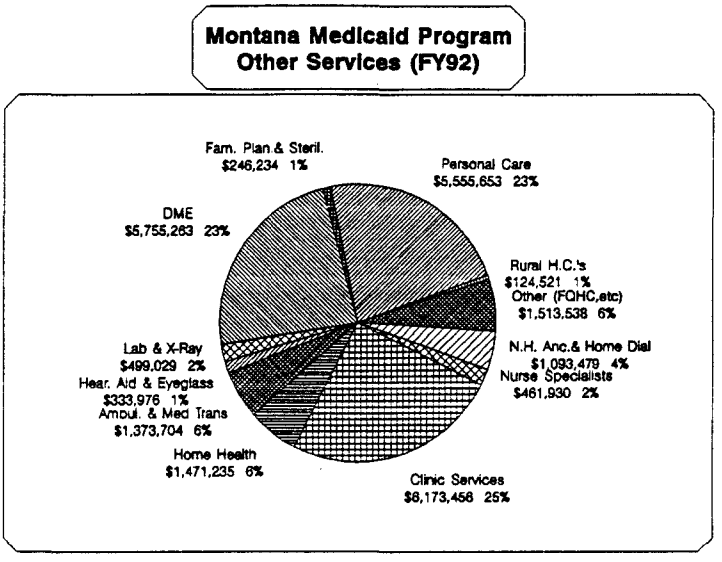
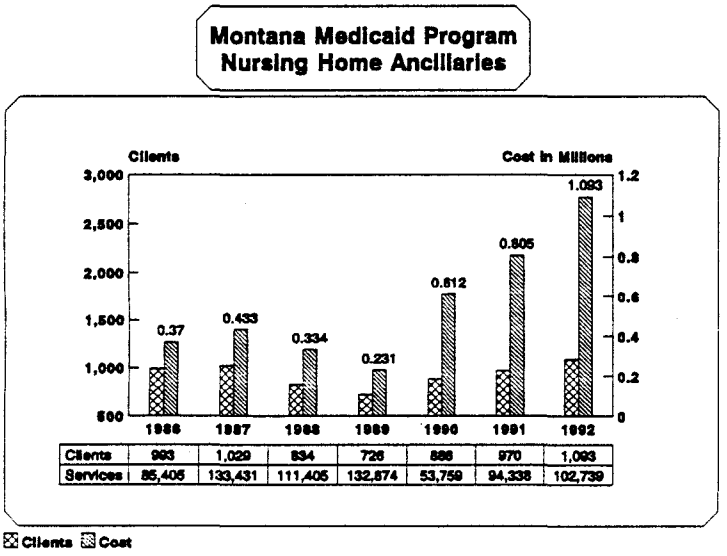
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
NURSING HOME ANCILLARIES

DESCRIPTION: Ancillary services are those Medicaid covered services which are not included in the daily Medicaid reimbursement rate.
These medically necessary services may be billed additionally by the nursing facility at their direct acquisition cost with no mark-up or indirect charges and must be physician prescribed. A few examples of ancillary items are: oxygen, dextrostick or glucose test strips, catheters, enteral and parenteral feeding solutions which are the resident's sole source of nutrition, and ostomy and colostomy supplies. Some services require prior authorization from the Department before they can be billed by the nursing facility.



Recipients and Funding: Nursing home ancillary services are included in the "Other Services" section of the Medicaid Primary Care Program. It is funded at approximately 71% Federal Funds and 29% State General Funds. The decrease from 1988 to 1989 is due to the implementation of the Medicare Catastrophic Coverage Act. The 1990 increase in cost and services reflects the repeal of certain Medicaid cost savings measures of this act.



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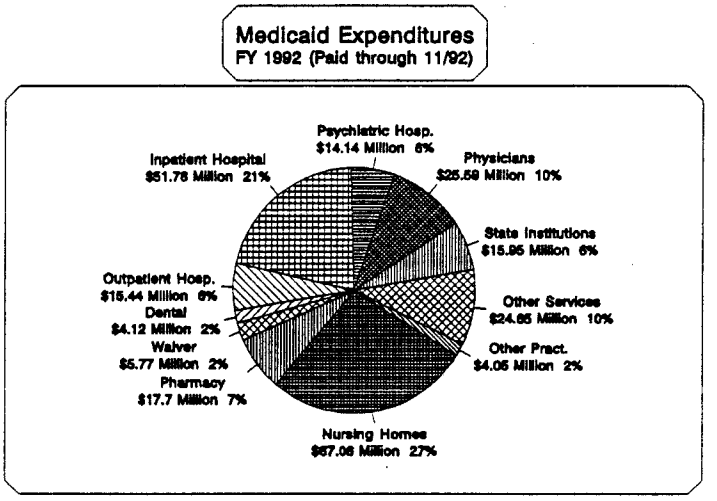
STATE OF MONTANA - MEDICAID
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
HOME DIALYSIS

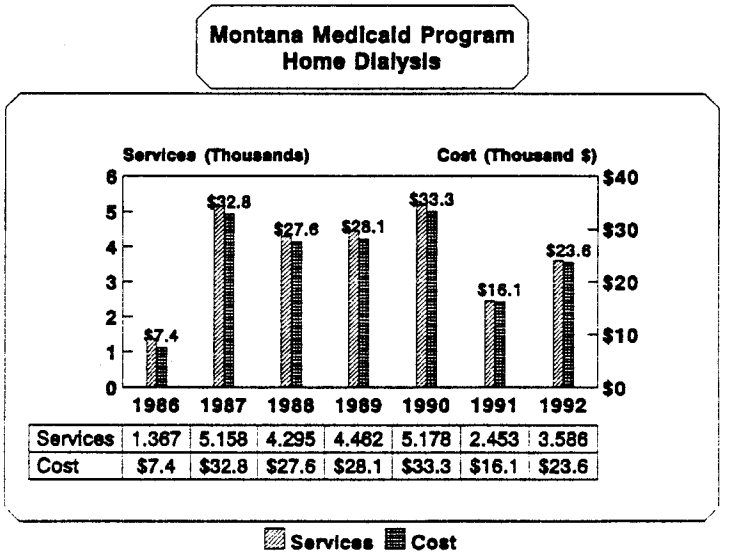
DESCRIPTION: Home dialysis services are in home services provided to persons with a diagnosis of "End Stage Renal Disease". Services are provided by a trained attendant. The attendant assists the recipient in performing the dialysis procedure and cares for the dialysis equipment.

Home dialysis care is provided under the direction of a physician. Dialysis is performed on a set schedule of 3 or more days per week. Medicaid payment is made for attendant assistance only, and is made only to non-related individuals.



Based on Medicaid Paid Claims through November 1992
Total 1992 Medicaid for these Benefits is $255.4 Million
Does not include Indian Health or Buy-In Expenditures

RECIPIENTS AND FUNDING: This program is budgeted under the "Other Services" section of the Medicaid Primary Care Program. It is funded at approximately 71% Federal Funds and 29% State General Funds. Program costs rose sharply between 1986 and 1987 in relation to increases in the number of clients but have remained roughly static since. Recipient needs for dialysis have remained fairly constant since 1986.



	1986	1987	1988	1989	1990	1991	1992
Services	1.367	5.158	4.295	4.462	5.178	2.453	3.586
Cost	$7.4	$32.8	$27.6	$28.1	$33.3	$16.1	$23.6

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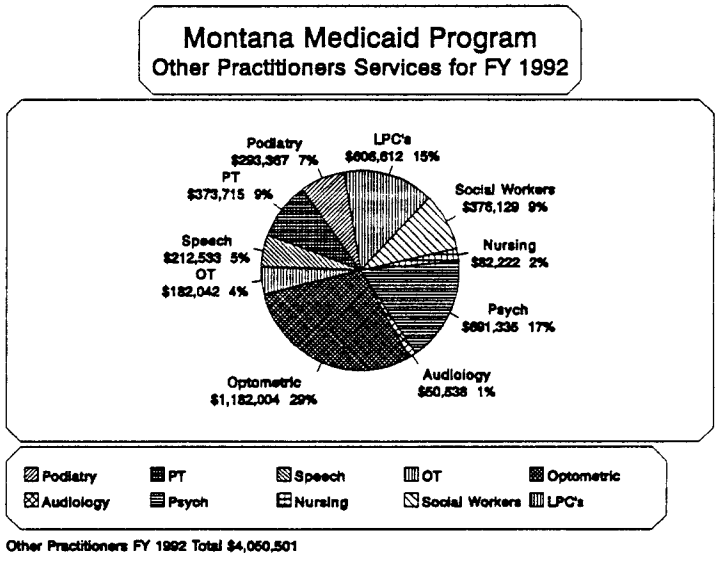
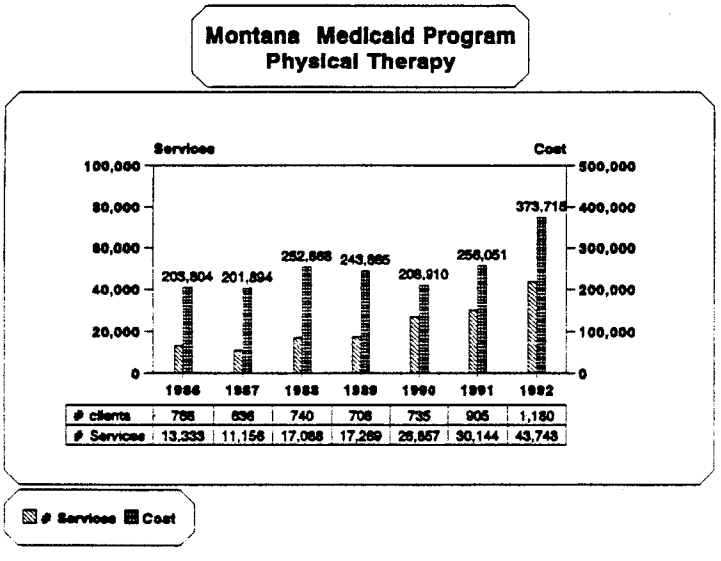
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
PHYSICAL THERAPY

Physical therapy as defined under the Medicaid Program as the evaluation, treatment, and instruction of clients to assess, prevent, or correct physical disability. Physical disability includes bodily malfunctions, pain, injury, or disability. Treatment may include physical measures, activities, devices, exercises, rehabilitative procedures, massage, mobilization, and physical agents. Physical therapy may also include the administration, interpretation, and evaluation of tests and measurements of bodily functions. All services must be under the scope of professional practices as defined by law.

Recipients and Funding: This service is funded under the Medicaid Program at a rate of approximately 71% federal and 29% state funds. Physical therapy accounts for 9% of the "Other Practitioners" budget unit under Primary Care. Physical Therapy has increased in total cost from $203,804 in 1986 to $373,715 in 1992. However, the number of services has increased dramatically from 13,333 in 1986 to 43,743 in 1992. In 1988 costs and the number of services increased by over 25% (almost 6000 services). Since provider reimbursement rates were frozen during this period, this increase was attributable to increased utilization of services. In response to this increase, the Medicaid Program developed several changes which resulted in a reversal of this trend. Prior authorization is now required for all services in excess of 70 hours for adults, and all units are now measured in increments of 15 minutes. These measures slowed program growth for several years. Costs again rose in 1992. We believe that this is due in large part to the implementation of OBRA 89. OBRA 89 prohibits states from restricting medically necessary services to children by hourly or dollar limits.



Other Practitioners FY 1992 Total $4,050,501



Issues: These providers did not receive a provider rate increase in 1988 or in 1989, a 2% rate increase was awarded in 1990 and 1991 - no increase since. Low provider reimbursement rates could result in decreased participation in the Medicaid Program.

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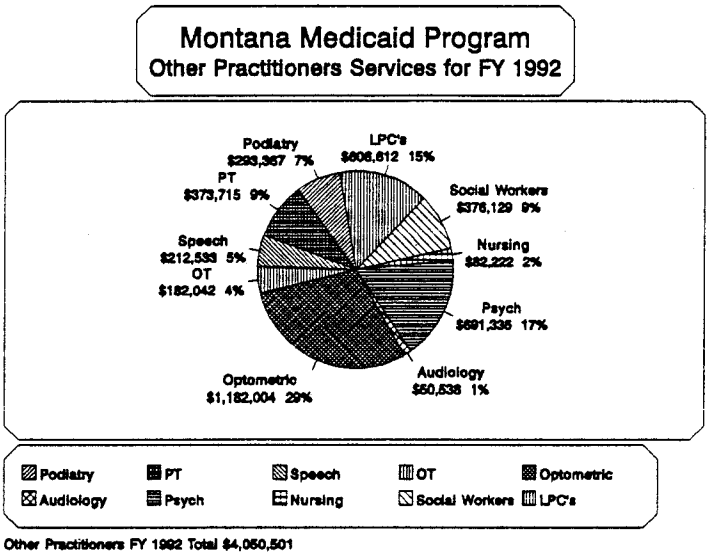
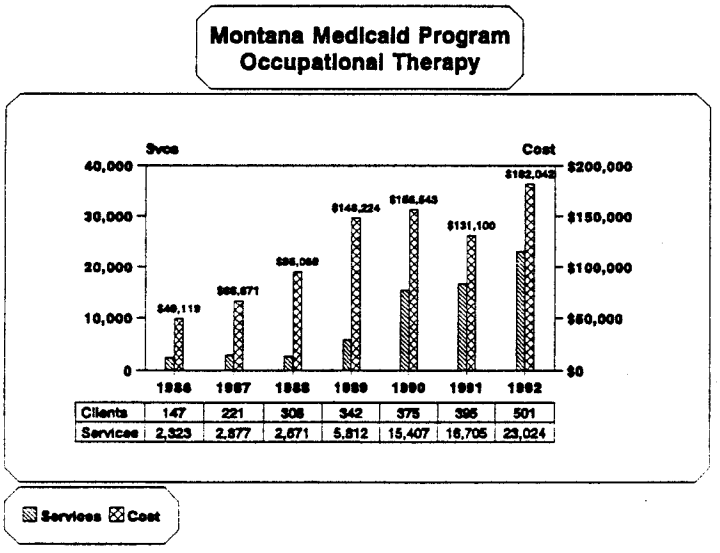
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
OCCUPATIONAL THERAPY

Outpatient occupational therapy means medically directed treatment of physically or mentally disabled individuals by means of constructive activities designed and adapted by a qualified occupational therapist to promote the restoration of useful function.

Recipients and Funding: This program is budgeted under the "Other Practitioners" section of the Medicaid Primary Care Program. It is funded at approximately 71% Federal Funds and 29% State General Funds. In 1992 this program accounted for approximately 4% of the "Other Practitioners" total cost. The costs in this program have risen from $49,119 in 1986 to $182,042 in 1992. Prior authorization of services in excess of 70 hours was implemented in FY 89. This cost containment measure appears to have slowed the growth of this program from FY 89 to FY 90. Service units were changed from hourly to 15 minute units in FY 89 as well.



Issues: Under OBRA 89 medically necessary services to children served under the Kids Count (or EPSDT program) cannot be limited by hours. Utilization and costs have increased, in part as a result of this change.



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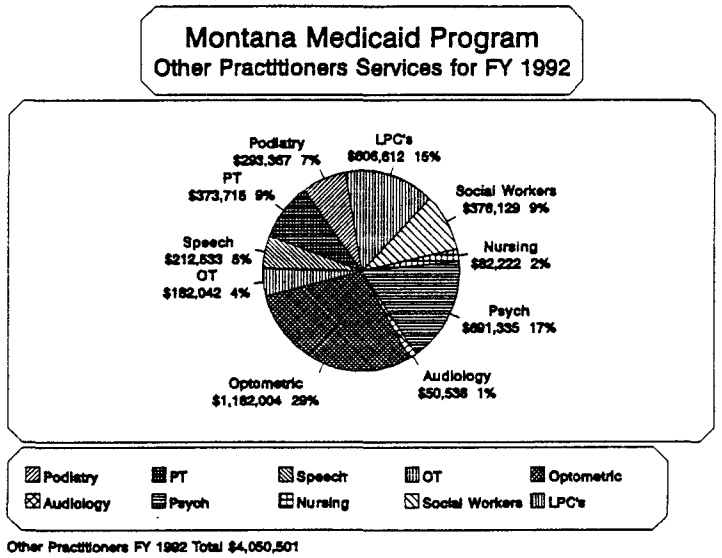
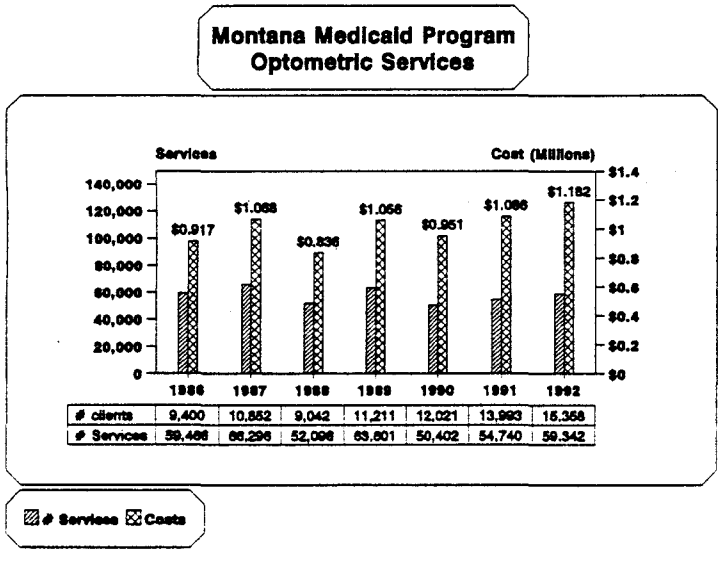
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
OPTOMETRIC SERVICES

Optometric services include medical services related to the care and treatment of the human eye and eyeglasses provided by a licensed optometrist in accordance with Federal and State statutes, rules, regulations, and other licensure requirements. All services must be within the scope of professional practices as defined by law. Reimbursement is limited to medically necessary services rendered to Medicaid eligible clients.

Recipients and Funding: This program is funded under the "Other Practitioners" section of the Medicaid Primary Care program. It is funded at approximately 71% Federal funds and 29% State general funds. In 1988 the Department restricted optometric services to only those which were necessary to prevent serious deterioration of the client's health. This restriction resulted in legal action and was discontinued in 1989. In 1989 CPT-4 procedure codes were adopted for optometrists, resulting in global service codes being used for routine care, rather than a separate billing for each individual service. This resulted in a reduction in the number of services billed and in the overall cost of the service.



Issues: The Medicaid Program will institute a volume purchasing contract for eyeglasses in February 1993. Medicaid recipients will continue to go to their optometric practitioner for eye exams and eyeglass fittings/adjustments, but a single lab will be used to make all eyeglasses. A reduction in Medicaid costs for eyeglasses is anticipated as well as a more consistent selection of good quality frames statewide.



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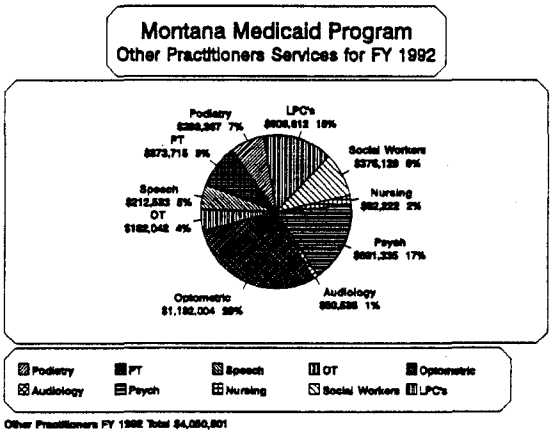
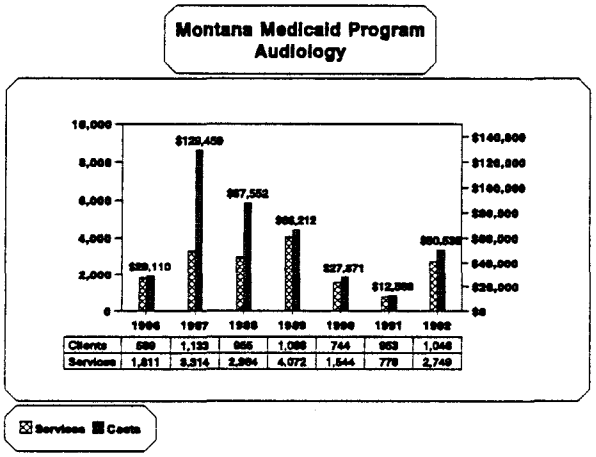
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
AUDIOLOGY SERVICES

Audiology services under the Medicaid Program are those services dealing with hearing aid evaluation and basic audio assessment. These services may only be provided to Medicaid eligible persons diagnosed with hearing disorders by a licensed audiologist upon referral by a physician.

Recipients and Funding: This program is budgeted under the "Other Practitioners" section of the Medicaid Primary Care program. It is funded with approximately 71% Federal funds and 29% State general funds. In 1987 program costs rose over 400% to $129,459. Since 1987 the Medicaid Program has been designing and installing program management changes in order to control and reduce costs in this service. These include the requirement that audiologists bill hearing aids under a separate billing category and the use of an audiology consultant to prior authorize certain services.



ISSUES: OBRA 89 mandates that Medicaid provide all medically necessary services coverable under federal Medicaid regulations to children. Audiology testing services are currently limited and may require expansion to meet this federal mandate.



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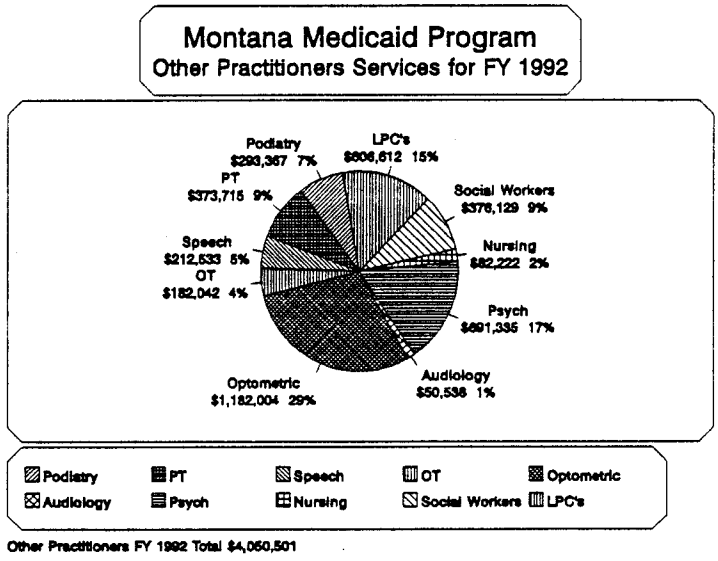
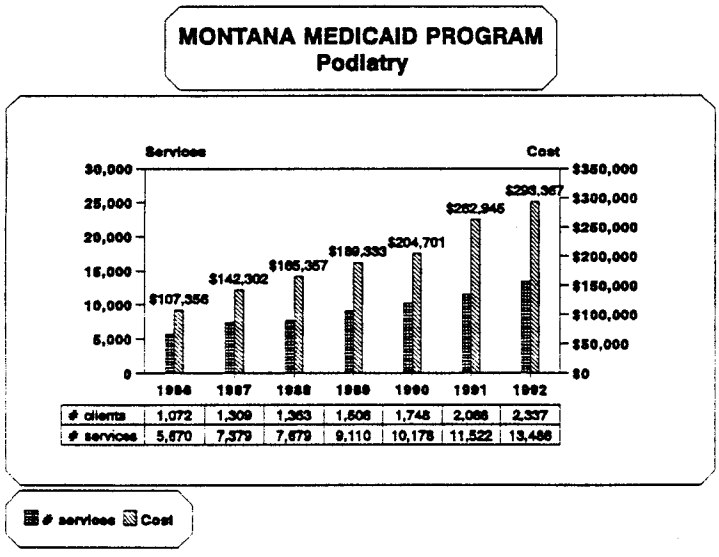
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
PODIATRY SERVICES

Podiatry services are medical services related to the care and treatment of the human foot. Under the Medicaid program podiatry services must be provided by a licensed podiatrist in accordance with Federal and State statutes, rules, regulations, and other licensure requirements. All services must be within the scope of professional practices as defined by law.

Recipients and Funding: This program is funded under Medicaid benefits at a rate of approximately 71% federal and 29% state funds. Podiatry is included in the "Other Practitioners" budget unit under Primary care. Overall program reimbursement has increased from $ 107,356 in 1986 to $ 293,367 in FY 1992. This amounts to only 7 % of the other practitioners budget for FY 1992. The increase over the last 5 years is not due to provider rate increases. It actually reflects an increase in the number of recipients, and a large increase in the number of services utilized per recipient. In 1986 services totaled 5,670 and increased to 13,486 in 1992. This increase in utilization and the increase in the number of clients accounts for the majority of the program cost increases over this period. Provider reimbursement rates did not increase from 1986 to 1989, and providers received a 2% increase in rates in 1990 and 1991. No increase yet.



Issues: None



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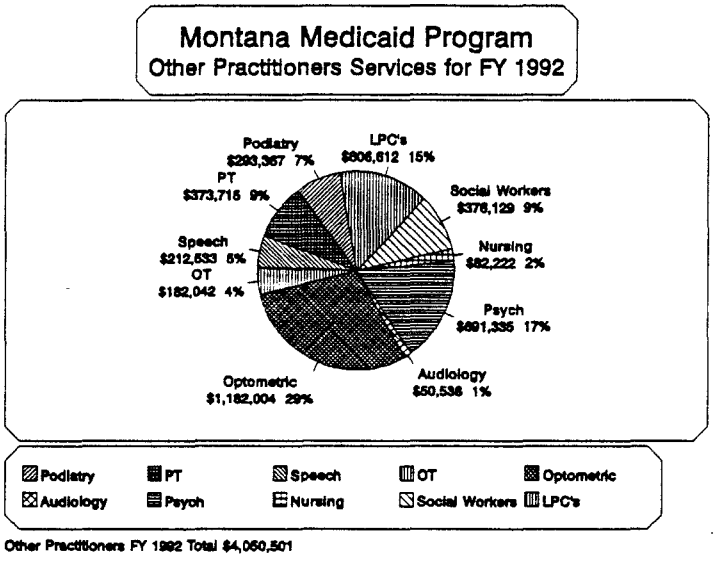
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
PSYCHOLOGICAL SERVICES

Psychological Services are those services provided by a licensed psychologist within the scope of the profession. Under the Medicaid Program, psychological services include individual, group, and family therapy, psychological testing and consultation. Psychological services are limited to 22 hours of services for persons over the age of 21.

RECIPIENTS AND FUNDING:
This program is budgeted under the "Other Practitioners" section of the Medicaid Primary Care Program. It is funded at approximately 71% federal funds and 29% state general funds. Program costs for psychological services have increased moderately from $544,773 in 1986 to $691,335 in 1992. The number of services have also increased from 55,230 in 1986 to 71,659 in 1992. However, there has been a significant increase in the number of clients served. In 1986, 1688 clients were served compared to 2124 in 1992. Increase in the number of clients served, is due in part, to the OBRA '89 requirement which prohibits dollar or hourly limits for medically necessary services to persons under the age of 21.



Issues: Reimbursement rates in this program were frozen in 1988 and 1989, and were increased by 2% in 1990 and 1991 respectively. There has been no increase since. Providers often express their desire for rate increases. Another area of concern for providers and recipients is the 22 hour service limit placed on persons over the age of 21. Providers believe this limit should be increased to allow for completion of therapy. Some diagnoses require that more time be spent in therapy than other diagnoses. Providers feel the 22 hour limit on services results in premature discontinuation of services which may result in more costly hospitalization.

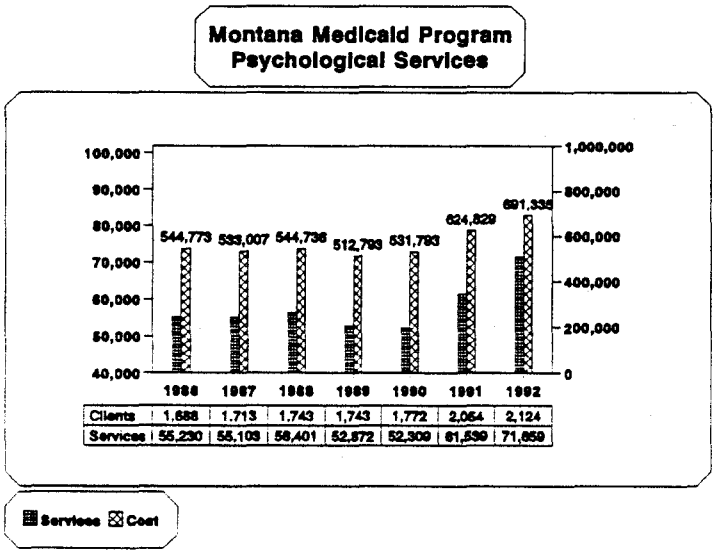


Figure 2

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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
SPEECH PATHOLOGY

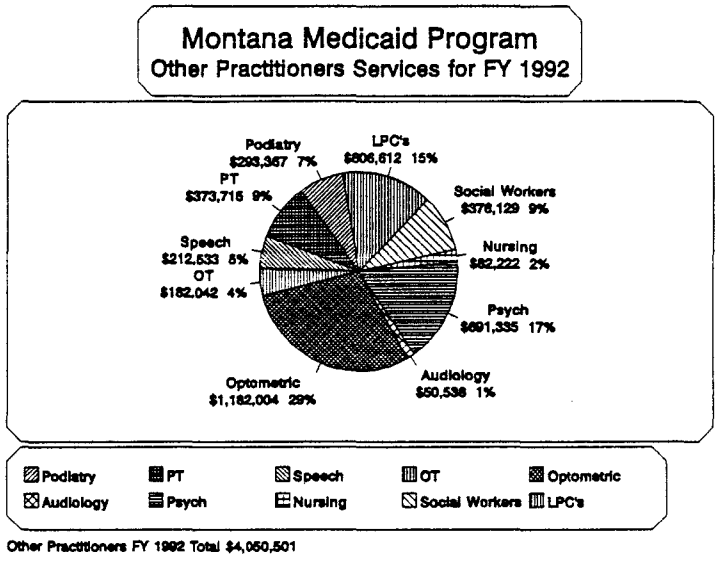
Under Montana's Medicaid Program speech pathology includes those diagnostic, screening, preventive, and corrective services provided by a licensed speech therapist, upon physician referral, to Medicaid eligible individuals with speech and language disorders.

Recipients and Funding: This service is funded under the Medicaid Program at a rate of approximately 71% federal and 29% state funding. It is included in the "Other Practitioners" budget section under Primary Care. In 1992 this service had a total cost of $212,533 which is approximately 5% of the cost accounted for under "Other Practitioners".

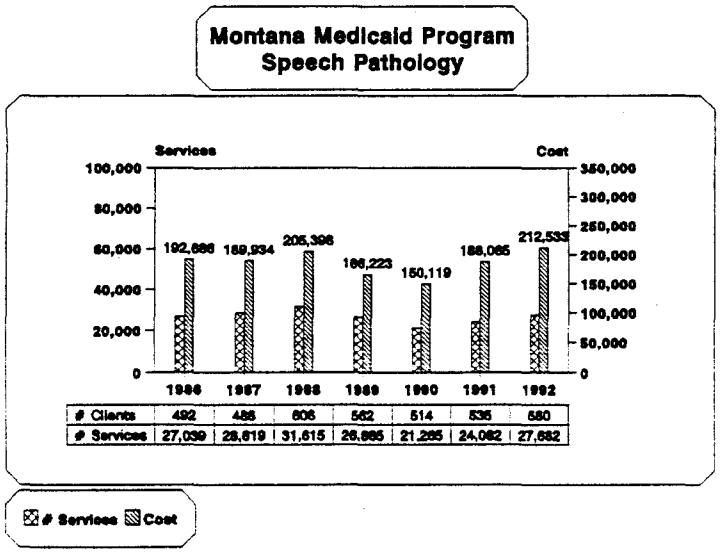
In FY 89 speech therapy services were limited to 70 hours per year. This limitation appears to have resulted in decreased utilization.

ISSUES

Under OBRA 89 federal mandates, hourly limits may not be imposed on services to children. An increase in utilization and costs may result in this program as a result of this change.



Other Practitioners FY 1992 Total $4,050,501



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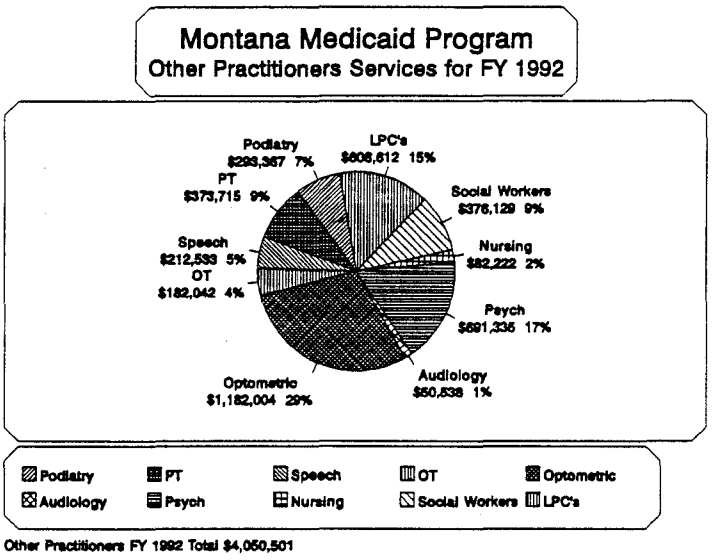
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
LICENSED CLINICAL SOCIAL WORKERS SERVICES

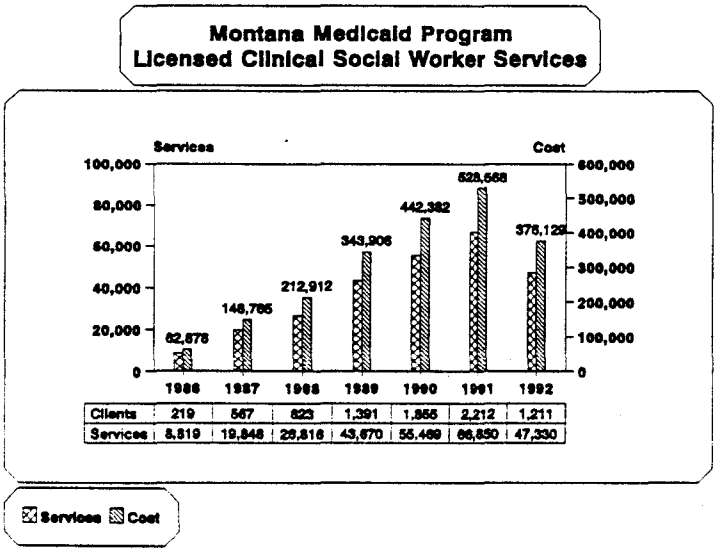
Licensed Clinical Social Worker Services are those services provided by a licensed clinical social worker within the scope of the profession. These services may include individual, group, family therapy and consultation..

RECIPIENTS AND FUNDING:
Since it inception as an optional service in Fiscal Year 1986 this service has experienced steady growth in clients, number of services, and cost. In 1986 total costs were $62,878. In 1992 total costs had grown to $376,129. This service is subject to a 22 hour service limit per fiscal year for adults, but it has experienced a five year growth rate of 500% in the number of clients. This is the major force behind the growth in cost. Currently licensed clinical social workers are reimbursed based on 80% of psychological service fees.



Issues: Under OBRA 89, medically necessary services to children served under the Kids Count (formerly Early Periodic Screening Diagnosis and Treatment (EPSDT) program) cannot be limited by hourly limits. This federal mandate was implemented in December, 1990.

Reimbursement rates in this program were frozen in 1988 and 1989, and were increased by 2% in 1990 and 1991 respectively. Rates were frozen again in 1992 and 1993.



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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
TARGETED CASE MANAGEMENT
FOR
HIGH RISK PREGNANT WOMEN

Case management for high risk pregnant women entails planning and coordinating care and services to meet individual needs and maximize access to necessary medical, social, nutritional, educational and other services.

The case management provider must meet certain criteria and be approved by the Department of Social and Rehabilitation Services.

The major goals of this Program are to:

1. reduce infant mortality and morbidity;
2. ensure provision of comprehensive services to pregnant women and their infants; and
3. assist pregnant women and caretakers of infants in meeting priority needs that affect their well-being and that of their families.

The primary reason for including case management in the Medicaid Program is to help remove two major barriers that negatively affect pregnancy outcomes. They are:

1. fragmentation and lack of coordination in service delivery; and
2. lack of patient knowledge of and ability to successfully access the health care system.

Reducing the incidence of high risk pregnancies, thus high cost infants, reduces Medicaid Program expenditures.

Recipients and Funding: The match rate for this service is 71% Federal and 29% State Funds. Medicaid coverage of this service was instituted in July of 1991. Currently 10 Miami Projects offer targeted case management. These projects are located in counties which have 65% of Montana's pregnant population.

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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
TARGETED CASE MANAGEMENT
FOR
YOUTH WITH SEVERE EMOTIONAL DISTURBANCE

Case management for youth with severe emotional disturbance. It entails planning and coordinating care and services to meet individual needs and maximize access to necessary medical, social, nutritional, educational and other services. Individuals who are eligible for Medicaid, are less than eighteen years of age (or are less than twenty-one years of age being served by an education agency), have severe emotional disturbance, and who reside in Missoula County or the Helena Valley are targeted for case management. Case management services must be provided by a licensed mental health center or other approved provider under contract with the Montana Department of Corrections and Human Services.

Recipients and Funding: The General Fund portion of this match is provided by the Department of Corrections and Human Services (DCHS) through agreements with the two Regional Mental Health Centers. The match rate is 71% Federal and 29% State funds. Case management services for this group became effective in June of 1992.

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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
PRIVATE DUTY NURSING SERVICES

Private Duty Nursing Services are provided by a registered nurse or licensed practical nurse to a person under the age of 21 who lives at home or in a group home. The client has a medical condition which requires skilled nursing services to which cannot be provided by a non-licensed person (example-nursing care for a respirator dependant individual).

Recipients and Funding: This program is funded as a component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. OBRA '89 mandated that under EPSDT (known in Montana as Kids Count), a state is required to furnish children and adolescents up to the age of 21 all medically necessary diagnostic and treatment services that are federally allowed under section 1905(a) of the Medicaid statute, even if these services are not otherwise covered in the state plan. Private Duty Nursing for non-institutionalized patients under 21 is an expansion mandated by OBRA '89, and was implemented September 1991.

The funding mix is approximately 71% Federal funds and 29% State funds.

ISSUES: None

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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
RURAL HEALTH CLINICS

Rural Health Clinic (RHC) services are outpatient diagnostic and therapeutic services and supplies provided by provider-based and independent clinics located in a rural area designated as a medical services shortage area by the federal government. A provider-based RHC is an integral and subordinate part of a hospital, skilled nursing facility or home health agency participating in medicare and licensed, governed and supervised with other departments of the facility. An independent RHC is a clinic other than provider-based.

Recipients and Funding: RHC services are included in the "Other Services" section of the Medicaid Primary Care Program. Services are funded at approximately 71% Federal and 29% State fund match. RHC services are reimbursed at 100% of reasonable cost. Interim reimbursement is set at the average cost of delivering a Medicaid covered service.

Medicaid began covering RHC services in July 1991. There are currently 13 providers.

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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
CHEMICAL DEPENDENCY TREATMENT

Chemical dependency treatment services are medical services related to the care and treatment of patients who are addicted to alcohol or drugs. Under the Medicaid program chemical dependency treatment services may be provided only by an outpatient facility approved by the Montana Department of Corrections and Human Services. Chemical dependency treatment services include intensive outpatient services, basic outpatient services, and aftercare. When an eligible child receives outpatient chemical dependency treatment, and the certified chemical dependency counselor consults with the parent as part of the child's treatment, the consultation is also a reimbursable service.

Outpatient chemical dependency treatment must be determined appropriate by a certified chemical dependency counselor. Reimbursement is limited to medically necessary services rendered to Medicaid eligible individuals under the age of 21.

Recipients and Funding: This program is funded as a component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. OBRA '89 mandated that under EPSDT (known in Montana as Kids Count), a state is required to furnish children and adolescents up to the age of 21 all medically necessary diagnostic and treatment services that are federally allowed under section 1905(a) of the Medicaid statute, even if these services are not otherwise covered in the state plan. Chemical dependency treatment is an expansion mandated by OBRA '89, and was implemented July 1, 1992.

The funding mix is approximately 71% Federal funds and 29% State funds.

Issues: Recipients and providers have expressed the desire to see this service expanded to cover adults as well as children.

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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Center (FQHC) services are ambulatory services provided by community health centers, migrant health centers and providers of care for the homeless who have been designated as an FQHC, a provider must be a, or eligible to be a, recipient of grant funds under section 329, 330 or 340 of the Public Health Service Act. FQHC services include physician, nurse practitioner, physician assistant, nurse midwife, clinical psychologist, clinical social worker, part-time or intermittent nursing services and drugs, biological and supplies incidental to such services; pneumococcal vaccinations; and, any other ambulatory service covered by the Medicaid program.

Recipients and Funding: FQHC services are included in the "Other Services" section of the Medicaid Primary Care Program. Services are funded at approximately 71% Federal and 29% State fund match. FQHC services are reimbursed at 100% of reasonable costs. Interim reimbursement is set at the average cost of delivering a Medicaid covered service.

FQHC services became effective in July 1991. There are currently three providers of the services, two in Billings and one in Butte.

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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
TARGETED CASE MANAGEMENT
FOR
ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS

Case management for adults with severe and disabling mental illness consists of planning and coordinating care and services to meet individual needs and maximize access to necessary medical, social, nutritional, educational and other services. Individuals who are eligible for Medicaid, are at least eighteen years of age and have both severe mental illness and ongoing functional difficulties because of mental illness are targeted for case management. The availability of these services help reduce costly hospital stays, assure access to appropriate care and improve quality of life for these consumers and their families. Case management services must be provided by a licensed mental health center (or other approved provider) under contract with the Montana Department of Corrections and Human Services.

Recipients and Funding: General fund match for these services is contained in the Department of Corrections and Human Services budget. The match rate is 71% Federal and 29% State funds. Coverage of case management services for this group became effective in July of 1991.

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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
RESPIRATORY THERAPY

Respiratory therapy services are medical services related to the care and treatment of the human respiratory system. Under the Medicaid program respiratory therapy services may be provided only by a licensed Respiratory Care Practitioner. Reimbursement is limited to medically necessary services rendered to Medicaid eligible individuals under the age of 21.

Recipients and Funding: This program is funded as a component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. OBRA '89 mandated that under EPSDT (known in Montana as Kids Count), a state is required to furnish children and adolescents up to the age of 21 all medically necessary diagnostic and treatment services that are federally allowed under section 1905(a) of the Medicaid statute, even if these services are not otherwise covered in the state plan. Respiratory therapy is an expansion mandated by OBRA '89, and was implemented July 1, 1992.

The funding mix is approximately 71% Federal funds and 29% State funds.

ISSUES: None

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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
NUTRITION SERVICES

Nutrition services are medical services related to the care and treatment of dietary problems. Nutrition services may include screening, assessment, counseling, consultation, education, and related services. Under the Medicaid program nutrition services may be provided only by a licensed or registered Nutritionist or Dietician. Reimbursement is limited to medically necessary services rendered to Medicaid eligible individuals under the age of 21.

Recipients and Funding: This program is funded as a component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program (known in Montana as Kids Count) OBRA '89 mandated that under EPSDT states furnish children and adolescents up to the age of 21 all medically necessary diagnostic and treatment services that are federally allowed under section 1905(a) of the Medicaid statute, even if these services are not otherwise covered in the state plan.

The funding mix is approximately 71% Federal funds and 29% State funds. Medicaid began funding this service in December 1990.

ISSUES: Providers and recipients have expressed interest in having this service expanded to cover adults as well as children.

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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
LICENSED PROFESSIONAL COUNSELOR

Licensed Professional Counselor services are medical services related to the care and treatment of psychological problems provided by a counselor who is licensed in accordance with State statutes, rules and regulations. All services must be medically necessary and must be within the scope of professional practices as defined by law. Services for adults are limited to 22 hours of service per recipient, per state fiscal year. Under federal Early Periodic Screening Diagnosis and Treatment (EPSDT) regulations, individuals under age 21 are not subject to the 22 hour per fiscal year limitation.

RECIPIENTS AND FUNDING: This program is funded under the "Other Practitioners" section of the Medicaid Primary Care program. The funding mix is approximately 71% Federal funds and 29% State general funds. Licensed Professional Counselor services became available for Medicaid reimbursement as of July 1, 1991.

ISSUES: Many providers and recipients do not believe the 22 hour per fiscal year limit on psychological services for adults is adequate. This limit was set several years ago on the recommendation of the Montana Psychological Association who felt that 22 hours of psychological services should cover ninety percent of a recipient's yearly needs. Data collected from Medicaid's paid claims for fiscal year 1991 show that of all adults using counseling services from psychologist, masters of social workers and licensed professional counselors, less than 200 recipients over age 21 met the 22 hour limit. Recipient's affected by the hour limit can seek additional service in a mental health center where no limits exist. However, some mental health centers have a waiting list to receive new clients and changing therapists may disrupt client's progress in therapy.

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STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
TARGETED CASE MANAGEMENT
FOR
PERSONS AGE 16 AND OVER WITH DEVELOPMENTAL DISABILITIES

Case management for persons with developmental disabilities entails planning and coordinating care and services to meet individual needs and maximize access to necessary medical, social, nutritional, educational and other services. Individuals who are eligible for Medicaid, are at least sixteen years of age and have a developmental disability are targeted for case management. The case manager must be employed by or under contract with the Montana Department of Family Services.

Recipients and Funding: General fund match for this service is contained in the Department of Family Services budget. The match rate is 71% Federal and 29% State funds. Coverage of this group became effective in July of 1991.

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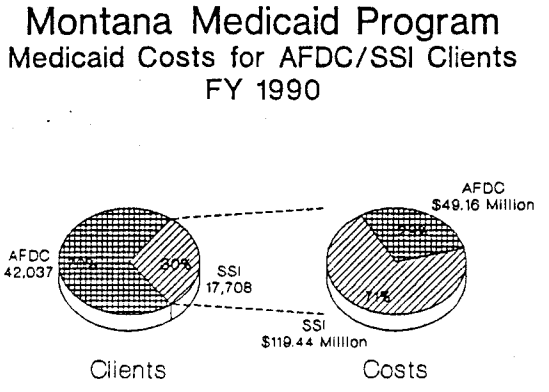
STATE OF MONTANA - MEDICAID PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES
PROGRAM OVERVIEW

Under Title XIX of the Social Security Act and Title 53 MCA, the staff of the Medicaid Services Division administers the Montana Medicaid Program. Medicaid is a joint Federal/State funded program designed to meet the cost of medical care for eligible low income groups of people: persons 65 and over, the blind, the disabled, members of families with dependent children and poverty related pregnant women and children. The Montana Medicaid Program also covers a group classified as medically needy. These people have income in excess of the AFDC and SSI thresholds, but have medical bills that reduce their income levels enough for them to become eligible.



Source is the HCFA 2082

Within Federal guidelines, the state has the flexibility to determine who is eligible for the program, what medical services are covered and the amount reimbursed for services. Medicaid programs must provide certain mandatory services, including inpatient and outpatient hospital services, physician services, skilled nursing care, early periodic screening diagnosis and treatment (EPSDT) for children, lab and x-ray, home health, family planning, and rural health clinic services. In addition, Montana provides a number of optional medicaid services that have been authorized by the legislature. These include prescription drugs, dental services, eyeglasses, hearing aids, and intermediate care facility services among others.

The Medicaid Services Division also administers the State Medical Program, which is designed to provide medical care to low income persons who do not qualify for Medicaid. This program is 100% state funded.

The Medicaid Program has grown significantly over the last few years and is projected to see furthur growth in the upcoming biennium. Much of this growth is a result of growing caseloads, medical inflation, increased utilization, and new medical technologies. However, a large amount of the growth is due to Federal mandates which have expanded eligibles and services. Federal OBRA 87, OBRA 89, OBRA 90, and Medicare Catastrophic Coverage Acts are adding millions to the cost of Medicaid Services.

Presentation Date: 1/18/93
LRS Staff: Nancy Ellery
John Chappuis
Norm Rostocki
Committee: Human Services Appropriations Subcommitt

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D. Myths and Fac
Understanding
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I. GENERAL

A. What is Medicaid?

Medicaid is the state's major public financ
health care to low-income Montanans. This
1965 as an entitlement program primarily
Since then, it has become a major source c
for low-income populations who may or may
check.

B. What is our Mission?

The mission of the Medicaid Services Divi
Montana's low-income citizens have access t
which is equitable to both the provide
taxpayer.

C. What is Medicaid's Role in Health Care Svs

Medicaid plays a critical role in the healt
eight (8) Montanans (U.S. - one in 11)
protection in case of illness or disability
of health insurance coverage for low-income
and the disabled. It also provides suppl
Medicare beneficiaries. It is also the p
provided in nursing homes.

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Myth: Medicaid provides health care coverage to all of the nation's poor.

Fact: Being poor does not automatically qualify a person for Medicaid. In fact, Medicaid covers less than half of the poor. Limits restrict coverage based on income and assets and exclude individuals outside the welfare system or in the wrong type of family. Currently, the income eligibility level for a low-income family of three averages $5,859 or 42 percent of poverty. Individuals eligible under the medically needy program can have more income but must use it on medical bills to spend down to this level. Adults without children are not eligible for Medicaid, regardless of income or medical expenses, unless they are disabled or elderly.

Myth: Medicaid is a failure in its role as a health insurer.

Fact: Medicaid has reshaped the availability and provision of medical care to the poor. Those who are covered by Medicaid are far better off than the uninsured because they enjoy far better access to health care. Despite persistent inadequacies in the delivery system, the program has improved coverage of the poor and brought the poor up to the level of the privately insured in terms of doctor visits, and provides benefits tailored to meet the

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complex health needs of the poor. While more needs to be done, much has been accomplished.

Myth: Medicaid costs are out of control.

Fact: There is no doubt that Medicaid costs are increasing at a rapid pace. Medicaid is expensive because health care in America is expensive. Many of Medicaid's beneficiaries have needs that are more extensive than traditional insurance coverage. The program's responsibility to cover both the acute and long term care needs of its beneficiaries would be costly under any circumstances.

I. HOW DOES MEDICAID WORK?

Each state designs its own Medicaid program within the federal guidelines. Each state determines who will be covered, what services will be paid for, how much providers will be paid and how the program will be administered.

A. Eligibility - who is covered?

Eligibility is based on criteria set by the federal government and further defined by state policy. The eligibility process has categorical, income and asset requirements. A person applies for Medicaid at their local county welfare office. Eligibility has been covered thoroughly by Roger La Voie during his presentation so I won't go into any more detail.

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B. Who Does Medicaid Serve?

Medicaid primarily covers children and adults in poor single-parent families who qualify for AFDC; low-income pregnant women and young children and low-income elderly, blind and disabled persons who qualify for Supplemental Security Income (SSI). Refer to Chart 1 for program expenditures by eligibility category.

Chart 2 shows that Medicaid per capita costs in FY 92 were almost $8000 for the elderly and almost $7000 for the disabled. This compares to only $1,064 for AFDC children and $1462 for AFDC adults.

C. Benefits - what services are covered?

Montana Medicaid program covers a wide range of services. Some services are federally mandated for all Medicaid clients while others are offered at a state's option. Montana Medicaid covers 27 out of the 31 optional services allowed under federal regulations.

Chart 3 shows what mandatory and optional services are covered by Montana's Medicaid Program. It also shows how many other states cover these optional services.

Many of the optional services provided under the Montana Medicaid program allow clients to use the most cost-effective and least restrictive way to receive medically necessary services. For

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example, the availability of prescribed medicine enables persons to control disease and avoid hospitalization. Personal care services allow many individuals unable to perform routine activities of daily living to remain at home rather than be institutionalized.

Medicaid imposes certain limitations on services provided to adults. For example, there are limits on eyeglasses, counseling, home health, personal care, etc. Federal regulations prohibit service limitations on children.

Montana Medicaid also imposes copayment on many services. Copayments are not permitted for children, pregnant women, nursing home recipients, waiver and emergency services. Copayment is a flat fee that varies from service to service that a recipient is required to pay as a portion of his/her medical care. By federal law, recipients cannot be required to pay more than a nominal amount toward their medical care.

Copayments result in a direct cost savings to the Medicaid program because provider payments are reduced by the amount of the copayment. Providers can not refuse to provide services if clients cannot pay the copayment. The majority of providers do not collect copayment because it is such a small amount.

Montana Medicaid has copayments on more services than any other state Medicaid program. Copayments in FY 92 amounted to $1,025,381 ($296,130 GF).

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Chart 4 shows what was spent on each Medicaid service in FY 92. Almost 70% of the dollars spent was for care provided in hospitals and nursing homes. These services are used primarily by the elderly and disabled and are the most expensive services Medicaid covers.

These expenditure patterns contrast sharply with the utilization of services. (Refer to Chart 5)

Although inpatient hospital and nursing care accounted for 50% of total spending, only a small proportion of persons used these services. Less than 16% of Medicaid clients used inpatient hospital care and less than 6% used nursing home care.

The largest proportion of clients in FY 92 used ambulatory services. 68% received physician services, 58% received prescription drugs and 40% used outpatient hospital care.

D. Reimbursement - how are providers paid?

Providers are paid directly for the services they provide to Medicaid clients. Payments are not made directly to clients. There are over 6,000 providers enrolled in the Medicaid program. Not all providers enrolled are participating in the program.

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States have some flexibility in determining the method of payment and amount providers are paid. Under federal guidelines providers must accept Medicaid payment as payment in full and cannot charge clients anything extra. (Doesn't count co-payment)

Except for Indian Health Services, Medicaid is designated as the payor of last resort with all other resources tapped before Medicaid dollars are spent. Third party resources like Medicare or private insurance are important means of reducing Medicaid costs. In July 1992, Medicaid began to pay private health insurance premiums of Medicaid eligible when it was determined to be cost effective. In the program's first year over $700,000 was saved.

Ninety-eight cents out of every dollar spent in Medicaid goes directly back to health care providers. This has an enormous impact on the state's economy. The revenue received by health care providers pays the salaries of thousands of health care workers who buy goods and services and pay taxes in the state. Using the common economic multiplier of three, Medicaid expenditures generated over $759 million worth of business in Montana in FRY 92 ($253 million x 3).

(1) Reimbursement for Primary Care Services

States have more flexibility in determining payment rates for primary care services than for hospitals or nursing homes. Primary

care providers include physicians, dentists, nurse practitioners, etc. Montana (like 42 other states) use a fee schedule to pay physicians. Many of these fees were set years ago and have had minimal inflationary increases in the interim. There is a wide range in payment for different physician services. Payments for physician services range from 22% of charges for a thoracentesis to 85% of charges for a global vaginal delivery.

OBRA '89 created a special class of health facilities that include many community and migrant centers. This class is called Federally Qualified Health Centers (FQHC) and the federal government requires that Medicaid pay 100% of the costs for certain covered services provided in the facility.

(2) Reimbursement For Hospital and Long Term Care

Montana reimburses hospitals and nursing homes on a prospective payment system. Hospitals are paid a rate set in advance based on the person's diagnosis or DRG. Nursing homes are paid a daily rate based on costs and an inflationary index.

The Boren Amendment requires that we pay hospital and nursing home rates that are reasonable and adequate to meet costs incurred by efficient and economically operated facilities. This has been a major reason for growth in our most expensive budget areas.

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I will be discussing the hospital and nursing home program in more detail later.

E. Financing & Administration

The Medicaid Program is financed jointly by the federal and state government. We incur the expenditures and request payment from the federal government for covered services provided to eligible persons.

In Montana the federal government matches 71% of every dollar we spend. This means that for every state dollar spent, the federal government kicks in approximately $3. Each state's federal match varies based on a formula which looks at state per capita income.

Chart 6 shows how Montana's match rate has changed since 1982. For every 1% decrease in the Federal participation, state general fund expenditures increase $3.2 million. In FY 93, our Federal match decreased for the first time since FY 84.

Federal funds are not currently limited by a dollar ceiling or cap but this may change under the Clinton Administration due to the rapidly increasing federal deficit.

Besides matching payments for services, the federal government helps to support the state's administrative costs. It pays 50% of

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these costs across all states. For some services such as MMIS, the federal government pays a higher match as an incentive for states to implement such system.

HCFA is the federal agency that administers Medicaid and oversees program financing and operation. HCFA has broad responsibility for defining regulations. Each state operates its program under a state plan that is submitted to HCFA. HCFA staff monitor implementation on a regular basis and disallows federal matching funds if states are found to be out compliance with federal regulations or the state plan.

To administer the program, states must establish and conduct eligibility determinations, certify and pay providers and perform quality control and fraud and abuse activities. Despite the program's complexity, costs to administer Medicaid benefits are less than two percent of total expenditures..

III. WHAT ARE CHALLENGES FACING MEDICAID?

A. Access to Care

The most difficult task in Medicaid is balancing costs and access to care. The cost containment dilemma is how to contain costs without restricting access to health care. This is frustrating to

providers and other insurers who argue that you are shifting costs from one payor to another. It is also frustrating to consumers and their advocates who demand quality medical care. And it is frustrating to taxpayers who must pay for the services.

Congress has attempted through mandates to use the Medicaid program as an incremental approach to health care reform. The increasing numbers of uninsured and the lack of a universal health plan puts pressure on the program to cover those who fall between the cracks. But rising program costs and fiscal problems at the state and national level undermine our ability to respond.

In Montana, over 142,000 persons are uninsured. Over 35% are children. Groups interested in health care reform continue to look to expanding the Medicaid program as a way to cover the uninsured. But there is a big price tag associated with this.

Medicaid clients experience barriers to receiving some types of care and receiving that care in the most appropriate setting. Having a Medicaid card does not guarantee that a client will be able to access the care they need. Medicaid clients often have difficulty finding a provider that will accept Medicaid.

The Medicaid Division conducted a survey of Medicaid clients in August 1992 which confirmed problems with access to care. The major barriers to care that were identified included not knowing

what the program covers, finding providers who accept new Medicaid clients, delays in getting appointments, lack of transportation and inability to pay the co-payment. Gaps in provider availability and continuity of care weaken our effectiveness at providing primary and preventive care and increases our expenditures for acute and long term care services.

B. Provider Participation and Payment

The data on the number of physicians enrolled in the Medicaid program can be very misleading. Many providers enrolled in the program do not actively participate or accept all Medicaid clients.

SRS conducted a survey of primary care providers with DHES in May of 1991. The majority of physicians responding to the survey stated they were enrolled in Medicaid but 30% limit the number of Medicaid patients they will see. The main barriers to participation they cited were low reimbursement, administrative barriers and client behavior.

OBRA 89 requires states to demonstrate that obstetric and pediatric care is available to Medicaid clients at least to the extent that care is available to general population. The 1991 legislature increased fees in these areas from 50% to 80% of charges for pediatric services and to 85% of charges for obstetrical services to improve access. Access has improved in these areas but problems

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remain in the other areas. One of the most critical areas is dental services. There are many areas of the states where no dentists participate in the Medicaid program. Dentists are currently paid less than 50% of charges.

Several lawsuits have been filed over the issue of access to care for Medicaid recipients. I will briefly summarize a few for you:

A temporary restraining order has been issued against Arkansas to prevent them from cutting most ambulatory rates by 20%. Arkansas was ordered to reinstate full reimbursement rates for OB, pediatrics, occupational and physical therapies.

A lawsuit has been filed in Tennessee alleging inadequate reimbursement for OB services which resulted in inadequate access for Medicaid recipients.

Two lawsuits have been filed in Pennsylvania alleging that the state is not providing adequate services in their EPSDT program. One of these lawsuits focuses on the need for better outreach to inform clients of available services. The other focuses on the fact that the state does not have a comprehensive state-wide system for mental health services for children.

In California, the court ruled that Medicaid was not paying enough to enlist dentists. They were ordered to raise the reimbursement

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rate from 45% to 80% of charges.

Lack of provider participation causes many clients to rely on emergency rooms and results in fragmented and un-coordinated care. These concerns about cost, quality and access led us to develop the Passport to Health Program for AFDC families.

Under this program, a primary care provider (who can be a physician, clinic, nurse practitioner or physician assistant) acts as a gatekeeper by providing services and coordinating the client's other care in return for fee-for-service payment and a monthly case management fee of $3.

In an effort to meet deficit-reduction goals, the January, 1992 special session moved PASSPORT's implementation date from January, 1993 up to October, 1992. Unfortunately, we were unable to meet the expedited deadline. Here is why.

First, there was much more to the implementation process than anticipated. We had only one FTE to implement a program for which other states devote a minimum of three people, yet we were still able to implement in 15 months what takes other states a minimum of two years. The process of preparing an acceptable federal waiver request, changing the eligibility and claims processing computer systems, recruiting providers, and the innumerable other tasks implementation entailed were extraordinarily time-consuming.

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A major reason for the delay was the slow pace of PASSPORT provider enrollment. Some providers embraced the program outright, but many had concerns which took considerable effort to address and allay. The concerns were numerous: what exactly the requirement for 24-hour coverage encompassed, the potential liability of being a gatekeeper, and the impact of making a commitment to a population for which reimbursement is so low.

Many were willing to participate, but only if they could limit their PASSPORT caseload to <u>just</u> their current patients and be assured that no new Medicaid patients could choose them. Because we do not want to disrupt existing provider-patient relationships, we made this accommodation. However, it required a labor-intensive manual intervention; a minimum of an hour for each of the over 130 requests we received.

PASSPORT was implemented in Silver Bow and Hill counties this month. Next month PASSPORT will start in Carbon, Gallatin, Lake, Lewis and Clark, Missoula, and Yellowstone counties. We expect statewide implementation by April.

The Executive budget includes a budget modification to expand PASSPORT to SSI recipients. It requests 1 FTE and $495,062 for operating costs and estimates net savings of over $2 million over the biennium.

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C. Managing Costs

The Medicaid Program has become a major budgetary commitment for both the federal and state government. Medicaid accounts for 13% of US spending. In Montana, Medicaid accounts for 12% of state spending.

Intended to be the country and state's health care "safety net", Medicaid is at the heart of the debate over the role and costs of entitlement programs.

On one hand, Medicaid faces continuing pressure to improve or expand the coverage it provides by covering more of Montanans who have no insurance and by providing more access to those it does cover. On the other hand, the program faces annual cost increase that are breaking state budgets and undermining its ability to meet growing needs.

Chart 7 describes the growth in Medicaid expenditures since 1982. In that time period, expenditures have grown from $76 million in 1982 to over $253 million in 1992.

Chart 8 shows the growth in Medicaid spending at the state and national levels. In FY 91, Montana Medicaid expenditures increased by 12% compared to 27% on the national level. In FY 92, Montana expenditures grew by 21% compared to 30% on the national level.

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D. Reasons For Growth

Chart 9 describes the reasons for the growth in Montana Medicaid expenditures between FY 91 and FY 92. The reasons are caseload growth, federal mandates, medical cost inflation and utilization. I will discuss each reason separately.

Caseload growth accounted for 26% of the increase. During this period, medicaid recipients grew from 72,000 to 78,000 individuals.

In terms of overall growth (including both federal mandates and enrollment increase) AFDC recipients increased approximately 10%, about 5,000 recipients. The increased cost for all AFDC recipients was $18.2 million. The average cost per recipient was $1,307.

The aged and disabled recipients grew by about 2,300 persons while the costs associated with this group grew by $25 million. The average cost per recipient in this group was $7,476 or nearly six times the cost of an AFDC recipient. This is because the costs of long term care (primarily for the elderly) is substantially more expensive than the services used by the AFDC recipients.

Federal mandates accounted for 38% of the increase. Since 1987, Congress has passed no less than 30 mandates which have expanded eligible, services and reimbursement. NASBO estimates the national cost of mandates to be $16 billion through 1994. To the extent

that eligibility, benefits and payments are fixed, states have little flexibility to control costs. We need to lobby Congress not to pass additional mandates unless they pay 100% of the costs. Chart 10 lists the Medicaid Mandates since 1987

Medical Cost Inflation accounted for 27% of the increase. Rapid escalation in health care prices is outside Medicaid's control but has driven up Medicaid spending. To the extent that health care cost increases are not controlled, Medicaid spending will continue to rise. Addressing Medicaid costs requires confronting overall health care spending. Even small increases in hospital or nursing home prices substantially affect Medicaid because these services comprise such a large share of Medicaid spending. (70%).

Increases in Utilization accounted for 9% of the increase. This reflects increased demand for services from sicker populations, and increases in our effort to obtain Medicaid matching funds through refinancing strategies.

Medicaid has experienced increased use of services due to coverage of sicker populations, such as those with AIDs or other disabilities or those needing organ transplants.

A recent Medicaid case involving a four year old child has received much state and national attention. The child has lived in a hospital or nursing home since birth. This Fall, she was

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transferred to a Pittsburgh hospital where she received a multivisceral (five organ) transplant. She is still in the hospital today and I'm happy to report she is making great progress. Medicaid has so far spent over one million dollars on her care.

In FY 92, the 10 highest cost recipients used medical services totalling $2.8 million.

E. WHAT HAS MEDICAID DONE TO CONTAIN COSTS?

Cost containment in Medicaid is an ongoing process. Major cost control initiatives that have been implemented include the following:

1. Utilization review to review the medical necessity of admission and continued stays in hospital, nursing homes and psychiatric services.
2. Prospective payment systems in hospitals and nursing homes.
3. Medical consultant review and prior authorization of high cost or over-utilized services.
4. Drug rebate agreements with manufacturers which discount the price of drugs.
5. Drug utilization review programs to review usage and appropriateness.
6. Volume purchasing of eyeglasses and wheelchairs.
7. Copayments on most services.
8. Continuum of home based services as alternatives to institutionalization.

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9. Targeted case management for high risk groups.

10. Emphasis on prevention services.

F. SUMMARY

The Kaiser Commission on the Future of Medicaid recently issued a report of the Medicaid cost explosion. They concluded that the main underlying cause for cost increases in Medicaid is the combined pressures of caring for the disabled and vulnerable in a medical marketplace with costs out of control. They indicate that solutions for addressing the "Medicaid crisis" requires system wide cost containment and national health care reform.

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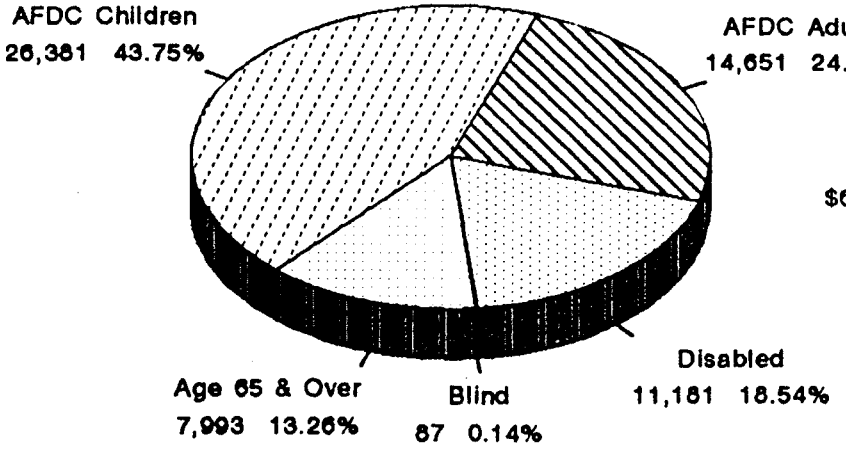
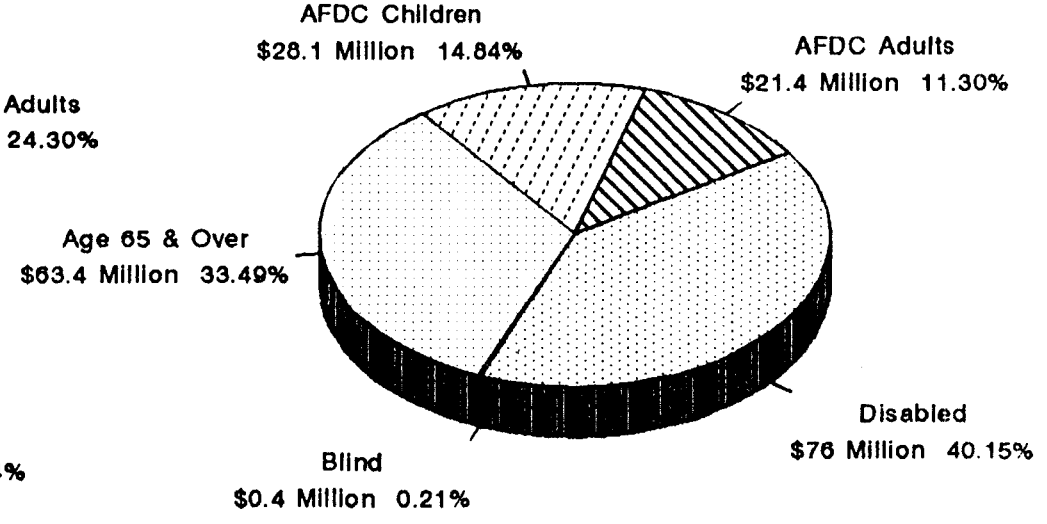
Chart 1
Medicaid Services by Category and Cost



# of Recipients



Total Cost

Total Medicaid Recipients 60,293
Information based on HCFA 2082, for FY 1991

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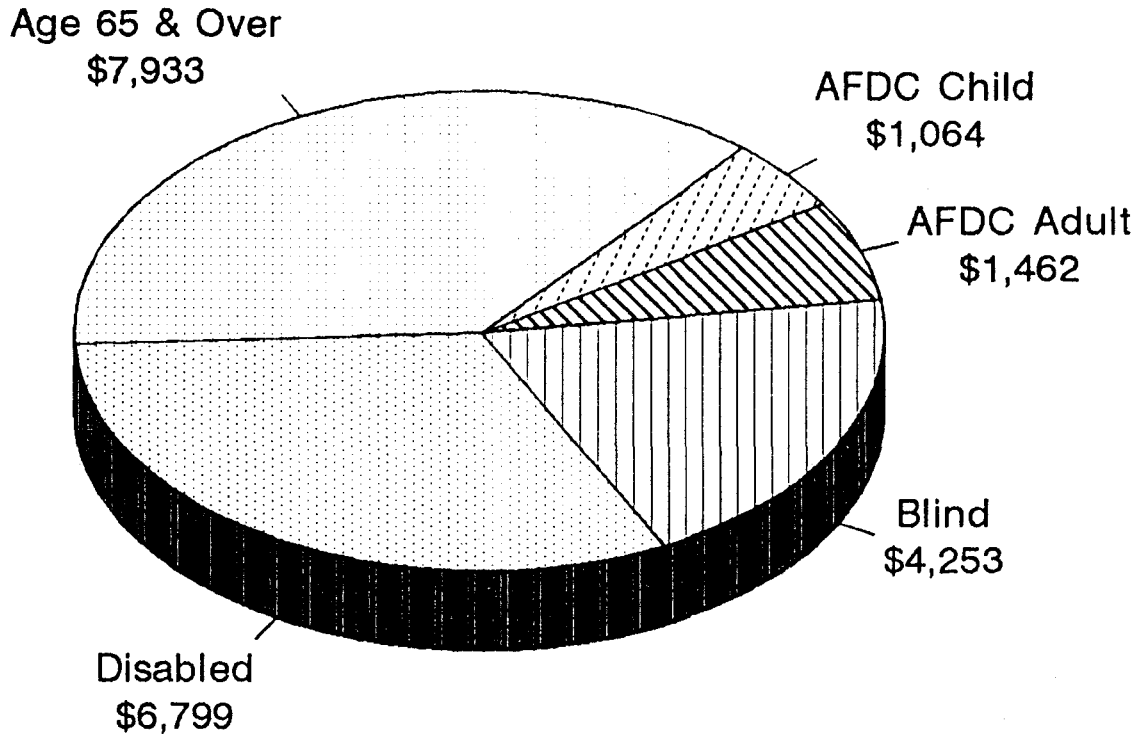
Chart 2
Medicaid Services by Category and Cost



Average Cost Per Client

Total Medicaid Recipients 60,293
Information based on HCFA 2082, for FY 1991

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Chart 3

MANDATORY AND OPTIONAL MEDICAID SERVICES, 1992

Mandatory Services (Covered in All States)

Inpatient hospital
Outpatient hospital
Physician
Rural health clinics
Federally qualified health centers
Prenatal care
Family planning
Nurse specialists
Early and Periodic Screening, Diagnosis, and Treatment for children
Laboratory and x-ray
Nursing facility
Home health care

OPTIONAL SERVICES COVERED IN MONTANA	NUMBER OF STATES
Prescribed drugs	51 states
Transportation	51 states
Clinic	50 states
Prosthetic devices and hearing aids	50 states
Intermediate care facilities for the mentally retarded	49 states
Optometrist services	46 states
Eyeglasses	46 states
Podiatry	45 states
Other practitioner	45 states
Rehabilitative services	45 states
Dental services and dentures	45 states
Targeted case management	43 states
Physical therapy	43 states
Speech therapy	42 states
Inpatient psych under 21	39 states
Hospice care	33 states
Occupational therapy	32 states
Personal care	28 states
Private duty nursing	28 states
Chiropractic	26 states
Diagnostic services for adults	24 states
Screening services for adults	21 states
Preventive services for adults	21 states
SERVICES NOT COVERED IN MONTANA	
Christian Science sanatoriums	15 states
Respiratory care	14 states
Christian Science nurses	3 states

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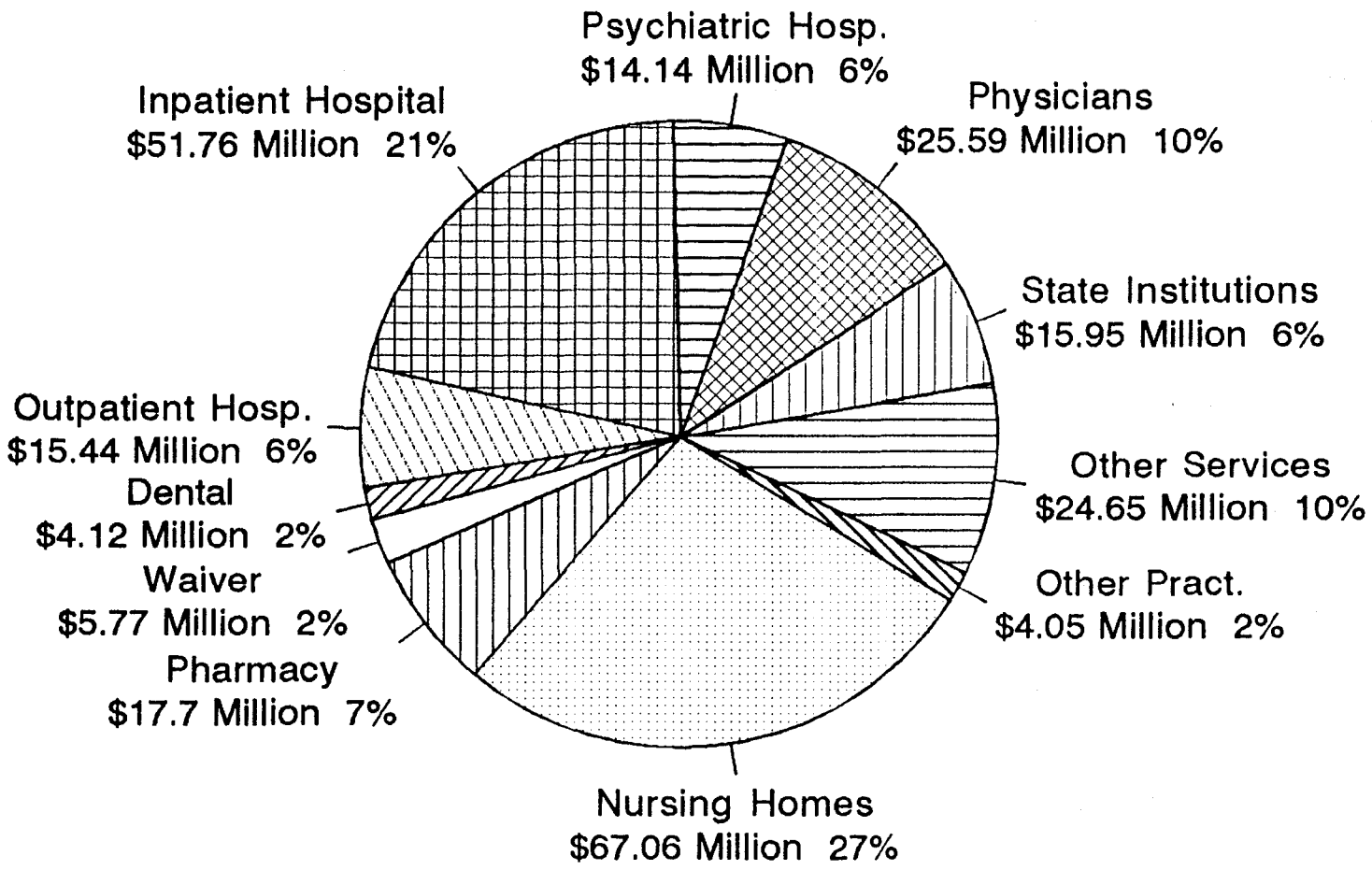
Chart 4
FY 1992 (Paid through 11/92)



Based on Medicaid Paid Claims through November 1992
Total 1992 Medicaid for these Benefits is $246.2 Million
Excludes Indian Health and Medicare Buy In

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Chart 5

Utilization and Expenditures for Medicaid Eligibles by Percentage for Selected Services

The top bar indicates the # of clients using the services by %.
The lower bar indicates the cost of the service as a % of total Medicaid

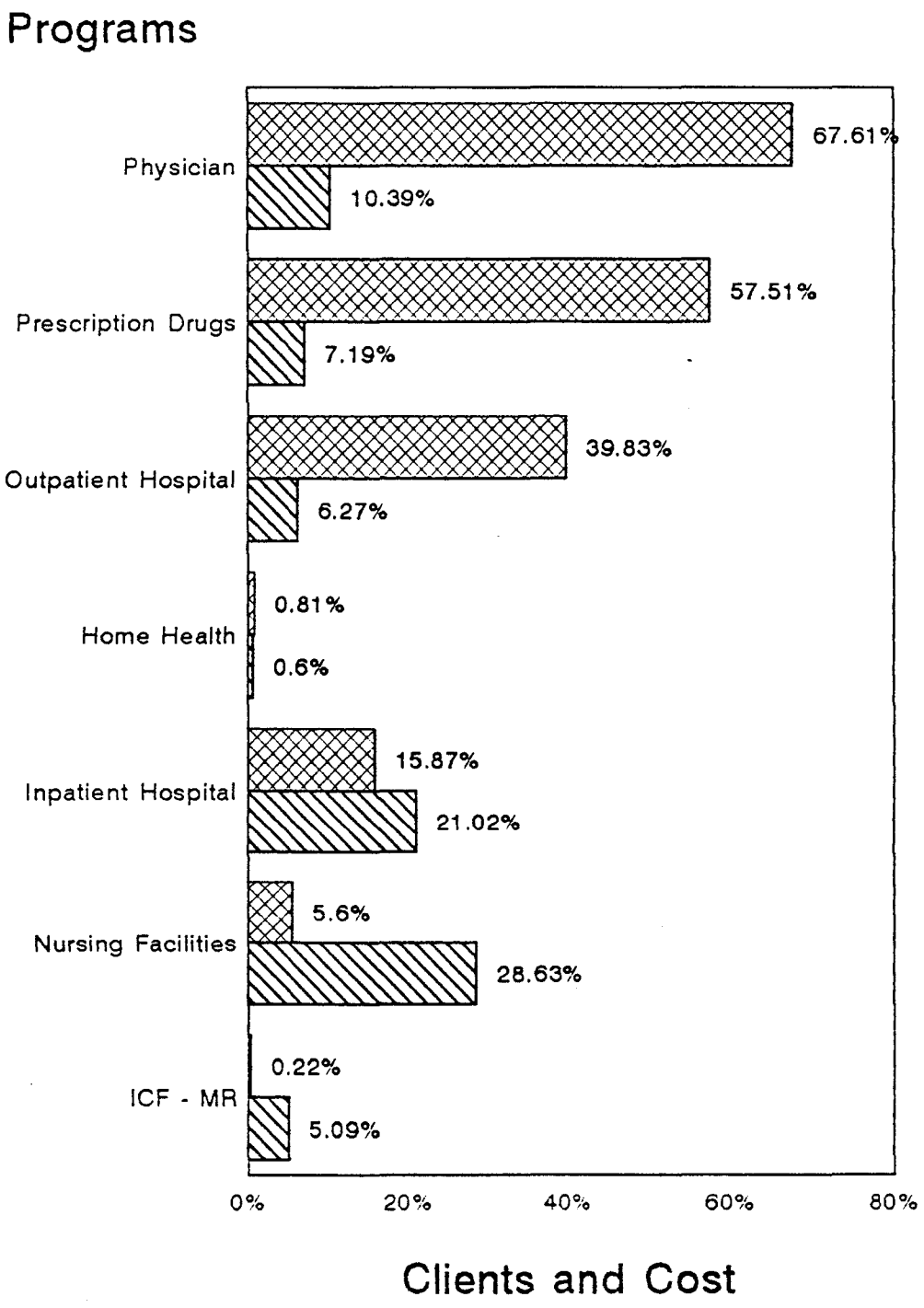

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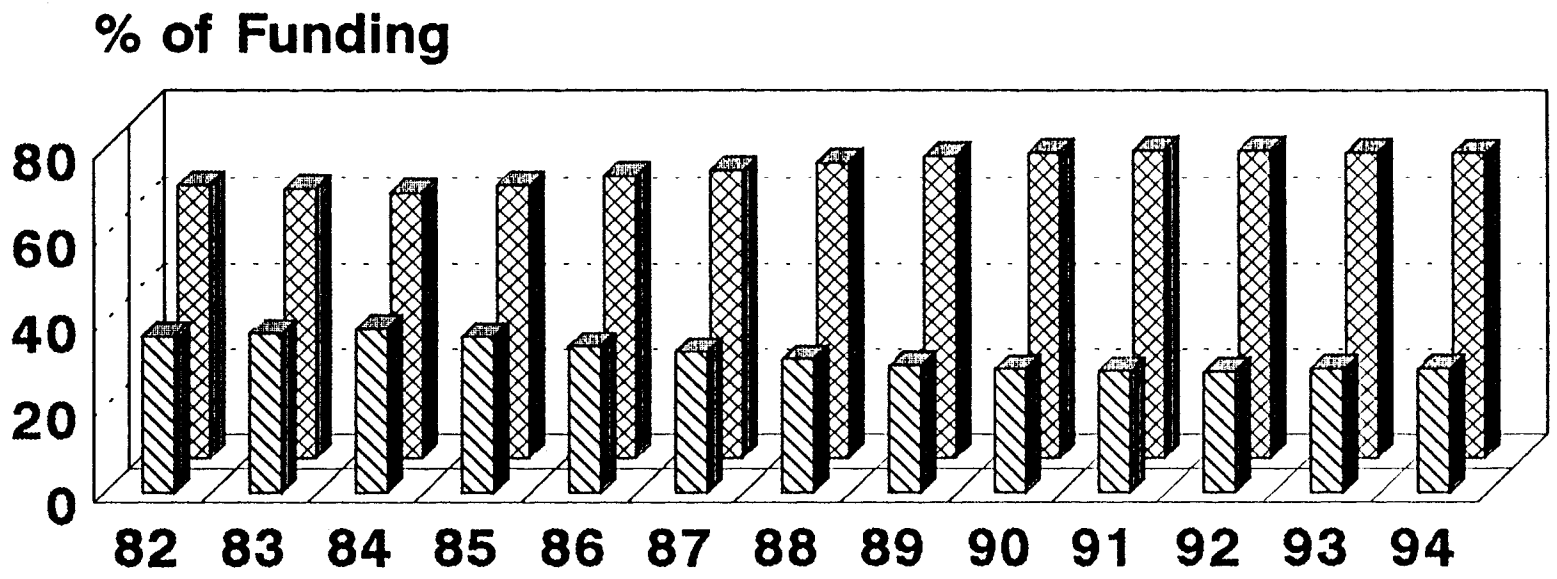
Chart 6
Federal Matching Rate
FY 1982-1994



	82	83	84	85	86	87	88	89	90	91	92	93	94
Federal %	63.61	62.89	61.82	63.69	65.89	67.18	68.91	70.32	71.17	71.64	71.71	71.12	71.02
State %	36.4	37.11	38.18	36.31	34.11	32.82	31.09	29.68	28.83	28.36	28.29	28.88	28.98

Fiscal Year

State % Federal %

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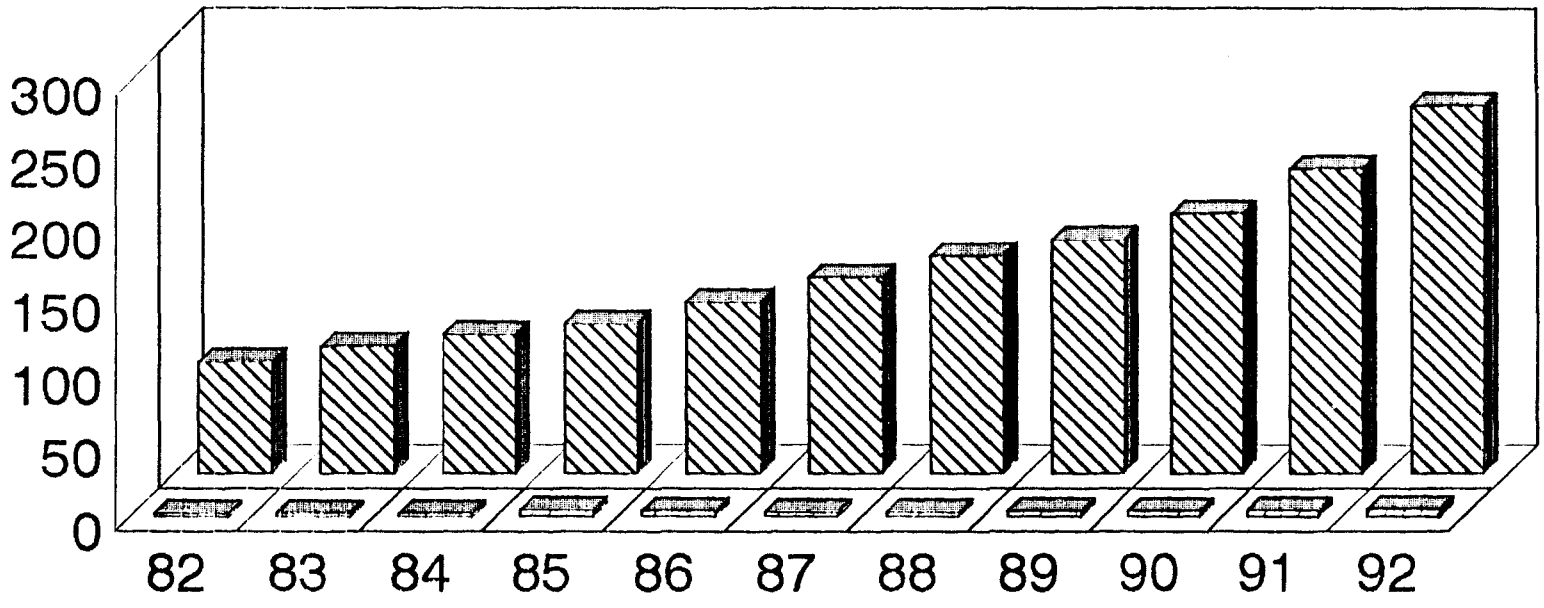
Chart 7
Montana Medicaid Program
Cost Comparison 1982 to 1992



	82	83	84	85	86	87	88	89	90	91	92
Benefits	76.5	87.1	95.2	102.6	117.2	134.4	149.5	160.7	178.6	210.3	253
Admin	2.02	2.04	2.36	4.65	3.98	2.72	2.8	3.59	3.71	4.2	5

Fiscal Year

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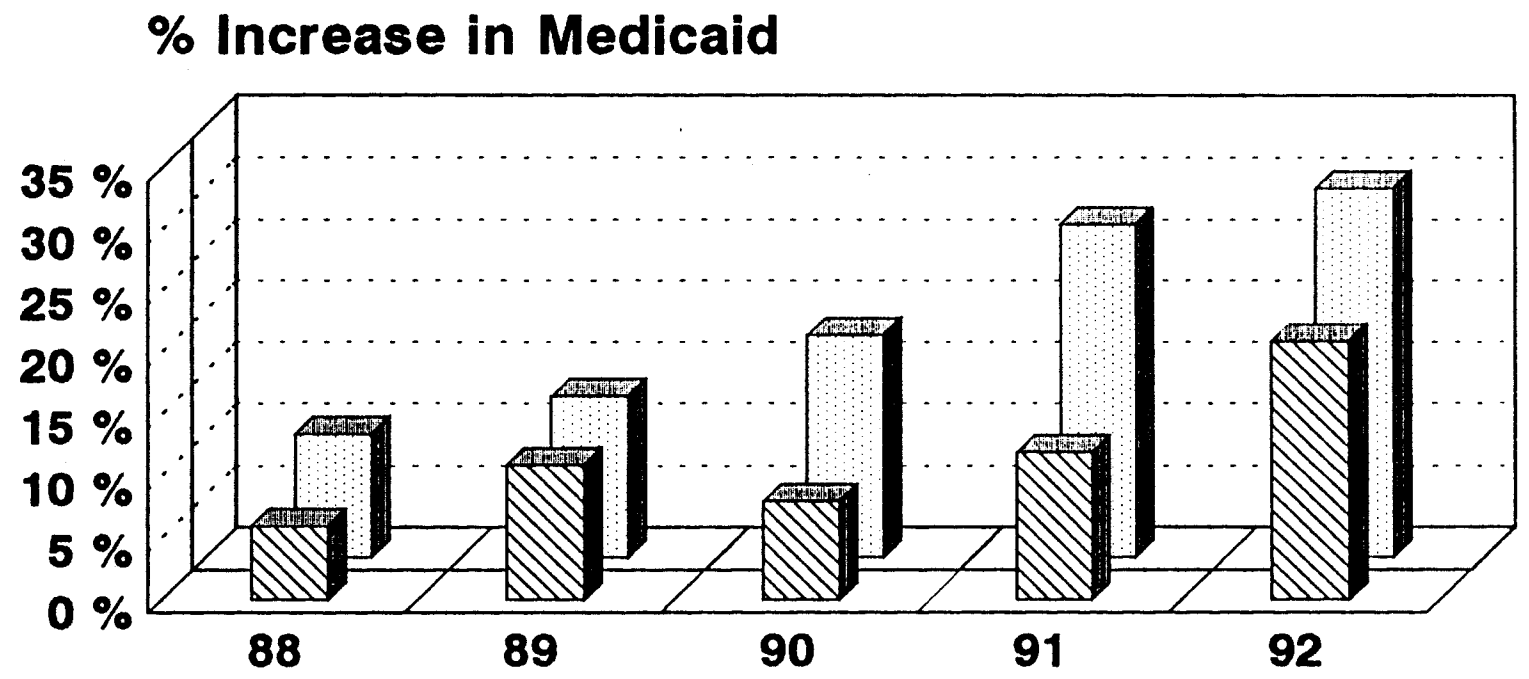
Chart 8
Growth in Medicaid Benfits
Montana vs National Levels



	88	89	90	91	92
US	10 %	13 %	18 %	27 %	30 %
Montana	6 %	11 %	8 %	12 %	21 %

Fiscal Year

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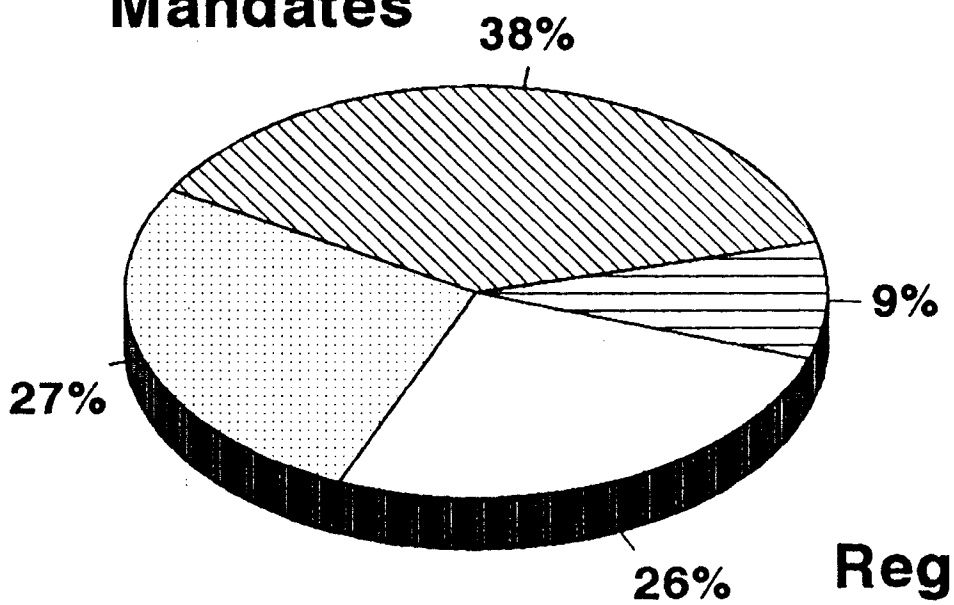
Chart 9
Reasons For Growth in Medicaid Expenditures Between FY 91 and FY 92



Total Increase in Medicaid Costs = $32,821,015
FY 92 total costs are estimated.

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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

December 24, 1992

Dear Legislator:

Medicaid expenditures are a major component of state spending. Given the estimated budget deficit, state spending in this and other areas will receive much of your attention in the next regular session.

It is for this reason that I want to provide you with a brief report describing Montana's Medicaid Program. Hopefully, this report will give you a good overview of this complicated program.

In view of the mission of the Medicaid Program, the report also focuses upon current and planned initiatives to help serve the health care needs of low-income Montanans and to control program expenditures.

If you have any questions about the Medicaid Program or this report or would like additional information, please contact Nancy Ellery at 444-4540.

Thank you for taking the time to learn more about Montana's Medicaid Program.

Sincerely,

Julia E. Robinson

Julia E. Robinson
Director

Sincerely,

Nancy Ellery
Administrator
Medicaid Services Division

Nancy Ellery, Admin.

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MONTANA'S MEDICAID PROG

INTRODUCTION

The mission of the Medicaid Services Division is to ensure that Montana's low-income residents have access to medical care at a cost which is equitable to both the provider of service and the taxpayer.

Medicaid is the primary source of health care for Montana's most vulnerable citizens: aged, blind and disabled individuals and low income families who can not afford to pay for their own health care expenses.

The Montana Department of Social and Rehabilitation Services, Medicaid Services Division administers the Medicaid and State Medical Programs.

FUNDING

The Medicaid Program is jointly funded with federal and state monies. In FY 92 the federal share was 71.12% and the state share was 28.88%. The federal share fluctuates annually according to the relationship of our state average per capita income to national per capita income. For each state dollar used, Montana Medicaid receives approximately three federal dollars.

ELIGIBILITY REQUIREMENTS

Client participation in Medicaid depends upon eligibility determinations made by the local county office of Human Services or welfare office. To qualify for Medicaid, persons must meet citizenship requirements and prove they "intend to reside" in Montana. Federal law prohibits a residency requirement beyond an "intent to remain".

Persons who qualify for Aid to Families with Dependent Children (AFDC) are automatically eligible for Medicaid. Persons not eligible for AFDC may be eligible for Medicaid if they are under age 19 and have limited income and resources or if they are disabled, blind or over age 65. In addition, pregnant women in families with low income are generally eligible for Medicaid. Montana Medicaid also covers the optional "medically needy" group which allows persons to use medical bills to "spend down" to allowable income levels.

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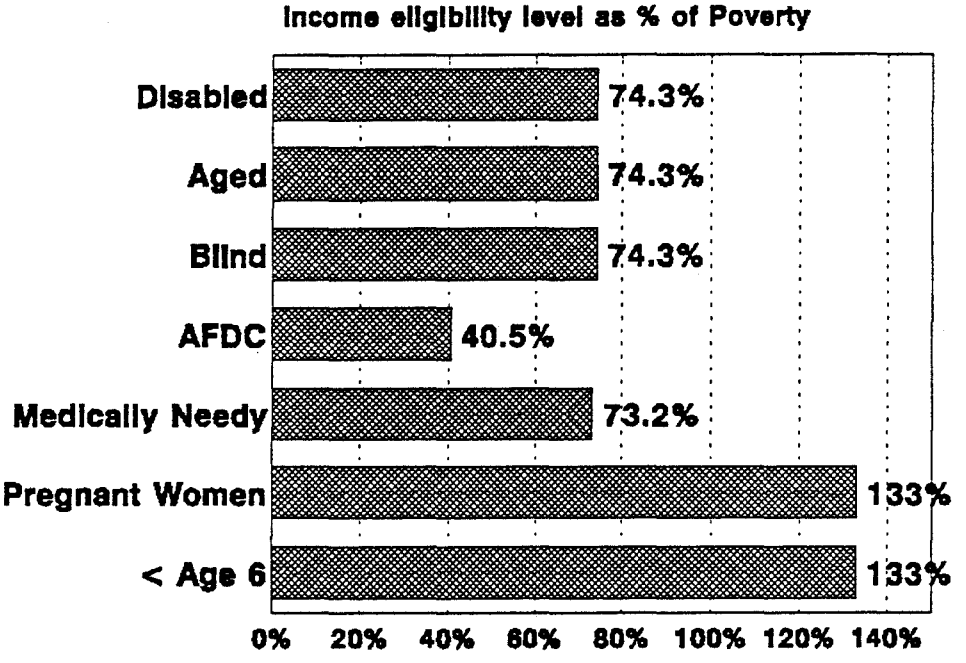
Chart 1A describes the poverty level of eligibility for each benefit category. Chart 1B describes the percentage of caseload in each benefit category.

Chart 1A
Poverty Level of Eligibility For Benefit Catagories
FY 92



EXPENDITURES

During FY 1992, Medicaid spent $253.2 million for necessary health care for nearly 78,000 of Montana's neediest citizens. This represents 9.7 percent of the state's population. Appendix 1 shows the number of Medicaid clients and Medicaid expenditures for each county in the state. Chart 2 shows how Montana Medicaid costs compare to other states.

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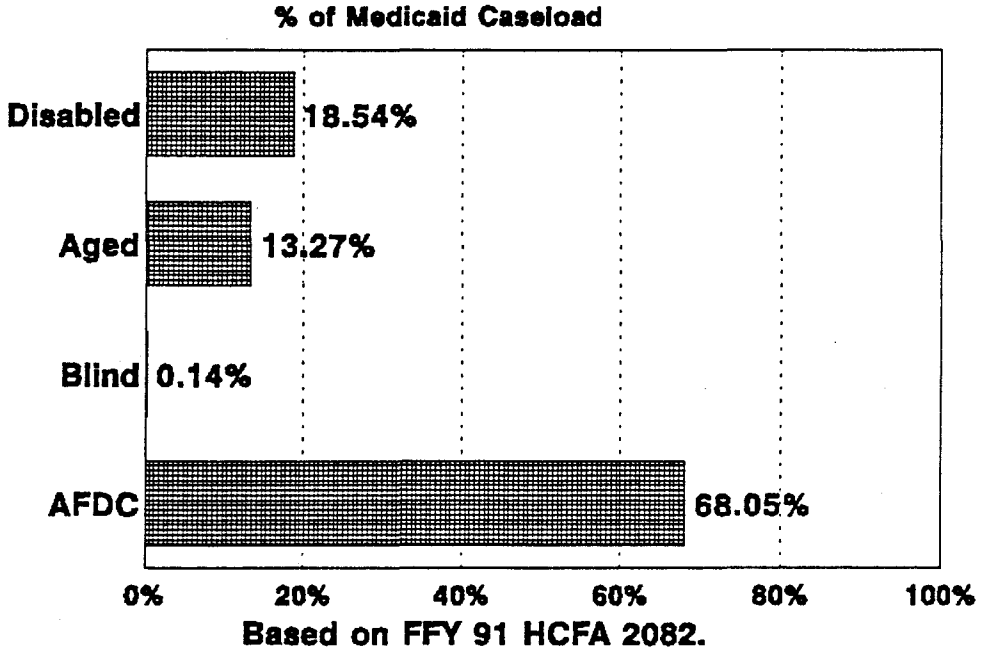
Chart 1B
Caseloads For Benefit Categories
FY 92



Based on FFY 91 HCFA 2082.

The largest proportion (74%) of Medicaid's service budget was spent for services to aged, blind and disabled persons. Twenty six percent of the service budget was spent on care for low-income families and children. The average annual Medicaid expenditure per client was $3,139 in FY 92. Per capita expenditures vary widely by the category of eligibility. Chart 3 shows the number of recipients, total cost and average cost per client according to eligibility category.

Expenditures incurred by clients are paid directly to licensed providers of medical care. Medicaid contracts with Consultec, Inc. to pay claims and serve as a focal point for claims questions and problems, enroll and train new providers and fulfill many reporting requirements. Consultec processed over 2,540,000 claims in FY 92. There are over 4,000 providers enrolled in Montana's Medicaid Program. Appendix II shows the number of enrolled providers in each service area.

Under federal law, participating providers must accept Medicaid

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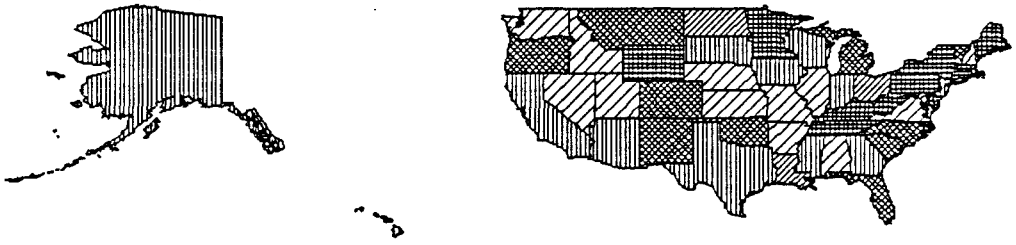
Chart 2
Per Capita Medicaid Cost By State

Top 10 Big Spenders	Semi - Big Spenders	Intermediate Costs Per Capita	12 Most Frugal States	Did Not Respond
N.Y.$ 625	Wi. $ 386	Ok. $ 321	Ne. $ 268	Louisiana
Pa. $ 553	Ak. $ 375	Fl. $ 319	Il. $ 255	Rhode Island
Tn. $ 470	Tx. $ 372	S.C.$ 316	Al. $ 249	North Dakota
Me. $ 449	Ma. $ 361	N.C.$ 314	Id. $ 245	Ohio
MA. $ 448	In. $ 358	N.M.$ 313	Ar. $ 239	Maryland
Mn. $ 446	N.J.$ 340	Mt. $ 312	Nv. $ 234	
Wy. $ 427	CA. $ 331	Vt. $ 306	Mo. $ 229	
W.V.$ 418	Ga. $ 329	Dl. $ 301	Va. $ 229	
Ky. $ 405	S.D.$ 328	Or. $ 293	Ka. $ 222	
Cn. $ 402	Ha. $ 326	Co. $ 282	Ut. $ 220	
	Az. $ 325	Mi. $ 276	Ws. $ 197	
	Ia. $ 324		N.H.$ 183	



Information based on Colorado survey using estimates available in 4/92.

payment as payment in full. Several methods are used to determine provider reimbursement, including a statewide fee schedule, cost-based and negotiated rates. The largest proportion of the budget was spent on care provided in nursing facilities (27%), hospitals (37%) (including psychiatric hospitals) and physicians (10%). The remainder was spent on other types of preventive and acute care. Chart 4 shows the amount of Medicaid expenditures by type of service.

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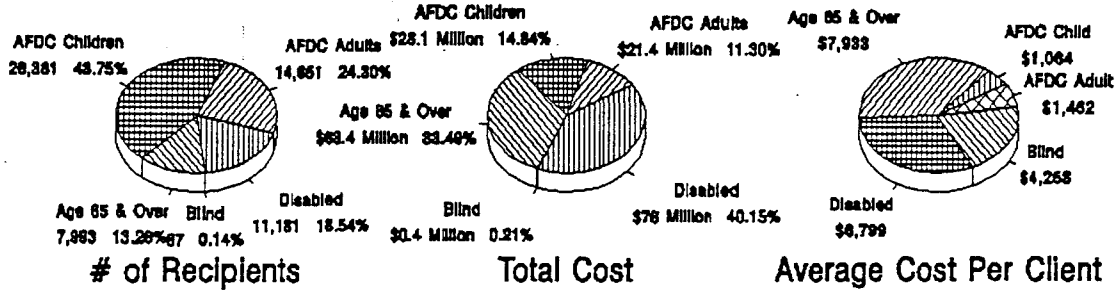
Chart 3
Medicaid Services by Category and Cost



Information based on HCFA 2082, for FY 1991

COVERED SERVICES

The federal government requires all states to provide certain mandatory services. Montana Medicaid also covers 27 of the 31 optional services allowed. All optional services must be provided to eligible persons under age 21 and to persons who reside in a nursing facility.

Many of the optional services provided under the Montana Medicaid program allow clients to utilize the most cost-effective and least restrictive way to receive medically necessary services. For example, the availability of prescribed medicines enables persons to control diseases and avoid hospitalization. Personal care services allow many individuals unable to perform routine

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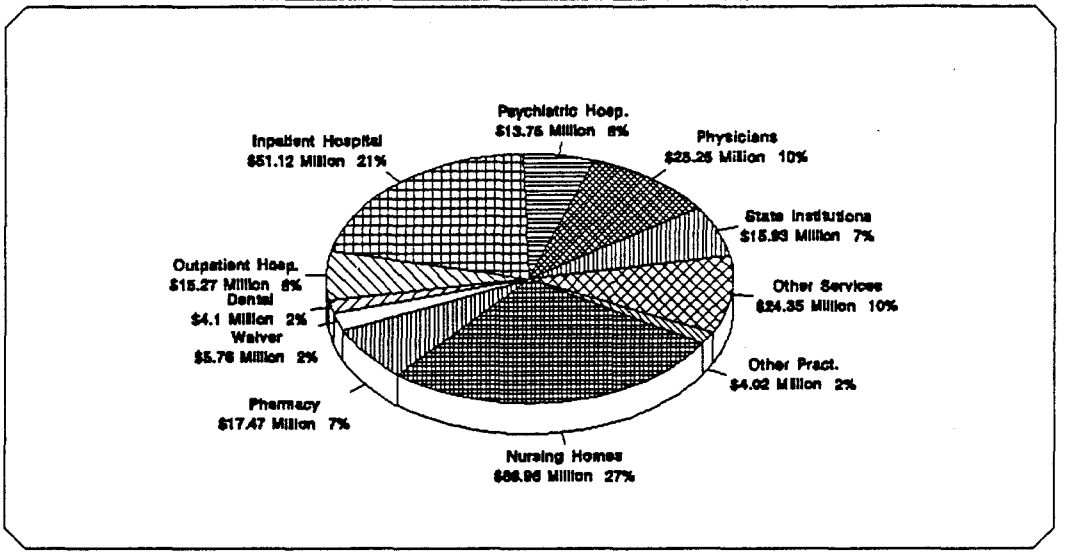
Chart 4
Medicaid Expenditures
FY 1992 (Paid Through 10/92)



Based on Medicaid Paid Claims through October 1992
Total 1992 Medicaid for these Benefits is $243.9 Million
Excludes Indian Health and Medicare Buy In

activities of daily living to remain at home rather than be institutionalized.

Medicaid imposes certain limitations on services provided to adults. For example, there are limits on eyeglasses, counseling, home health, personal care, etc.

EXPENDITURE GROWTH

From 1982 to 1992, Medicaid expenditures have grown from $76.5 million to $253.2 million. The number of unduplicated Medicaid recipients has grown from 52,000 in FY 1986 (earliest available year) to approximately 78,000 in FY 92. Chart 5 describes the growth in Medicaid expenditures and recipients in the last 10 years.

In over 25 years of operation, Medicaid's programmatic complexity has paralleled the growth in expenditures and recipients. However, Montana's Medicaid program spends only an average of 2% of its budget on administration of Medicaid benefits. This level of expenditure is testimony to Medicaid's use of efficient administrative methods and innovative cost control strategies.

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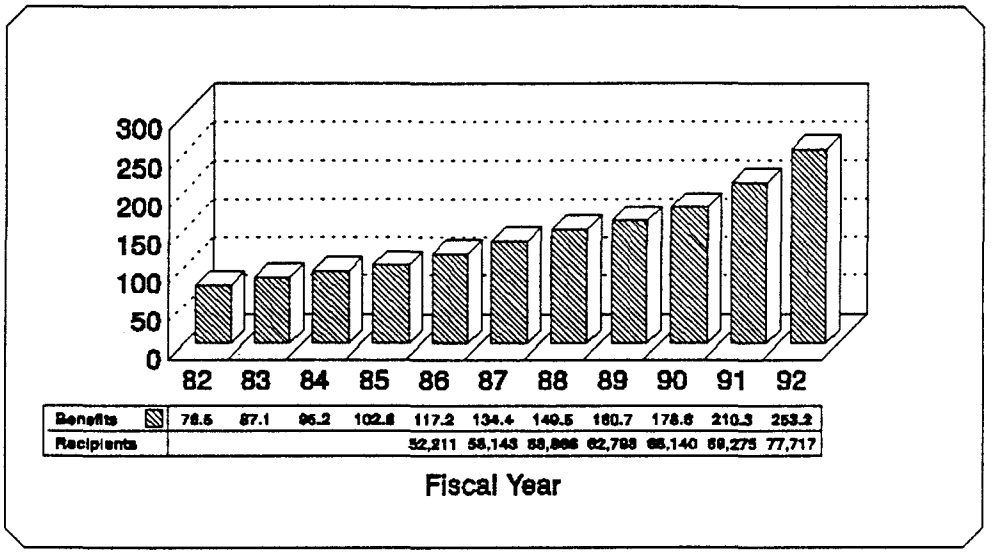
Chart 5
Montana Medicaid Program
Cost Comparison 1982 to 1992



Medicaid expenditures grew an average of 16% per year from FY 82 to FY 92. The increase in expenditures is driven by increases in eligibles, federal mandates, medical inflation, new technology and utilization. Chart 6 shows the reasons for growth in Medicaid expenditures.

A major reason for the growth in Medicaid expenditures is federal mandates. Since 1987 Congress has handed down no less than 30 mandates which have expanded Medicaid eligibility, services and reimbursement.

These and other new Congressional mandates cost the state of Montana $12.2 million in total dollars in FY 92 alone. These changes include, but are not limited to the following:

(1) Expanded coverage for 20,790 additional children and 6,288 pregnant women.
(2) Expanded Medicaid payment of premiums for Medicare coverage for an additional 800 individuals who are aged, blind or disabled.
(3) Increased allowance for the spouse of a nursing home resident to keep more income and resources but have the nursing home resident retain eligibility for program benefits.
(4) Provided for cost-based payments to federally qualified health clinics and rural health clinics.
(5) Increased payments to obstetricians and pediatricians to

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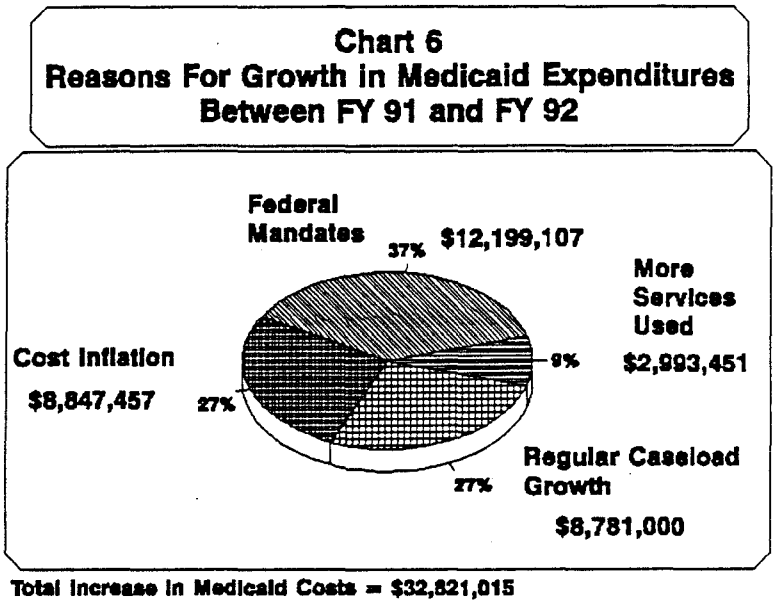
ensure sufficient access to medical care.

IMPROVED SERVICE DELIVERY INITIATIVES AND COST CONTAINMENT PROGRAMS

Health care costs in Montana's Medicaid Program are subject to the same pressures which affect all service agencies - increased cost of service and increased demand for services. Montana's Medicaid Program has implemented many management initiatives to help serve the health care needs of low-income Montanans and to contain program expenditures. Some of our major initiatives are:

1. IMPROVED ACCESS TO PRIMARY AND PREVENTIVE CARE FOR PREGNANT



WOMEN AND YOUNG CHILDREN

A 1990 study of high cost Medicaid infants (birth cost exceeding $10,000) revealed that Medicaid spent over 55% of the total delivery budget of $11.9 million on only 5% of the Medicaid eligible infants. Many of these infants were born prematurely or at a low birth weight because of inadequate access to early and continuous prenatal care. Women are more likely to deliver low birth weight babies who require more intensive care and have a higher incidence of future health problems that result in a higher cost to Montanans.

The Montana Medicaid Program has implemented many programs to ensure that low-income women receive early and continuous care and ultimately have a greater chance to deliver healthy babies. Some examples are:

. Medicaid fees paid to obstetrical and pediatric providers were

significantly increased in October 1991.

- Medicaid eligibility for pregnant women and young children was increased to 133 percent of the federal poverty level in April 1990.
- Presumptive and continuous eligibility were implemented in January 1991 to allow pregnant women to get on Medicaid quickly and stay on while they are pregnant.
- In July 1992, Medicaid began reimbursing for maternity case management services provided by ten MIAMI projects in the state.
- Medicaid provides 50 percent of the funding for the statewide Baby Your Baby Campaign which is a multi-media campaign using donations from the public and private sectors to increase awareness of the importance of early and continuous prenatal care. Studies show it has reached 86% of Montana households.
- Medicaid expanded coverage of preventive health care for children under the Kids Count Program to include such cost-effective services as nutrition, outpatient chemical dependency treatment and nursing.

Preliminary data show that the number of obstetrical and pediatric providers who are seeing more Medicaid patients has increased and that the number of women with little or no care has decreased. During FY 92 Medicaid paid for 4011 deliveries - nearly 35% of all births in the state.

2. UTILIZATION CONTROL AND REVIEW

Medicaid operates several programs directly or under contract to make sure Medicaid funds are spent appropriately. The programs are designed to prevent and recover payments for care that are not medically necessary.

Medicaid contracts with the Montana Wyoming Foundation for Medical Care to review the medical necessity of nursing home admissions and continued stays. These reviews annually result in total savings in excess of $1,000,000.

To reduce over utilization and encourage provision of care at the appropriate level, approval must be obtained by Medicaid staff before many services can be provided. These services include but are not limited to the following: High cost durable medical equipment; wheelchairs, dental services, hearing aids, transplants; private duty nursing, etc.

In the wheelchair area alone, focused review and prior authorization by a staff nurse resulted in savings of $200,000 in FY 92 compared to FY 91 costs.

Beginning January 1, 1993, the department will reinstate a contract to review the medical necessity of hospital stays and provide intensive case management to high cost cases.

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3. INPATIENT AND RESIDENTIAL PSYCHIATRIC SERVICES FOR PERSONS UNDER AGE 21.

Medicaid contracts with Mental Health Management of America (MHMA) to review admissions and continued stays in psychiatric hospitals and residential treatment facilities. Since the contract began in July 1990, the department has substantially slowed the rate of growth in expenditures in the psychiatric hospitals while controlling the addition of residential treatment facilities. Tighter medical review has reduced hospital lengths of stays from 55 to 35 days and reduced residential lengths of stays from 360 to 120 days. This results in estimated total annual savings of $1,000,000.

4. DRUG UTILIZATION REVIEW (DUE CARE PROGRAM)

This program will be implemented January 1, 1993 and will allow better information exchange between pharmacies and prescribers on drug utilization resulting in more appropriate and less expensive care. Other states experience with established DUR programs show a potential savings of 2 to 3% of drug expenditures. In Montana, a 2 percent savings in total funds would amount to $562,000 in FY 94.

5. MANAGED HEALTH CARE SYSTEMS

Managed health care decreases the unnecessary use of emergency room, pharmacy and physician services.

The program contracts with Managed Care of Montana to review inpatient and outpatient hospital admissions of state medical clients. The contractor also provides intensive case management to high risk clients. Since the contract began in September '91, $214,000 in general fund has been saved.

6. PASSPORT TO HEALTH PROGRAM

Effective January 1993, the Passport to Health Program will be implemented for AFDC clients. This managed care program will enroll primary care providers to act as the recipient's gate-keeper for more specialized and expensive service. The goals of the program are to improve access to primary care and contain program costs by reducing fragmented utilization of expensive services. The Passport Program is expected to save $1.3 million in general fund this year and $7 million in general fund next biennium if the 1993 legislature approves an expansion to aged, blind and disabled recipients.

7. MEDICAID ERROR RATE

The department works hard to make sure that it only pays for necessary health care to those who are eligible. As part of the

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effort, the department's Support Services Division conducts continual quality reviews of Medicaid eligibility determinations and claims payments. Because of the efforts and those of county eligibility staff, Montana's error rate for FFY 91 is less than three percent which is one of the ten lowest error rates in the nation.

8. PROGRAM INTEGRITY

The Support Services Division also identifies providers and recipients who abuse or defraud the program; identifies and collects overpayments; and educates providers or recipients when errors or abuses are detected. The division also operates the surveillance and utilization Review System (SURS) to identify providers and recipients whose patterns of practice and use of services fall outside of the norm for their peer groups.

9. THIRD PARTY RECOVERY (TPL)

By law, Medicaid is designated as the payor of last resort, with all other resources tapped before Medicaid dollars are spent. Third party resources for medical care, such as health insurance and Medicare, are important means of reducing Medicaid costs. In FY 92, over $35 million was saved by utilizing third party resources. Items 9-11 highlight some of the recent initiatives of the Third Party Liability Unit.

10. MEDICARE BUY-IN SAVINGS

To assure maximum savings from Medicare, the Medicaid program requires recipients to enroll in Medicare. Medicaid then pays the premiums. In FY 92, a new method of paying the premiums was implemented which will save over $800,000 in general fund money per year.

11. HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

If cost effective private health insurance is available to a recipient, the department will pay the premium. This assures the insurance will continue to pay the medical expenses instead of Medicaid. In FY 92, the program's first year, over $700,000 was saved.

12. AUDIT

During Fy 92, Medicaid contracted with a private audit firm to conduct financial audits of hospitals and nursing homes. These audits supplement in-house audit activities and verify the accuracy of providers' cost reports.

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13. MEDICAL SUPPORT ENFORCEMENT

State law requires certain absent parents to provide insurance to their children. The Child Support Enforcement Division requires the parent to get the insurance if it is available. In FY 92, these efforts led to over $850,000 in Medicaid savings.

14. MEDICAID COPAYMENTS

Montana's Medicaid Program requires client copayments on more services than any other state Medicaid program. The federal government requires the copayment to be nominal and not applied to children, pregnancy related services, emergency services or to persons in nursing homes. In FY 92, client copayments amounted to $1 million.

15. TARGETED CASE MANAGEMENT

Montana Medicaid provides reimbursement for severe and disabling mental illness, adults who are developmentally disabled and high risk pregnant women statewide. Targeted Case Management is also provided to severely emotionally disturbed children in two locations (Missoula and Helena). This service is designed to assist clients to access and use medical and other related services more appropriately.

16. HOSPITAL AND NURSING HOME REIMBURSEMENT CHANGES

In July 1991, the Department implemented a change in how nursing homes were reimbursed. The goals of the new reimbursement methodology were to comply with federal requirements for reimbursement, develop an equitable system for reimbursement, improve quality and access to care, and reduce cost shift to private sector. The 1991 Legislature authorized a total increase of $22,179,736 over the base to improve the level of reimbursement to nursing facilities. Part of the increase was funded by a bed fee of $1 per bed day in FY 91 and $2 in FY 92.

A study of the hospital reimbursement system was undertaken in FY 1992. As a result, several changes are being proposed in the hospital reimbursement system for FY 94-95. The primary goals of the proposed changes are to give the program more control over the rate of cost increases in the program; to promote equity among hospitals and to ensure that reasonable and adequate rates are provided to hospitals.

17. COMPETITIVE PURCHASE OF WHEELCHAIRS AND EYEGLASSES

In February '93, the Medicaid Services Division will begin contracting for the purchase of wheelchairs and eyeglasses. These services will be purchased under competitively bid contracts and

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will ensure that services are available in the most cost-effective manner. Annual total savings from the bulk purchase of these items are expected to be $250,000.

MEDICAID'S IMPACT

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

Citizens who are not eligible for Medicaid also benefit from the program. Health care is one of the state's most important industries, and medicaid contributes to that industry in a significant way. For instance, during FY 92 Medicaid paid approximately $253 million to providers on behalf of persons eligible for the program. The federal government paid approximately three-quarters of this amount. These funds paid the salaries of thousands of health care workers who bought goods and services and paid taxes in the state. Using the common economic multiplier effect of three, Medicaid expenditures generated over $759 million worth of business in Montana in FY 92. A strong health care delivery system is vital to Montana's economy.

Summary

The need to contain costs of care while providing quality care is a great challenge. To achieve this balance, new and creative strategies must continue to be developed. Montana's Medicaid Program will continue to play a key role in state and federal health care reform and can contribute strategies based on many years of experience as a major purchaser of health care services.

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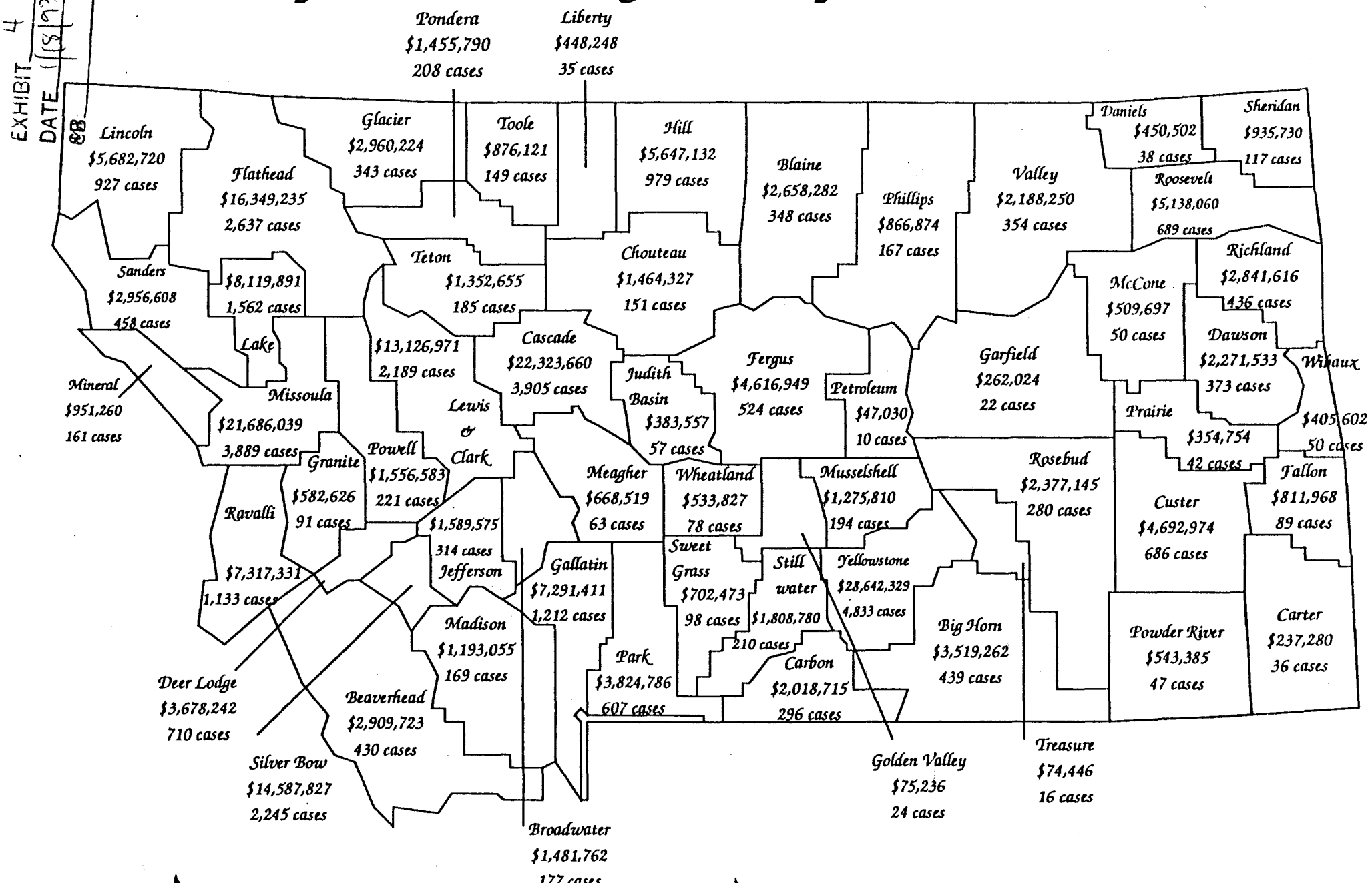
Appendix I
Medicaid Payments and Average Monthly Caseload FY 92



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APPENDIX II

PARTICIPATING PROVIDERS BY TYPE OF SERVICE FFY 92

Type of Service	Providers Participating
Inpatient Hospital	123
Inpatient Psychiatric and Residential	6
ICF Mentally Retarded	3
ICF Other	114
Skilled Nursing Facility	53
Physician	1,715
Dental	397
Other Practitioners	694
Outpatient Hospital	176
Clinic	33
Home Health	47
Lab & X-Ray	28
Drugs	313
Rural Health	14
Other	706
TOTAL	4,442

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

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

MEDICARE CATASTROPHIC COVERAGE ACT - 1988

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

FAMILY SUPPORT ACT - 1988

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

OBRA - 1989

- Expansion of EPSDT Program to cover all Medicaid Services.
- Coverage of Pregnant Women and Children up to age Six Below 133% of Feder Poverty Level.
- Requirement to Pay Obstetrical and Pediatric Providers at Rates Which Assure Equal Access.
- Reimburse Federally Qualified Health Centers and their Look-alikes at 10 of Reasonable Costs.
- Coverage of Qualified Working Disabled Individuals.

OBRA - 1990

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

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VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. _____

DATE 1-18-93 SPONSOR(S) _____

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Bob Ol[illegible]	MHA		
Sharon Hoy	MT Catholic Conf.		
[illegible]	MAHSC MHAC		
[illegible]	MHA		
Judith Carlson	MHAC DIR MHA MT Co NASW		
[illegible]			
[illegible]	West Mont		
Kate Cholewa	MT Womens Lobby		
Mary E. Walton	Medicaid		
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Penny Robbins	SRS		

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Dan Shea	MLIC		

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