MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN JOHN COBB**, on January 19, 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:	INPATIENT HOSPITAL SERVICES WITHIN THE MEDICAID SERVICES DIVISION AND OUTPATIENT HOSPITAL SERVICES WITHIN MEDICAID SERVICES DIVISION
Executive Action:	NONE

CHAIRMAN COBB opened the meeting by explaining the day's agenda.

Ms. Nancy Ellery, Administrator, Medicaid Services Division, introduced staff present: **Mr. Dave Thorsen, Supervisor, Hospital Section; Ms. Kathleen Martin, Program Officer, Hospital Section; and Ms. Mary Dalton, Bureau Chief, Primary Care Bureau.**

Ms. Dalton explained physician's fees, how inflation affects them, and current fee structure.

HEARING ON INPATIENT HOSPITAL SERVICES WITHIN THE MEDICAID SERVICES DIVISION

Tape No. 1:Side 1

Ms. Ellery presented information. **EXHIBIT 1**

Dr. Blouke and Ms. Ellery answered questions of committee members about Medicaid and hospital rates.

Dr. Kathleen Stevens, M.D., Medical Director, Newborn Services, St. Vincent Hospital, Billings, spoke to **EXHIBIT 2.**

HEARING ON OUTPATIENT HOSPITAL SERVICES WITHIN MEDICAID SERVICES DIVISION

Ms. Ellery discussed **EXHIBIT 2.**

The committee heard testimony from **Mr. Bob Olsen and Mr. Jim Ahrens of the Montana Hospital Association; Mr. Mark Petich, St. Vincent Hospital, Billings, Mr. Dan Shea, and Paulette Kohman, Montana Council for Maternal, Child and Health.**

ADJOURNMENT

Adjournment: 10:07 A:M

JOHN COBB, Chairman

BILLIE JEAN HILL, Secretary

JC/bjh

HOUSE OF REPRESENTATIVES

HUMAN SERVICES **SUB-COMMITTEE**

ROLL CALL **DATE** Jan 19 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
DATE 1-19-93

Presentation Date: 01/19/93

SRS Staff: **Nancy Ellery, John Chappuis, Dave Thorsen, Kathleen Martin**

Committee: **Human Services Appropriation Subcommittee**

INPATIENT HOSPITAL SERVICES

I. Current program:

Medicaid is not the major funding source for Montana hospitals - we represent only about 10% of the total reimbursements made to hospitals, however, these inpatient hospital costs comprise about 21% of the total Medicaid budget. The Montana Medicaid Program reimburses the 54 in-state acute care hospitals under what is called a "prospective payment system" (PPS). Prospective reimbursement means that rates are established in advance using what is called a DRG payment system to accomplish the payments. DRG stands for Diagnosis Related Groupings, and payment is based on the patient's diagnosis and procedures performed. Additional payments, called "outliers", are available for exceptionally high cost or long inpatient stays. The prospective system currently in use is based on 1983 costs trended forward and 1986 medical coding and diagnostic groups. Payment rates for the different diagnostic groups were initially set by examining claims data and rates from four other states. Hospitals are reimbursed at cost for capital expenditures allocated to Medicaid recipients. The base price for hospital services is a state-wide rate. No allowance is presently given for the size or location of a given hospital.

EXHIBIT 1
DATE 1-19-93
SB

Hospitals that serve a disproportionate number of Medicaid recipients receive additional payments called Disproportionate Share Payments (DSH). At present, only four hospitals receive DSH payments - the three inpatient psychiatric hospitals and the Poplar Community Hospital. Federal regulations limit the amount of DSH payments that may be made.

Payments to out-of-state hospitals, which account for 19-20% (see Graph #2) of all inpatient hospital costs, are based on a percentage of charges to approximate cost. The payment percentage is hospital specific, and is determined by an examination of the facility's Medicare audited cost report. Rates for major out-of-state providers are reviewed and adjusted annually at July 1. There is currently no limit on the rate of increase in costs allowed for these facilities and no cost settlements are performed.

Effective 1/1/93, the Department has contracted with the Colorado Foundation for Medical Care (CFMC) to provide utilization review for the hospital program through June 30, 1994. CFMC will focus on out-of-state hospital admissions by conducting preadmission and continued stay reviews. CFMC will also conduct retrospective reviews, selected targeted reviews, and medical case management of high cost cases. CFMC has been able to achieve a $4 return for each dollar invested in review for the Colorado Medicaid program. The Department anticipates a similar return on Montana's

investment.

Rehabilitation units of in-state acute care hospitals are paid cost, retrospectively. An interim rate is set for each facility, allowing us to pay a percentage of charges. When the annual cost report is filed, the Department cost settles with the provider. The cost of providing services to Medicaid recipients is determined, and any total overpayment or underpayment for the year is resolved by payment either to the state or to the provider. The rate of increases in costs of these facilities is limited to the TEFRA increase rate each year. The audits and cost settlements are prepared by the Medicare intermediary in conjunction with the Medicare settlement.

Program Growth/Cost Increases:

Inpatient hospital costs have doubled in the last six years - from $26.4 million in FY86 to more than $52 million in FY92 (see Graph #1). The primary reasons for increases in overall costs of the hospital program are;

- the number of persons eligible for Medicaid has increased - in large part to new federal mandates,
- the number of services provided have increased,
- medical inflation
- new technology

In addition, as the reimbursement system ages, certain reimbursement thresholds become less realistic and more and more

cases begin to qualify as high cost cases. These outlier cases are paid at a higher rate than ordinary hospital admissions (see Graph #3).

Another major contributor to the rising cost of the hospital program is the increased utilization of out-of-state services over the past several years. The Department has recommended changes aimed at keeping some of these patients in-state and at controlling the reimbursement to out-of-state hospitals.

Abt Study:

The 1991 legislature authorized a study and evaluation of Medicaid reimbursement to hospitals. The contract for the study was awarded to Abt Associates of Bethesda, Maryland. The key objective of the study was to determine the strengths and weaknesses of the system and to make recommendations for improvement.

The Department believes that the recommendations of the Abt study should be implemented in order to contain cost increases, to more equitably distribute Medicaid funds to hospitals and to provide the Department with a strong defense against potential Boren lawsuits. Implementing the recommendations however, requires major modifications to the MMIS system. These modifications are targeted to be implemented by 10/1/93 and are estimated to cost about $300,000 of which $75,000 would be general fund. These funds are not included in the Department's budget.

EXHIBIT
DATE 1-19-93
SB

A summary of the Abt study conclusions and recommendations is available upon request.

The Abt contractor has recommended:

1. The twenty hospitals in "rural" or "very rural" communities (see Attachment #1) will be exempted from the prospective payment system, and be paid at reasonable cost for Medicaid patients. We propose that they be paid retrospective cost, with increases in costs limited to the TEFRA increase rate.

2. Medicare grouper version nine is recommended for grouping cases to DRGs. This more current grouper will have a significant impact on the alignment of payments with cost.

3. Create different DRG weights depending on the intensity of the services provided.

4. Create a payment pool for "catastrophic" cases that exceed a specific charge threshold. These catastrophic cases would be reviewed by a standing committee comprised of agency employees and representatives of the health care industry. If the care given is deemed appropriate and medically necessary by the medical reviewers, then additional payment will be made to the hospital.

5. Pay the three hospitals that have neonatal intensive care

units at cost for neonate cases. This is to encourage the retention of neonate cases in state. The in-state costs for neonates are significantly lower than the out-of-state costs.

The study also indicates that the age of the current reimbursement system has made it more difficult to control the rate of increases in costs in this program. Our system is not capable of recognizing medical coding that relates to medical and technological changes since 1987. If the system cannot recognize currently accepted coding, then we may be over or under paying certain claims. For example, while this system pays primarily on the basis of the patient's diagnosis, there is no classification in Montana Medicaid's system for HIV or HIV related diagnoses. In order to fairly and accurately reimburse the hospitals for services, while maintaining control of the increase in costs, it is imperative that we update the hospital reimbursement system.

BOREN AMENDMENT:

Federal regulations require Medicaid to pay rates for inpatient hospital services which are "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities."

The Abt study found that Montana has been paying adequate rates in the aggregate, but that certain types of facilities were disadvantaged by the design of the system. Several important

adjustments to the system design have been proposed.

The Abt study concluded that, in the aggregate, Montana Medicaid should have paid approximately 93.5% of hospital costs in 1991 in order to satisfy the Boren Amendment requirements. If we rebase the system based on 1991 data, we can satisfy the Boren requirements in the 94-95 biennium by inflating the 1991 hospital rate by the TEFRA increase rate (approximately 4.5% per year) to 7/1/93.

While it is important to update the payment rate to protect the state from a possible Boren Amendment suit, it would not be wise to just update the rate and not update the entire system. The applicable, defensible rates calculated by Abt for SFY 94 and SFY 95 are based in part on the assumption that the state will choose to update the reimbursement system to recognize changes in the medical community since 1987.

Funding for FY94 and FY95:

The Executive Budget for the 1995 biennium does include new funds to pay for increases in the projected number of services, however, no increases were included for provider rates. The Montana Hospital Association has agreed in principal to forego any rate increases for the 1995 biennium and does support the implementation of the Abt study recommendations contingent on the legislature's designation of a separate appropriation for hospital reimbursement.

Specifically, SRS and MHA believes that the number of out-of-state services can be reduced and that the services would be channelled to in-state hospitals. The redirection of the services would allow SRS to:

1. Implement an air ambulance program for fixed wing aircraft whereby more individuals could be served by in-state hospitals.

2. Adjust the DRG weights of the hospital reimbursement program.

3. Increase fees to physicians providing neonate services.

II. Expenditures:

(see Medicaid One-Pager, Page 12)

III. Program Options:

The Executive Budget recommends that SRS revise the reimbursement method for out-of-state hospitals. Currently, one of every six Medicaid hospital dollars is spent out-of-state. Out-of- state care is typically provided in teaching hospitals that specialize in high-risk, complex cases. Costs per case in these hospitals is significantly higher than in our in-state hospitals.

We are proposing a three-pronged effort to reduce the dollars spent

out-of-state for hospital care:

1. Referral: All cases referred out-of-state must first be approved by our utilization review contractor, Colorado Foundation for Medical Care (CFMC). If the service is available in-state and the patient has not yet been transferred, the referring physician will be asked to refer to in-state options. Physicians who refer out-of-state when services are available in-state will receive reminder letters, letting them know what is available and asking their cooperation in utilizing Montana services. If the service is not available in-state and the requested inpatient service is medically necessary, CFMC will approve the admission.

2. Return: Once a patient is admitted out-of-state, our UR contractor (CFMC) places the emphasis on returning the patient to an in-state facility as soon as feasible. Many complex procedures performed out-of-state have long recovery periods. If the recovery can occur in Montana, CFMC will work with the facilities to transfer the patient back in-state as soon as possible.

3. Reimbursement: We currently pay approximate cost for out-of-state hospital services. Each facility is paid a percentage of allowable charges. The facility specific percentage of charges is determined by an examination of their most recent

Medicare cost report and there is no "settlement" of costs for these providers. That is, no underpayments or overpayments are calculated and adjusted and there is no limit on the rate of increase in costs allowed.

We are proposing to pay out-of-state hospitals in the same manner we do for cost based, in-state providers. That is, an interim payment rate will be established; a base year cost per discharge will be calculated; cost increases will be limited to the TEFRA inflation allowance; costs will be settled annually, and overpayments recovered from the provider; the provider will be required to file a cost report with the Montana Medicare intermediary to facilitate settlement. We propose using 1991 as the base year for out-of-state hospitals.

We have approximately 100 out-of-state hospital providers. However, 20 of those providers receive 75% of the reimbursement paid out of state. We would like to set a minimum reimbursement threshold to identify facilities where cost settlement would be cost effective, while maintaining the option to settle any provider when we feel to do so would benefit the state.

If we settle the top 20, there would be additional contract costs for the Medicare intermediary to perform the additional annual settlements.

EXHIBIT 1
DATE 1-19-93
SB

Advantages of this proposal:

1. Reduced cost to the State by recovery of overpayments and limits on cost increases.

Estimated Savings:	FY 1994	FY 1995	Biennium
General Fund	$ 227,515	$ 248,077	$ 475,592
Federal Fund	$ 557,561	$ 592,862	$ 1,150,423
Total Fund	$ 785,076	$ 840,939	$ 1,626,015

2. Reduced stress on families, by providing services in-state and reducing the amount of travel required.

3. Increased utilization of in-state services, providing more reimbursement to Montana providers.

Disadvantages of this proposal:

1. Increased contract cost for settlement.

Estimated Savings:	FY 1994	FY 1995	Biennium
General Fund	$ 3,000	$ 1,500	$ 4,500
Federal Fund	$ 3,000	$ 1,500	$ 4,500
Total Fund	$ 6,000	$ 3,000	$ 9,000

2. Possible discontent among major out-of-state providers. Some may threaten to withdraw as Montana Medicaid providers, possibly causing access problems.

EXHIBIT 1
DATE 1-19-93
SB

3. Increased in-state transportation costs to give physicians immediate access to in-state services. (SLC has air transport available by hot-line, while in Montana we often rely on ground transport, which may not be suitable even if we can provide the appropriate hospital care.)

EXHIBIT 1
DATE 1-19-93
SB

Outpatient Hospital Services

I. Current program:

All 54 in-state hospitals also provide outpatient hospital services such as outpatient surgery and physical therapy. The 43 sole-community hospitals are reimbursed 100% of costs for outpatient services. Outpatient costs are settled each year and there is currently no limit on the rate of increase in costs allowed for these services. The 11 hospitals that are not sole-community hospitals are paid at a maximum of 94.2% of cost for outpatient services, by federal rule.

Program Growth/Cost Increases:

Outpatient hospital services have increased steadily since 1986 (see Graph #4), as have the number of clients served and the number of services provided. These increases appear to be consistent with the intent of both the inpatient and outpatient hospital programs to treat patients in the least restrictive, medically appropriate setting. However, the Department has been reviewing ways to control the rate of growth in this program. There has been an increase in the types of programs that are offered to consumers through outpatient departments over the last several years. Some of these programs may not provide the most cost-effective or appropriate delivery of services. Our current policy of paying the cost of these services when provided to Medicaid recipients may be

contributing to the provider preference for hospital-based programs. The Department proposes to reduce the percentage of costs paid for outpatient services over the next biennium, and to study ways to make payment for services in this setting comparable to payment for the same services in other less costly settings.

II. Expenditures:

(see Medicaid One-Pager, Page 11)

III. Program Options:

The Executive Budget proposes a reduction in reimbursement for outpatient hospital services. This proposal would reduce payments for outpatient hospital services by 1.2% for all providers. Concurrently, we advise undertaking a study of outpatient services to devise a reimbursement system that will allow us to more effectively control the rate of increase in costs in this program. It is likely that a fee-based or a prospective payment system will be recommended.

Estimated Savings:	FY 1994	FY 1995	Biennium
General Fund	$ 44,940	$ 70,428	$ 115,368
Federal Fund	$ 110,132	$ 168,311	$ 278,443
Total Fund	$ 155,072	$ 238,739	$ 393,811

While HCFA has verbally indicated that it is not necessary for us to pay the maximum percentage of costs in a retrospective cost system, they have also said they would probably not approve a state

plan that includes any arbitrary reduction of the percentage. A study is needed to 1) confirm our belief that it would be reasonable to reduce reimbursement for these services, and 2), to design a reimbursement system that will be more effective in containing costs.

The study, which would be completed by January, 1995, will tell us the best method for reducing the percentage of costs reimbursed.

We can reduce each hospital's interim outpatient rate in the meantime. However, if the study finds that we have no basis for reducing reimbursement, we would have to compensate the in-state hospitals upon settlement. In that case, there would be no savings in this biennium....but the study contractor should be directed to design a reimbursement system that would contain costs in the future.

Conversely, the study may indicate that we have a basis for reducing reimbursement even further in this biennium.

The proposed study, which is estimated to cost $180,000 (50/50 funding), is necessary because SRS staff do not have the expertise required to analyze and make recommendations for such a complex program. The savings projected by implementing the reductions noted above are net of the funds required for the study. In any instance, the study should result in the design of an outpatient

EXHIBIT 1
DATE 1-19-93

reimbursement system that will allow us to reduce costs and/or control the increase in costs.

EXHIBIT 1
DATE 1-19-93
SB

ATTACHMENT #1

Hospitals exempt from PPS:

Hospital	Location
Fallon County	Baker
Granite County	Philipsburg
Phillips County	Malta
Big Sandy Memorial	Big Sandy
Mineral County	Superior
Chouteau County	Fort Benton
Clark Fork Valley	Plains
Roundup Memorial	Roundup
Ruby Valley	Sheridan
Sheridan Memorial	Plentywood
Mountain View	White Sulphur Springs
Madison Valley	Ennis
Carbon County	Red Lodge
Sweetgrass Memorial	Big Timber (closed)
Teton Medical	Choteau
Broadwater Health	Townsend
Stillwater	Columbus
Liberty County	Chester
Wheatland Memorial	Harlowton
Daniels Memorial	Scobey

The following Medical Assistance Facilities (MAFs) are also exempt from PPS:

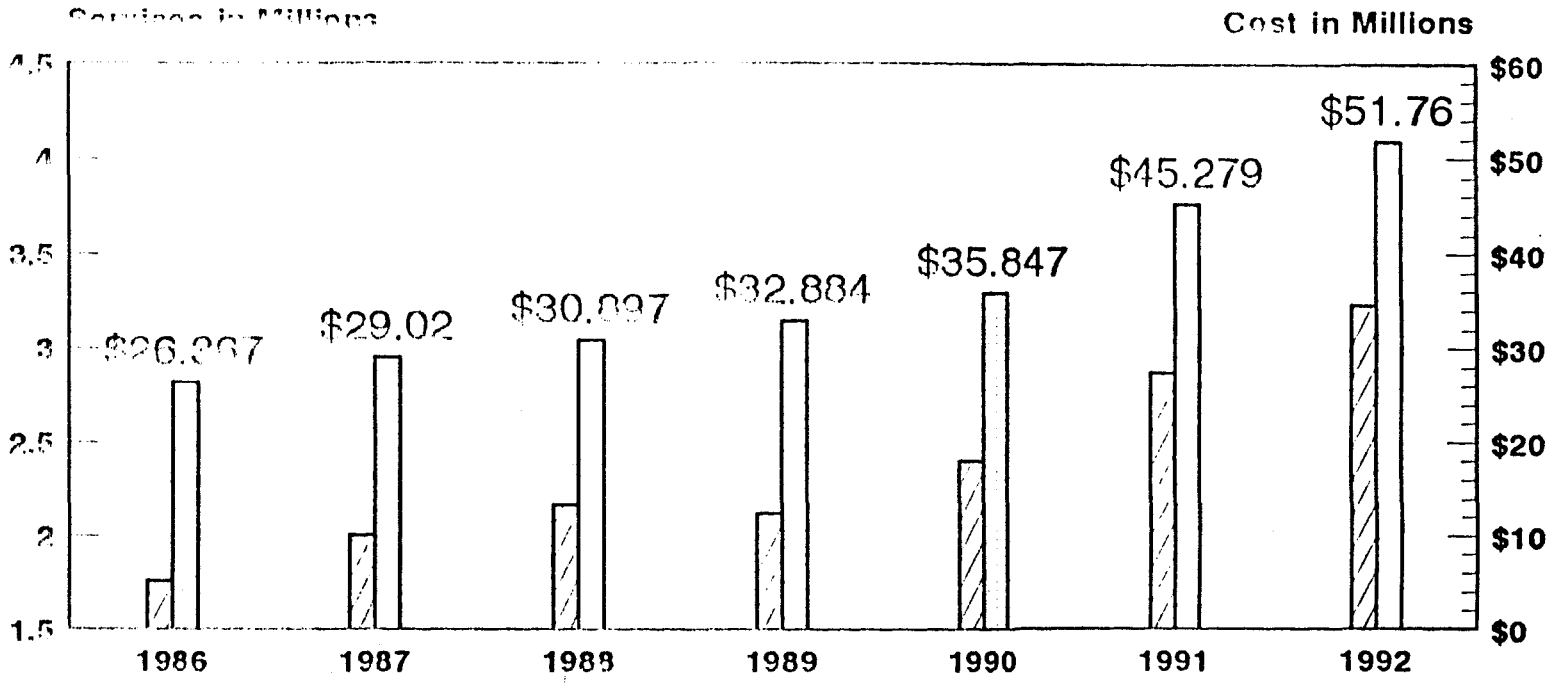
Garfield County MAF	Jordan
McCone County MAF	Circle
Dahl Memorial MAF	Ekalaka
Sweetgrass MAF	Big Timber
Roosevelt County MAF	Culbertson
	Prairie

Note: Medical Assistance Facilities is defined as:

> "...a facility that:
> (a) provides inpatient care to ill or injured persons prior to their tansportation to a hospital or provides inpatient medical care to persons needing that care for a period of not longer than 96 hours; and
> (b) either is located in a county with fewer than six residents per square mile or is located more than 35 road miles from the nearest hospital."

EXHIBIT 1
DATE 1-19-93
SB

Graph 1
Inpatient Hospital Services



Clients	11,166	11,986	11,964	11,917	12,213	13,764	15,577
Services	1.757	2.002	2.166	2.121	2.398	2.87	3.229

Services Costs

EXHIBIT 1-19-93 Graph #2
DATE
SB

Inpatient Hospital Reimbursement

By Size of Facilities

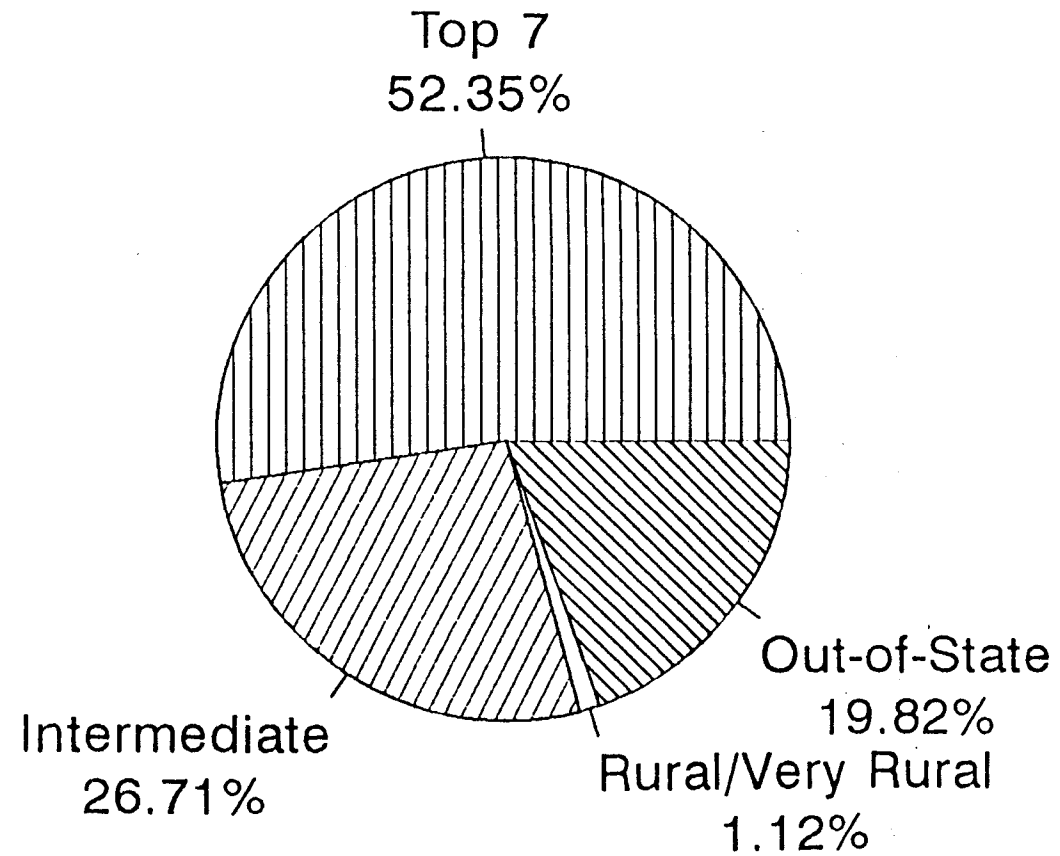
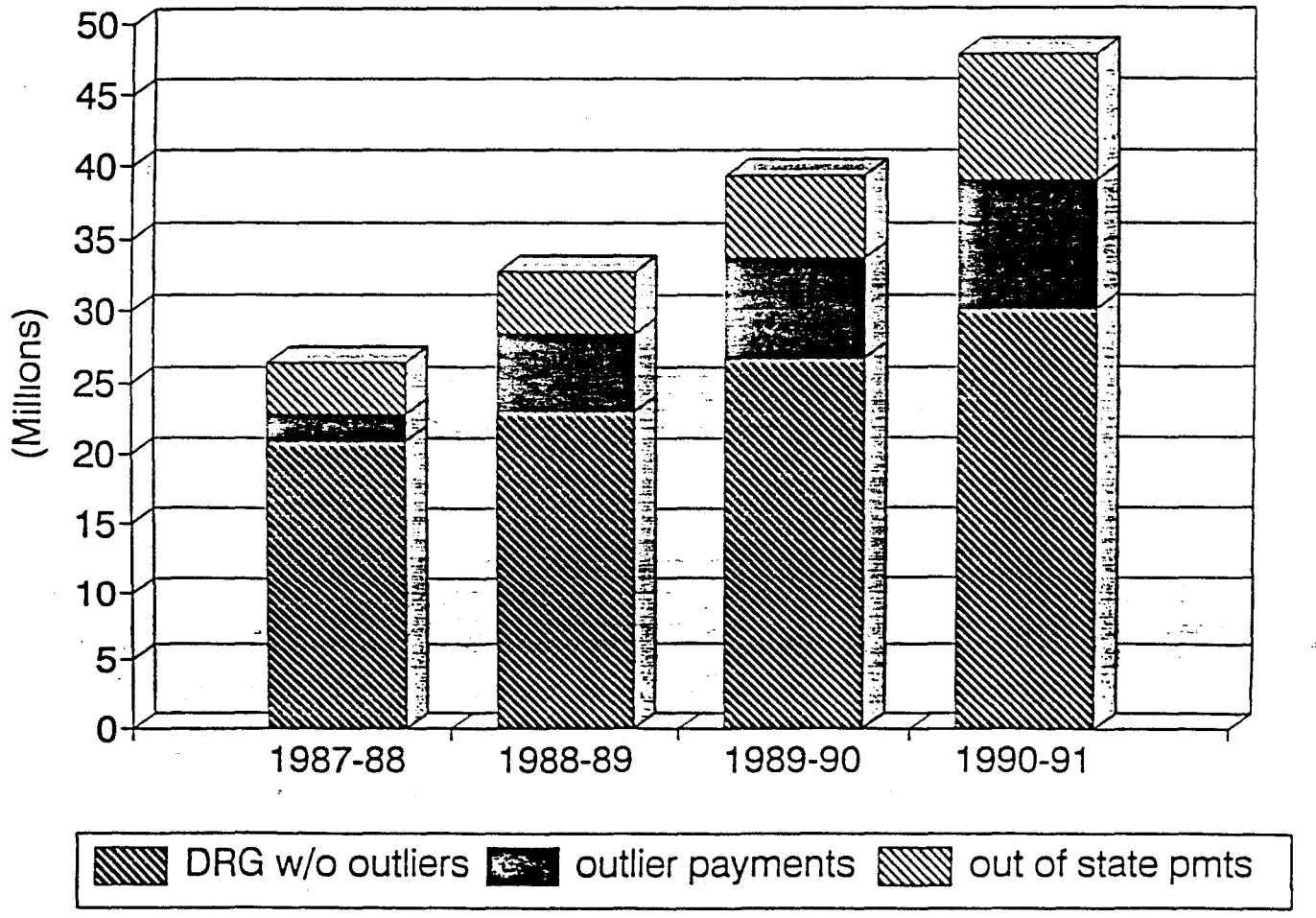


EXHIBIT 1
DATE 1-19-93
SB

Graph #3

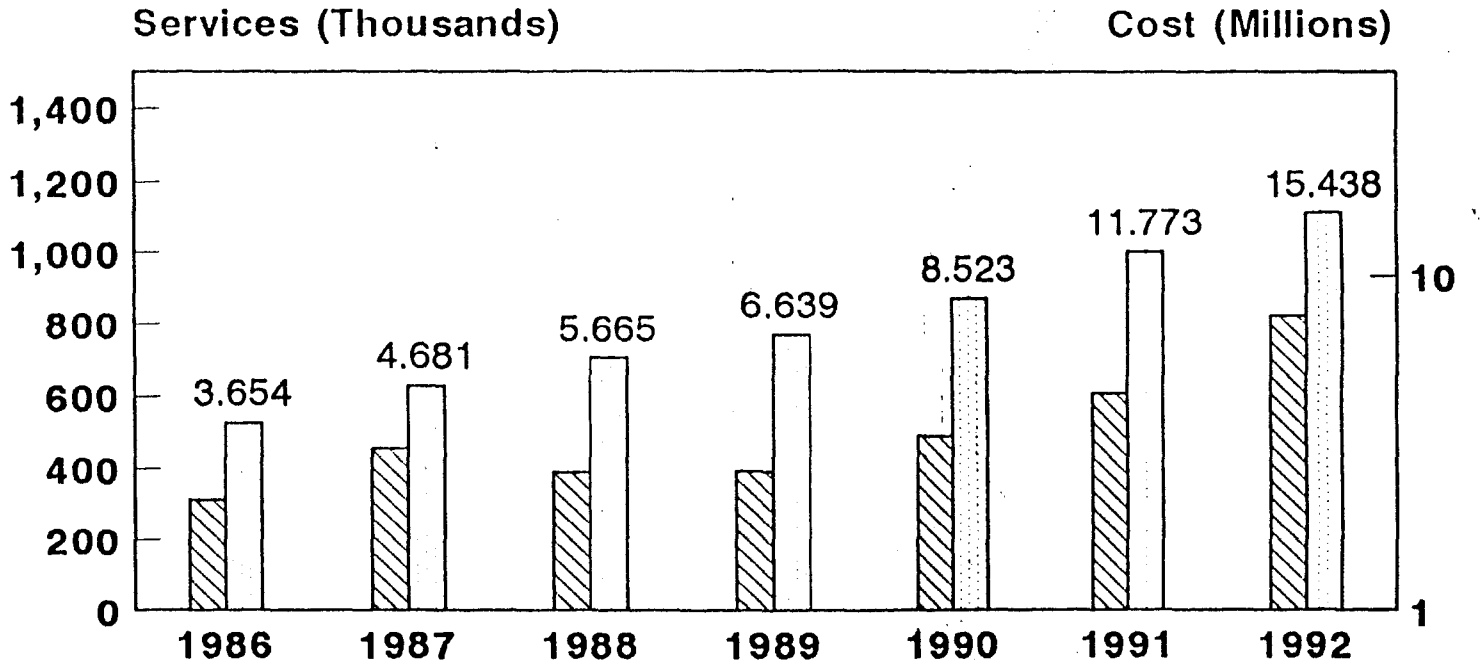
Components of Medicaid Hospital Payment



Graph #4

EXHIBIT 1
DATE 1-19-93

Montana Medicaid Program
Outpatient Hospital Services



	1986	1987	1988	1989	1990	1991	1992
Clients	18.654	21.696	23.576	24.817	28.262	32.673	39.356
Services	312.029	457.195	391.044	394.858	490.415	606.538	822.902
Average Cost	11.16	9.96	14.38	16.69	17.19	19.24	18.62
Svces per Recip	8.07	10.22	7.92	7.58	8.43	8.83	9.91

Service Cost

EXHIBIT 2
DATE 1-19-93
SB

Saint Vincent Hospital and Health Center

January 19, 1993

Hearing on Medicaid Reimbursement
Human Services Appropriations Subcommittee
Statement of Kathleen Stevens, M.D., Medical Director,
Newborn Services, Saint Vincent Hospital and
Health Center, Billings, Montana 59107 406-657-7075

Today's presentation by the Department of Social and Rehabilitation Services (SRS) has alluded to the fact that a large number of Montana infants who require neonatal intensive care services are cared for in out of state hospitals. The average total cost for this out of state care is twenty five to fifty percent higher than the average total cost is in comparable existing facilities in Montana.

There are approximately 11,500 births in Montana each year. Up to ten percent of infants need the services of an intensive care nursery. Based on analysis of several years of data provided by SRS on 11,434 neonates who were Montana Medicaid recipients, 230 of these babies were transferred out of state for care or were born out of state. The SRS data reveal that the average total cost of care on an extremely immature infant [Diagnosis Related Group(DRG) 386], was $ 16,297 in a Montana hospital compared to an average total cost of $ 23,463 to $ 43,230 in out of state facilities.

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406-657-7000

We touch your life.

This is direct cost of care and does not take into account family travel requirements. A non-Medicaid, but very real added cost, is a family's emotional and financial hardship caused by having an infant in an out of state hospital. Analysis of data on 155 Montana infants who were transferred out of state for care revealed that at least sixty seven percent of these infants could have been cared for in facilities and with services that already exist at Saint Vincent Hospital and Health Center in Billings and at two other Montana hospitals.

The reasons for referring babies to out of state facilities have been (1) perceived non-availability of neonatologists to direct neonatal intensive care; (2) perceived inadequate transportation services for patients and physicians compared to those provided by out of state institutions; (3) reluctance of physicians to change established referral patterns because of good physician to physician relationships and satisfaction with patient care; and (4) no financial incentive for Montana hospitals or physicians to keep patients in state.

Saint Vincent Hospital and Health Center has a Level III neonatal intensive care unit under the direction of a board certified neonatologist; this has been the case for the past three years. Either a neonatologist or a pediatrician is on duty in the hospital twenty four hour a day to oversee the care of neonatal patients. Furthermore, the hospital maintains a fixed wing and helicopter transport service which is staffed by nurses and respiratory therapists who are specially trained in neonatal

transport. The medical direction for the transport team is provided by a board certified neonatologist.

Physician referral patterns are difficult to interrupt and cannot be changed without financial pressure. Physicians who refer patients out of state need to be made aware of in state services and required to use them. Physicians should also be required to use in state services as a means of reducing stress on families in crisis.

The cost of care in Montana hospitals for 1641 babies in four infant intensive care DRG's (385, 386, 387, 389) was $ 9,963,196. In the same period of time, 216 infants in the same four DRG's were cared for in out of state hospitals at a total cost to Medicaid of $ 6,238,665. Montana should adopt a policy stating that if services are available in state for infant intensive care, there will be no authorization for payment for care in out of state hospitals. Recovery care can often be provided in Montana hospitals; when infants are through the acute phase of their illnesses and no longer require specialized out of state services, they should be transported back to Montana for continuing care at a much lower cost. If care is not available in state, reimbursement for out of state care should be based on the same scheme that is used for in state hospitals, regardless of the out of state institutions' qualifications beyond those required for suitable neonatal care. SRS or other appropriate state agency should be directed to notify Montana physicians of new in state

service usage requirements and to revise Medicaid reimbursement rules accordingly.

Hospital reimbursement for neonatal intensive care services should be at cost to encourage in state retention of neonatal patients and to encourage development of neonatal services which are not presently available, further reducing the requirement for out of state care. The three established Montana units capable of providing neonatal intensive care should be reimbursed using this payment formula; other facilities should be paid on a DRG determined basis. This will allow the three existing units to continue to provide and develop comprehensive services for neonates and insure the continuation of the existing high caliber of infant intensive care in Montana.

Thank you. I will be happy to answer your questions and to provide additional data.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. _____

DATE 1-19 SPONSOR(S) _____

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Kathleen Gilbert Billings MT	St Vincent Hosp		
MARK PETESCH Billings MT	ST VINCENT HOSP		
Bob Olson	MT Hospital Assn.		
MAXINE HOMER	CHRISTIAN CHURCH WOMEN		
Dan Shea	MCIC		
Chuck Tuss	CMHC		

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