MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN JOHN COBB**, on January 22, 1993, at 8:05 A:M.

ROLL CALL

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

Members Excused: 0

Members Absent: 0

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: MEDICALLY NEEDY PROGRAM; MEDICAID OPTIONAL SERVICES; AND MEDICAID REFINANCING STRATEGY
Executive Action: NONE

HEARING ON MEDICALLY NEEDY PROGRAM

Tape No. 1:Side 1

Mr. Roger La Voie, Administrator, Family Assistance Division, Social and Rehabilitation Department, gave a brief overview with no exhibit.

Ms. Penny Robbe, Bureau Chief, Family Assistance Division, Social and Rehabilitation Department, EXHIBIT 1

HEARING ON MEDICAID OPTIONAL SERVICES

Ms. Nancy Ellery, Administrator, Medicaid Division, Social and Rehabilitation Department, EXHIBIT 2

HEARING ON MEDICAID REFINANCING STRATEGY

Tape No. 1:Side 2

Ms. Mary Dalton, Medicaid Division, EXHIBIT 3

Ms. Debra Hemmer, Testimony on Mental Illness, EXHIBIT 4

Ms. Gail Wheatley, President, American Physical Therapy Association, EXHIBIT 5

Ms. Sandra Nelson, Nursing Home Adaptive Equipment, EXHIBIT 6

Mr. Dale Taliaferro, Administrator, Health Services Division, DHES, EXHIBIT 7

ADJOURNMENT

ADJOURNMENT: 12:10 P:M

JOHN COBB, Chair

BILLIE JEAN HILL, Secretary

JC/bjh

HOUSE OF REPRESENTATIVES

HUMAN SERVICES **SUB-COMMITTEE**

ROLL CALL **DATE** 1-27-92

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	✓		

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LEGISLATIVE TESTIMONY

MEDICALLY NEEDY

Medically Needy coverage is an optional coverage group under the Medicaid Program. Montana may choose to: 1) totally eliminate Medically Needy coverage, 2) provide limited Medically Needy coverage to certain groups, 3) eliminate Medically Needy coverage for persons in Nursing Home situations, but adopt a "special income limit", 4) adopt any or all of the 100% poverty programs available, or 5) if any Medically Needy options are kept, implement the cash payment option.

Total elimination of coverage would most severely affect persons in nursing homes (2888), those on the waiver programs (152)--which allows them to be served at home, instead of in a nursing home--and those aged and disabled clients living in the community (1862). However, some children living in the community will also be adversely impacted (467). Total number of persons who were eligible for Medically Needy coverage in all settings in November, 1992 was 5376. By totally eliminating the Medically Needy program, approximately $53,438,55 million will be saved. (Chart 1)

In considering what choices could be made to reduce costs other than complete elimination of the Medically Needy program, two major groups need to be considered.

The first group are individuals in nursing homes who are considered Medically Needy. It is generally considered that some protection for those persons must be offered. (It is useful to keep in mind for these groups the term "Medically Needy" usually applies to individuals who have more than $416 in countable income.)

If the Medically Needy program is eliminated, but the desire is to still offer some persons in nursing homes protection, the choices in eligibility are:

1) Implement a **special income limit** for nursing home (NH), and home and community based/waiver service (HCBS) clients. The special income limit is 300% of the SSI benefit payment for one individual. That currently amounts to $1302 (300% X $434 = $1,302). Persons who have income less than that are categorically needy and eligible for Medicaid without an incurment/spend down. Persons who have income over that figure are ineligible. (Chart 2)

   Note: As a further option, protection could be offered those current recipients whose income exceeds the special income limit by paying for their coverage with state funds. (Chart 2)

2) Reduce Medically Needy eligibility coverage to only those in nursing homes, those receiving waiver services and pregnant women and children in the community. (Costs for Medically Needy children in the community are projected at $290,000 in FY94 and $351,000 in FY95).

   Note: By federal law, if a state has any Medically Needy

program, at a minimum, pregnant women and children **must** be covered.

The second group to consider are those Medically Needy individuals not in nursing homes or on waiver programs. These persons are generally grouped into one of three categories: 1) aged, 2) blind or disabled and, 3) pregnant women and children. We generally refer to these groups as "receiving Medically Needy in the community." Again, there are some options which may be implemented instead of Medically Needy coverage to provide some persons in these groups protection. Cost constraints are an issue.

1) Disabled in community option: Disabled or blind individuals who reside in the community and have income exceeding the allowable limit (generally $416) will be severely affected with the elimination of Medically Needy coverage. It is important to note that these individuals are not Medicare eligible until they have been disabled for two years. Additionally, Medicare does not cover prescriptions outside a hospital setting. To minimize the impact on this group of people, Montana could adopt **categorical coverage for disabled people living in the community with income up to 100% of poverty** (1992 poverty level is $568 for one and $766 for two people). (Chart 3)

2) Aged in community option: Aged (65 and older) individuals who reside in the community and have income exceeding the allowable limit (generally $416) will also be adversely

impacted with the elimination of Medically Needy coverage. Aged individuals are Medicare eligible; however, Medicare does not cover prescriptions. Again, to minimize the impact on this group of people, Montana could adopt **categorical coverage for aged people living in the community with income up to 100% of poverty** (1992 poverty level is $568 for one and $766 for two people). (Chart 3)

3) Pregnant women and children option: The last population in the community which would be affected by eliminating Medically Needy coverage, are pregnant women and children. This coverage group, while small, has current eligibility coverage more generous than afforded our elderly or disabled citizens. However, to minimize the affect on this population, Montana could **increase categorical coverage up to 100% of poverty for children from age 9 to 18.** (Chart 3)

Note: While pregnant women and infants (to one year old) are currently covered to 133% of poverty, it is also optional to increase that coverage to 150%, 185%, or any other percentage of poverty which is determined to be appropriate.

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CASH PAYMENT OPTION:

The last option to consider is the proposal the Department has submitted in the budget which allows a cash payment equal to the amount of the client's incurment (similar to a deductible). Currently, clients cannot establish Medically Needy coverage until they have incurred medical expenses equal to their deductible. The clients are responsible to pay 100% of the deductible expenses, and coverage begins the day the deductible is met. That could be anywhere from the first day of the month until the last day of the month.

Under the cash payment proposal, Medically Needy clients may choose to meet their deductible obligation by either incurring medical expenses or **making a cash payment** equal to the amount of their deductible. If the cash payment is chosen, eligibility begins the first day of the month and a Medicaid card is mailed which is exactly the same as the card AFDC and SSI recipients receive. Under this method, Medicaid pays for all covered services in the month.

For clients who choose not to pay the cash, but wish to continue to incur bills, a Medicaid card is also issued the first day of the month. However, this card is different because it specifies the client has a Medically Needy deductible to meet. This is similar to health insurance programs non-assistance persons have, such as a Blue Cross/Blue Shield identification card.

The difference is these cards are issued monthly, with the benefit month clearly distinguished on the card. One of the changes in administrative procedures in processing these cases is that our MMIS agent, Consultec, would track all medical bills submitted and apply them, in the order received, to the client's deductible. Once the deductible is met, Medicaid payments are issued for all remaining bills within the month.

To illustrate why the cash payment option is a cost savings to the state, compare the following: (Assume in both circumstances a client had a $100 deductible.)

Current Policy:

1. Client must incur $100 in medical services;
2. Client must arrange a payment agreement with the medical provider;
3. Client is responsible to pay the full $100; and
4. Medically Needy coverage does not begin until the day the deductible is met.

Proposed Policy:

1. Client pays the Medically Needy Program $100 cash;
2. Medically Needy coverage begins the first day of the month, so providers do not pursue client payment agreements or collections from clients;
3. Medicaid covered services are paid at the Medicaid rate (approximately 65%); and
4. The Medically Needy Program realizes $35 ($100 cash collected minus $65 paid) which could be used as a match for other medical costs.

NOTE: Of the 65% reimbursed to the provider, 71% is federal matching funds and 29% is state matching funds. This means that the actual amount realized to the Medically Needy Program is $35 + $46 = $81!

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BENEFITS ASSOCIATED WITH PROPOSED CHANGE

The benefits associated with this proposed change include:

For the client:

1. Clients no longer have to incur medical expenses and take the bills to the county office before establishing Medically Needy coverage;

2. Clients do not have to make payment arrangements with medical providers;

3. Clients make a single payment (similar to a health insurance premium) and establish Medically Needy coverage beginning the first day of the month; and

   NOTE: This will be especially beneficial to clients receiving Home and Community Based/Waiver Services. These people are typically developmentally disabled residing in a group home or aged and disabled clients who would otherwise reside in a long-term care facility.

4. If clients pay for Medically Needy coverage but do not use medical services totalling the amount they paid, they may receive a refund (i.e., premium amount minus amount of services actually incurred).

   NOTE: Because providers have 365 days to bill for services, client refunds cannot be paid for at least that period. They would also only be paid upon client request.

Medical Providers:

1. Medical providers will receive timely payment for Medicaid covered services;

2. No payment arrangements or client collection efforts are necessary.

   NOTE: There is a trade-off for providers. Providers are currently entitled to collect 100% of the deductible from the client. However, payments may be received sporadically which requires additional office provider staff time, postage, possible collection agency involvement, etc..

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NOTE: In the event clients choose to incur expenses to meet the deductible obligation, they will be issued a Medically Needy ID card indicating the client must meet a deductible before Medicaid will begin paying for covered services. Similar to private health insurance, as bills are received, they will be applied toward the deductible until the deductible is met.

State of Montana:

1. Some county staff time will be saved because eligibility staff will not have to evaluate stacks of medical bills or wait for medical bills to be incurred to determine Medically Needy coverage; and

2. There will be a "windfall" to the Medicaid Program (i.e., the difference between the premium collected and the Medicaid payment) which can be used as matching funds.

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Chart 1
FY92 Medically Needy Population
Total Expenditures $53,438,511

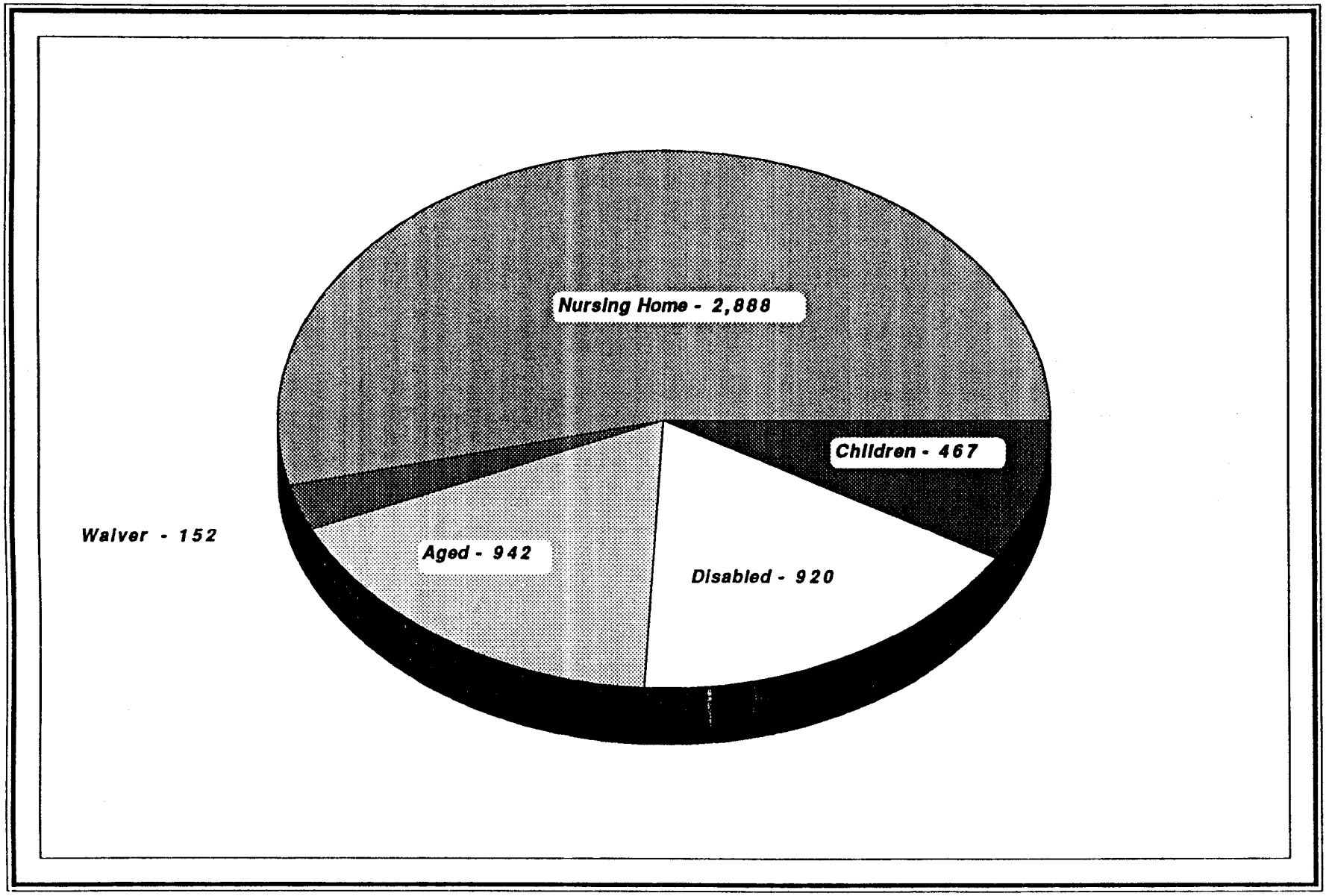

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Chart 2
Nursing Home

	Projected 94	Projected 95
Nursing Home Total Dollars	$41.900	$42.700
Nursing Home General Fund	$12.140	$12.600
300% Total Dollars	$40.900	$41.700
300% General Fund	$11.850	$12.300
300% Grandfather*	$13.150	

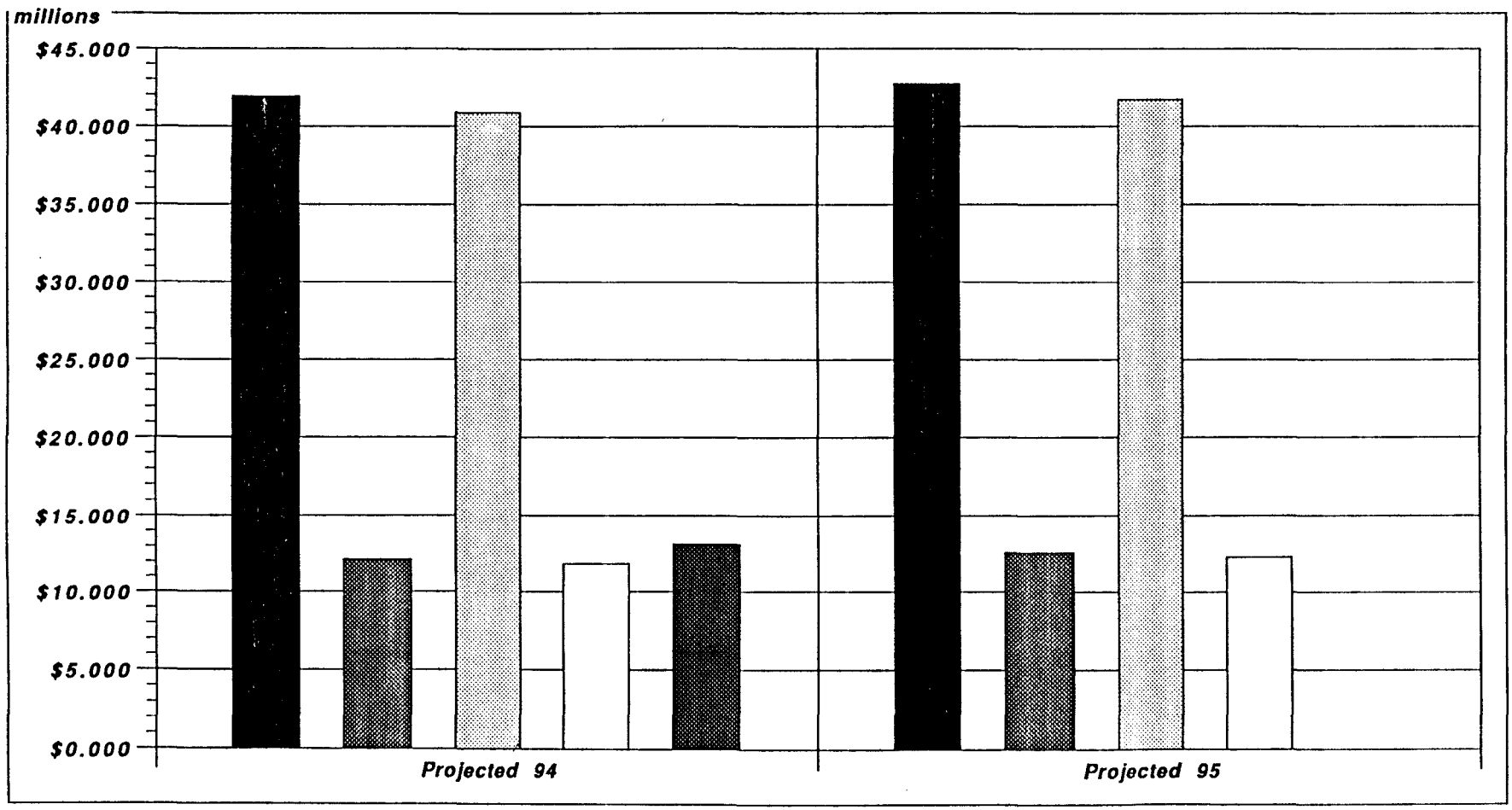
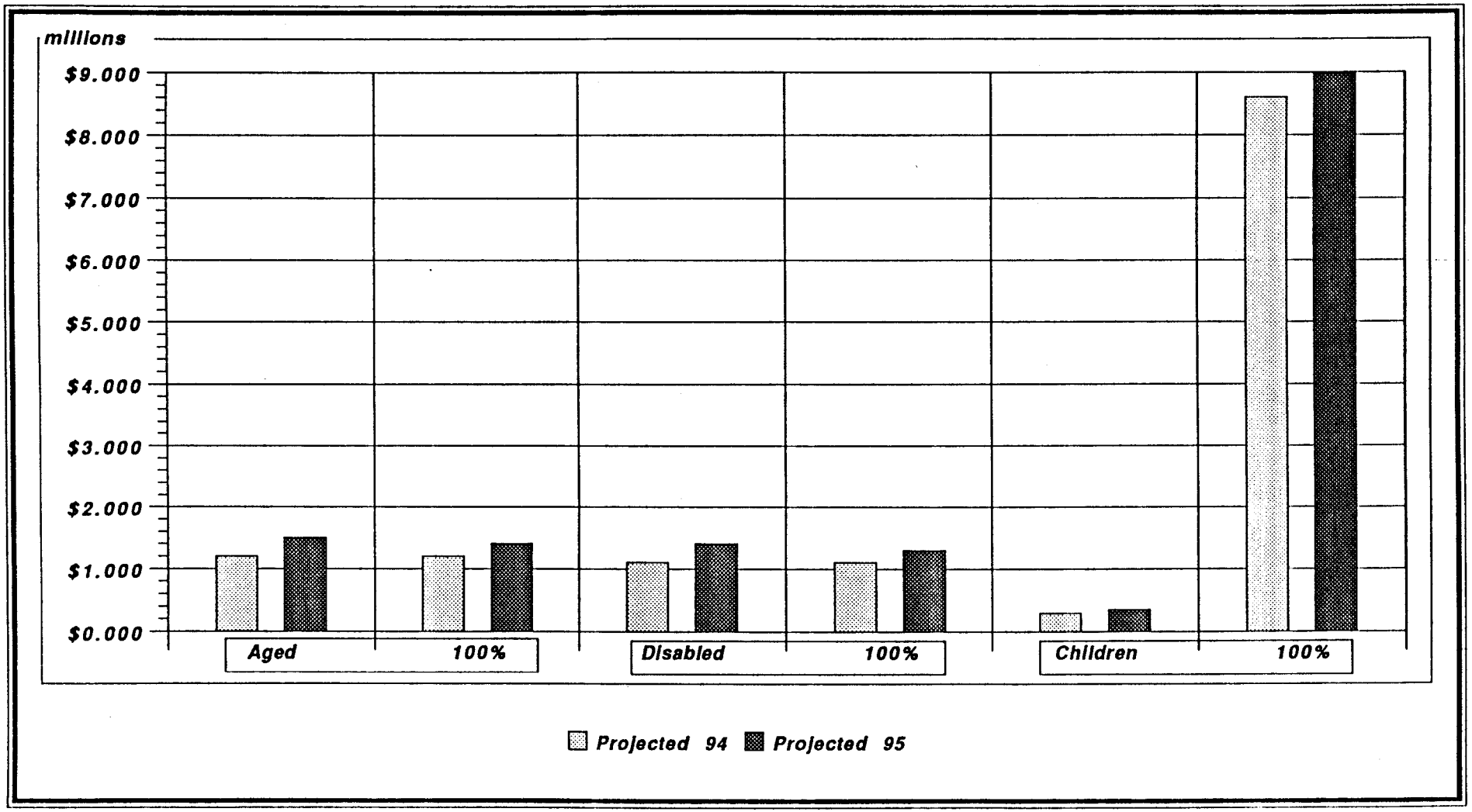


Chart 3
Aged, Disabled and Children

	Projected 94	Projected 95
Aged	$1.200	$1.500
100%	$1.200	$1.400
Disabled	$1.100	$1.400
100%	$1.100	$1.300
Children	$0.290	$0.351
100%	$8.600	$9.000



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Presentation Date: 1/22/93
SRS Staff: Nancy Ellery
John Chappuis
Mary Dalton
Committee: Human Services Appropriations Subcommittee

Medicaid Optional Services

Mr. Chairman, members of the committee, we have already discussed optional services during the Medicaid overview.

I would like to summarize for the committee just a few of the important points about optional services before we go into the options Chairman Cobb requested the department prepare.

1. Federal law does not allow states to cut optional services for children (up to age 21) or persons living in nursing homes. The individuals that will be affected by cuts in optional services are adults living in the community.

2. Adult optional services represent only 18% of the total Medicaid budget. Refer to Chart 1.

3. Over half of the dollars spent on adult optional services are in only 2 areas - prescribed medicine and ICF\MRs. Chart 2 breaks out costs for each of the major optional services provided to adults.

4. Optional services allow clients to receive services in the most cost-effective and least restrictive setting. Many of the services are preventative in nature. If the services are eliminated the

potential for costs being shifted to more expensive mandatory settings could result in an increase in total Medicaid costs. It is difficult to assign a dollar value to the cost shift because of the unique health status of each individual receiving the service. The amount of cost shift would also vary for each optional service. South Carolina, a few years back, limited the number of prescription drugs that they would pay for under Medicaid to 3 prescriptions per month. Subsequent studies by them have shown that no savings were achieved from this measure because the decrease in the pharmacy budget was obliterated by the subsequent increase in nursing facility admissions. What started out as a cost containment measure, ended up costing more in the long run!

5. If the cost shift is to a service that must be provided by the state, there will be an increase in general fund expenditures because of the loss of federal funds. For example, the state operates two ICF\MR facilities. If ICF\MR services are eliminated as an optional service, general fund spending would increase by $12.7 million/year.

6. Eliminating optional services just for the adult population will almost certainly result in a legal challenge. In 1988, the state was permanently prohibited from eliminating the optional services cuts approved by the 1987 Legislature. The judge cited earlier Supreme Court decisions on equal protection and ruled the state's action was arbitrary, unreasonable and unconstitutional. Advocacy groups for the disabled have indicated that if optional

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services are eliminated they would pursue legal action under the provision of the Americans with Disability Act. (New Mexico was sued by advocacy groups under this Act and subsequently reached an agreement not to make the cuts that they had proposed.)

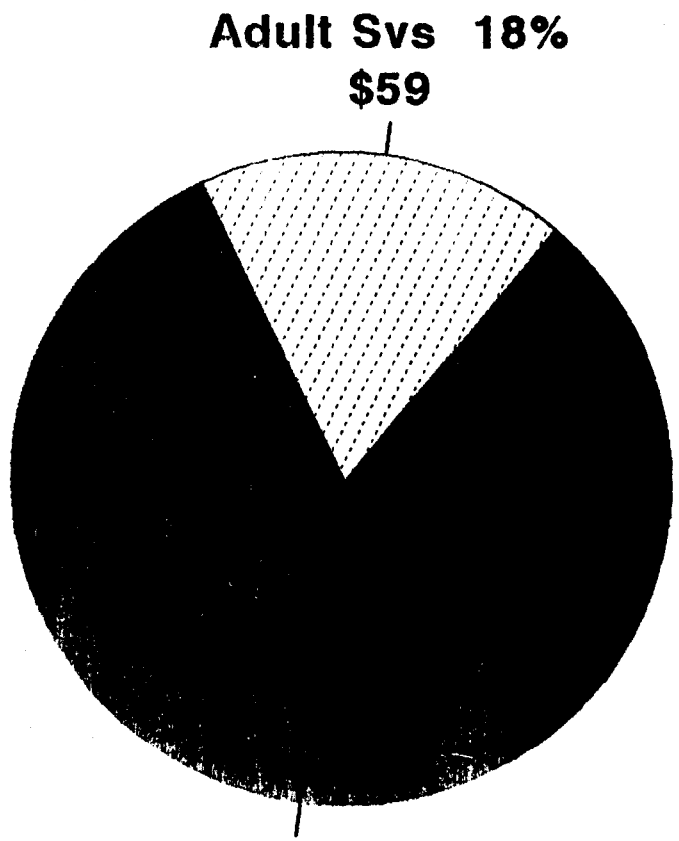
I would now like to discuss one of the cost savings proposals in Governor Racicot's budget relating to optional services. Neither Governor Stephens' nor Governor Racicot's Executive Budget contained proposals to eliminate Medicaid optional services.

Competitively Bid Oxygen Services represent the largest portion of the durable medical equipment (DME) program. It is estimated that FY 92 expenditures for oxygen are approximately $2,000,000. The program could attempt either competitive bidding for oxygen service or direct purchase of equipment items such as oxygen concentrators. The goal of the project would be to achieve a 15% savings in the cost of the service. Services would not be cut; rather they would be provided in a more economical manner.

Savings	FY 94	FY 95	Biennium
General Fund	$ 86,940	$ 88,500	$ 175,440
Federal Fund	$213,890	$217,728	$ 431,618
Total	$300,830	$306,228	$ 607,058

I would now like to discuss the options that Representative Cobb asked us to prepare for the committee. I want to emphasize that the department is not recommending or supporting these changes.

Chart 1
Adult Optional Services
FY 1994 Cost Projections



Amounts Shown are in Million $.

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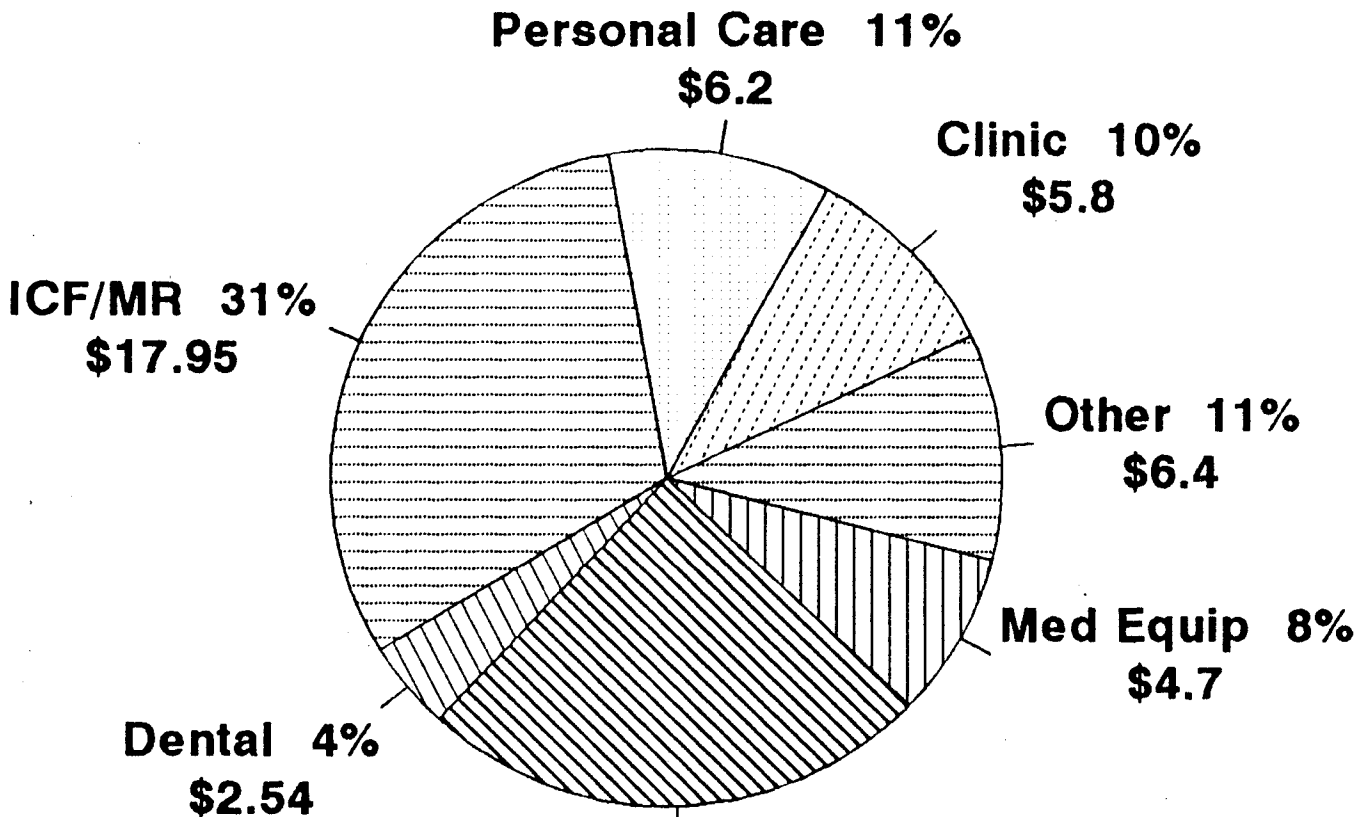
Chart 2
Adult Optional Services
FY 1994 Cost Projections



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Amounts Shown are in Million $.

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Primary Care Options

1. **Eliminate Eyeglasses and Optical Services for Adults**: Under this option, eyeglasses and routine eye care services provided by opticians, optometrists, and ophthalmologists would be eliminated for adults who do not reside in nursing homes. Treatment for eye disease currently provided by optometrists would continue to be available on a limited basis as a mandated physician service.

   Individuals impacted: Not available at this time.

   Impact:

   a. Adults, who live in the community, will have limited access to routine eye care.

   b. Nursing facility costs will increase since these facilities will be required to provide eyeglasses to meet certification requirements. Nursing facilities may not be able to obtain eyeglasses for the current rate that Medicaid pays so costs for these recipients may double or triple.

   c. The Department will enact a volume purchasing contract for eyeglasses on February 1, 1993. If adults are no longer covered for this benefit, it is likely that the contractor will terminate this contract because the volume of eyeglasses purchased will significantly decrease. The anticipated savings will then be lost for glasses for children.

   d. Eye care specialists in small, economically depressed ares may not have sufficient private pay patients to continue to practice in those communities.

   Savings*:

	FY 94	FY 95	Biennium
General Fund	$186,530	$191,320	$ 377,850
Federal Fund	457,120	475,221	914,341
Total	$643,650	$648,541	$1,292,191

   * Costs reflect the same growth rate as the rest of the primary care budget. Cost shift to nursing facilities and lost savings from volume purchasing contract have not been calculated at this time.

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2. **Eliminate Mental Health Services at CMHC:** Under this option, mental health services for adults provided through the five regional mental health centers would be eliminated. Mental health services may or may not remain available through private providers in the community.

Individuals impacted: 2,480 adults.

Impact:

a. Either the Department of Corrections and Human Services will have to absorb community mental health center treatment costs with 100% general fund or clients will be denied outpatient treatment.

b. Costs at Montana State Hospital (funded with 100% general fund) will escalate if clients are unable to receive treatment in the community. Lawsuits from advocacy groups can be expected because clients will not be treated in the least restrictive environment.

c. Costs for Medicaid in the outpatient (ER) and inpatient hospital setting will increase as clients seek the only "community" care available.

d. If the services of private social workers, licensed professional counselors, and psychologists remain a Medicaid covered service, the adverse impacts described above will be reduced but not eliminated.

Savings*:

	FY 94	FY 95	Biennium
General Fund	$1,693,870	$1,997,187	$ 3,691,057
Federal Fund	4,151,093	4,772,939	8,924,032
Total	$5,844,963	$6,770,126	$12,615,089

* Costs reflect the same growth rate as the rest of the primary care budget. Cost shift to private mental health providers, hospitals and DCHS has not been calculated at this time.

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3. **Eliminate Coverage for Diapers**: Under this option, Medicaid would no longer pay for diapers for either children or adults. Diapers are not covered by either Medicare or private insurance. (Current Medicaid coverage for children is limited to those children who are past the normal developmental age for attaining bladder and bowel control i.e., kids beyond age 2 or 3). Diapers are considered to be part of the facility cost of providing services in a nursing home and are not reimbursed for separately.

Individuals Impacted: Approximately 180 children and 220 adults.

Impact:

a. DD recipients would be negatively impacted. Elimination of this service may be "the straw that breaks the camel's back" in a family's decision to maintain an individual in his own home rather than place him in a group home or institution.

b. Other physically handicapped individuals would be affected in similar ways.

c. Costs for this service would shift to individual recipients and to DD group homes.

Savings*:

	FY 94	FY 95	Biennium
General Fund	$115,920	$118,000	$232,920
Federal Fund	284,080	282,000	566,080
Total	$400,000	$400,000	$800,000

* Savings based on FY 92 costs with no inflation for number of recipients or services.

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4. **Eliminate Purchase of Wheelchairs**: Under this option, Medicaid would no longer directly purchase wheelchairs for nursing facility residents. Currently, nursing facilities are expected to supply residents with standard wheelchairs i.e., wheelchairs that can be used by more than one particular resident. Medicaid purchases "specialized" wheelchairs for nursing facility residents. These are wheelchairs which may be lighter weight than the normal wheelchair, power wheelchairs for clients who can not operate a manual chair, and customized wheelchairs which may have molded parts to fit a recipient's unique physique i.e, chairs to fit a person with a particular problem such as trunk rotation in someone with cerebral palsy.

In a survey of nine states during the summer of 1991, four of the states indicated that they purchase wheelchairs for nursing home residents and five indicated that they do not. Medicare does not purchase wheelchairs for residents of skilled nursing facilities. They will purchase or rent a wheelchair when the patient is discharged from the nursing facility.

It is estimated that over half of the wheelchairs purchased by Medicaid are for nursing home residents. The estimated annual cost for all wheelchairs and accessories is $600,000.

Individuals impacted: Not available at this time.

Impact:

a. Costs for these wheelchairs will be shifted to nursing facilities which will affect their charges for services to private pay clients and to Medicaid.

b. Nursing facility residents may see a decrease in the number and type of chairs available to them.

c. This would reduce the number of wheelchairs purchased under our wheelchair contract and may affect the contractor's ability to provide the wheelchairs at the contract amount.

Savings*:

	FY 94	FY 95	Biennium
General Fund	$ 86,940	$ 88,500	$175,440
Federal Fund	213,060	211,500	424,560
Total	$300,000	$300,000	$600,000

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* The potential increase in nursing facility costs has not been estimated at this time. Savings estimates may be overstated.

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5. **Eliminate Per Diem Reimbursement**: Under this option, Medicaid would only reimburse for mileage and not reimburse per diem expenses for recipients who must travel to receive medical services. Maximum daily per diem (meals and lodging) for one individual is $22.44.

Individuals impacted: Not available at this time.

Impact:

a. States are mandated to provide access to necessary medical care. Any reduction in transportation benefits would seriously affect this access. The individuals who would be most affected are those who live in rural areas and those who must travel out-of-state. This reduction would be scrutinized closely by HCFA and might result in a federal sanction if the state could not successfully argue that payment for mileage is adequate to ensure access to needed medical care.

b. If access is limited, recipients may not receive needed health care. Not receiving care may lead to worsening of their condition or handicap and result in more costly care or institutionalization.

Savings*:

	FY 94	FY 95	Biennium
General Fund	$ 27,782	$ 29,165	$ 56,947
Federal Fund	68,084	66,701	134,785
Total	$ 95,866	$ 95,866	$191,732

* In FY 92, $191,733 was spent on mileage and per diem. Assuming 1) the same amount would be spent in FY 94 and 95, and 2) one-half of that amount is mileage, the State would potentially save $95,866 total funds.

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6. **Eliminate Audiological Services**: Under this option, audiological services and hearing aids for adults not residing in a nursing facility will be eliminated as an optional service under the Medicaid program. Medicaid currently prior authorizes all hearing aids through contract with an audiologist to ensure that each one purchased is medically necessary. Hearing aids are not covered by Medicare or the State Employee's Medical Plan.

Individual's Impacted: Approximately 757 recipients per year.

Impact:

a. Recipients who do not reside in a nursing home will be forced to purchase their own hearing aids.

b. Many of the recipients of hearing aids reside in nursing facilities. There will be a cost shift to nursing facilities who will have to provide this service to meet certification requirements.

Savings*:

AUDIOLOGY

	FY 94	FY 95	Biennium
General Fund	$ 8,390	$ 10,581	$ 18,971
Federal Fund	20,560	25,287	45,847
Total	$ 28,950	$ 36,868	$ 64,818

HEARING AIDS

	FY 94	FY 95	Biennium
General Fund	$ 27,965	$ 34,648	$ 62,613
Federal Fund	68,534	84,911	153,445
Total	$ 96,499	$ 119,559	$216,058

AUDIOLOGY & HEARING AIDS COMBINED

	FY 94	FY 95	Biennium
General Fund	$ 36,355	$ 45,229	$ 81,584
Federal Fund	89,094	110,198	199,292
Total	$125,449	$ 155,427	$280,876

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* Costs reflect the same growth rate as the rest of the primary care budget. Cost shift to nursing facilities has not been calculated at this time.

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7. **Eliminate Outpatient Occupational Therapy**: Under this option, Medicaid would no longer reimburse outpatient occupational therapy services for adults. Occupational therapy services would remain available as an outpatient hospital and a home health benefit.

Individuals impacted: 304 adults.

Impact:

a. Occupational therapy services would remain available under the outpatient hospital and home health options. It is expected that a percentage of those being served on an outpatient basis would choose one of these potentially more costly options for services.

b. Nursing facility costs can be expected to increase as they will need to provide this service to meet certification requirements.

Savings*:

	FY 94	FY 95	Biennium
General Fund	$ 16,542	$ 19,505	$ 36,047
Federal Fund	40,540	46,612	87,152
Total	$ 57,082	$ 66,117	$123,199

* Costs reflect the same growth rate as the rest of the primary care budget. Cost shift to hospital outpatient services, home health agencies and nursing facilities has not been calculated at this time.

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8. **Eliminate Outpatient Speech Therapy:** Under this option, Medicaid would no longer reimburse outpatient speech therapy services for adults. Speech therapy services would remain available as an outpatient hospital and a home health benefit.

Individuals impacted: 290 adults.

Impact:

a. Speech therapy services would remain available under the outpatient hospital and home health options. It is expected that a percentage of those being served on an outpatient basis would choose one of these potentially more costly options for services.

b. Nursing facility costs can be expected to increase as they will need to provide this service to meet certification requirements.

Savings*:

	FY 94	FY 95	Biennium
General Fund	$ 33,559	$ 42,324	$ 75,883
Federal Fund	82,240	101,147	183,387
Total	$115,799	$143,471	$259,270

* Costs reflect the same growth rate as the rest of the primary care budget. Cost shift to hospital outpatient services, home health agencies and nursing facilities has not been calculated at this time.

9. **Eliminate Outpatient Physical Therapy:** Under this option, Medicaid would no longer reimburse outpatient physical therapy services for adults. Physical therapy services would remain available as an outpatient and a home health benefit.

Individuals impacted: 1,034 adults.

Impact:

a. Physical therapy services would remain available under the outpatient hospital and home health options. It is expected that a percentage of those being served on an outpatient basis would choose one of these potentially more costly options for services.

b. Nursing facility costs can be expected to increase as they will need to provide this service to meet certification requirements.

Savings*:

	FY 94	FY 95	Biennium
General Fund	$ 80,201	$ 94,563	$174,764
Federal Fund	196,545	225,989	422,534
Total	$276,746	$320,552	$597,298

* Costs reflect the same growth rate as the rest of the primary care budget. Cost shift to hospital outpatient services, home health agencies and nursing facilities has not been calculated at this time.

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10. **Eliminate Dental Services Including Dentures**: Under this option, all dental services, including dentures, would be eliminated for adults.

Individuals impacted: 13,587 adults.

Impact:

a. Recipients with an acute dental problem will seek relief from physicians and/or emergency rooms. Some cost shifting to these areas can be anticipated.

b. Care in doctors offices and emergency rooms will probably consist of "pulling teeth" resulting in more serious dental problems for clients in the future.

c. Nursing facility costs may increase to the extent that they will have to assure patients have access to dental care in order to meet certification requirements.

d. Dentists in small economically depressed communities may not have sufficient patients to continue practicing in these communities.

Savings*:

	FY 94	FY 95	Biennium
Dental Services Only			
General Fund	$ 737,824	$1,023,070	$1,760,894
Federal Fund	1,808,153	2,444,965	4,253,118
Total	$2,545,977	$3,468,035	$6,014,012

	FY 94	FY 95	Biennium
Dentures Only			
General Fund	$ 190,789	$ 224,953	$ 415,742
Federal Fund	467,557	537,599	1,005,156
Total	$ 658,346	$ 762,552	$1,420,898

	FY 94	FY 95	Biennium
Dental & Dentures Combined			
General Fund	$ 928,613	$1,248,023	$ 2,176,636
Federal Fund	2,275,710	2,982,564	5,258,274
Total	$3,204,323	$4,230,587	$7,434,910

* Costs reflect the same growth rate as the rest of the primary care budget. Cost shift to hospital emergency rooms, physician offices, and nursing facilities has not been calculated at this time.

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11. **Eliminate Podiatry Services**: Under this option, Medicaid would no longer reimburse podiatrists. Similar services would remain available under the physician program.

Individuals impacted: 2,187 adults.

Impact:

a. Services will be available through physician's offices but physicians may not offer the same degree of expertise in disorders of the feet as a podiatrist does.

b. The cost of providing podiatry services will be shifted to higher cost settings including physician offices and hospital settings.

Savings*:

	FY 94	FY 95	Biennium
General Fund	$ 91,872	$108,323	$200,195
Federal Fund	225,147	258,875	484,022
Total	$317,019	$367,198	$684,217

* Costs reflect the same growth rate as the rest of the primary care budget. Cost shift to physician and hospital services has not been calculated at this time.

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12. **Limit Adult Transplant Services to Cornea and Kidney Only:**

Impact:

a. Limit coverage of adult transplant services to cornea and kidney only. Cornea transplants can be done in-state at a relatively low cost. Kidney transplants are reimbursed primarily by Medicare.

b. Medicaid currently covers heart, liver, bone marrow transplants as well as cornea and kidney. Since 1/1/92, the Department has screened 42 individuals (adults and children) for covered transplant services (8 bone marrow; 4 heart; 4 liver; 26 kidney). All individuals have been placed on waiting lists.

Savings*:

	FY 94	FY 95	Biennium
General Fund	$ 96,535	$ 98,267	$194,802
Federal Fund	236,575	234,843	471,418
Total	$333,110	$333,110	$666,220

* Savings are based on actual expenditures in FY 92 for 3 adult transplants (1 liver, 2 bone marrow) with no inflation for number of recipients. The actual budget impact could vary by as much as $500,000 depending on TPL/Medicare coverage or lack of for covered related services.

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13. **Eliminate Licensed Clinical Social Worker, Licensed Professional Counselors, and Licensed Clinical Psychologist Services:** Under this option, psychological services for adults provided by these three providers would be eliminated. Services may or may not be available through the community mental health centers.

Individuals impacted: 2,488 adults*

Impact:

a. If community mental health centers continue to be funded as a Medicaid service, recipients will seek services there, resulting in a cost shift to that service. These centers have traditionally had waiting lists and may or may not be able to accept the increased clientele.

b. If services are not available through community mental health centers, either because they are no longer covered by Medicaid or because of waiting lists, recipients will seek care in the emergency rooms and inpatient hospital settings. This will be the only "community care" available under Medicaid

c. Ultimately, admissions to Montana State Hospital may rise if community care is not available. This will be at 100% general fund cost to the state.

Savings*:

	FY 94	FY 95	Biennium
General Fund	$200,851	$212,490	$413,341
Federal Fund	492,216	507,815	1,000,031
Total	$693,067	$720,305	$1,413,372

* Costs reflect the same growth rate as the rest of the primary care budget. Cost shift to community mental health centers, hospitals and Montana State Hospital has not been calculated at this time. Number of adults impacted may be slightly overstated as an individual client may have gone to more than one type of practitioner.

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Presentation Date: 1/22/93
SRS Staff: Nancy Ellery
John Chappuis
Mary Dalton
Committee: Human Services Appropriations Subcommittee

Medicaid Refinancing Strategy

Refinancing strategy, in a nutshell, is a way to capture currently untapped federal funds to either expand or maintain current human services programs with minimal or no increase to the state general fund. Specifically, I am here today to talk to you about Medicaid refinancing strategies.

Refinancing has been going on for years in Montana. Examples of this strategy include the Montana Developmental Center which was at one time a 100% state funded institution. This facility is now reimbursed by the Medicaid program under the ICF/MR option and 71% of the cost for treatment there is borne by the federal government. Another example is inpatient psychiatric services for children which were at one time provided at Montana State Hospital with 100% general funds. In the early 1980's the state decided to fund at least a portion of these services under the Medicaid program and built the Montana Youth Treatment Center in Billings. This facility was later sold to Rivendell in 1986. Now children's inpatient psychiatric care is provided through private providers and the majority of reimbursement is through Medicaid.

These examples are important because they reinforce the caution which must be taken whenever Medicaid funding is used as a

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refinancing source. While there is great opportunity with Medicaid, there are also potential pitfalls. Care must be taken so that service systems are not designed based on funding sources, but rather on the need(s) of the population you are seeking to serve. It does no good to have a well funded system that doesn't deliver the services that are really needed. I would like to talk briefly about some of the limitations that are associated with Medicaid coverage of any service before I summarize where we are with refinancing and where we hope to go.

One of the major differences between Medicaid and other state funding sources is that Medicaid is an entitlement program. That means that if a person is Medicaid eligible and he needs a medically necessary service, the state cannot arbitrarily limit the number of services or the number of recipients by putting caps on services. An example would be that Medicaid cannot provide physician services to only 100 people.

Medicaid can also only pay for certain "medical" services. Room and board costs in the foster care program are legitimate costs, but they are not "medical" costs, so they cannot be reimbursed by Medicaid.

Medicaid services, with the exception of the home and community based waiver and targeted case management services, must be provided on a state wide basis. You cannot target only certain people in a certain town for a certain service.

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Medicaid also comes with a variety of federal regulations about what kind of providers can provide what kind of services in what kind of setting. Program coverage, with some exceptions, is mainly confined to licensed or certified medical professionals and licensed facilities.

This is not to be negative about the Medicaid program. The program provides necessary funding, but it is not the answer to all of Montana's refinancing needs.

MEDICAID ROLE

Medicaid has participated in a variety of refinancing projects over the past two years with various departments/agencies. We have tried to work smarter and better in these efforts than perhaps has happened in the past. In most instances we have asked that the agency proposing a new service come forward with both the general fund and the program or service definition and design. We have met with the providers and the other agency staff to finalize program goals and then Medicaid staff have then taken this information, massaged it so that it fit federal guidelines, written rules and state plans, developed a reimbursement system, trained providers on documentation and billing procedures, and brought the service up. This has proven to be a good working relationship.

Briefly, I would like to describe some of the new programs that we have initiated in the past two years:

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Targeted Case Management

Targeted case management or TCM is an exciting program for us. This is one of the most flexible Medicaid options. The program does what its name implies, it allows the state to fund case management in a targeted manner. Unlike most Medicaid programs, services can be directed at a specific group (for example, high risk pregnant women). Services can also be restricted to a certain area, for instance a county or city rather than having to be provided across the state. On your "one-pagers", on pages 34, 35, 40, and 44 there is a description of the four targeted case management groups that we are covering: high risk pregnant women, severely emotionally disturbed children, adults with severe and disabling mental illness, and developmentally disabled individuals over the age of 16.

All four of these groups share a similar goal. Case managers for each group help clients plan and coordinate care and services to meet individual needs. The goal of case management is to maximize access to necessary (and the emphasis is on that word necessary) medical, social, nutritional, educational and other services. Let me give you an example of what that means. People aren't born being good health care consumers. It's a learned behavior. If you don't know about and understand the normal physiological changes which occur with pregnancy you may overuse services like the emergency room or doctor's visits because you think something is wrong. Conversely, not knowing the normal physiology of pregnancy

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might also cause you to ignore early warning signs of premature labor and not go to your physician when you should.

These four target groups were brought up to address certain needs that were identified in other Departments. Targeted case management for high risk pregnant women was instituted in July of 1991. It is a cooperative effort with the Department of Health and Environmental Sciences. Currently 10 MIAMI projects offer this service. The general fund for this particular group is in the Medicaid budget. It was appropriated by the legislature last session. In later presentations by DHES you will be hearing about grants to these projects which along with local funds are used to pay for the non-Medicaid portion of the population.

TCM for high risk pregnant women has proven to be very cost effective. The addition of Medicaid funding for the MIAMI projects has allowed them to hire more staff so that more women can be seen. The projects have been successful in reducing both low birth weights and infant mortality in the areas that they serve. 50 fewer low birth weight babies were born in 1992 than would have been expected based on 1986 data. (Based on a decrease from an average of 9.23% of low birth weight babies born in 1986 in the pilot project population to an average low birth weight rate of 6.08% in FY92.) Considering that 56% of the projects' clientele are Medicaid and that the average cost for a Medicaid low birth weight baby in calendar year 1991 was $47,770, the conservative estimate of savings to the Medicaid program from this reduction in

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low birth weight babies alone is $1,337,560. There are many other convincing statistics about the success of the MIAMI projects that the Department of Health and Environmental Sciences will be addressing in greater detail in their presentations before the committee.

TCM for adults with severe and disabling mental illness was also started in July of 1991. General fund for this service is the Department of Corrections and Human Services budget. The 5 Regional Mental Health Centers are the providers. The service is almost identical to the Intensive Case Management services that are provided to non-Medicaid people utilizing DCHS general fund.

TCM for persons age 16 and over with developmental disabilities was instituted in ~~July~~ Oct. 1991. Case managers for this service are either DFS staff or organizations that they contract with to provide the service. In the past, Medicaid has financed this service as an administrative match and the state received 50% FFP. As a TCM service, the matching rate has been enhanced to 71% FFP. General fund for this service is in the DFS budget.

TCM for youth with severe emotional disturbance is the latest addition. This target group was added in June of 1992. Unlike the other TCM services which are state wide, this service is only available currently in Missoula County and the Helena Valley. General fund for this service is provided by DCHS through agreements with the two Regional Mental Health Centers.

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Chemical Dependency

Chemical dependency treatment is outlined in greater detail on page 38 of your one-page handouts. This service was instituted July 1, 1992. Treatment is limited to individuals under the age of 21 in outpatient facilities approved by DCHS. These services were previously paid for by both DCHS and DFS. General fund for this service is in the SRS budget. This is part of the money appropriated for EPSDT/Rehabilitation services last year.

Schools/EPSDT

Schools provide several medical services that are reimbursable under the Medicaid program. In the past two years, some of the larger schools have begun to bill the speech therapy, occupational therapy, physical therapy, licensed professional counselor, licensed clinical social worker, licensed clinical psychologist, nurse practitioner, and physician services that they provide to Medicaid clients. This has not been a great deal of money, $159,428 was reimbursed in FY92. Currently the Billings, Great Falls, Butte, Laurel and Lewistown public schools are Medicaid providers. This group represents approximately 27% of all school children in Montana.

Schools face some unique challenges in becoming Medicaid providers because they cannot bill Medicaid for something that they provide without charge to other children. If they become a Medicaid provider they must also bill other insurance companies for the same services. Some parents have been reluctant to let schools bill

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insurance company for these type of services because they are that schools are mandated to provide these type of medical es for "free" as part of the federal law that requires that s provide a free and appropriate public education. This that for some children who are covered by insurance and id, if the parent does not agree to bill the private nce first, Medicaid cannot be billed either.

:ly the general fund for these services is in the SRS budget. ndment to the general appropriations bill (HB2) will be ıced to authorize up to 1% of the general fund appropriation ecial education allowable costs to be used for Medicaid

This will allow OPI to fund the general fund portion of osts in the coming biennium. This is another example of the tion that is taking place between agencies.

Chairperson

JTIC GROUP HOMES

l and DFS have just completed a joint initiative to allow ıtic group home providers to bill Medicaid. This service effective on January 1 of this year. Providers, DFS, and together and agreed upon the kind of services that need to ded, developed utilization criteria for who should be in lity, and developed staffing levels. This is a service ll provide a much needed intervention at the community General fund is contained in the DFS budget for this

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FUTURE PLANS

The question now remains of where do we go from here. Medicaid stands willing to help re-design programs within the resources available to us. It must be understood that these efforts take a great deal of creativity and hard work on the part of all agencies involved. We are not able to bring up everything at once because we do not have staff that can be devoted solely to this project. What we have tried to do is proceed in an orderly fashion bringing up what projects we can. DFS, SRS, OPI, DCHS, and DHES have met for the last two years to prioritize these projects based on the projected savings and the degree of need for services.

Part of this prioritization of projects has been based on a contract with the Institute for Human Services Management. They completed a study in mid-November of 1991 to assess the potential for capturing different federal funding sources in Montana. They identified several areas that needed to be studied further and gave some ballpark figures of dollars that might be available for reallocation. Some of you may have heard reports that there was $10 to $16 million dollars available. Those estimates were very preliminary, they were not based on complete information in all cases and they were being presented by a company that was hoping to be awarded a contract to do a further in-depth study.

A contract for an in-depth study was not awarded because when bids were received on the project they ranged from $167,000 plus 4% of any federal revenue recovered to $1.2 million or 10% of all federal

revenues recovered, whichever was less. In addition, they involved dedicating at least 5 to 6 full time employees to do nothing but work with the contractor for a minimum of 6 months.

The agencies involved agreed that the resources, both financial and in terms of employees, were beyond what they could support.

The next two areas that Medicaid will be focusing on as "refinancing" projects will be therapeutic foster care with DFS and possibly making the Montana School for the Deaf and Blind a Medicaid provider. Let me discuss very briefly these two options and then answer any questions you may have.

Therapeutic Foster Care

DFS currently obtains therapeutic foster care from 9 different providers who manage approximately 170 different homes. By July of 1993, Medicaid will be covering the therapeutic portion of care in these homes. The therapeutic portion is the care provided to emotionally disturbed children which is in excess of what a "normal" child might need. Let me give you an example. The average 8 year old might need 4 hours of direct care in a day for things like bathing, dressing, meal preparation, etc. - this portion of care is not eligible for Medicaid funding. But if that youth is emotionally disturbed, he might need an additional 5 or 6 hours a day for behavior management. That portion would be eligible for Medicaid. DFS will continue to be responsible for the board and room costs of care. They will also supply the general

fund portion for the therapeutic part of the care. Medicaid will obtain the FFP for the service.

Montana School for the Deaf and Blind

We are currently working with the Montana School for the Deaf and Blind to determine which services they currently provide might be matched with Medicaid federal funds. At a minimum we should be able to match traditional medical services like physical and occupational therapy. We have also asked for clarification from HCFA as to whether orientation/mobility specialists, interpreter tutors, and itinerant resource consultants can be covered under Medicaid. Funding details will need to be worked out during this legislature as to where the general fund for these services will come from or be appropriated to. We do not yet have a good estimate of the cost of these services.

This concludes my presentation. Do you have any questions?

med/refoverv.iew

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1/22/93 Deb Hemmer/Medicaid Testimony

Mr. Chairman and members of the committee,

My name is Debra Hemmer, I'm from Missoula, and I have a mental illness. I take two medications for my mental illness, plus medication for diabetes. Medicaid currently pays for most of this.

If you were to cut the coverage for prescription medication, I could not afford to pay for these on my SSI monthly income of $438. I can barely afford to make ends meet now.

I'm sure you understand the severe complications of not taking care of diabetes. What you may not understand is what will happen if I don't have my medication for my mental illness.

When I am not on medication I have panic attacks so severe it feels as though there is a flash-fire in my veins. I forget how to breathe normally for days and even weeks at time. I feel as though I am drowning in air. My mind will not slow down enough for me to sleep for 5 or 6 nights in a row, and when I finally drop from exhaustion, I have hideous nightmares. I cannot eat solid food for fear of choking to death. I can't go outside during the daytime because ordinary daylight will suddenly look like the white flash of a hydrogen bomb. I have strange urges to do terribly destructive things like stare at the sun until I blind myself, stick needles in my eyes, electrocute myself with a space heater, pour gasoline on myself and set myself on fire, or get into a head-on collision.

This is not about suicide; I have no desire to kill myself. This is more like "irresistible impulse". These thoughts are absolutely the most terrifying experience I've ever had. In addition, I become so physically clumsy that I become covered with bruises from tripping over furniture and banging into walls. I have no sense of depth perception. I once bent my thumb back to my wrist trying to get inside my apartment during one of these episodes.

Without medication I need help with washing and dressing. I cannot even cross a street, let alone shop for groceries, and since I now live alone, there is no one to help me when I cannot function.

My illness took away my child-bearing years, destroyed my marriage, and made strangers out of my family. I do not blame my husband for leaving me. He stuck with me for a long time, but it can't have been easy living with me. Neither of us had any hope that I would get any better.

Luckily, I ran into a psychiatrist who correctly diagnosed my illness and began treatment with medication that worked. It literally saved my life. I was able to go back to college and get my degree while on medication. Now I am going to adult education classes, so I can learn math up through 2nd year college-level calculus. I am also learning basic computer skills. This is so that I can either get a masters degree, or get some practical vocational training. Then, I can get off SSI, get a decent job, and become a tax-paying citizen.

I do not think I am asking a lot. Please do not take away the money that pays for the prescription drugs that have allowed me to have some hope for my future. With the medications I am able to get on with my life, I

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am able to accomplish things like being President of Missoula's Consumer Group, Open Minds, and serving as Vice President of the Meriwether Lewis Institute.

Without medications, I am certainly dangerous to myself, and probably dangerous to others. I would have to be hospitalized at Warm Springs. This would cost the state much more money than picking up the cost of my prescriptions.

I have lost so much of my past; please let me have a future. Thank-you.

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January 21, 1993

TO: Representative Cobb and members of the Joint Subcommittee on Human Services

FROM: Gail Wheatley, P.T. GW
President, MT Chapter American Physical Therapy Association

RE: Medicaid Optional Benefits

As President of the Montana Chapter of the American Physical Therapy Association representing over 200 therapists in the state, I urge your support for the retention of optional benefits which includes physical therapy provided in private settings. I understand that budget cuts will be deep and painful this session; physical therapists certainly will bear our share of that responsibility. However, when looking fiscally at this proposal, dollars WILL NOT be saved.

Over the sessions in years past, this same issue has arisen. Previous committees have taken up the same question. When the pencil is actually put to the paper, the most cost-effective location for the delivery of out-patient physical therapy is the private office. No matter how hypnotic the thought of cutting these services may seem, in the final analysis, there will be nothing more than a cost shifting to higher cost facilities.

Physical therapy is a federally mandated service so cannot be eliminated from the system. I do not doubt your appreciation of the value of physical therapy for the population in general. Services will be provided and it is your obligation to look for the provider who can render that service most efficiently, effectively, and at the most advantageous cost to the state. I know that you clearly recognize that hospital costs are traditionally higher than private offices due to numerous factors including overhead. Surprisingly, reimbursement to hospitals varies and may be as high as 100% of the billed charges. Hospital hourly rates for physical therapy may be $40-50 higher PER HOUR in a hospital than at a private office.

In addition, private offices are already subject to annual hourly limitations; 70 hours per year and up to 100 hours with prior authorization of the final 30. Hospitals have no such caps; when coupled with higher charges and reimbursement rates, the price differential sky-rockets. It is my understanding that the 100 hours is rarely, if ever, achieved so perhaps the upper limit could be modified.

Optional benefits have been termed "alternate benefits." This implies not a benefit which could easily be stricken in times of financial crisis, but benefits which give the state a more cost-effective option. Without these alternate

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benefits, all Medicaid recipients would be forced to obtain treatment at the higher cost hospital. If there were any dollars to be saved, your counterparts in past legislatures would have red-lined these services long ago.

Physical therapists in private practice currently obtain approximately 50% of the charges they submit. They have taken significant losses over the years to provide services when medically necessary. They truly can take no more losses. Small (and large) hospitals are floundering in the state; they scramble for every reimbursement dollar. The impact of a greater Medicaid percentage in their facility, with the associated losses, could be deadly. We are a rural state; the continued health of Montana and Montanans depends on the availability of services in rural communities. We cannot afford to sacrifice our hospitals by needlessly increasing their responsibility for Medicaid write-offs.

I urge you to preserve optional benefits to best serve our people and the state. Do not yield to pressure to cut just for the sake of cutting. Loss of optional benefits will not save you money. As you make recommendations, let me offer one additional to you. Currently physical therapy claims are subject to virtually no utilization review. This Chapter of physical therapists believes that additional savings can be realized by reviewing claims for appropriateness of treatment, methods of therapy, frequency and duration. We are very willing to work with the state on creating those utilization guidelines and implementing review. Thank you.

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January 22, 1993

Sandra Nelson

Human Services Appropriations Subcommittee
Representative John Cobb, Chairman
Subject: Nursing Home adaptive equipment funding

Thank you for the opportunity to have this information entered into the hearing record. I am hear representing Nelson Medical, Inc. A supplier for durable medical equipment in Montana and Wyoming for six and a half years.

My concern today is for that special nursing home client who's equipment needs are greater than what can generally be provided by the nursing home. Let me preface my remarks with a couple of comments:

We have been told by the Department of SRS that equipment amounts to around two (2) percent of the total Medicaid budget. We were also told that the adult equipment portion is not mandated and therefore is subject to cuts. This past year the wheelchair portion of equipment needs was put out to bid. The bid has been awarded and this should result in a substantial savings to the department.

We as a supplier acknowledge that in the past, there has been placement of some unnecessary wheelchairs and equipment in nursing home to clients who did not need specialized equipment. Not all nursing home patients require custom or adaptive equipment. Nelson Medical does not feel that the Medicaid system should purchase standard or non-modified wheelchairs and equipment for nursing home clients. When we have been asked to provide such non-specialized equipment to nursing home clients, that we felt did not meet creiteria, we have declined to provide the equipment. However, upon subsequent trips to that facility we have found that in many instances the equipment has been provided by another vendor. We feel that the professionals ordering the equipment need to assume some of the responsibility for this situation. It is difficult for a dealer to tell a professional (physician or therapist), that they, (the dealer), will not provide the equipment that they are requesting or that the equipment is not justified. The relatingship between the two entities is a dependent one and you also get into the issue of prescribing which dealers are not licensed to do. Our attitude as a company is that if we bankrupt the system, the system is no good to anyone.

However, there are some patient who benefit from the proper positioning and the mobility this specialized equipment provides. It allows some patients to feed themselves and to perform other necessary and personal tasks for themselves, because they are not spending all of their energy struggling to stabilize and keep themselves upright and in their chair.

Because nursing homes have to now be restraint free (federal law) some patients cannot sit independently without seating or positioning devices and have to remain in bed. Though this is not the facilities fault, some patients are forced to remain in bed or in reclining geri chairs. There have been instances where inappropriate equipment has been used and a client has inadvertently been injured, and in one instance died. This is an impossible situation for the facility as well as for the patients. The feds have tied the facilities hand so to speak.

We have a client who resides in a nursing home. He is 41 years old

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and has been bed confined for a number of years. Since we began working with him and his therapist four years ago, he is now able to sit upright most of the day, operate a power wheelchair, and use a communication device. In June or July of this year he is scheduled to move into his own apartment and will be working at a sheltered workshop. It has been documented that if this gentleman had not been left lying in bed for years for lack of equipment, he probably could have been out on his own some years ago--saving the system the large sums that have been paid out to institutionalize this gentleman. Besides the dollars involved, we also have to take a look at the quality of life involved when we warehouse people.

In the past we have made successful efforts to retrieve wheelchairs and equipment when the clients have died. With a few modifications and with very little money being spent, we can make these chairs appropriate for another client's needs. Though the agency does not at this time have the manpower to do so, we feel that it is important that someone track the wheelchairs going to nursing home clients so that when the patient dies the equipment goes back into the Medicaid pool to be used again for Medicaid clients. Often this equipment remains in the nursing home and is used on non-Medicaid clients.

In closing my testimony, I invite you ladies and gentlement, before a final decision is made that will affect these clients least able to state their cases, to visit a few facilities and witness patients who have been provided proper equipment vs. those patients left lying in bed or placed in improper equipment. The difference can be remarkable.

Thank you.

EXHIBIT 7e
DATE 1-22-93

INTERACTIONS BETWEEN PUBLIC HEALTH AND MEDICAID

TESTIMONY PRESENTED TO THE HUMAN SERVICES APPROPRIATIONS SUB-COMMITTEE BY DALE TALIAFERRO, ADMINISTRATOR, HEALTH SERVICES DIVISION, MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

JANUARY 22, 1993

The following programs and projects are representative of current cooperation and collaboration between public health programs and the Medicaid Division of SRS.

IMMUNIZATION PROGRAM: Some public health departments have billed Medicaid for administrative costs for providing immunizations. If the county health department purchases the vaccine (vaccines not provided through DHES), such as influenza and pneumococcal, they have included the vaccine cost in the Medicaid billing. County health departments cannot bill Medicaid for the cost of vaccines provided by DHES via the Centers for Disease Control.

HEALTH EDUCATION/RISK REDUCTION: Personnel from DHES and Medicaid have discussed an initiative to pilot projects with Medicaid populations to educate about behavior changes conducive to healthy lifestyles. Economically deprived populations have been shown to have a higher than average prevalence of risk factors which predispose them to chronic conditions.

AIDS/STD: At this time, local health departments do not find it necessary to bill Medicaid for AIDS-related services because they are able to bill the DHES Consortia Project.

INSURANCE CONTINUATION PROJECT: This project provides funds to pay insurance premiums for persons with AIDS so that their private health insurance can continue. Loss of insurance would require those in this program to utilize Medicaid. Funds received by DHES from HRSA are passed through to SRS via an interagency agreement; SRS administers the program for DHES.

MIAMI PROJECT: This program utilizes Targeted Case Management dollars to reimburse professional services provided to high risk pregnant women. Approximately 56% of local MIAMI projects' participants are Medicaid recipients. The average cost for a Medicaid low birth weight baby in CY 1991 was $47,770, the conservative estimate of savings to the Medicaid program from reducing the number of low birth weight babies by 50 is $1,337,560. Medicaid funds have enabled local projects to provide staff necessary to offer comprehensive services.

BABY YOUR BABY: The multi-media public education focus of the

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MIAMI project has produced television documentaries, public service announcements, printed materials and offered a toll-free telephone line for women to register for the Baby Your Baby Program. Over one-half of the women calling the toll-free number have needed services and been linked with appropriate contacts. Medicaid funds were used to match private donations and other non-federal dollars available for the Baby Your Baby project.

FOLLOW ME: Follow Me is a public health program for children at risk of developmental problems. It is being developed as a part of a comprehensive, community-based system of family support services in collaboration with state, local, public and private agencies including hospitals, tribal and Indian Health services. Follow Me builds on existing public health services to families, offering supportive services to new parents and families with young children through public health nurse home visiting.

Through an interagency agreement for Part H mandated services, DHES is designated the agency responsible for developing and maintaining a tracking and referral system for children from birth through age two who have been diagnosed and/or are at risk for special needs and/or developmental delay. Tracking is used in this sense to include identification, monitoring, and connection to appropriate service providers.

Preliminary discussions have been held with Medicaid staff regarding the expansion of MIAMI targeted case management services to children in the Follow Me program.

1/20/93

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. _____

DATE 1-22-93 SPONSOR(S) _____

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

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Sandra Nolan	Montana Medical		
Rosemary Harrison	Billings Senior Nurses		
KAREN SLOAN	State Fam. Plan. Council		
PAT POPE	Meriwether Lewis Institute		
DEBRA HEMMER	MERIWETHER LEWIS INSTITUTE		
JOE ROBERTS	DD Systems Advocacy		
[illegible]	[illegible]		
[illegible]	DD		
[illegible]	[illegible]		
Dana Aline	MAPTA		
KIRK HANSON	MT ASSOC PRIVATE PRACTICE PHYSICAL THERAPISTS		
Joe Cullen	MAPTA		
Kathy McGowan	MCMHC		
Judith Gedrose	DHES		

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HOUSE OF REPRESENTATIVES
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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Mary L. Wilson	Medical Women	X	
Penny Rapke	SRS		
Connie L Arenn	Occupational Therapy		
Terry Kraft	SRS		
[illegible]	[illegible]		
Maurice O'Keefe	West Mont		
Mona Jamison	Mt. Assoc. Physical Therapy Mt. Assoc. of Speech Path + Audiol.		
[illegible]	Mental Health Assoc		
Stuart Klein	Mental Health Assoc		
[illegible]	SRS		
[illegible]	MASW		
JUDITH [illegible]	HRDC MT CH., NASW		
SHARON [illegible]	MT CATHOLIC [illegible]		
DAVE KASTEN			

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Human Services COMMITTEE BILL NO. _____

DATE 4/20/93 SPONSOR(S) _____

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
[illegible]	[illegible]		X
[illegible]	[illegible]		
[illegible]	Rocky Mt O.T. & P.T. Therapists		
Leo O'Sullivan	Physical Therapy		X
[illegible]	[illegible]		
[illegible]	[illegible]		
Dan Shea	MLC		
[illegible]	MSHP		✓
[illegible]	SRS		
Mary E. Dalton	Medicaid SRS		
Roger LaVoie	SRS		
[illegible]	[illegible]		
John M Shontz	Mental Health Assoc.		

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Dawn Kramer	Medicaid Svcs.		
Bob Runkel	Office of Public Instruction		
Judy Wright	DHES		
Dawn Peterson	Medicaid for Mental Health		
Dale Taliaferro	DHES		

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