MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - SPECIAL SESSION ONE CONTINGENCY STARTUP

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **JOHN COBB, CHAIRMAN**, on August 10, 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: Betty Lou Kasten

Members Absent: None

Staff Present: Lisa Smith, Legislative Fiscal Analyst
Lois Steinbeck, Legislative Fiscal Analyst
Alberta Strachan, Committee Secretary

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

Committee Business Summary:
Hearing: Medicaid.

CHAIRMAN COBB stated that the meeting was in response to a request of the leadership in the House and Senate to consider ways to make possible cuts in case of a Special Session. After he had talked to all of the members it seemed that the Committee should concentrate on the big area which is Medicaid and not so much of the smaller ones. AFDC is currently being worked on by a task force. Most of the money seems to be in the Medicaid area. **CHAIRMAN COBB** then presented the agenda for the day. **Exhibit 1**

Peter Blouke, Director, Department of Social and Rehabilitation Services, stated that the Governor had requested SRS to prepare a budget reducing spending by $70 million. It was made clear to the subcommittees that by August they would not be prepared in most cases to present a revised budget. The first meetings are billed as brainstorming sessions to discuss subcommittees' ideas for reducing spending. **Mr. Blouke** stated that SRS will be presenting some of the options they were discussing with the Governor. These are not as final list they are the types of issues that will be presented in case there is a Special Session.

More importantly it is recognized that SRS has a projected increase in Medicaid for the next biennium of $66 million in general funds. SRS recognizes that changes need to be made in Medicaid.

Dave Lewis, Director of Budget and Program Planning, also stated that changes need to be made in Medicaid. If a Special Session was not in the future, reduction in the budget will continue on through the next year and it will culminate in the presentation of the Governor's budget in January 1995. The Governor's budget has usually been worked on by their office in conjunction with the departments and kept under wraps until January of the year the Special Session meets. They have agreed to present their preliminary recommendations to the entire Finance and Claims and Appropriations committees sometime early in September. A package will be presented sometime this month so the Fiscal Analyst can review it before the meeting. They are "laying all of their cards on the table" before a final decision on what the Governor's budget recommendations will be. They want the input from the subcommittee.

SENATOR CHRISTIAENS asked what amount of money they were looking at from this Subcommittee if they are looking at the total of $90 million. **Mr. Lewis** stated that they are attempting not to do across-the-board cuts. They want to identify program reductions. They have established a quota. They have an idea of what may be possible, while conferring with **Mr. Blouke** about the reductions in the range of $10 million to $15 million for that program. They are concerned about setting the stage for moving into the next biennium budget with the projected shortfall. They have not made any final decisions on that but they are not going to have in their budget any recommendations for across-the-board cuts; they will identify program reductions that will total the amount they have been asked to come up with.

SENATOR WATERMAN asked if this was general fund. She is concerned that the increases are in the Medicaid budget and that the state needs to gain control of that budget in the long term. **SENATOR WATERMAN** asked if cuts were going to be considered in the Department of Family Services and if so how much. **Mr. Blouke** stated that the Governor wanted all of the new directors to take a look at their programs and make recommendations on what priorities might be set. Family Services was dramatically cut. There were big changes made. Labor and Health have small amounts of money from the general fund but that does not mean that those programs should not be looked at.

SENATOR WATERMAN stated that cuts were made in the seriously emotionally disturbed program. These departments are finally getting the opportunity to establish some long term prevention programs that are more appropriate. **Mr. Lewis** stated that Family Services were going to be reviewed.

SENATOR KEATING stated that Family Services should be reviewed.

Mr. Lewis stated that there were still state special and proprietary funds and switching was made from the general fund. Some of the agencies were trying to duck out of being considered as a part of the budget process by saying they were not a part of the general fund.

Mr. Blouke stated that the state needs to step back and take another look at the practice of regulatory agencies funding themselves with fees assessed to the industries they regulate. The Governor wants agencies go consider the whole issue of state regulation.

SENATOR KEATING questioned the interest income and statutory appropriations of severance taxes which are going to special programs. He asked whether they have the same priority that the human services programs have. If those programs are eliminated, that interest income can to the general fund to balance the budget.

CHAIRMAN COBB stated that Family Services will be doing some reorganization. **Mr. Blouke** said that $72 million is based on the projected loss of the income tax increase approved by the Legislature which could be suspended by the petition drive. Fund balance has not been discussed because one time revenues should not be used for a balance. Concern with reducing the ongoing level of expenditures by the amount of loss of revenues was considered.

CHAIRMAN COBB asked what the new fund balance was this last July. **Mr. Blouke** stated that reversions were $9 million from general fund. It was higher than projected but the exact amount is not known.

CHAIRMAN COBB asked when **Mr. Blouke** would know what the new balance was and the projected income for the next two years. The question is whether to cut $70 million or $90 million but the figure is only $50 million. Before committees can actually act on what to cut, they need to know how much money is actually coming in. **Mr. Blouke** stated that what SRS intended to present to the joint committees is tentatively being discussed and would be a balance of the budget that would include the disposal of fund balances, changes in revenue, etc. The fiscal analyst will make his report to the Legislature.

CHAIRMAN COBB asked if the committee would know sometime in August, before the next meeting, what the new fund balance was and also what the changes in revenue estimates will be. **Mr. Blouke** stated that a package will be given to the fiscal analyst for review by the end of the month.

CHAIRMAN COBB asked **Mr. Lewis** if the special session will be in late October or early November. **Mr. Lewis** stated that assumption was that if the petition drive was successful, the signatures would be turned in on the 24th of September and the Secretary of

State has up to three weeks to certify the signatures so the final resolution would not be apparent until sometime in mid October. It would seem the very earliest would be early in November. There is talk also of potential litigation and questions on whether or not that would in fact take place. If there is litigation, the option exists of proceeding with a special session or waiting for the courts to decide what the status of the petition drive is.

CHAIRMAN COBB then asked how lengthy the session should be. **Mr. Lewis** stated it could be a short session or a week to a week and a half.

Paul Gorsuch, M.D., representing Project 94 which was developed by physicians who support market oriented and individualized reforms, presented a model for reform of Medicaid. **Exhibit 2**

SENATOR KEATING asked why the physician growth stood out. **Dr. Gorsuch** stated that the main reason was the increase in coverage for routine services and routine physician fees by third parties. **Dr. Gorsuch** also stated that the first method cost control is to limit services and that is almost always where the discussion focuses. There could be a medical savings account which would be tax free accounts similar to IRA's owned by the individual but used to pay for medical expenses; catastrophic costs would still be paid for by insurance. Arizona has had the best success in the Medicaid program.

Mr. Blouke, then discussed the Medicaid Program. Medicaid is a joint state and federal program. Medicaid in the current biennium will account for 18% of the total general fund spending. That is up 16% from the last biennium. Medicaid is a rapidly growing program in this state and nationally. A projected Medicaid expenditure in chart form was then discussed. **Mr. Blouke** then stated that there were three guiding principles which must be used: 1. the basic expenditures for Medicaid must be reduced; 2. quality of care and reasonable access must be maintained; 3. federal Medicaid statutes must be complied with. What other state's have done on the issue of Medicaid was then discussed. Medicaid now consumes about 15% of the average states budget. Montana is at 18%. This in an ongoing strain for all states. The problems that Montana is facing with the Medicaid program are not unique. Most of the states' cutbacks and reforms have focused on primary and acute care. There is an increasing focus on long term care issues. Nursing home care takes about 1/3 of the Medicaid budget. The cost containment that has been used in other states can be categorized into: 1. raising revenue through selective provider taxes and donations, and 2. eliminating optional Medicaid services. **Exhibit 3**

SENATOR WATERMAN then asked if there was not a legal challenge. **Mr. Blouke** affirmed this, adding that the case was lost.

SENATOR WATERMAN asked if people were not signing up for the

program. **Mr. Blouke** said that this is an area where the Department is moving forward; they are optimistic that they will be able to meet their goal.

SENATOR CHRISTIAENS asked **Mr. Blouke** what the average cost per day in the nursing home beds would be. **Mr. Blouke** said that the average was $40.00 per day. Several states have gotten themselves into serious financial difficulty with that because when the 25% limit happened, there were states that had exceeded that amount. They were faced with cutting services back to the level that would fit into the 25% or maintaining those services with pure 100% general fund. The other problem is that eventually that health care reform would be coming out of the administration. Probably the Medicaid program will be ruled into that but states will be expected to maintain a certain level of expenditure. Medicaid expenditures will be the base on which the federal government will do their calculations.

CHAIRMAN COBB asked if there was $16 million left to spend per year. The solution would be to put the provider tax on the hospitals in which you could in some way figure a way to reimburse those hospitals that paid more than they got back and then reduce the general fund so you could actually take out over $14 million or $15 million a year of general fund. **Mr. Blouke** stated that it could be possible but that SRS is also constrained by the tax limits on how much they could increase the reimbursement rates to hospitals. j In effect, to raise that kind of money and still not hold the hospitals harmless would be difficult.

CHAIRMAN COBB asked if any other agencies had approached **Mr. Blouke** regarding provider taxes and **Mr. Blouke** stated no.

SENATOR KEATING asked if the federal government will allow this. **Mr. Blouke** said the federal government will allow it but they are setting limits on how much states can tax which is still 25%. He then talked of Medicaid expansion. Many of the states have expanded their Medicaid programs to cover more of the uninsured. Many of these initiatives have targeted pregnant women and children. Montana has implemented all mandates to expand eligibility for pregnant women and children. Currently pregnant women and children under age six can have family incomes up to 133% of the poverty level which is about $15,800 per year for a family of three. Children from age six to nine are covered up to the poverty level which is $11,890 for a family level. Eligibility then phases in for youth between the ages of nine and eighteen, one year at a time until the year 2000 when all children eighteen and below would be eligible. Montana has not implemented the optional eligibility expansion for pregnant women and infants up to 185% of the poverty level which would be $21,996 for a family of three. The federal regulations allow states to go up to 185% of the poverty level to provide coverage if they choose. Some states have found a loophole in the regulations that have allowed them to go even beyond the 185% of

the poverty level, and 33 states provide coverage above the mandated 133%.

Mr. Blouke then discussed the options in the Medicaid program. Several SRS staff members were acknowledged for their work in making reductions. None of the reductions are easy or painless. They will have a direct impact on clients, and people will in fact lose services they are currently receiving. The reductions discussed by **Mr. Blouke** for consideration were the elimination of adult podiatry services; the elimination of adult hearing aids and audiology services; the reduction of adult physical, speech and occupational therapy services; the elimination of adult eyeglasses and optical services; the elimination of adult denture and dental services; the increase of co-insurance on impatient hospital stays; the reduction of a limit on the number of mental health services (exclusive of day treatment and targeted case management) to 22 hours; mental health services to adults; the nursing facility program; the special income limit; the limit of services to medically needy to primary and prevention care; and the reduction of AFDC payment levels. **Exhibit 4**

SENATOR CHRISTIAENS asked of any of the programs would be eliminated entirely.
Mr. Blouke stated that the Department did not look at eliminating the entire service. He also stated that these proposals had been proposed to the Governor and he has made no decision.

SENATOR WATERMAN asked that the term medically needy be explained. **Mr. Blouke** stated that medically needy was defined as the elderly who receive medication because Medicare does not pay for drugs. A very large percentage of the cost of this program are attributed to this.

REPRESENTATIVE WANZENRIED asked for a profile of the people who would be affected. **Mr. Blouke** stated that the low income adult person with no money who is in need of dental, mental services or any of the services provided, older individuals, and the disabled.

REPRESENTATIVE WANZENRIED asked how much of these savings were administrative or how will SRS change administratively to help to contribute to that total. **Mr. Blouke** stated that administrative costs were 2 1/2% of the total expenditures. 97% of the Medicaid budget goes to client benefits. No staff will be reduced. When services are cut eligibility is cut.

SENATOR WATERMAN stated that this committee and SRS came up with some ideas in the regular session that in the long term would have provided better services which were more cost effective and provide some long term savings. Everything in the long term solution is being brought to a virtual standstill. This administration is losing its most productive period of time because of this crisis.

Charles Butler, Vice President of External Affairs, Blue Cross and Blue Shield of Montana, stated that they would work with SRS to design a managed care program for Medicaid which will assure access to quality health care services in a cost effective arrangement and in a partnership with government and health care providers. Copies of a Tennessee proposal and several other articles on Medicaid and managed care was provided to the Committee. **Exhibit 5**

SENATOR KEATING asked if the services offered by the medical providers that BC/BS services were any different than the services required under the federal government. **Mr. Butler** stated that they provide the same high quality of care for everybody that needs the services. Access to care for people on assistance sometimes is a very difficult problem in Montana. One of the problems is reimbursement.

Frank Cote, Deputy Insurance Commissioner, State Auditor's Office, distributed to the committee the insurance provisions of Senate Bill 285. He discussed qualified previous coverage which is what the insurance provisions allow for the guaranteed issuance of coverage. If someone is on Medicaid who is uninsurable and they are not actively seeking a job this bill provides that they can obtain insurance and actually come off the Medicaid rolls by enrolling in a job that is covered under this bill. The Uniform Claim Insurance form was also discussed. **Exhibit 6**

CHAIRMAN COBB asked when this would be available. **Mr. Cote** stated that July 1, 1994 was the date.

CHAIRMAN COBB then asked when the Uniform Claim Insurance form was going to be finished. **Mr. Cote** stated about three years.

Bob Robinson, Director, Department of Health and Environmental Sciences, spoke of the history of health planning and the certificate of need (CON). In 1974, the National Health Planning & Resources Development Act was signed into law establishing a national health planning policy and providing federal funds to support state and local planning activities. A health care facility or service operating in a state with a CON law must submit an application to a state health planning agency before spending money that exceeds specific dollar thresholds, typically established for categories such as major medical equipment, capital construction and operating costs. The Certificate of Need reviewable services are nursing home services, personal care services, hospital swing beds, home health care, inpatient chemical dependency treatment, ambulatory surgery, inpatient psychiatric services, inpatient mental health services, residential treatment facilities, intermediate care facilities for the mentally retarded, medical assistance facilities, inpatient rehabilitation services, health maintenance organizations, changes in bed capacity, the addition of a health service, the incurring of an obligation of a capital expenditure

and any proposed capital expenditure. **Exhibit 7**

James Ahern, Montana Hospital Association, stated that Montana has 51 general acute care hospitals, 4 psychiatric hospitals, 5 medical assistance facilities, 3 Indian health service hospitals, 2 veterans administration hospitals and one facility at Malmstrom Air Force Base. Besides Montanans, hospitals serve people who live in neighboring states and Canada as well as those visiting the state. Hospitals are a major employer in their communities, and provide a significant boost to the local economy. A strong hospital industry is crucial to the economic development of Montana. Cutting payments and programs for health services is not going to help solve the problem of health care cost inflation Such actions will only worsen the problems with health care. A comprehensive restructuring of the health care system is the only real solution to health care cost inflation. Hospital costs are growing by about 10 percent per year, not the 20 percent per year Medicaid is experiencing. Taxing hospital revenues adds more to the cost to deliver care than is returned to hospitals in the form of increased payments. A tax just doesn't work for hospitals like it did for nursing homes. But if it becomes necessary, hospitals will exercise their legal rights under the Boren Amendment which enables them to continue to deliver health care to their communities. Reforming the health care system is the only solution to control health care cost growth. A reformed health care system must better align the incentives for hospitals, physicians and other providers to deliver cost effective services. Allowing providers to cooperate with one another to reduce health care holds great promise to reduce expenditures. Cuts made now that increase uncompensated care raise barriers to reforming health care. More cuts means lowering the quality of care, or reducing access to needed services. Montanans, even those who live in the more urban communities, may someday find themselves forced to travel outside the state for anything more than primary care. **Exhibit 8**

John A. Guy, St. Peter's Community Hospital, stated that last year there was a decrease of 10% in inpatient admissions. There is increasing out of pocket costs, changing technology, continued shift to outpatient and home care services, overall reduction in admissions, increased percentage of Medicare/Medicaid, cost cutting, establish a productivity monitoring system, implementing a cost accounting system, maximize the existing resources, sharing technology, case management, shift in resources to outpatient, home care. In summary, hospitals are being pressed from all corners, they don't have the ability to continue absorbing cuts and they need to support overall health reform. **Exhibit 9**

Kirk Wilson, President, Montana Deaconess Medical Center, spoke of the employee layoffs in the hospital which totaled 72%, the increase of out patient care and the air transport of newborns.

Charles Briggs, Director, Rocky Mountain Area IV Agency on Aging,

identified some changing service needs, as well as specific problem areas facing the aging population. He focused on the central fact of the changing needs of the senior population and reviewed one state's model which has served to help deal with mushrooming expenses for long term care. Montana is experiencing a significant expansion of the population over the age of 75. **Mr. Briggs'** proposal to the committee was rather than categorical service reductions, which will probably only exacerbate the problem, to consider diverting a greater share of service dollars to less costly community options. **Exhibit 10**

Rob Hunter, Managed Care and Benefits Consultant, endorsed the direction being taken by Blue Cross/Blue Shield and SRS with respect to Medicaid risk contracting. **Mr. Hunter** also represented the Montana Medical Benefit Plan.

Stuart Klein, Executive Director, Mental Health Services, Inc., serves the twelve counties in southwestern Montana. SRS wants to limit the outpatient therapy visits by the mental health centers. This would affect the sickest of the sick which are people with serious disabling mental illness. Ninety percent of all persons on Medicaid would, with certain mental disorders, be affected. The type of services these individuals would receive are proposed to be capped. Institutionalization in Montana would then befit these people. $1.8 million in services would be lost as a result of cost shifting.

Daniel Shea, submitted two letters that he had sent to Mr. James Ahrens of the Montana Hospital Association, Senator Fred R. VanValkenberg and Representative John Mercer on SB 285. **Mr. Shea** stated that he had given a certain amount of thought to the petition drive to suspend SB 671 and said that if a lawsuit was filed, Montana's constitutional provisions are going to be held unconstitutional on the basis of equal protection of the law. There is no way that 7% of the people of Montana can be allowed to basically enact a law to suspend; it will be declared unconstitutional. **Mr. Shea** stated further that he did not think that if there was a special session it would not be for that reason. He added that the Certificate of Need exemptions granted to the hospitals in 1989 had been harmful. As soon as a CON application is acquired, the hospitals oppose it. If there is a Special Session, an appeal may be made for this exemption. A resolution can be passed to ask Congress to either repeal or amend the Boren Amendment. **Exhibit 11**

Christina Medina, Executive Director, Montana Low Income Coalition, stated that she opposed the cuts for the programs for the poor. Welfare is not a way of life and it is a demeaning program. There is not one person or family who wants to be on welfare. **Ms. Medina** stated that she was skeptical about cuts in the medically needy program after hearing Dr. Black's presentation. The people who were using this program are also working mothers and fathers who have no medical insurance so they rely on this program.

SENATOR WATERMAN asked that whether cutbacks in the medical needy eliminate families of children. **Peter Blouke** answered that the majority on the medical needy programs are the elderly. The low income with dependent children would in all likelihood qualify for the categorical grant. He also stated that there were no families on the medically needy program.

Ms. Medina then stated that cuts were being made for adults who were poor but whose resources are too high for Medicaid or SSI. These people will try to apply for these programs and try to get these benefits. Many of the working folks are being taxed unfairly.

SENATOR KEATING stated that he had no intention of cutting human services budgets any more than what they did in the regular session. If there are some efficiencies that can be found in this process without cutting services to the people he agrees with this.

Neil Haight stated that the needs were obvious. Many of the people are signing this petition. Christian values have some economic value.

SENATOR CHRISTIAENS asked what was happening with the work that **Mr. Haight** was doing to procure benefits from SSI on a faster basis. **Mr. Haight** stated that this process was going on in some of the counties but other counties do not have the proper referral.

John Shontz, Public Policy Coordinator, Mental Health Association of Montana, stated that the Association aggressively supported tax reform during the 1993 session of the Legislature. The Association understood then and understands now the consequences of the failure of fundamental tax reform in Montana. However, the Legislature's options are limited. The Montana Constitution mandates that services be provided to mentally ill indigent Montanans. The mental health system in Montana is becoming more cost effective as institutional services are replaced with community based services. Patients are certainly better treated Development of adequate services to severely emotionally disturbed Montana children at the community level is just beginning. Funding reductions now will again commit the general fund to support very high cost institutional care. The same is true for Medicaid and medically needy service for mentally ill indigent adults in Montana. The Association encourages this committee to again meet jointly with the Subcommittee on Institutions to address these issues. **Mr. Shontz** stated that the committee would be appalled at the increased costs to general fund if the medically needy and the Medicaid optional services are cut or reduced at the community level. **Exhibit 12**

SENATOR CHRISTIAENS asked what was happening with the women incarcerated at the Montana State Prison. **Mr. Shontz** stated that the Mental Health Association stated that moving persons who were

currently in the correction facility into the forensic unit at Warm Springs and Pintler Lodge would require the mixing of mentally ill persons and a felony population. That is not appropriate. The Legislature appropriated $1 million to move Montana State Hospital toward accreditation. If the Legislature chooses to mix populations, there is no reason to spend that money.

SENATOR CHRISTIAENS asked for an update on community based programs for the severely and emotionally disturbed people. **John Shontz** stated that the department had put its plan into place which includes case management programs. It is not up and running across the state. Time has not been allowed for that to occur. People are working very hard to prevent children from falling between the cracks. People are making a good faith effort to implement that program. All of the State agencies and the local providers are working hard to do that.

Peter Blouke stated that the coordination between the Department of Family Services, the Department of Corrections and SRS in pulling together this managed care program has been by and large very successful. The problems are pretty massive. It is unrealistic to expect that within a month, the system is going to be running and the care will be provided. There has been some very genuine and very sincere cooperation between all of the parties. They have put together the funding, there has been a minimal amount of jurisdictional turf sort of things which are the nature of interagency interactions. It is started and they are moving forward but it will take a period of time for people to become comfortable with the rolls of the different agencies to get the money out there to build the community based resources that are going to make the thing operate over a long period of time. They are optimistic that it is going to work.

Mike Meyer, Executive Director, Summit for Independent Living Coalition, spoke on behalf of Montana's living centers. He recommended that as the committee weighs potential cuts they would look at restructure of health care for the State. Ways for meaningful involvement and input from the people who are most affected by this will be considered. Consumers of those services who live with them every day, particularly people with disabilities should be consulted. His coalition work with people every day to help them obtain an independent living arrangement in the community and help them maintain that independence and improve their quality of life.

SENATOR WATERMAN stated that if input could be obtained from the people who utilize those services and if they have suggestions with ways that the cuts be more palatable or avoid the cuts, it is important.

Mona Jamison, representing the speech pathologists, physical therapists and audiologists of the State of Montana asked the committee to consider the elimination of the benefits associated

with audiologists. The biennium saving for hearing aids and audiology services is $40,000 plus. The benefit that an individual receives for being able to hear is much greater than that. A hearing aide is the ability to function, to work, to be productive. With physical therapy, and speech therapy a reasonable approach is to limit business. They understand that cuts need to be made and that is a reasonable way to doing it. At this particular point, the Department and Subcommittee must not feel that they get locked into the recommendation 35 visits per individual. She said that perhaps the recycling of equipment could save some money. Part of the argument that the Department made in support of not cutting optional benefits when SRS was making their presentation is that there would be a cost shift. All of a sudden she sees a totally opposite position in their analysis in this cost shift. Maybe there could be prior authorization.

Peter Blouke stated that this proposal is fundamentally different from our position during the regular Legislative Session. SRS had argued that there would be a tremendous shift probably at a higher cost to completely eliminated the service. They are not proposing to eliminate the service, they are reducing the hours. They have looked at the average number of hours that clients receive; by reducing the hours, there is now a totally different proposal. SRS has simply done a different analysis.

Ms. Jamison stated that the recipients of the service appreciated that this was not a proposal to eliminate those optional services.

Paul Smetanka, Montana Podiatric Medical Association, stated that MPMA suggests that SRS may be discriminating against doctors of podiatric medicine. Finding true cost efficiency and true savings is extremely difficult to do. Certainly, SRS admits there will be a substantial cost shift from DPM's to other service providers. The MPMA does not feel that SRS has thoroughly considered the additional potential for hospitalization costs and claims administration for foot care coverage or a greater risk of exposure to Montanans due to complications. While SRS is concerned with hospitalization admissions in one area, they seem to be ignoring the fact that DPM's avoid those admissions in another area. He suggested that the fairest way to approach this is to eliminate all providers of services to the lower extremities. MPMA suggests that it is rather shallow conjecture that this would better serve its citizens through providing care and reducing costs by eliminating the specialists in the foot care field.

Paul Peterson affirmed the services of podiatrists and that their services were vital.

Paulette Cohman, Executive Director, Montana Council for Maternal and Child Health, stated that when the MIAMI money was granted, the saving that was projected was deducted in advance. This

budget savings is not a savings because the Legislature has already anticipated removal from the budget the savings from the fewer sick babies.

Written testimony was also provided by **Lisa Smith, Associate Fiscal Analyst, Montana Office of the Legislative Fiscal Analyst,** indicated that she was responding to the Legislature's request concerning Department of Health and Environmental Sciences for the allocation of its vacancy savings and budget balancing reduction. **Exhibit 13**

Rose Hughes, Executive Director, Montana Health Care Association, has written her comments on SRS/administration proposals; specific proposals for controlling Medicaid costs and general comments which stated that while it is always easier to reduce Medicaid costs by simply not paying the costs associated with providing the services. This is not an appropriate way to reduce costs since the unpaid costs are simply shifted to other payers and the eligibility and regulatory issues are never addressed. The Montana Health Care Association believes that Medicaid should accomplish savings by limiting eligibility to those who are truly needy and by seeking changes to (or waivers from) statutes and regulations which form barriers to the efficient and economic delivery of health care. **Exhibit 14**

G. Brian Zins, Executive Vice President, Montana Medical Association, stated that the members of the Association believe that essential services must continue to be provided and that cuts be considered in the optional service areas. They further believed that no cuts should be made for services provided children and pregnant women. Physician reimbursement under Medicaid is 50% to 55% of billed fees, any lowering would have a drastic effect upon the program. **Exhibit 15**

Robert B. Chaney, Jr., Consulting Audiologist, SRS, strongly urged the Legislature to include in their deliberations the professionals most knowledgeable and involved with those who will be affected by the cuts, so that maximum savings can be achieved with the least impact on the recipients. **Exhibit 16**

Bonnie L. Tippy, Executive Director, Montana State Pharmaceutical Association, gave the following recommendations for saving dollars in the Medicaid budget. 1) Institution of prior authorization of some drugs; 2) Elimination of payment for fertility drugs, and 3) Institution of formularies. **Exhibit 17**

CHAIRMAN COBB then stated that public testimony had closed. The next meeting would be held after the Budget Office prepares a cut list and presents it to the Fiscal Analyst for review. Separate hearings will still be conducted. Recommendations to the administration were discussed. Suggestions included were mental health, welfare reform package, more demographics on the medically needy; catastrophic care for the needy, organization plan from the Department of Health, MIAMI Program, the federal

budget changes which were made on SRS, reversions from AFDC from the last session, the status of the general fund budget, single billing, update from Family Services status, update on Blue Cross/Blue Shield on managed care, provider taxes, administrative bill by January on rule changes, and a feedback from the physical therapists.

ADJOURNMENT

Adjournment: 5:20 P.M.

CHAIRMAN JOHN COBB

ALBERTA STRACHAN, Secretary

JC/AS

EXHIBIT #1
DATE 8-10-93
S.S. HUMAN SERVICES
AGIN

SCHEDULE OF HUMAN SERVICE APPROPRIATIONS
8 a.m. Aug. 10th. Room 104, Capitol building, Helena, Montana

8.a.m. overview of schedule for the day
presentation by Budget Office of possible time for special session, possible cuts or changes to be proposed for all agencies under the human service appropriations committee.

8:30 presentation by SRS concerning medicaid

1. growth of medicaid over the years and projected growth
2. causes of growth
3. SRS implementation of cost savings over the years
4. what other states are doing to slow costs and general fund growth in medicaid
5. provider taxes
6. possible ways to cut medicaid as other states have done
7. what can be cut in medicaid
8. expansion of health care to non medicaid recipients
9. expansion of health care to more medicaid recipients
10. presentation concerning other states ways of controlling long term health care for the elderly and the State of Montana's committee looking into this issue.
11. certificate of need- by Dept. of Health
12. any other comments by the Dept. of SRS, Family Services

10:30 break

10:45 presentation by Blue Cross
1. possible ways to control costs by Blue Cross in medicaid
2. what Blue Cross is doing in other states with medicaid
3. what blue cross is doing in Montana to expand health care, any other proposals to control medicaid costs and health costs in general.Other comments by Blue Cross.

11:30 presentation by State Auditors Office on health care committee

12:00 lunch

1:00 presentation by Montana Hospital Association as to their perspective on medicaid, costs, growth and possible ways to control costs and health care costs in general, national view of health care reform.

1:45 Charlie Briggs to discuss other states proposals to control long term health costs for the elderly.

2:30 break
2:45 comments by the public, written comments to be discussed,committee to make tentative proposals on possible cuts, efficiencies, paying for growth in medicaid, expansion of health care and followup on any questions or request for more information at second meeting.set agenda for second meeting and plan date.

EXHIBIT #2

August 10, 1993

Briefly

Medical Inflation & Medicaid

And

Draft Legislation for Medicaid Reform

An Individual Approach

by

Project '94

Prepared by Paul Gorsuch, Jr., M.D.

For More Information, Contact:
Project 94
400 15th Ave. South #204
Great Falls, MT 59405
1 (800) 720-3181

EXHIBIT 31
DATE 8-10-93
HB HUMAN SERVICES & AGING

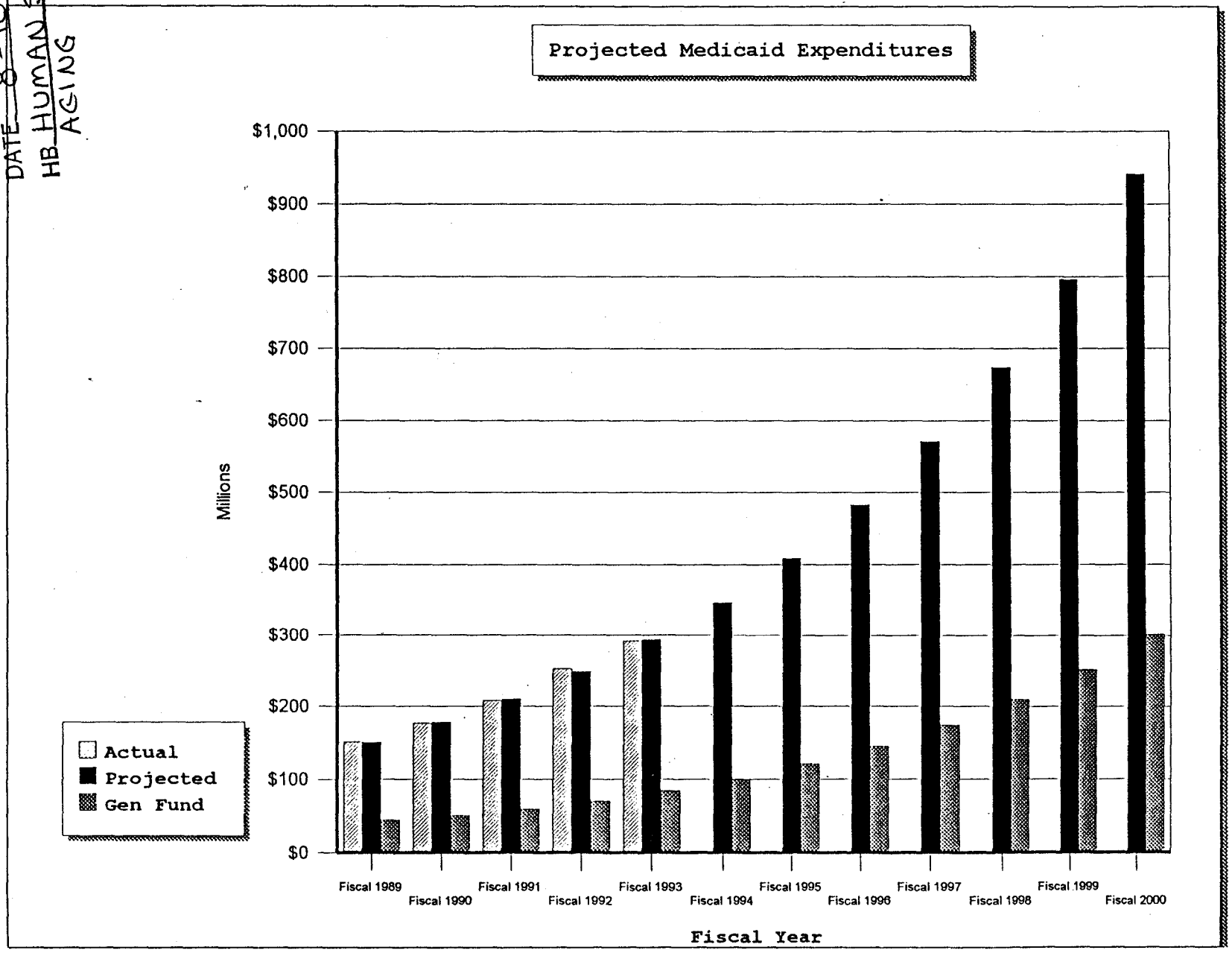
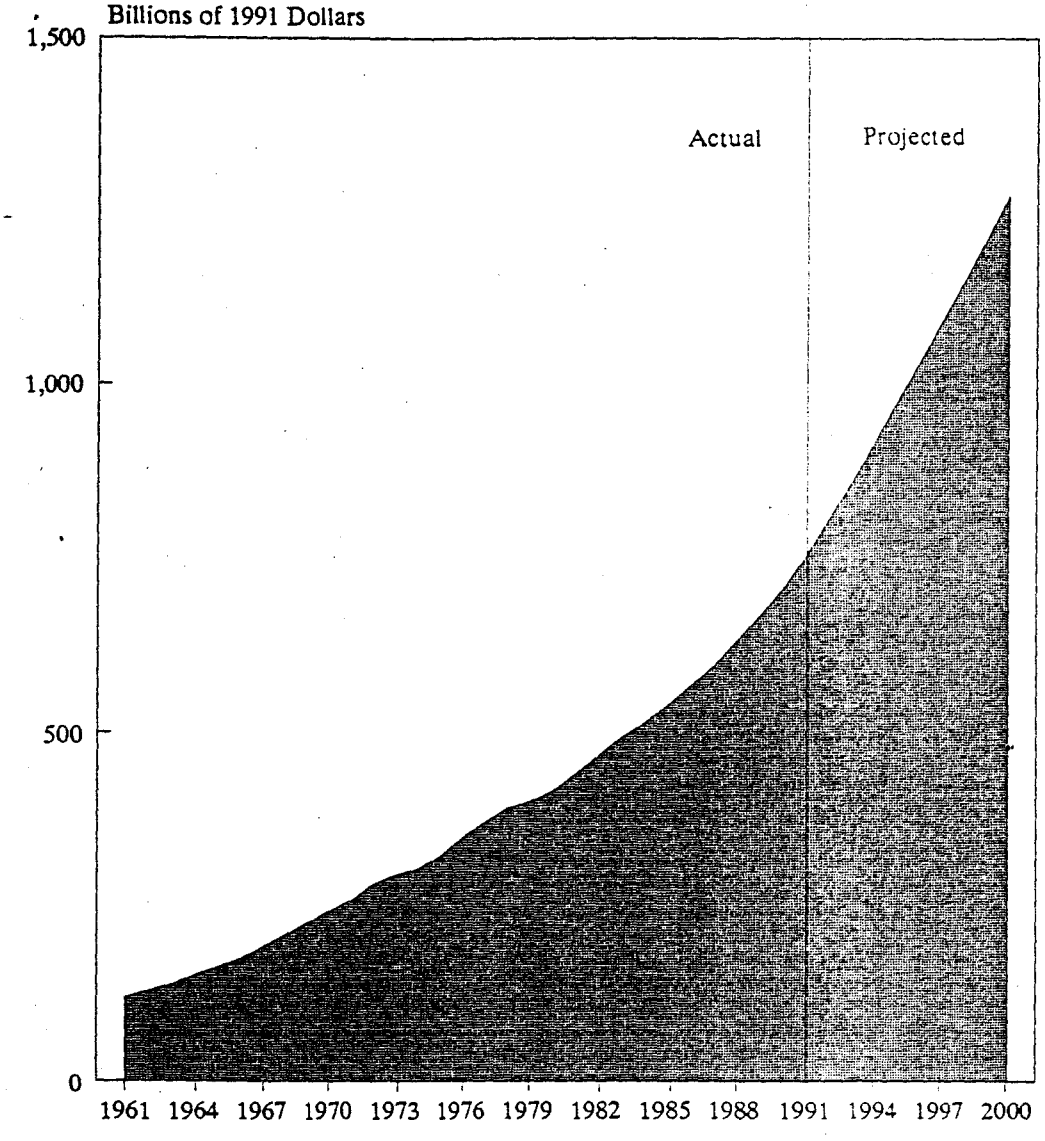


Figure A–1.
Real National Health Expenditures, 1961–2000



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1992.

NOTES: The word "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Expenditures for health are adjusted to 1991 dollars using a variant of the consumer price index for all urban consumers (CPI-U-X1) that incorporates a consistent treatment of the costs of home ownership since 1961.

See Table A-1 for the yearly data series.

EXHIBIT 4
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DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
SPECIAL SESSION I
POTENTIAL BUDGET REDUCTIONS

REDUCE OPTIONAL SERVICES

The federal government requires all states to provide certain mandatory services including such services as inpatient and out patient hospital care and physician services. Montana's Medicaid program covers 27 of 31 optional services allowed under federal regulations. The only optional services not covered are chiropractic services, respiratory care and services provided by Christian Science Nurses and sanitariums. Among the options available to the legislature is elimination of adult eyeglasses and optical services, adult hearing aides and audiology services, adult dentures and dental services, and adult podiatry. Federal regulations require that the state continue to provide these services to children, pregnant women, and individuals residing in nursing homes and ICF-MRs. Eliminating these optional services may increase expenditures in the mandatory service areas (e.g. hospitals, physician, etc). Cost shifts have been noted where appropriate. Elimination of these services may also result in reduced access to care and a deterioration of health status.

NOTE: Data on optional services savings are overstated because they do <u>not</u> reflect the cost of providing optional services to persons in institutional settings. This data will be incorporated once it is available and will <u>decrease</u> the savings identified. Approximately 11% of adult optional services expenditures are for persons in nursing homes. In Fiscal 1992, a total of 25,188 unduplicated adult recipients received optional services.

1. ELIMINATE ADULT PODIATRY SERVICES

<u>Description of Change</u> - The Medicaid program currently covers podiatry services provided by licensed podiatrists. This change would eliminate coverage of these services to adults who do <u>not</u> reside in nursing homes. Similar services are available through the physician services program which is a mandatory and may be more costly service.

<u>Considerations</u> - This service is covered by the state insurance plan and on a limited basis by Medicare. A total of 16 states do not provide podiatry services under their Medicaid program.

<u>Cost Shift</u> - Minimal cost savings are anticipated if this service is eliminated. This is based on the assumption that 90% of the recipients will receive their care from a physician. Only 10% will go unserved.

Number Affected

Recipients	2,187
Providers	30

Net Savings	FY 94	FY 95	Biennium
General Fund	$ 4,865	$12,271	$17,136
Federal Fund	11,923	29,326	41,250
Total Funds	$16,788	$41,597	$58,386

2. ELIMINATE ADULT HEARING AIDS AND AUDIOLOGY SERVICES

Description of Change - The Medicaid program currently covers hearing aids and audiology services provided by audiologists and hearing aid dispensers. This change would eliminate these services for adults who do not reside in nursing homes.

Considerations - This service is not available under Medicare, the State Employee Health Plan or is it proposed to be included as a benefit under National Health Care Reform. A total of 21 states currently do not provide this service under their Medicaid Program.

Cost Shift - No cost shift is anticipated from elimination of this service.

Number Affected

Recipients	757
Providers	50 Audiologists
	40 Hearing Aid Dispensers

Cost Savings	FY 94	FY 95	Biennium
General Fund	$10,646	$ 29,959	$ 40,604
Federal Fund	26,089	71,597	97,685
Total Funds	$36,734	$101,555	$138,290

3. REDUCE ADULT PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY SERVICES

Description of Change - The Medicaid program currently provides rehabilitative, physical, speech and occupational services provided by licensed therapists. This change would reduce annual coverage of these therapy services for adults from the current limit of 100 hours for each service to 35 hours per service. If deemed medically necessary, therapy services could continue to be provided under outpatient hospital and home healthcare but at a greater cost.

Considerations - This service is available under the State Employee Health Plan. A total of 19 states currently do not provide any physical therapy services, 24 states do not provide any occupational therapy and 21 states do not provide any speech therapy service under their Medicaid Program.

Cost Shift - Minimal cost shift is anticipated based on the assumption that these people will not be homebound so they will not qualify for home health services nor will they seek outpatient hospital services.

Number Affected	Physical	Speech	Occupational
Recipients	156	264	306
Providers	70	35	Unknown

Cost Savings	FY 94	FY 95	Biennium
Physical Therapy			
General Fund	$18,942	$ 51,323	$ 70,265
Federal Fund	46,419	122,654	169,073
Total Funds	$65,361	$173,977	$239,338
Speech Therapy			
General Fund	$ 4,871	$11,875	$16,746
Federal Fund	11,937	28,379	40,316
Total Funds	$16,807	$40,254	$57,062
Occupational Therapy			
General Fund	$ 3,708	$ 8,455	$12,164
Federal Fund	9,088	20,206	29,295
Total Funds	$12,797	$28,661	$41,458
TOTAL SAVINGS			
General Fund	$27,521	$ 71,653	$ 99,175
Federal Fund	67,444	171,239	238,683
Total Funds	$94,965	$242,892	$337,858

4. ELIMINATE ADULT EYEGLASSES AND OPTICAL SERVICES

Description of Change - The program currently covers eyeglass and routine eye care services provided by opticians, optometrists and ophthalmologists. This change would eliminate services for adults who do not reside in nursing homes. Treatment for eye disease would continue to be available on a limited basis under physician services.

Considerations - This service is not available under the State Employee Health Plan nor is it proposed to be included as a benefit under National Health Care Reform. Medicare only covers optical services and eyeglasses for surgical conditions such as cataract removal. Routine eyecare is not covered by Medicare. A total of 16 states currently do not provide eyeglasses and 14 states do not provide optical services under their Medicaid Program.

Cost Shift - No cost shift is anticipated from elimination of this service.

Number Affected

Recipients	9,559
Providers	400+

Cost Savings	FY 94	FY 95	Biennium
Routine Eye Care			
General Fund	$ 29,590	$ 69,279	$ 98,869
Federal Fund	72,516	165,565	238,080
Total Funds	$102,106	$234,843	$336,949
Eyeglasses			
General Fund	$ 83,816	$196,236	$280,052
Federal Fund	205,405	468,971	674,376
Total Funds	$289,221	$665,208	$954,428
Total Eyeglasses & Eye Care			
General Fund	$113,406	$265,515	$378,921
Federal Fund	277,921	634,536	912,456
Total Funds	$391,327	$900,051	$1,291,377

** Note these savings may be overstated. A volume purchasing contract for eyeglasses was implemented in February, 1993 and cost savings since this change was implemented are not yet available.

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5. ADULT DENTURE AND DENTAL SERVICES

Option A: Eliminate All Adult Dental Services

Description of Change - The Medicaid program currently covers dental services provided to adults including provision of dentures. This change would eliminate coverage of all dental services to adults who do not reside in nursing homes.

Considerations - Dental and denture services are optional under the State Employee Health Insurance. Services are not covered by Medicare. It is not known if dental services will be included under the National health Plan. A total of 15 states currently do not provide dental services and 20 states do not provide dentures under their Medicaid program.

Number Affected

Recipients	13,403
Providers	500

Cost Shift - Assume that 40% of the recipients will seek care one time in an emergency room at a cost of $200 if no dental services are available ($1,072,240 annually).

Cost Savings	FY 94	FY 95	Biennium
Dental (only)			
General Fund	$ 167,677	$ 393,091	$ 560,768
Federal Fund	410,920	939,420	1,350,340
Total Funds	$ 578,597	$ 1,332,510	$ 1,911,108
Dentures (only)			
General Fund	$ 166,401	$ 390,099	$ 556,500
Federal Fund	407,793	932,270	1,340,063
Total Funds	$ 574,194	$1,322,369	$1,896,563
Total Dentures and Dental Cost Net Savings			
General Fund	$ 334,078	$ 783,190	$1,117,268
Federal Fund	818,713	1,871,690	2,690,403
Total Funds	$1,152,791	$2,654,880	$3,807,671

Option B: Reduce Adult Dental Services To Emergency Treatment

Description of Change - Currently the Medicaid program covers dental services to adults including provision of dentures. This

change would eliminate coverage of everything except emergency dental treatment to relieve pain and infection. Nursing home and waiver residents will continue to receive all dental services.

Considerations - Dental and denture services are optional under the State Employee Health Insurance. These services are also not covered by Medicare. It is not known if dental services will be included under the National Health Plan.

This option would provide very limited coverage for extractions and fillings.

Cost Shift - Assume that recipients will seek care from emergency rooms, but to a lesser degree than if no dental services are available. Assume that 15% of the 13,403 recipients of dental care will seek care in the emergency room but that the average cost for the service will be $75 because limited dental services will be available. (total shift $150,784 annually)

Number Affected

Recipients	13,403
Providers	500

Net Savings	FY 94	FY 95	Biennium
General Fund	$ 97,389	$ 469,480	$ 666,869
Federal Fund	83,730	1,121,979	1,605,709
Total Funds	$681,119	$1,591,459	$2,272,578

6. INCREASE PHARMACY COPAY

Description of Change - Currently Medicaid recipients make a copayment of one dollar for each prescription. This change would increase the copayment from one to two dollars per prescription for brand name (non-generic) products. Copayment for generic prescriptions would remain at one dollar. Groups excluded from copayment are children, pregnant women and nursing home residents.

Considerations - This change is another method to increase clients' participation in the cost of their health care. The cost of prescriptions has increased over 40 percent in the last four years with no increase in recipient responsibility for copayment. This copayment increase, coupled with the increased client responsibility in other areas and the changes to the copayment cap will provide more client responsibility in their cost of care. Other state pharmacy copayments vary from zero to flat rates ranging from $.50 to $2.00 and variable rates of $.50 to $3.00.

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Number Affected

Recipients	60,000
Providers	300 - 400

Cost Savings	FY 94	FY 95	Biennium
General Fund	$ 9,032	$18,389	$27,421
Federal Fund	22,135	43,945	66,080
Total Funds	$31,167	$62,334	$93,501

7. INCREASE COPAYMENT LIMIT

Description of Change - Currently copayments made by Medicaid recipients are limited to $127 per family per state fiscal year. This change would increase the copayment limit to $300 per family. The feasibility of applying this limit on an individual rather than a family basis will also be pursued. Copayment does not apply to children, pregnant women, nursing home residents or persons seeking emergency care. A total of 1,463 families exceeded the copayment limit of $127 in FY 1993. This represents about 2.3 percent of those who have a copayment liability.

Considerations - Increasing the copayment limit will increase the client's responsibility toward the cost of their health care. This changes assumes that all people currently spending up to the $127 limit would also spend up to the $300 limit. However, other changes in copayment policy resulting in reduction of Medicaid expenditures duplicate savings projections and may result in overstated estimates of cost savings. The amount of duplication has not been estimated at this time.

Number Affected

Recipients	1500
Providers	all

Cost Savings	FY 94	FY 95	Biennium
General Fund	$ 37,332	$ 74,664	$111,996
Federal Fund	89,217	178,435	267,652
Total Funds	$126,549	$253,099	$379,648

8. INCREASE COINSURANCE ON INPATIENT HOSPITAL STAYS

Description of Change - Medicaid recipients currently are required to make a copayment of $3.00 for each day of an inpatient hospital visit. This change would replace the copayment with a coinsurance amount equal to $200 per discharge (total number of inpatient

hospital days). The average hospital stay is approximately 4 days and the total medicaid payment is approximately $1,811. The maximum coinsurance allowable under federal regulations is 50% of the payment that Medicaid makes for the first day of care in the hospital. A coinsurance amount of $200 is less than 50% of the Medicaid payment for the first day of care. Groups or services excluded from coinsurance are children, pregnant women, nursing home recipients and persons needing emergency care. Only about 25% of the recipients will be required to pay the coinsurance because of the exemptions noted above.

Considerations - Implementing a larger coinsurance amount will encourage Medicaid recipients to avoid unnecessary inpatient hospital services. Requiring the medicaid recipient to share in more of the cost of their health care should also increase individual responsibility and encourage more informed choices.

Number Affected

Recipients	4,500
Providers	54 hospitals

Assumes coinsurance will be applied to 4,500 discharges (25% of 18,000) and that the coinsurance amount is $200. Estimated savings are then reduced by the amount currently saved through co-pay - $85,000.

Net Savings	FY 94	FY 95	Biennium
General Fund	$118,093	$240,425	$ 358,518
Federal Fund	289,406	574,575	863,981
Total Funds	$407,499	$815,000	$1,226,499

9. REDUCE OUTPATIENT HOSPITAL REIMBURSEMENT

Description of Change - Currently, hospitals are reimbursed retrospectively for outpatient services to Medicaid patients. During the year, hospitals receive interim payments based on a percentage of their billed charges. At the end of the year, annual cost reports are filed with the department and outpatient payments are then adjusted according to actual hospital costs. Prior to July 1, 1993, sole community hospitals were paid at 100% of cost, and non-sole community hospitals were paid 94.2% of cost. The 1993 Legislature reduced these payment rates by 1.2% for all hospitals effective July 1, 1993.

The Department will contract for a study of the outpatient hospital reimbursement system. Based on the results of the study, it is anticipated that Medicaid outpatient reimbursement can be legally and legitimately reduced.

Considerations: - Outpatient hospital services have steadily increased due to the rising caseloads and the shift from inpatient programs to treat patients in the least restrictive setting. The state's current reimbursement system of paying costs may also be contributing to the increase. It is anticipated that the outpatient hospital reimbursement study will identify ways to contain costs in the hospital outpatient program. The Department will be able to implement the changes on July 1, 1994. Preliminary estimates of savings for Fiscal 1995 is a five percent reduction in outpatient costs.

Number Affected

Recipients	40,000
Providers	56 hospitals

Cost Savings	FY 94	FY 95	Biennium
General Fund	-0-	$ 474,864	$ 474,864
Federal Fund	-0-	1,134,846	1,134,846
Total Funds	-0-	$1,609,710	$1,609,710

10. PERSONAL CARE SERVICES

Description of Change - The Medicaid program currently allows personal care services up to 40 hours per week per recipient, with no more than 1/3 of the total hours being assigned for household tasks. Personal care services include assistance with activities of daily living and are provided by personal care attendants who are supervised by registered nurses. This change would reduce the allowable hours per week for all personal care recipients to 35. This limit would not apply to children receiving personal care services. It is estimated that approximately 20 recipients affected by the reduction in personal care services will require placement in a nursing facility.

Considerations - Personal care services are not provided in 27 other states and limits on the number of hours of care vary from state to state. This degree of reduction will not have a significant adverse affect the majority of recipients.

NUMBER AFFECTED

Recipients	150
Providers	1

Cost Shift

Cost shift is calculated by taking the average rate of nursing facility care minus the average rate of patient contribution times the 20 recipients anticipated to enter nursing facilities due to

the personal care reduction. To net the cost shift, the personal care costs for the 20 recipients were subtracted from the total nursing facility cost figure. Therefore, the net cost shift of total funds is $78,709 for FY94 and $107, 033 for FY95.

Cost Savings	FY94	FY95	Biennium
General Fund	$ 44,850	$106,173	$151,023
Federal Fund	109,912	253,736	363,648
Total Funds	$154,762	$359,909	$514,671

11. LIMIT THE NUMBER OF MENTAL HEALTH SERVICES (EXCLUSIVE OF DAY TREATMENT AND TARGETED CASE MANAGEMENT) TO 22 HOURS

Description of Change - Medicaid currently reimburses up to 22 hours of individual, group or family therapy provided by any combination of social workers, psychologists and licensed professional counselors. This change would add community mental health centers to the existing limit. Day treatment and targeted case management would not be included in the limit.

Considerations - The vast majority of recipients receive less than 22 hours of outpatient treatment.

Number Affected

Recipients	579

Cost Shift - Assume that some recipients will seek care from Medicaid funded outpatient hospital services or from Department of Corrections funded community mental health center programs. This shift has not been estimated.

Cost Savings	FY 94	FY 95	Biennium
General Fund	$ 55,865	$146,535	$202,400
Federal Fund	$136,905	$350,194	$487,099
Total Funds	$192,770	$496,729	$689,499

12. LIMIT THE NUMBER OF DAY TREATMENT SERVICES PROVIDED

Description of Change - Medicaid currently has no limit on the hours of day treatment that an individual can receive from a community mental health center. This change would place limits on this service.

Considerations - The majority of recipients receive less than an average of 15 hours of day treatment per week. Decreasing the number of services to the top users would be preferable to eliminating mental health services to the majority who use relatively few services. This option was considered and is the

recommendation of a small provider/recipient subcommittee who looked at different cost containment alternatives for mental health services.

Cost Shift - Assume that some of the recipients may seek care in general hospitals and some will be hospitalized at Montana State Hospital or will be treated with 100% general fund in the community mental health centers. This cost shift has not been estimated.

Savings	FY 94	FY 95	Biennium
General Fund	$ 82,694	$217,348	$ 300,043
Federal Fund	202,656	517,425	722,081
Total Funds	$285,350	$736,774	$1,022,124

13. CAPITATE ALL MENTAL HEALTH SERVICES TO ADULTS

Description of Change - Medicaid currently reimburses a wide range of mental health providers including community mental health clinics, psychologists, psychiatrists, hospitals, licensed clinical social workers and licensed professional counselors. Under this option, Medicaid would competitively bid for providers who would provide all inpatient and outpatient mental health services for a fixed capitated amount per recipient. The mental health provider would manage all mental health care for a fixed amount and be at risk for costs exceeding the fixed amount. The system would provide a single point of entry for all mental health care and include contractor requirements to ensure quality care is provided. A freedom of choice waiver must be approved by HCFA to implement this change. A contract to write the RFP and establish the capitated amount would be required. Program implementation could not occur before January 95.

Considerations - Five states have implemented a capitated mental health system. Preliminary results indicate that a total cost savings of at 5% should be achievable.

Number Affected

Recipients	All consumers of Mental Health services
Providers	All Mental Health Providers

Cost Savings	FY 94	FY 95	Biennium
General Fund	(50,000)	$ 69,404	$ 19,404
Federal Fund	(50,000)	200,609	150,609
Total Funds	$100,000	$270,013	$170,013

14. NURSING FACILITY PROGRAM

Description of Change - Delay implementation of property reimbursement changes and provide no increases in property reimbursement for fiscal year 1995. Provides no rebasing of the reimbursement formula for fiscal year 1995.

Considerations - The department had planned to implement changes to the property reimbursement system based upon a property study performed by our consultants in December 1992. However, the department has not yet developed a final plan to change the reimbursement methodology that would incorporate the property component or establish final rates for fiscal 1995.

Cost Shift - No projected impact on cost shifting to other programs.

Number Affected - All nursing facility providers.

Cost Savings	FY 94	FY 95	Biennium
General Fund	$0	$ 466,682	$466,682
Federal Fund	0	$ 1,115,290	$ 1,115,290
Total Funds	$0	$ 1,581,972	$ 1,581,972

15. SPECIAL INCOME LIMIT

Description of Change - Implement a special income limit for nursing home eligibility. Currently, nursing home residents who apply for medically needy coverage are eligible if their monthly income does not exceed the nursing home rate paid by private payers. The statewide average of the rate paid by private payers or insurance companies is $2,340 per month. However, states have the option to establish a lower monthly income limit for nursing home eligibility. The income limit cannot exceed 300 percent of the SSI Federal Benefit Rate (1993 FBR is $434). This change would impose a special income limit for nursing home eligibility. The special income limit would be $1,302 per month. Individuals with income above this limit would no longer be eligible for Medicaid reimbursement for nursing home care. under this option, there are approximately 170 people who would lose nursing home eligibility. The special income limit would also apply to persons served under the Home and Community Services waiver and in ICF-MRs. This option

would only effect nursing home eligibility. Eligibility for other medicaid services in the community would continue to be established under the current policy.

Considerations - Nursing home expenditures account for over one third of the entire Medicaid budget; and costs for the medically needy nursing home population is one of the fastest growing items of the budget. As indicated above, eligibility for the medically needy program for nursing home care is based on the private pay rate which is established by the nursing home industry and has increased at a minimum of once a year. In order to contain the costs of long term care, a limit must be placed on eligibility. Approximately 17 other states use a special income limit for institutional eligibility.

Montana could adopt a 300 percent special income limit for eligibility for nursing home reimbursement effective January 1, 1995. Delaying implementation until January, 1995 would allow those individuals who currently have income in excess of the 300 percent limit at least one year to locate private financing for their nursing home care or locate other residential alternatives. Under this option, there would be no savings in fiscal 1994 or for the first six months of fiscal 1995. Beginning January 1, 1995 there would be a general fund savings of approximately $241,300 for fiscal 1995. Limiting eligibility to the 300 percent special income limit would generate approximately $1.2 million general fund for the 1997 biennium.

Number Affected

Recipients	170
Providers	90

Savings	FY 94	FY 95	Biennium
General Fund	-0-	$241,322	$241,322
Federal Fund	-0-	576,740	576,740
Total Funds	-0-	$818,040	$818,040

16. LIMIT SERVICES TO MEDICALLY NEEDY TO PRIMARY AND PREVENTION CARE

Description of Change - The current Medically Needy program offers the same services allowed under the general Medicaid program. Federal regulations allow states to provide less services under the Medically Needy program. Under this option, covered services would be limited to primary and prevention care provided by primary care providers, pharmacies and lab and x-ray. The limit would not apply to children, pregnant women and persons eligible for the waiver.

Considerations - Expenditures for the medically needy have dramatically increased over the past five years and are expected to grow significantly in the future as a result of demographic changes. Only 36 states provide coverage to the medically needy population. Limiting the service package may be a preferred alternative to eliminating the entire program.

Number Affected

Recipients 2,000 elderly and disabled in community
170 in nursing homes

Cost Savings	FY 94	FY 95	Biennium
General Fund	$2,294,019	$ 5,276,244	$ 7,570,263
Federal Fund	$5,621,851	$12,973,299	$18,615,150
Total Funds	$7,915,870	$18,269,543	$26,185,413

17. REDUCE AFDC PAYMENT LEVELS

Description of Change - The AFDC benefit payment is set by the Legislature as a percentage of the current federal poverty index. This change reduces the percentage from 40.5% to 37.5%. This change would reduce the actual dollar amount to the 1990 payment level. Federal regulations do not allow states to reduce payments beyond 1988 levels. For example, the current maximum benefit payment for a family of three would be decreased from $401 to $372 per month.

Considerations - This change may jeopardize the AFDC recipient's ability to provide basic needs, particularly shelter. Affordable housing for low-income families is difficult to locate. Many AFDC households must now use the greater portion of their grant for shelter.

Number Affected

Recipients: 34,744

Cost Savings	FY 94	FY 95	Biennium
General Fund	492,854	1,055,933	1,548,787
Federal Fund	1,332,190	2,795,738	4,127,928
Total Funds	1,825,044	3,851,671	5,676,715

DEPARTMENT SOCIAL AND REHABILITATION SERVICES
SPECIAL SESSION 1, POTENTIAL BUDGET REDUCTIONS

	PROGRAM	Gen Fund	Total Fund
1.	Eliminate Podiatry	17,136	58,386
2.	Hearing Aids Audiological	40,604	138,290
3.	Reduce Therapy Limit	99,175	337,858
4.	Eyeglasses & Optical	378,921	1,291,377
5.	Denture and Dental	1,117,268	3,807,671
6.	Pharmacy Copay	27,421	93,501
7.	Increase Copay Limit	111,996	379,648
8.	Inpatient Hospital Coinsurance	354,280	1,226,999
9.	Reduce Outpatient Reimbursement Rate	474,864	1,609,710
10.	Reduce Personal Care to 35 Hours	151,023	514,671
11.	Limit Mental Health services	202,400	689,499
12.	Limit Daytreatment	300,043	1,022,124
13.	Capitate Mental Health	19,404	170,013
14.	Delay NH Property Increase	466,682	1,581,972
15.	NH Special Income Limit	241,322	818,040
16.	Preventive Care for Med Needy	7,570,263	26,185,413
17.	AFDC @ 37.5%	1,548,787	5,676,715
	TOTAL REDUCTION	$13,121,589	$45,601,887

* The above are preliminary estimates and are subject to change based on availability of additional information and analysis.

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PEBUP3573

US Medicaid Drug Formularies
Do they Work?

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Summary Does the use of a restricted drug formulary achieve cost savings within state Medicaid programmes? Restricted formularies are often justified by putting forth the attributes of a perfectly operating and implicitly costless policy. Analysis suggests, however, that the operation of 'actual' restricted formularies produce realised effects that are substantially at odds with the desired effects. Although the implementation of a restricted formulary can reduce a state's drug expenditures, service substitution causes expenditures to increase elsewhere in the system. Furthermore, direct savings in the drug budget are completely offset by these spillover effects.

The phenomenal growth over the past 2 decades in US federal and state government spending on the Medicaid programme for the poor has made it a dominant factor in health care budgeting. From 1973 to 1989, programme payments to medical providers increased dramatically, with an average annual growth rate of more than 12% (National Pharmaceutical Council 1990). The long term trend of spending outpacing revenue growth has produced pressure for the development of new strategies to curb the cost of providing medical care to a growing number of recipients at both the federal and state level. The problem for state governments is particularly acute. State governments are not permitted deficit budgets and because Medicaid is an open-ended entitlement programme, states cannot establish fiscal control directly through budget limits or controls on the number of recipients. Instead, states must act indirectly by altering programme design, e.g. eligibility standards or optional services covered.

Many states have attempted to reduce their total programme costs by reducing expenditure on prescription drug services. While the provision of prescription drugs is optional in the Medicaid programme, all states but one are currently offering such services. In the 1989 fiscal year, total vendor payments for prescription drugs amounted to $US3.69 billion, 6.7% of all Medicaid expenditures (National Pharmaceutical Council 1990). State authorities have implemented various cost-containment measures to restrain Medicaid spending on prescription drugs. Price limits for reimbursement purposes are imposed on drugs for which generic and other substitute drugs exist. Some states limit prescription refills and the number of prescriptions available monthly for Medicaid patients. Limits have also been placed on pharmacy dispensing fees under the programme.

Finally, some states have imposed restrictive formularies and prior approval programmes to limit prescription drug availability and to lower the average price paid for drugs. Medicaid drug formularies are lists of drugs that will be reimbursed under the programme. The drugs on the list are determined by the state agency responsible for ad-

ministering the Medicaid programme, with advice provided by a state Medicaid drug formulary committee, usually comprising physicians and pharmacists. Some states have sought to control the level of drug and total Medicaid expenditures by adopting more restrictive formularies. Currently, 20 states have been classified as having a restricted formulary.[1] In general, restricted formularies are adopted in the hope of reducing both drug and total Medicaid expenditures.

1. The Logic of Restricted Formularies

Proponents of restricted formularies contend that physicians often do not choose the cheapest drug because they are ill-informed and too easily swayed by drug company representatives (Rucker & Schiff 1990). Further, it is argued that physicians have no incentive to acquire the information necessary to make cost-efficient prescription choices since it is not their money being spent. Physicians are considered to be imperfect agents for their patients. Finally, it is noted that Medicaid patients do not pay for prescriptions and other services provided under the programme – taxpayers do.

For these reasons, proponents contend that the implementation of a restricted formulary could reduce Medicaid drug expenditures by eliminating some drugs from coverage, forcing physicians to prescribe lower cost drugs, and in general improving physician prescribing practices (Rucker & Schiff 1990).

The actual outcome for a restricted formulary may differ from the desired outcome for 2 important reasons. Firstly, advocates of restricted formularies, like advocates of numerous other regulatory policies, tend to subscribe to what Demsetz (1966) refers to as the 'nirvana' approach to regulation. Those who adopt the 'nirvana approach' as a guide to regulation policy search for discrepancies between an ideal norm (i.e. a perfectly operating market) and the existing situation. If discrepancies are discovered they conclude that the existing situation is inefficient (i.e. a market failure exists) and government regulation is required. They assume that government regulation is a perfect solution to any perceived problem with the unregulated marketplace. Demsetz argues that there is no reason to assume that government regulation will function significantly better than the imperfect market it is supplanting. In deciding whether to regulate, he maintains, one should compare the defects of the unregulated market with the potential effectiveness or the likely defects of the proposed regulation.

In theory, a perfectly operating restricted formulary would eliminate only those drugs for which there are lower-cost substitutes available. Medicaid physicians will be forced to prescribe more efficient drugs and money will be saved. The second reason why a formulary does not work as planned is that it is difficult and costly to determine which drugs are more efficient, particularly since patients frequently respond differently to the same drug. If committees select drugs for inclusion on the formulary list on the basis of price or expected expenditures rather than efficiency, they will fail to minimise the drug budget. The formulary committee may be more knowledgeable about drug prices than physicians, but they will be less knowledgeable about individual patient reactions to administered drugs. Finally, members of the formulary committee may rely heavily on information provided by the drug companies and perhaps be just as influenced by their representatives as are physicians.

If restricted formularies fail to operate perfectly, they will do more than simply exclude Medicaid patients from receiving high priced duplicate goods. They will set off a chain reaction of indirect effects in the system that may cause expenditures to rise rather than to fall. We refer to this as the 'service substitution' effect.

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1 The distinction between open and restricted formularies has been made by the National Pharmaceutical Council (NPC) in Washington, DC. During our analysis period the same individual, Dick Fowler, has classified the types of formularies for the NPC based on survey responses from state Medicaid authorities. He assures us that the task of classifying the formularies is straightforward and that his classifications are consistent over time.

2. Restricted Formularies and Service Substitution

It is generally accepted that alternative combinations of health care inputs can achieve a similar level or quality of health care. This means that some health care inputs can be substituted for others with little or no loss in the level or quality of health care. However, it does not follow that all combinations of inputs will produce the same level of health care at the same cost. For instance, a prescription drug that an outpatient can administer to himself will be more cost-efficient than the same prescription administered to a patient in the hospital. Recognition of this principle goes a long way towards reconciling the formulary/expenditure paradox. The elimination of a certain type of treatment (in this case, the removal of certain drug items from the formulary) may cause physicians and patients to substitute other forms of therapy. If access to one form of therapy is reduced or eliminated, there may be an increased demand for other available services. To the extent that some other forms of therapy may be more expensive, 'service substitution' may result in higher total Medicaid expenditures. Higher programme costs may result, for example, from substituting a less expensive drug that will require extended treatment or from substituting a more expensive means of treatment, such as physicians' visits or institutional care. Thus, while it is true that a restricted formulary may save money by excluding some drugs, it does not follow that such a policy will reduce total Medicaid outlays. The implementation of a restricted formulary will result in adjustments that will affect the use of other Medicaid services, which may more than offset any savings attributable to the formulary restrictions. Whether the dollar effects of the service substitution phenomenon are sufficient to offset the savings from formulary restrictions is essentially an empirical question.

3. What Do We Know About the Actual Effects?

A number of state-specific studies have examined the short term effects of a Medicaid programme moving from an open to a restricted formulary or the reverse (reviewed in Jang 1988). Most of these studies have concluded that restricted formularies tend to reduce Medicaid expenditures on pharmaceutical services. At the same time, many of these studies have noted that changing the formulary status has a significant influence on other parts of the Medicaid budget. For example, Reeder and Lingle (1988) reported that in South Carolina drug expenditures, physician visits and outpatient hospital services increased under the 'open' formulary, but the number of hospital admissions, the average number of inpatient days per stay, the average expenditures per hospital day, and the average total inpatient hospital expenditures decreased. Similarly, Dranove (1989) reported that subsequent to relaxing formulary restrictions in 1984, medical utilisation by Illinois public aid recipients decreased, though not by enough to offset markedly higher drug costs.

Our own study builds on the earlier work in this area (Moore & Newman 1991). We used a multivariate regression model to analyse pooled cross-sectional state data for the period 1985 to 1989. Our analysis can be regarded as complementary to the earlier before-and-after state studies. Essentially we measured the long term effects of restricted formularies, many of which have existed for more than a decade. Unlike earlier studies, we estimated the effects of restricted formularies on the total Medicaid budget as well as on the prescription drug budget.

After accounting for differences between states in the characteristics of their recipient population, economic conditions and other cost-containment policies, using our multivariate regression model, we found that restricted formularies tend to lower Medicaid drug expenditures per capita by 13.4% on average (table I). This result is statistically significant by conventional standards and consistent with the estimates provided by the state before-and-after studies.

However, we find that restricted formularies have no significant impact on total Medicaid expenditures. It appears that the savings in the drug budget associated with a restricted formulary are completely offset by service substitution elsewhere

Table 1. Estimated effects of restricted formularies on per capita Medicaid expenditures and number of recipient visits by service categories (data for this analysis were obtained from the National Pharmaceutical Council, Pharmaceutical Benefits Under State Assistance Programs, various issues)

Type of Medicaid service	Dependent variables					
	log per capita expenditures			log recipient visits		
	coefficient	t-statistic	effect (%)	coefficient	t-statistic	effect (%)
Total Medicaid	−0.017	−0.49	NS	+0.005	+0.15	NS
Prescribed drugs	−0.126*	−1.93	−13.4	−0.039	−1.09	NS
Inpatient hospital: general	−0.319	+0.98	NS	+0.038	+0.58	NS
Inpatient hospital: mental	−0.330**	−1.54	−39.1	+0.456	1.15	NS
Skilled nursing facilities	−0.105	+0.77	NS	+0.125	+0.85	NS
Intermediate care: mental	−0.110	−1.00	NS	−0.149	−0.74	NS
Intermediate care: other	−0.197	−1.57	NS	−0.017	−0.68	NS
Physician services	−0.252*	+3.04	−28.7	+0.077*	−1.64	+8.0
Outpatient hospital services	−0.014	−0.15	NS	+0.262	−0.90	NS
Clinic services	−0.228	−0.85	NS	+0.283	−0.57	NS

Abbreviation: NS = nonsignificant.
* = $p \leq 0.05$; ** = $p \leq 0.1$ on a 1-tail test.

in the system. We estimated 8 additional Medicaid service expenditure functions and found that restricted formularies tend to cause significant increases in the level of expenditures and the number of recipient visits in the 'physician services' (28.7 and 8%, respectively) and 'inpatient hospital: mental' (39.1%) categories (table 1). On the basis of these findings, we concluded that the implementation of a restricted formulary does not save money when the total impact on the Medicaid system is considered. Thus, it is doubtful whether this form of regulation is an improvement over the unregulated market, especially when administrative costs are considered. To the extent that formulary restrictions entail administrative costs, the adoption of such a policy might actually increase overall Medicaid expenditures.

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EX 4
8-10-9
HUMAN SERV
& AGING

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Family Assistance Division

MEDICALLY NEEDY
(Basic Eligibility)

Medicaid is a medical assistance program provided to eligible individuals who are aged (65 or older), blind or disabled (according to Social Security criteria) or who would qualify under the Aid to Families with Dependent Children (AFDC) program (by being pregnant, or having a dependent child). To establish Medically Needy coverage under the Medicaid Program, individuals must meet both non-financial and financial criteria.

Non-financial criteria includes:

1. Providing or applying for a Social Security Number; and
2. Providing proof of U.S. citizenship or eligible alien status.

Financial criteria includes meeting established income and resource limits as follows:

RESOURCE LIMITS - January 1, 1993

Individual	$ 2,000
Couple	$ 3,000

For each additional family member add $100.

SSI-related applicants must be within the resource limit the first moment of the first day of the month in order to be eligible for any part of that month.

AFDC-related applicants must be within the resource limit as of the date of application in order to be eligible for any part of that month.

NOTE: There is no provision for eligibility to be granted with the expectation that resources will be applied to medical debts.

INCOME LEVELS -	Family Size	Monthly Income Level
(Effective 07/01/93)	1	$ 425
	2	425
	3	455
	4	484

If monthly income, less disregards*, exceeds the above standard, the individual(s) is/are eligible for Medically Needy coverage. Any amount of income, less disregards*, that exceeds the above standard becomes the Medically Needy Incurment (i.e., spend down) amount. The applicant must incur medical bills or make a cash payment equal to the incurment amount in order to have Medically Needy benefits authorized. (Medicaid will then pay for any eligible medical costs incurred in the balance of that month). Medically Needy eligibility is computed monthly.

Example - 1 person household with countable income of $500.

$500 - income
-425 - MN Income Level
$ 75 - incurment amount

*DISREGARDS - SSI-related categories are eligible for a $20 general income disregard. $65 plus 1/2 the remainder of total gross earned income is allowed as a disregard for earned income. AFDC-related categories may receive a $90 work disregard, babysitting expense up to $175 per child over age 2 and up to $200 per child age 2 and under, and the possible use of a $30 plus 1/3 of the remaining total gross earned income disregard.

LEGIS/002
10/01/92

August 10, 1993

The original of this folder presentation is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

EXHIBIT 5
8-10-93
HUMAN SERV
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EXHIBIT # 6
DATE 8-10-93
HB HUMAN SERV
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Insurance Provisions in Senate Bill 285

As passed by the state Senate, SB 285 represents very significant insurance reform for small employers -- businesses with 3 to 25 employers. Businesses with more workers can obtain preferential rates because of their size, and businesses with one or two individuals are covered by individual policies.

- The Small Employer Health Insurance Availability Act creates two health insurance plans. Insurance companies that market health benefit plans to small employers must offer the new plans to any small business in Montana as a condition of selling insurance in this market. That guarantees health care coverage to small employers and workers -- a major goal of health insurance reform. This insurance could be marketed to 11,600 (47%) of Montana's 25,000 total employers, and provide coverage to 90,000 employees of small business, or 40% of the 225,000 workers in Montana's private sector.
- The provisions also reduce the range of rates that can be charged, moving toward equity in premium payments. Currently in Montana, premium rates can vary by as much as a factor of 10. The act will allow variances up to a factor of 2, reducing current extreme disparities by a factor of 5.
- The act also will guarantee portability of insurance, allowing workers to switch their insurance from one small employer to another. That achieves another major goal of insurance reform -- guaranteeing health insurance to workers who switch jobs.
- The act includes a reinsurance mechanism that will protect carriers from bearing the catastrophic costs incurred by very ill employees in small firms.
- Insurance carriers will be required to cover any small group that applies. This achieves a major goal -- access to coverage. Currently, as many as 20% of applicants seeking coverage are rejected.
- Pre-existing condition exclusions will be limited: Pre-existing conditions will be covered after 12 months, and if an individual is continuously covered, no pre-existing condition exclusion period will apply.
- The act also says that statutorily mandated benefits must be covered.
- It goes a long way toward community rating. Age will be a characteristic by which insurance companies can discriminate. For instance, a 20-year-old individual with little health risk won't have to pay as much in premium as a 60-year-old individual with higher health risks.
- The basic (lower-cost) and standard health insurance plans will be established by a health benefit plan committee, appointed by the Insurance Commissioner. The plans will be drafted in public meetings, and the committee will include small employers and employees. The Insurance Commissioner must approve the final plans.
- A uniform health insurance claim form, to be developed by the state Insurance Commissioner, will reduce administrative costs and ease reimbursement for claimants.

EXHIBIT #4
DATE 8-10-93
HB HUMAN SERVI

HISTORY OF HEALTH PLANNING & CERTIFICATE OF NEED

In 1974, the National Health Planning & Resources Development Act was signed into law (PL 93-641), establishing a national health planning policy and providing federal funds to support state and local planning activities. The law, modelled in part after existing programs in New York and several other states, required states to establish and administer Certificate of Need (CON) programs as part of the overall health planning process. Program configuration in most of the states thus followed the standards and procedures that were established in the new federal law.

CON was a regulatory strategy, eventually carried out by local Health Systems Agencies in conjunction with state health departments, that required hospitals and other health care facilities to obtain approval to offer new services and incur capital expenditures that exceeded specific dollar thresholds. This included investments aimed at expanding the number of beds and equipment owned by hospitals and related health care facilities and services.

The purpose of CON was to eliminate unnecessary investment in expansion of capacity and to halt offerings of new services that were deemed to duplicate existing ones. The way in which this would be accomplished was through area-wide planning: applications were to be approved only if hospital expansions would improve health care in the communities.

In 1982, authorization of federal funds for state CON programs was eliminated, although a series of continuing resolutions extended available funding through September 1986. The federal health planning act (PL 93-641) was repealed later that year.

Between 1986 and 1989, many states scaled back. In the wake of the repeal, 11 states also repealed their CON review programs, while five others deregulated hospitals and other acute care services. Most states, however, took a more moderate approach, streamlining programs, deregulating services and providers--particularly those perceived as not contributing to long term health care cost increases--and raising expenditure threshold levels to exempt all but the most costly projects.

CURRENT STATUS OF STATE PROGRAMS

Currently, a health care facility or service operating in a state with a CON law must submit an application to a state health planning agency before spending money that exceeds specific dollar thresholds, typically established for categories such as major medical equipment, capital construction and operating costs. A state agency may refer an application to a local health planning agency if there is one, which then recommends whether a community need exists for the project. The state agency, however, ultimately approves or denies the application.

Currently, 12 states have eliminated CON: Arizona, California, Colorado, Idaho, Kansas, Louisiana, Minnesota, New Mexico, South Dakota, Utah, Wyoming and Texas. In addition, several states with CON programs still formally in place have deregulated hospitals and many related acute care services (Arkansas, Indiana, Montana, Oklahoma, Washington and Wisconsin). Many states with CON-like programs have enacted moratoriums on particular facilities or services.

MONTANA

Montana's original CON law was enacted in 1975. The law has gone through frequent changes, but has not abandoned the original purposes of CON. General hospital services, with some exceptions including ambulatory surgical care, home health care, long-term care, inpatient mental health care, inpatient chemical dependency treatment and inpatient rehabilitation, have not been reviewable since

1989. The capital expenditure threshold has increased from $150,000 in 1981 to $1,500,000 in 1990. Health care services and facilities that are reviewable under Montana's CON statute are shown on Chart 1.

CON is administered through the Department of Health & Environmental Sciences' Health Planning Program. The existence of CON and fair administration of the review criteria cited in the Montana Codes and Administrative Rules can result in prudent and rational growth of Montana's health care industry and encourages the following:

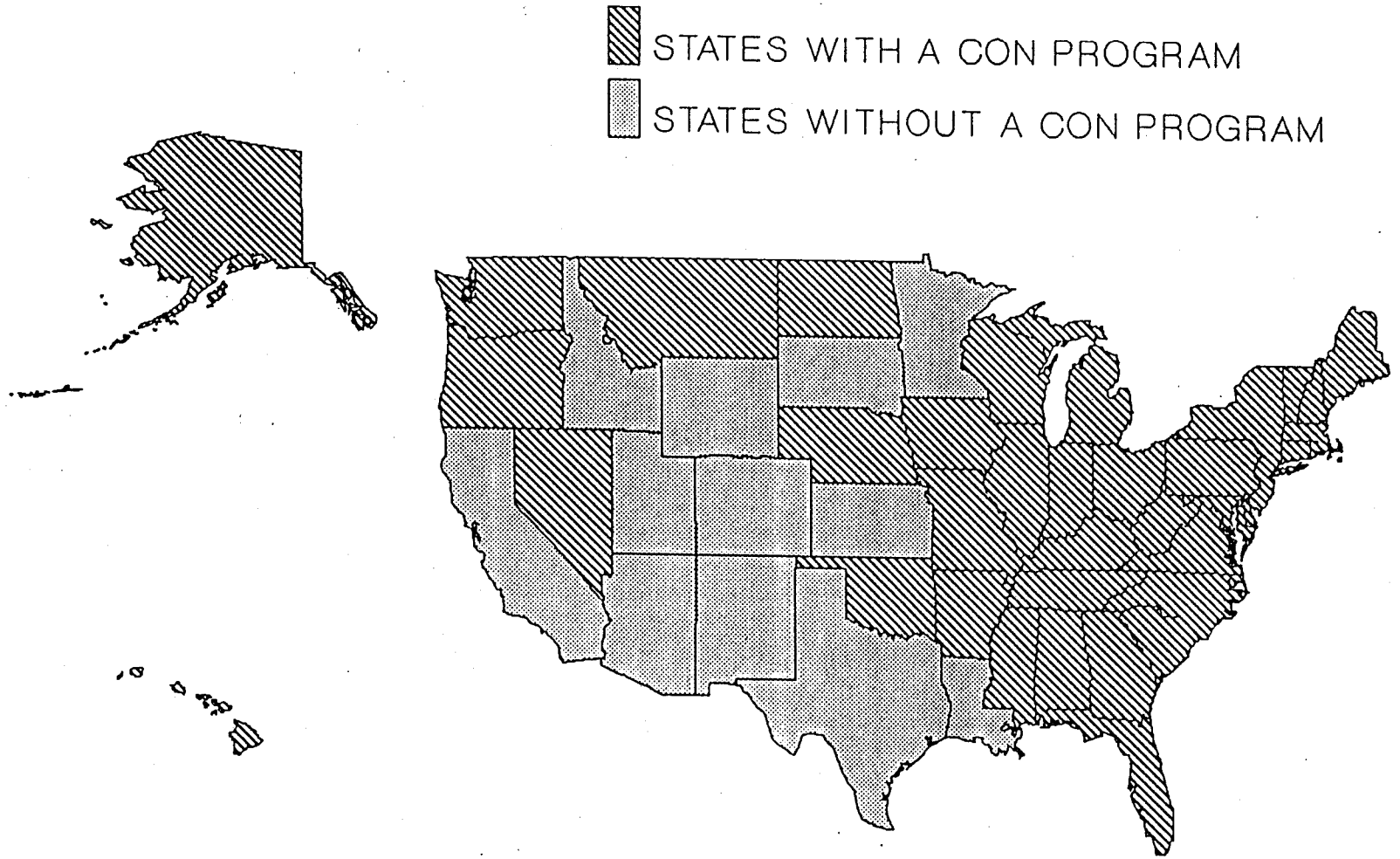
1. development based on local community health care needs;
2. evaluation of manpower needs for new or expanded services;
3. evaluation of financial feasibility of proposals;
4. public input and participation in the development of health services;
5. development of cost effective strategies through review of alternative services; and
6. development of health services that are affordable and accessible.

Chart 2, showing health care expenditures, represents the costs of CON reviewable projects from 1988 through 1992. Over the five year period, projects totaling $48,649,530 were submitted and subsequently withdrawn from consideration; projects totaling $9,038,827 were denied Certificates of Need; and projects totaling $59,583,383 completed the review process and were approved for operation. Projects that are either withdrawn from consideration or denied Certificates of Need potentially reflect unnecessary health care investments. Many applications are withdrawn during the course of CON review. Often times applicants discover there may not actually be a need for the proposed service, consumers are not interested in seeing the service initiated or the proposal is not financially feasible as they originally believed. Another relevant consideration is the fact that many high cost projects experience modifications to the proposed capital expenditure as a condition of approval. These approvals reflect the expenditures that are approved, not necessarily the total amount proposed.

While CON allows the state to control some Medicaid costs, primarily by promoting the rational growth in numbers of nursing home beds, well over $45 million has been spent on hospital construction projects in Montana during the 18-month period from July 1991 through January 1993. Currently there is no process by which these large expenditures are reviewed or regulated. The effects of these construction projects greatly impacts Medicaid expenditures.

CON and Health Planning are two separate but related functions. Health planning is a necessary activity by which state government looks at what health services are available, collects data on utilization, gathers public input and makes predictions as to what will be needed in the future. CON is a regulatory activity which uses the product of health planning activities to control the development of health services throughout the state.

Due to the lack of financial resources and personnel over the last eight years, health planning activities in Montana have been focussed on services that are CON reviewable. The 1993 Legislature funded two FTE to carry out program activities, with no operating budget. The FTE were funded half by general fund and half by application fees, which the program is not likely to generate.



Source: The George Washington University, 1992

CON REVIEWABLE SERVICES

NURSING HOME SERVICES

PERSONAL CARE SERVICES (sometimes known as assisted living, board and care, or residential care, reviewable only until July 1, 1994)

HOSPITAL SWING BEDS

HOME HEALTH CARE (creation of home health services or the expansion of existing home health services that also expands the geographical service area of the home health agency)

INPATIENT CHEMICAL DEPENDENCY TREATMENT

AMBULATORY SURGERY

INPATIENT PSYCHIATRIC SERVICES

INPATIENT MENTAL HEALTH SERVICES

RESIDENTIAL TREATMENT FACILITIES

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

MEDICAL ASSISTANCE FACILITIES

INPATIENT REHABILITATION SERVICES

HEALTH MAINTENANCE ORGANIZATIONS (if an inpatient facility or an increase in bed capacity is proposed)

CHANGES IN BED CAPACITY (through the increase of beds or relocation of existing beds to another site)

THE ADDITION OF A HEALTH SERVICE (that is offered by, or on behalf of, a health care facility that did not exist within the 12-month period before the month in which the additional service would be offered and which will result in additional annual operating and amortization expenses of $150,000 or more)

THE INCURRING OF AN OBLIGATION OF A CAPITAL EXPENDITURE (by any person or persons to acquire 50% or more of an existing health care facility unless a completed letter of intent is filed with the Department at least 30 days prior to such an obligation and the Department finds that the acquisition will not significantly increase the cost of care provided or result in an increase of bed capacity)

ANY PROPOSED CAPITAL EXPENDITURE (above the specific thresholds by any person or health care facility. Review occurs if new beds or new facilities are proposed or if expenditures exceed the following thresholds: a) $1,500,000 for construction of health care facilities; b) $150,000 for new services)

CHART 1

8-10-93
HUMAN SERVICES

CAPITAL EXPENDITURES
FOR CON PROJECTS 1988-1992

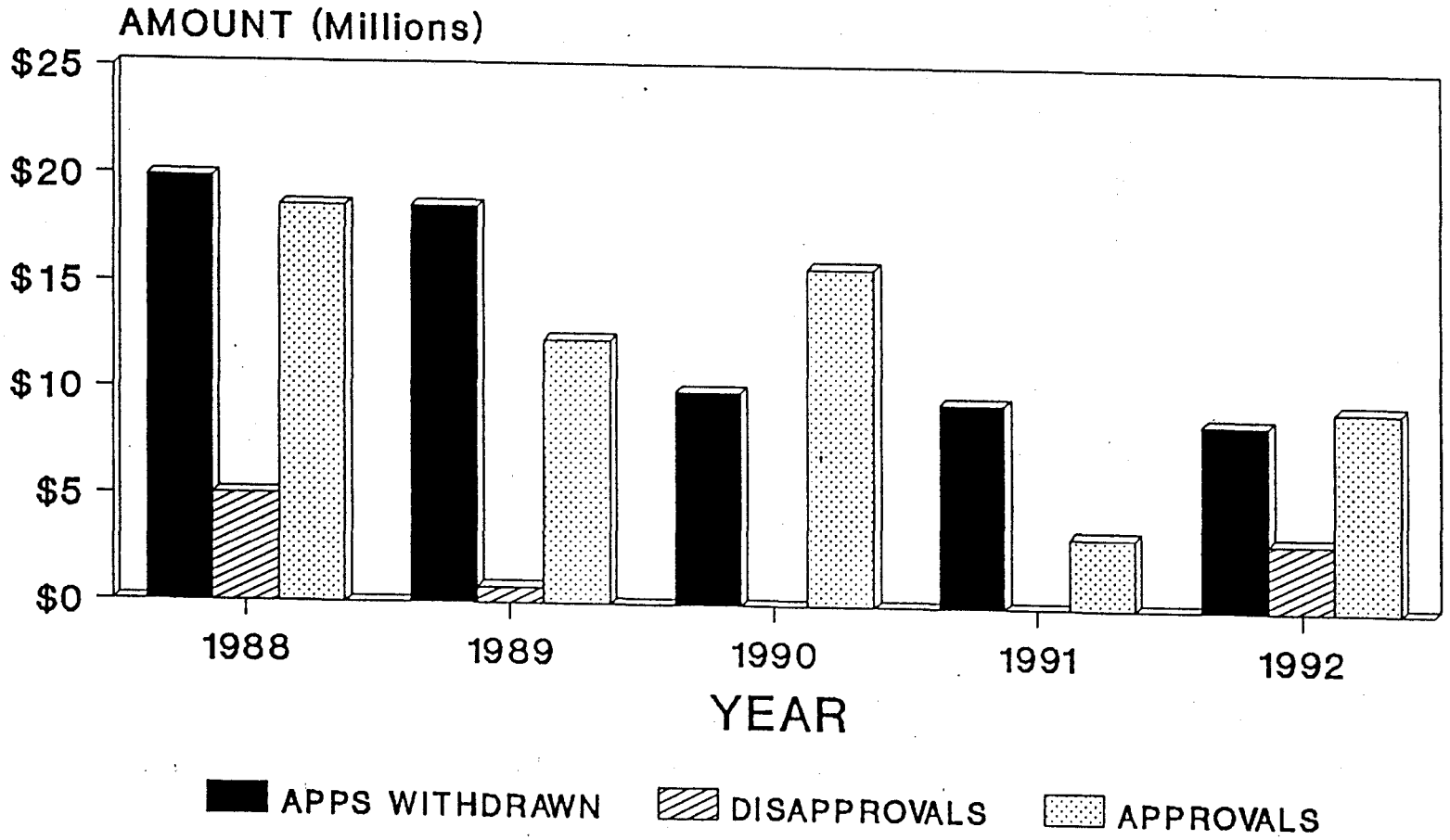


CHART 2

EXHIBIT # 8
DATE 8-10-93
HB HUMAN SERVICES

PRESENTATION BY THE

MONTANA HOSPITAL ASSOCIATION

TO THE

JOINT APPROPRIATIONS HUMAN SERVICES SUBCOMMITTEE

AUGUST 10, 1993

MHA

SUMMARY

Montana has 51 general acute care hospitals, 4 psychiatric hospitals, 5 Medical Assistance Facilities, 3 Indian Health Service hospitals, 2 Veterans Administration hospitals and one facility at Malmstrom Air Force Base in Great Falls. Besides Montanans, hospitals serve people who live in neighboring states and Canada as well as those visiting the state. Hospitals are a major employer in their communities, and provide a significant boost to the local economy.

A strong hospital industry is crucial to the economic development of Montana. Businesses will not locate in Montana without the existence of adequate services, especially medical care. State government is facing severe budget problems, and hospitals are prepared to help with solutions. All of us are concerned about health care cost inflation. **But cutting payments and cutting programs for health services are not going to help solve the problem of health care cost inflation. Such actions will only worsen the problems with health care.**

A comprehensive restructuring of the health care system is the only real solution to health care cost inflation. Reform would hold down the cost to deliver health care and reduce the cost shift of public programs to private payers. In addition, tax reforms are needed to generate stable and adequate revenues to operate state programs.

Hospitals understand that Medicaid is a program growing faster than state revenues. Patients covered by Medicaid are increasing as a share of hospital services as well. **But hospital costs are growing by about 10 percent per year, not the 20 percent per year Medicaid is experiencing.** Health care cost inflation remains a great concern to hospitals; and hospitals are doing everything they can to control their costs.

Some people insist that a tax on hospitals would help solve the Medicaid funding problem. Montana's hospitals have historically opposed taxes on providers as a means to fund Medicaid. Unlike nursing homes, Medicaid represents about 10 percent of the hospital patient volume. **Taxing hospital revenues adds more to the cost to deliver care than is returned to hospitals in the form of increased payments. A tax just doesn't work for hospitals like it did for nursing homes.** Hospitals believe programs like Medicaid should be funded by broad based taxes, not by taxing sick people.

Hospitals have not exercised the Boren Amendment's guarantee of adequate payment during Montana's budget crisis. Hospitals have tried to do their share, working toward tax reform and health care reform as the best answers to our current problems. **But if it becomes necessary, hospitals will exercise their legal rights under the Boren Amendment which enable them to continue to deliver health care to their communities.**

RECENT TRENDS IN HOSPITAL FINANCE

Hospitals are witnessing historic changes in the way health care is delivered. These changes are occurring at a very quick pace. Providers are responding to incentives from the government and other payers to deliver care in new, less costly ways. Other changes are due to the improvement in medical technology. Regardless of the reasons for change, hospitals are having to change with the times in order to serve the needs of their communities.

Inpatient Care...

The volume of inpatient care continues a downward spiral which began in the mid-1980's. Government payment systems have encouraged shorter hospital stays, and more outpatient services. **While the inpatient service "pie" gets smaller, the services continue to get more expensive. Most important, Medicaid is buying a bigger piece of that pie every year.** Figure 1 below illustrates the downward trend in persons served as inpatients in Montana's hospitals.

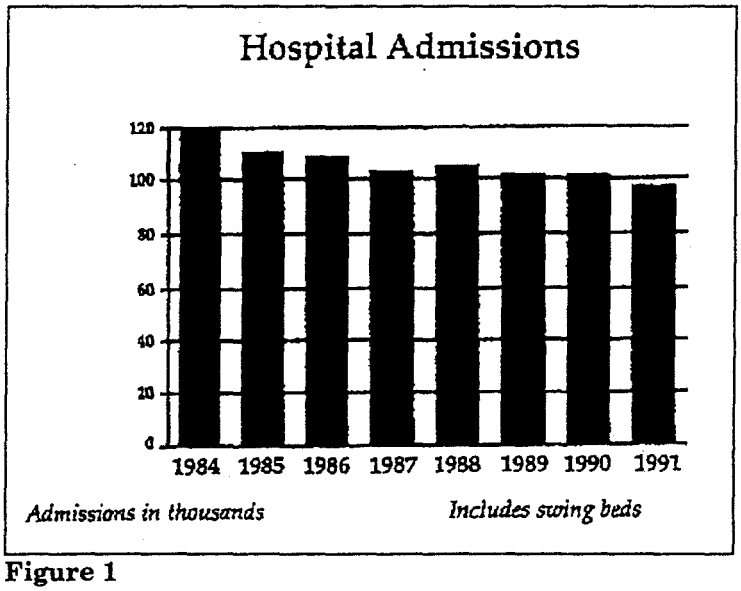


Figure 1

MHA expects inpatient admissions will continue to decrease by about 10 percent in both 1992 and 1993.

Even though fewer patients are served in inpatient settings, the cost to provide care remains. This is the main reason for growth in the unit cost of inpatient services.

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SERVICES

Outpatient Care...

Meanwhile, outpatient care is growing steadily in every hospital in the country. Responding to new technology and payment limits for inpatient care, more people are served in hospital outpatient departments. **The same trend is reflected with growth in the Medicaid program budget.** Because people often can't (or don't) wait for appointments in physician's offices, emergency room use is also increasing dramatically.

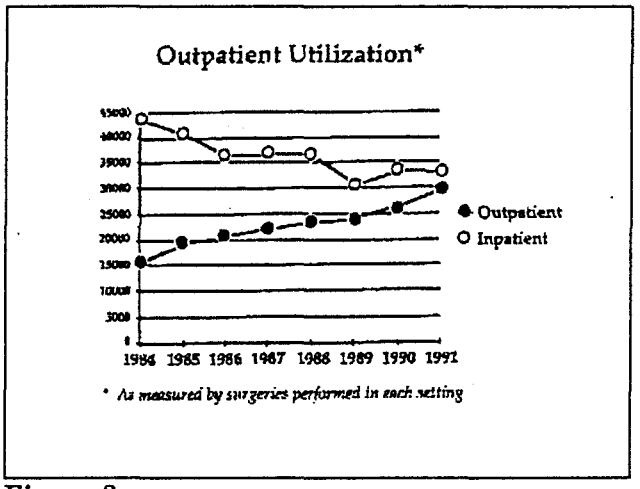

Figure 2

Hospitals have responded to the trend toward outpatient care by developing such services as rural health clinics, nursing homes, home health agencies, ambulances and in-home services. Hospitals still offer the emergency room care every community needs.

Even though Medicaid is growing, the program still accounts for just 10 percent of all hospital services. Montana's hospitals are not alone to blame for the increasing volume and cost in Medicaid's primary care budget.

The fastest growing portion of the Medicaid hospital program is payments made to hospitals outside Montana. According to a recent SRS funded study, **payments to hospitals outside Montana grew 142 percent in just 4 years.** Payments to those hospitals grew from $3.6 million in 1988, to over $8.8 million in 1991.

MHA has worked with SRS to implement new programs to deliver services in Montana whenever possible, and to develop new programs when needed. These actions save money.

RECENT BUDGET CUTS AFFECTING HOSPITALS

Montana's hospitals have taken their share of budget cuts over the last few years. Since hospital payments from worker's compensation were frozen in 1988, hospitals have provided millions of dollars to subsidize the state fund. Medicaid rates have been frozen since 1991. As shown on Figure 3 below, **the 1993 Legislature cut hospital payments by $57 million this biennium.**

Rate Freeze	$10.25 *
Youth Psychiatric Cuts	$27.90
Elimination of State Medical	$16.00
Outpatient Rate Cut	$.56
Out-of-state Cut	$ 2.30
TOTAL	$57.01

**In Millions, per biennium*

Figure 3

Hospitals are ready to work with the state to solve the crisis in funding health care. But current budget problems must be shared broadly across all government programs, not just a few large programs.

Hospitals do work to reduce their costs. **But for every dollar hospitals save, the state saves just 3 cents of general fund.** However, hospitals have had to raise prices whenever the state reduces the general fund which supports the Medicaid program. **And for every dollar of general fund cut, hospitals also lose 2 federal dollars.**

Many people believe that hospitals could save the state millions of dollars by not buying expensive equipment and building facilities. The latest data available from SRS shows that Montana spent just $1.38 million in general funds for all inpatient capital costs in 1991. That includes all buildings and all equipment for every Montana hospital. That means if there were no hospital services, Montana would save just over $1 million in general funds.

Hospitals have simply not created a crisis for the state with capital investment.

LEGISLATIVE ACTIONS AFFECTING HOSPITAL COSTS

Hospitals have worked hard to control their costs. Hospitals are reducing staff to meet declining inpatient volumes, sharing equipment and staff when possible, developing cost effective outpatient services and bulk purchasing supplies.

Even while the government expresses its concern about escalating costs, federal and state legislative initiatives have passed that add to the cost of health care. Figures 4a and 4b below lists several of the recent laws which increase health care costs.

Federal Actions
Clean Air Act
American's With Disabilities Act
Family Leave Act
OSHA Hepatitis B Standard
Clinical Lab Improvement Act
Omnibus Budget Reconciliation Act of 1989
Mammography Quality Standards Act
Emergency Medical Treatment and Active Labor Act

Figure 4a

State Actions
Licensure of Radiology Personnel
Payroll Tax for Workers' Compensation
Licensure of Laboratory Personnel
Repeal of State Medical Program
Infectious Medical Waste Laws
Prohibiting Jailing of Mentally Ill
Medical Parole of Inmates
Repeal of Youth Psychiatric Hospital Benefits

Figure 4a

These mandates may be well justified as a matter of public policy, but they all add to hospital and health care costs.

If the state desires to control health care costs, the state must stop passing laws which drive up the cost to deliver care.

FINANCIAL CONDITION OF HOSPITALS

Hospitals are not bloated organizations with fat bottom lines. Most hospitals attempt to earn a 5 percent margin, but most are unable to do that. Even hospitals who only recently earned positive margins are now struggling to maintain a healthy financial picture. Circumstances are changing rapidly, and hospitals must have some reserves to adapt to their new environment.

Net Patient Margins

	1985	1986	1987	1988	1989	1990	1991
All Hospitals	1.7	2.0	1.7	1.4	1.8	0.2	1.2
190 or More Beds	3.8	5.4	4.5	2.6	4.0	0.1	2.5
90-189 Beds	5.8	2.7	2.1	4.7	0.9	2.2	1.9
30-89 Beds	-5.3	-8.3	-2.4	3.3	0.0	2.1	2.7
Fewer than 30 Beds	-14.3	-11.4	-15.2	-20.7	-10.4	-10.2	-18.5

Figures in percent and represent profits and losses

Figure 5

Government programs continue to underfund their fair share of the cost to deliver service. Discounts below the actual cost to deliver care are now demanded by Medicaid, Worker's Compensation, Indian Health, CHAMPUS and Medicare. The lost revenue is made up by patients who are privately insured or pay their own bill.

MHA determined in 1991 that hospitals had to raise prices by 25 percent just to make up for the discounts demanded by government programs. Figure 6 shows the dramatic growth in discounts demanded by Medicare and Medicaid.

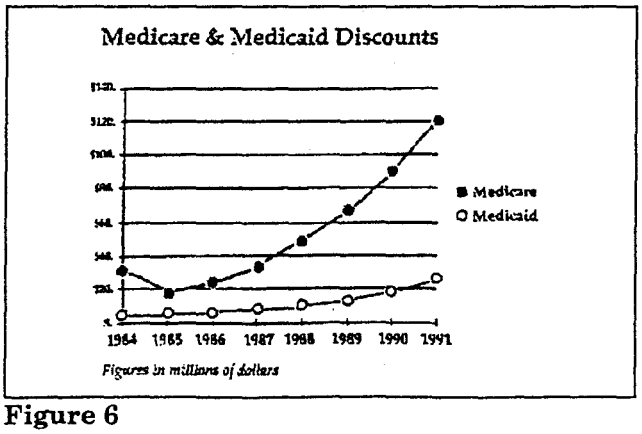

Figure 6

EX 8
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HUMAN SERVICES

CARING FOR UNINSURED MONTANANS

A major role of all hospitals in Montana is serving people who cannot pay for themselves, and those who refuse to pay their medical bills. Under federal law, hospitals may not turn away anyone who needs emergency medical care. Since the state has ended its support for the state medical program, counties whose welfare programs were assumed by the state are now asking hospitals to provide even more services without payment.

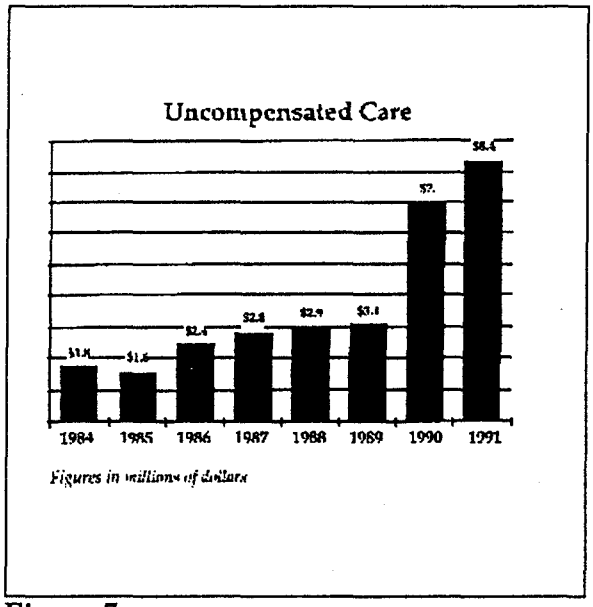

Figure 7

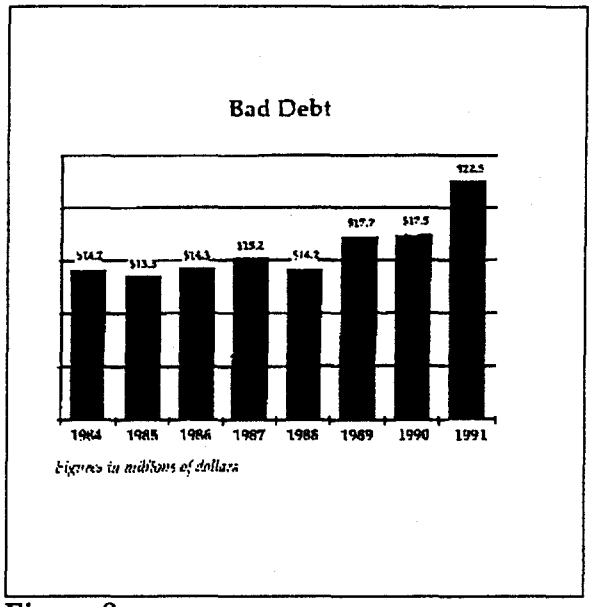

Figure 8

Figure 7 shows the growth in uncompensated care. Cuts proposed by SRS for the potential special session will likely result in continued growth in free care, and thus higher medical costs for privately insured patients.

The practice of shifting costs onto the private sector was worsened by the 1993 legislature by ending the state medical program. Hospitals cannot keep pace with the demand to provide free care.

SOLUTIONS TO THE GROWTH IN HEALTH CARE SPENDING

Reforming the health care system is the only solution to control health care cost growth. State and national reform proposals offer the best way to restructure the manner in which health services are delivered.

A reformed health care system must better align the incentives for hospitals, physicians and other providers to deliver cost effective services. Allowing providers to cooperate with one another to reduce health care holds great promise to reduce expenditures.

The state must enact tort reform to allow doctors, hospitals and other providers to end defensive medical practices.

Administrative processes and paperwork must be streamlined, ending duplication and needless overhead costs.

Cuts made now that increase uncompensated care raise barriers to reforming health care. As the state continues to cut eligibility standards and shift their costs, more people lose their insurance. One of the largest hurdles to reforming health care is guaranteeing access to care for all uninsured people. Another large hurdle will be for governments to fully fund their own programs and reverse the cost shifting. At the same time, government cuts means a weakened hospital industry without access to capital markets and unable to compete effectively, or deliver needed care.

More cuts means lowering the quality of care, or reducing access to needed services. Montana continues to lose full service hospitals. And remaining facilities are finding it harder to maintain services.

Montanans, even those who live in the more urban communities, may someday find themselves forced to travel outside the state for anything more than primary care.

EXHIBIT 1
DATE 8-10-93
HB HUMAN SERVIC

PRESENTATION

TO

THE JOINT APPROPRIATIONS
HUMAN SERVICES SUBCOMMITTEE

AUGUST 10, 1993

John A. Guy
St. Peter's Community Hospital
Helena, Montana

1. Throw Away the Rear View Mirror:

   o Last year there was a decrease of 10% in inpatient admissions.

   o This year's budget = 54. June average = 45

   o This seems to be the trend in many of Montana's hospitals.

2. Need to Look out the Windshield at What's Ahead:

   o increasing out-of-pocket cost

   o Changing technology

      - Laparoscopic cholecystectomies

      - Home IV antibiotics

   o Continued shift to outpatient and home care services

3. Two Trends: (Attachment 1)

   o Overall reduction in admissions

   o However, of those fewer admissions, increased percentage of Medicare/Medicaid

   o Nowhere to shift the cost

4. Effect on Bottom Line: (Attachment 2)

   o Some good years, some not so good

   o It will be increasingly difficult in the future to maintain a positive operating margin

5. What are Hospitals Doing to Cope with These Trends?

   o Cut costs: FTE reduction of 85 FTEs;
   Restructured Management Positions from 30 to 15

   o Established a productivity monitoring system.

   o Implementing a cost accounting system

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- o Using CQI to evaluate customer's expectations, quality and cost - i.e., DRG for joint replacements.
- o Maximizing existing resources: i.e., swing beds, rehab beds
- o Sharing technology: i.e., radiation therapy, lithotripsy
- o Case Management: decreased length of stay; overall LOS for June = 3 days
- o Shift in resources to outpatient, home care

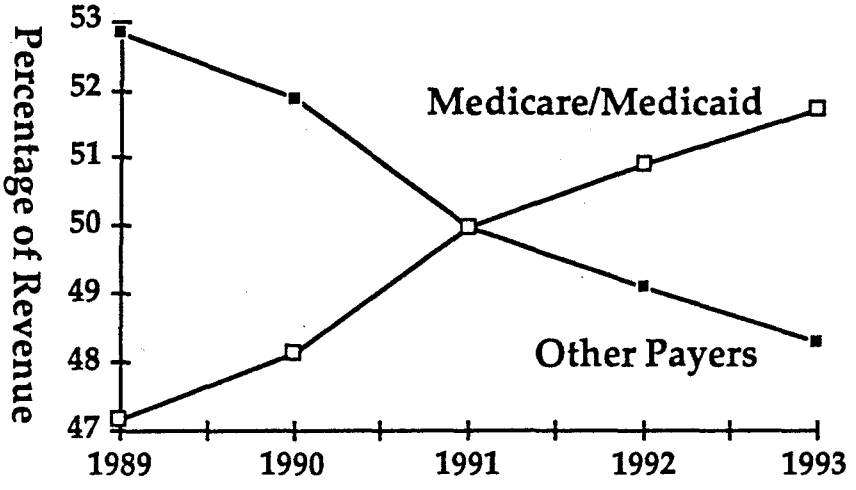
6. <u>Cost containment is difficult in the face of legislative/regulatory pressures:</u>

- o ADA, OSHA, CLEA, etc.
- o Example of medically indigent in L & C County
  - about $800,000 to approximately $170,000
  - SPCH covering diagnostic work, admission
  - "The buck stops here"

7. <u>Summary:</u>

- o Hospitals are being pressed from all corners
- o Don't have the ability to continue absorbing cuts
- o Need to support overall health reform - basic level of benefits available to all citizens

Source of Revenue



ATTACHMENT 2

EX 9
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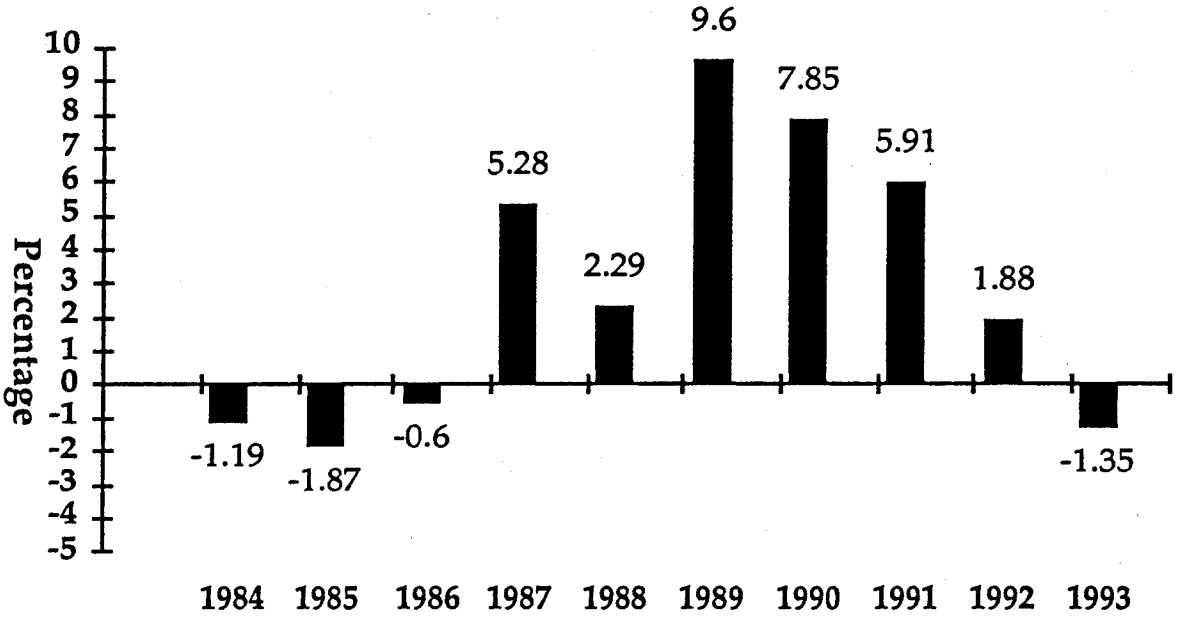
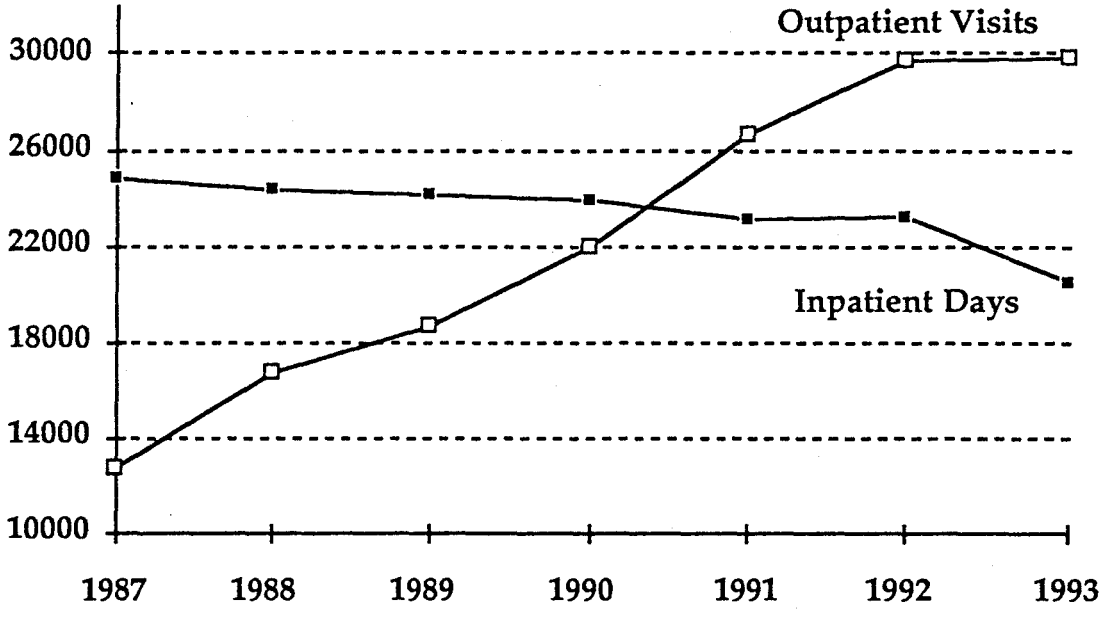
Net Income from Operations

(As a Percentage of Gross Patient Revenue)



Inpatient/Outpatient Utilization

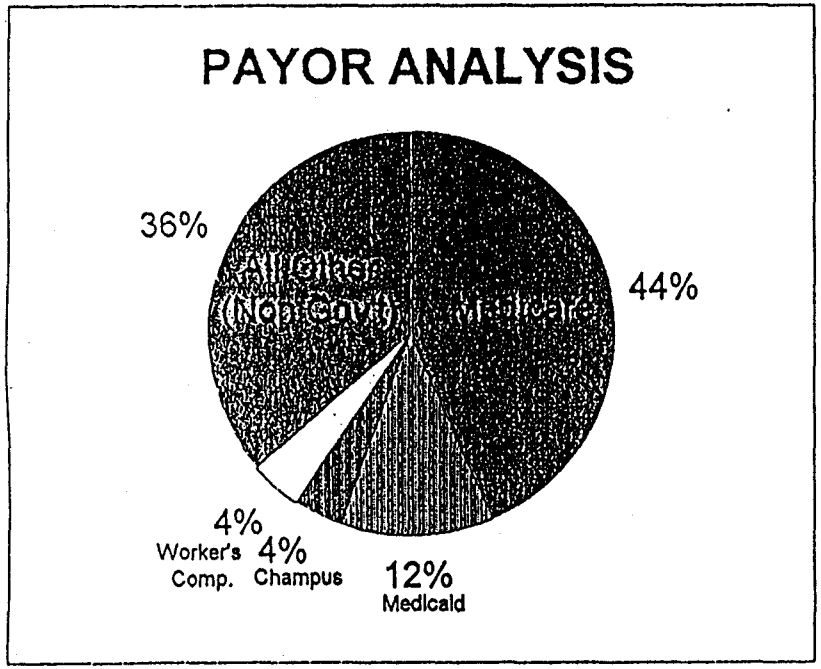


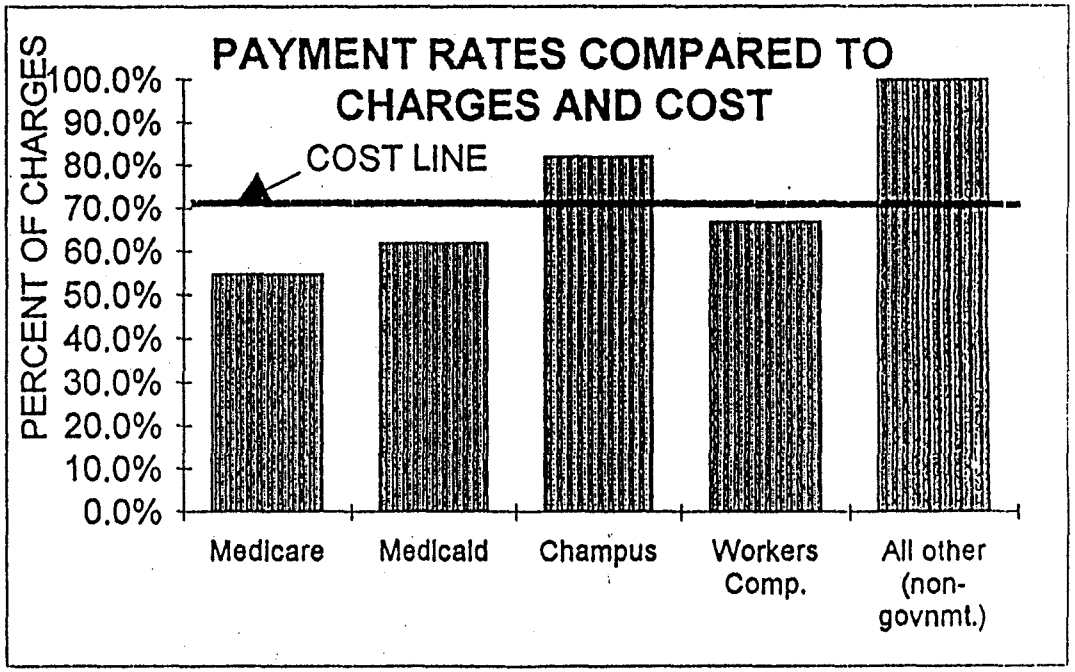
MDMC

GOVERNMENT PAYOR ANALYSIS

PAYOR	% OF GROSS REVENUE	REIMBURSEMT. AS % OF GROSS REV.	REIMBURSEMT. PAYMT. INCR. (5 yr. total)
Medicare	43.6%	54.8%	11.3%
Medicaid	12.0%	62.0%	6.1%
Champus	4.0%	82.1%	10.4%
Workers Comp.	4.2%	66.8%	0.0%
All other (non-govnmt.)	36.2%	100.0%	46.0%

Operating costs as a % of gross revenue = 71.7%





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HUMAN SERVICES

EXHIBIT #10
DATE 8-10-93
HB HUMAN SERVICES

LONG-TERM CARE AND COMMUNITY BASED SERVICES
HUMAN SERVICES APPROPRIATIONS SUB-COMMITTEE

PRESENTER: CHARLES BRIGGS, DIRECTOR
ROCKY MOUNTAIN AREA IV AGENCY ON AGING
AUGUST 10, 1993

Chairman Cobb and members of the Committee: I am Charles Briggs, Director of the Rocky Mountain Agency on Aging, encompassing the six counties of: Lewis & Clark, Broadwater, Gallatin, Jefferson, Meagher and Park.

I had the privilege to provide an overview of the aging service delivery system to this committee last January. There are a wide array of services currently being provided by area agencies on aging. Those which address community long-term care needs include: home-delivered (as well as congregate) meals; and in-home services, such as home chores and repairs; homemaker, home health and personal care services; skilled nursing; medical transportation; respite care; telephone reassurance; and physical therapy.

In that presentation I identified some changing service needs, as well as specific problem areas facing the aging population. Today, I want to, first, focus on a central fact of the changing needs of the senior population; and, second, review one state's model which has served to help deal with mushrooming expenses for long-term care.

Quite simply, Montana (like other parts of the country) is experiencing a significant expansion of the population over age seventy-five, (and, perhaps, more with those eighty-five age and over). In Attachment #1, the numbers (#1-15) correspond to the counties identified. While it is perhaps difficult to follow the lines, you will note that, for example, in Cascade County (#2) there were 2,807 adults over age-75 in the 1970 Census. The number in the 1980 Census only rose to 3,205 - only a 14.2% increase. But in 1990, that increase rose to 4,215 - an increase of 31.5%!

Likewise, Yellowstone County (#15) had 2,950 age-75+ in 1970, increased to 3,673 in '80 (a 25% increase), but then increased to 5,848 in '90, constituting almost a 60% increase. Again, Lewis & Clark County (#8) had 1,388 age-75+ in 1970; 1,603 in '80 (a 15% increase), but 3,322 in '90 (a 45% increase). And Flathead County tracked a 50% increase in '90 over '80. Furthermore, while a number of smaller counties witnessed an actual decrease from the 1970 to the '80 Census (e.g., Blaine/1, Choteau/3, Deer Lodge/6, et.al.), we, nonetheless, discover a sizable increase (even over the '70 Census) in 1990. McCone dropped 34% in '80 over the '70

Census, but increased 59% by '90!

The relevance of this is that while Montanans age 75-plus constitute something less than ten percent (10%) of the population at-large, they consume nearly sixty percent (60%) of Montana's Medicaid long-term care dollars. It is for this reason we place a premium on targeting not only the federal Older Americans Act funds to "at-risk", frail older adults, but also have allocated State General Funds for In-Home Services. These are directed toward the services I indicated earlier. The upshot is that you need to be aware any reductions you pose in services, such as the Medically Needy Program, will have a direct impact (an increase) on service demand in these programs, some of whom already have waiting lists due to lack of funding.

What I propose to members of this committee, and the legislature in general, is: rather than categorical service reductions, which will probably only exacerbate the problem, consider diverting a greater share of service dollars to less-costly community options.

Now, I would like to spend some time reviewing what one state, Oregon, did to try and deal with their financial hemorrhaging due to long-term care increases. I need, however, to preface my remarks by reviewing some patterns that helped bring us to this predicament.

The present system of long-term care in Montana and throughout the United States has been created by private industry chasing the Medicaid dollar. Since 1967, the only federal funding available in sufficient quantities for long-term care has been Title XIX of the Social Security Act, or Medicaid. From 1967-81, Medicaid was generally available only for medical or quasi-medical services. Over ninety percent (90%) of these available dollars were invested in nursing home care, and all states made nursing homes their primary long-term care services. Since 1981, Medicaid dollars have been available for community based services, but unfortunately not in large quantities, and it remains a fact today that over ninety percent of Medicaid long-term care funds are spent on nursing homes.

This situation has caused long-term care to be viewed by government, professionals, providers and the general public as a medical problem, and to provide most services under the "medical model" of care. This has caused some general failures in the national long-term care system and created general dissatisfaction with that system.

While the medical model works well for short-term acute medical care, it generally fails for long-term, chronic care for the following reasons:

1) The medical model emphasizes the disabilities of the patient & tends to minimize their capabilities.

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2) The medical model emphasizes the safety of the patient even if it results in loss of some of that patient's personal freedom or dignity.

3) The medical model usually results in the loss of privacy & control over the environment for patients.

Loss of functional abilities to perform the activities of daily living are insufficient reason to invoke the medical model of care. Medical problems that require complex nursing care usually best cared for under the medical model, but the percentage of persons requiring these medical services is small (estimates range from 20-40%). It would appear that a move away from the medical model for the majority of persons receiving, or in risking of receiving, long-term care is in the best interest of those persons, and I suggest that it would be more cost-effective as well. Allow me to explain.

If Montana were to make nursing home the placement of "last resort" rather than first, we would need to establish a system that, first, met the needs and preferences of the client to the maximum extent feasible; and second, met the needs of the Montana taxpayers.

Oregon became the first state to receive a Medicaid 1915 waiver (sub-section 1915 of the SSA), allowing Medicaid dollars to be spent on home and community care services, as well as nursing care. Without reviewing the history, let me say, Oregon established two key elements to their system: a) a "pre-admission screening" measure, to ascertain if nursing home care was the most appropriate; and b) the use of a uniform, coordinated case management system to facilitate the plan of care.

They have established a long-term care system composed of six categories of service:

A) Home & Community Based Social Services - These constitute a mix of funding sources for a wide variety of in-home care, client companionship, and home-delivered meals.

B) "Alternative" Community Care - Adult foster homes, residential care facilities (or personal care facilities in Montana), assisted living facilities; personal care (under physician authorization after RN assessment); home health care.

C) Social Services - Adult Protective Services, information & assistance, and a unique program, "risk intervention", to use case management to discover other community resources other than public funded services.

D. Nursing Facility Program - essentially skilled nursing facility care.

E. Medicaid Major Medical Services - includes durable and

miscellaneous medical services; state medical.

F. Local services, in conjunction with other services, such as senior companions, and others funded through the Older Americans Act and local resources.

Based on 1992 payments in Montana, nursing homes constituted twenty-seven percent (27%) of total Medicaid expenditures; home & community service waiver funds were two percent (2%). How can diverting funds into community based care provide effective savings?

A comparison was made by the Senior & Disabled Services Division in Oregon, between 1979 and 1986 actual expenditures (Attachment #2). Their conclusion was that without the development and expansion of community alternatives to nursing homes, conservatively Oregon could have expected nursing homes to have grown at the same rate as their primary users (the over age-75 population), in which case average nursing home bed monthly occupancy would have risen from 8,079 to 10,030. But the actual average monthly nursing home cases in 1986 was 7,590 - twenty-four percent (24%) less! Those people were being served in other community alternatives, I indicated earlier.

House Bill 2 charged SRS to develop a plan for meaningful alternative services and report its recommendations to the 1995 Legislature. The study will have to examine how other states, like Oregon,are grappling with this issue. This represents a promising step born of a dire necessity.

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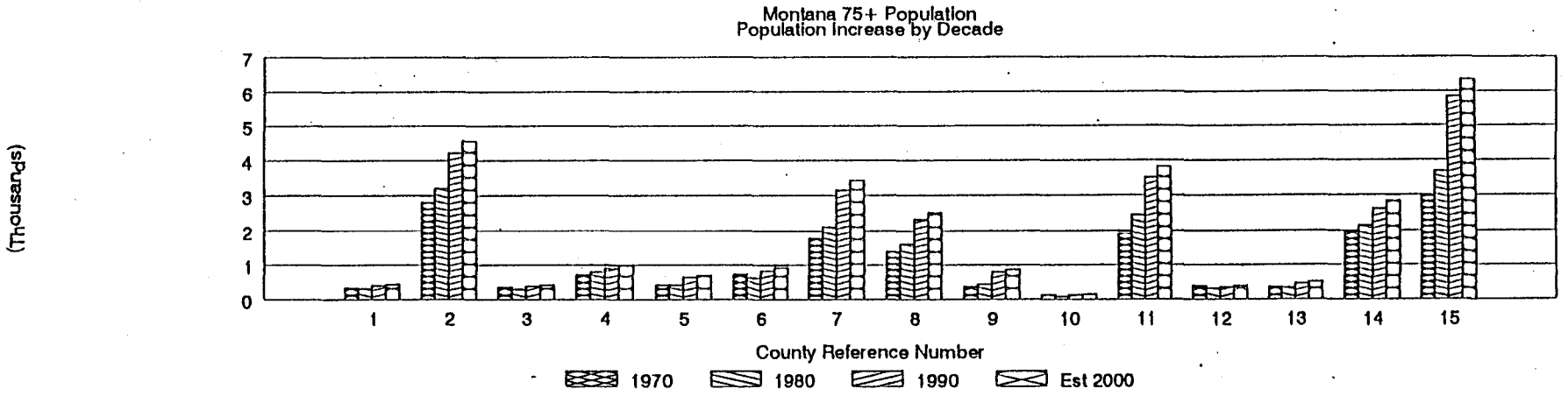
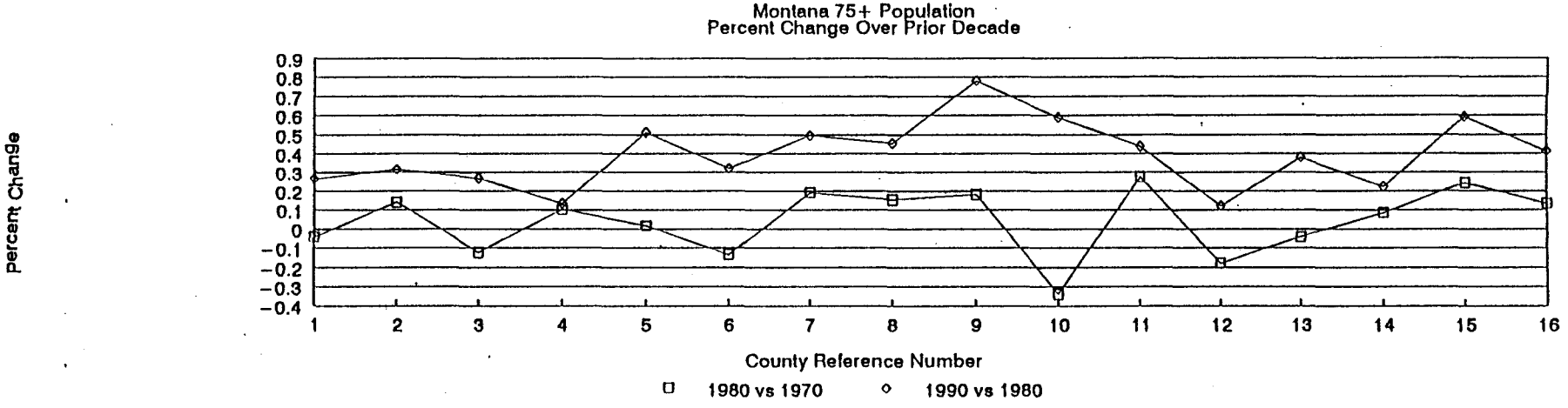
(Attachment 1)



75 plus populations

(Co Reference #)	1 Blaine	2 Cascade	3 Chouteau	4 Custer	5 Dawson	6 Deer Lodge	7 Flathead	8 Lewis & Clark	9 Lincoln	10 McCone	11 Missoula	12 Phillips	13 Sheridan	14 Silver Bow	15 Yellowstone	16 Total
1970	343	2,807	357	716	420	733	1,775	1,388	378	136	1,915	387	353	1,967	2,950	16,625
1980	329	3,205	313	790	427	635	2,115	1,603	447	90	2,447	318	339	2,138	3,673	18,869
1990	416	4,215	397	897	645	839	3,161	2,332	796	143	3,521	357	468	2,617	5,848	26,652
Est 2000	450	4,561	430	971	698	908	3,421	2,524	861	155	3,810	386	506	2,832	6,328	28,841



Percent Change Over Prior Year

(Co Reference #)	1 Blaine	2 Cascade	3 Chouteau	4 Custer	5 Dawson	6 Deer Lodge	7 Flathead	8 Lewis & Clark	9 Lincoln	10 McCone	11 Missoula	12 Phillips	13 Sheridan	14 Silver Bow	15 Yellowstone	16 Total
1980 vs 1970	−4.1%	14.2%	−12.3%	10.3%	1.7%	−13.4%	19.2%	15.5%	18.3%	−33.8%	27.8%	−17.8%	−4.0%	8.7%	24.5%	13.5%
1990 vs 1980	26.4%	31.5%	26.8%	13.5%	51.1%	32.1%	49.5%	45.5%	78.1%	58.9%	43.9%	12.3%	38.1%	22.4%	59.2%	41.2%

Year 2000 data projections from NPA DATA SERVICES, INC

8-10-93
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(Attachment 2)

TABLE 1

Comparison of Actual and Expected* Growth
in the Oregon Long-Term Care System for the
Elderly and Physically Disabled
1979 to 1986

Program	Actual Expenditures in 1979 and 1986			Actual Expenditures in 1979 and Expected Expenditures in 1986 Without Intervention		
	Monthly Average Cases	Monthly Average Cost Per Each Case	Total Expenditures	Monthly Average Cases	Monthly Average Cost Per Each Case	Total Expenditures
1979						
Nursing Homes	8,079	$ 550.33	$ 53,353,393	8,079	$ 550.33	$ 53,353,393
Federal - State Supported Community Based Care	3,412	123.02	5,036,931	3,412	123.02	5,036,931
State Only Community Based Care	2,750	51.32	1,693,565	2,750	51.32	1,693,565
Total	14,241	$ 351.59	$ 60,083,889	14,241	$ 351.59	$ 60,083,889
1986						
Nursing Homes	7,590	869.13	$ 79,160,599	10,030	825.67	$ 99,377,641
Federal - State Supported Community Based Care	6,084	271.96	19,855,566	4,236	258.36	13,132,956
State Only Community Based Care	3,650	75.62	3,312,258	3,414	71.84	2,943,141
Risk Intervention Care	900	-0-	-0-	--	--	--
Total	18,224	$ 467.92	102,328,423	17,680	$ 544.18	$115,453,738

* Expected equals the growth rate of the population age 75+, and assumes the cost per each case would have been 5% less than the 1986 activity and represents an estimate of conditions that probably would exist in 1986 and not interventions been made in the Oregon long-term care system.

5925P/sb5

EXHIBIT #11
DATE 8-10-93
HB HUMAN SERVICES

22 April 1993

Honorable Fred. R. VanValkenberg, President, Montana Senate, and Honorable John Mercer, Speaker of the Montana House of Representatives

Re: Senate Bill 285, and the conference committee hearing on proposed amendments on April 16, 1993

Dear Senator Van Valkenberg and Representative Mercer:

With some interest, I have been following the progression of Senate Bill 285, and I attended the conference committee hearing on Friday, April 16, 1993. I have some real concern about the hearing procedures in which the public was in effect shut out of the process even though private interest groups were permitted to advance their agenda by proposing amendments from the house passed version of Senate Bill 285.

As perhaps you are aware, the conference committee was created as a result of a request by Senator Franklin that one be created. To trigger the calling of a conference committee, on April 6, 1993, the Senate, as a courtesy to Senator Franklin, did not vote on the house passed amendments separately, but merely in a roll call vote, rejected the entire package of house passed amendments. What I am saying here, is that the amendments, as such, were never considered separately on their merits and voted on by the Senate.

As I read the rules on conference committees, the scope of inquiry is to focus on the disputed amendments. Here, because of the nature of the Senate's vote, rejecting the entire package of amendments, we must conclude that all the amendments were in dispute. Yet, the truth is that there was on the part of Senator Franklin, at least as was expressed at the hearing, a concern for allowing certain private interest groups to present proposed amendments to the house passed version of Senate Bill 285. And that is the concern I have.

Certain private parties were allowed at the hearing, to present proposed amendments to the house passed version of Senate Bill 285, yet the public was not allowed to participate in the process. Further, even if they were allowed to participate in the process, it is doubtful they could have given meaningful input because they had had no advance notice that any parties were going to propose amendmenrts, and they were not even given copies of the amendments at the hearing. Therefor the public, the entire process was meaningless--simply a spectacle for them, as they sat their helpless in the face of a hearing process that in essence excluded the public from participation, yet permitted private interests to have access to the hearing process by presenting and arguing their case.

Let me be more specific. The tremendously powerful interest group, the Montana Hospital Association, presented amendments on the question of Certificate of Need studies to be conducted as per the house passed version of the bill. (A copy of the proposed amendments is enclosed. I obtained a copy of these proposed amendments from the Hospital Association at the close of the hearing.) As far as I am aware, noone in the audience, other than of course agents of the Montana Hospital Association, was aware that the Association would be proposing amendments. I assume, but do not know as a fact of course, that the committee already had copies of the proposed amendments before the beginning of the hearing. Only the lobbyist of the hospital association was asked to give testimony. Nor did the chairman or any members of the conference committee tell the public that they had a right to participate as to these proposed amendments--either for or against. In effect the public was shut out of the process.

By a vote of 5-1 the conference committee voted to adopt the Montana Hospital Association's proposed amendments, thereby considerably watering down the house passed amendments on the question and issue of Certificate of Need. As I am sure you are aware, and much to the detriment of the public interest, the 1989 legislative session exempted only hospitals from the certificate of need process. In fact, the Montana Hospital Association was successful in the the Senate bill, in deleting any references to a certifiate of need study as part of the health care plan. But the House was able to resurrect the references, and even made them stronger.

It is my belief, based on the reading of the conference committee rules, that the committee had no authority to allow private parties to present proposed amendments to Senate Bill 285 as amended by the House. Private party participation, to the extent of proposing amendments, is not the function of a conference committee.

However, if we assume a conference committee has the authority to accept testimony and proposed amendments by private interest groups, then the hearing should have been a full public hearing with all interested parties as well as the public, having advance opportunity to see the proposed amendments as proposed by the Montana Hospital Association. Only then could the hearing be called in any sense, fair. But what took place in that hearing room on April 16, 1993, would fail a fairness test by any standards.

I am sure the process I have described will be verified by your examination of the hearing record. I respectfully request, that as leaders of the Senate and House, you consult with all appropriate channels, and then declare that the conclusions reached by the conference committee on April 16, 1993, are of no legal and legislative effect because of defects in the hearing process that excluded public participation.

EX 11
8-10-93
HUMAN SER

I believe the joint rules on conference committee procedures should be changed to make very express not only the limitations of the conference committee, but to protect private interest groups as well as the public who may be vitally and adversely affected by hearing procedures that exclude them from participation in situations where othere private interest groups so clearly have access to the amendment process.

This issue is vital to the public interest in maintaining the integrity of the legislative process from start to finish. I take this opportunity to give copies of this letter to the presss in the event they believe the issues raised here to be newsworthy.

Sincerely,

Daniel J Shea

Daniel J. Shea
Helena, Montana
Ph # 443-0219

Enclosure - Amendments proposed by Montana Hospital Association.

Senate Bill 285

Amendments

1. Page 7, line 9 - 10

   Following: "SYSTEM"
   Strike: "similar to the certificate of need system by which"
   Insert: "to control"

2. Page 7, line 10

   Following: "EXPENDITURES"
   Strike: "are controlled".

Section D, as amended, would read:

Controlled Capital Expenditures. The Authority shall consider adopting a system to control capital expenditures.

EXHIBIT #11
DATE 8-10-93
HB HUMAN SERVICES

Montana Hospital Association
Attention: Mr. James Ahrens, President
1720 9th Avenue
Helena, Montana 59601

Re: The Sales Tax and the Montana Hospital Association

Will the hospitals seek a rate increase during the 1995 legislative session if the sales tax passes? Will sales tax revenues be used in essence to bail out many of Montana's hospitals which have made huge capital expenditures since the 1989 legislature amended the law by exempting the hospitals from the Certificate of Need processes and procedures?

Dear Mr. Ahrens:

My perception is that the public is totally unaware of the connection between the sales tax issue and the politics of the Montana Hospital Association. It is my opinion, based on sufficient evidence, that if the sales tax passes the hospitals intend to use it as a revenue source to obtain rate increases to bail the hospitals out of their extravagent excesses committed after the legislature exempted the hospitals from the certificate of need processes in 1989. I intend to makes this letter public to alert the public to this very important issue, and also in the hope that you will respond to it publicly.

A series of situations exist, that if considered in isolation, may not mean too much, but when considered together, spell trouble for the public. Each of these situations, when put together, tell me that the hospitals expect a sales tax to be its bailout source of state money in order to obtain the federal matching funds for Medicaid rate increases.

First, we must consider the fact that the Montana Hospital Association went on record in both the Senate and the House committees in support of the Governor's sales tax bill. Second, is the fact that in 1989 and 1991, the hospitals sought rate increases, but backed off when they refused to accept a hospital bed tax as the funding mechanism for raising of the state funds needed to obtain the federal matching funds. Third, the fact that the hospitals did not seek a rate increase during the 1993 session because they did not want to accept a hospital bed tax and more important, because the hospitals supported the sales tax bill in the hopes that if the people voted it in, the revenues would be available in 1995 to obtain the long sought rate increase.

To the non-suspecting public, perhaps the support of the sales tax bill by the Montana Hospital Association was innocuous enough. However, the public is not aware of one of the major reasons the hospitals will be seeking a rate increase if the sales tax passes a vote of the people. The fact is that since 1989, after the legislature exempted hospitals from certificate of need requirements, the hospitals have gone on a major spending boom--investing in major capital expenditures such as new construction, major renovations, acquisition of other properties to be used as part of the hospital operations, and purchase of major medical equipment. These expenditures have amounted to millions, and millions, and millions of dollars. And now the hospitals want the public to pay for them, largely through the funding of the Medicaid program.

In particular, these huge spending extravaganzas have taken place in Billings, Missoula, Great Falls, and Helena, but I am sure in many other cities. In fact these spending extravaganzas went on at a time when it was apparent to the hospitals that hospital attendance was not increasing, but instead was leveling off if not decreasing. For example, a recent report over National Public Radio indicated that this year, 1993, was the 10th consecutive year that hospital occupancy rates had decreased.

So the long and short of ths situation is that in 1989 the hospitals obtained a certificate of need exemption but failed in 1989 and again in 1991 to obtain rate increases because the hospitals refused to accept a bed tax. Since the granting of the 1989 certificate of need exemtion to hospitals, the millions upon millions of dollars spent by the hospitals on expansion have not been paid for. Now they must come to the public, in the form of increasing the Medicaid rates, as the method of obtaining the money to pay for their extravagent and foolish expendidtures--all made in the name of competition. For example, Great Falls has two MRI machines, each costing several million dollars. And now the hospitals expect the public to pay for them, and for all of its other irresponsible spending extravaganzas after the legislature foolishly exempted them from certificate of need requirements.
cert

Medicaid, as the public is becoming more and more aware, is a huge expenditure of the State of Montana. For example, in 1993-1994 and 1994-1995, close to 220 million dollars will be spent in Montana for each of these years. This amount includes a increase for each year of approximately 33 million dollars. Approximately one-third of this money is direct state revenue that is used to obtain federal matching funds on approximartely a 2-1 basis. A huge amount of this annual medicaid funding goes to hospitals.

There are still more profound effects that the public is feeling and will continue to feel because of the extravagent spending sprees of the hospitals after the legislature lifted the certificate of need requirement for hospitals in 1989.

One huge impact on communities is the fact that hospitals have had to lay off many of their employees because the could not in effect pay the mortgages for their new purchases and pay their employees at the same time. Ths is particularly true in Great Falls and Helena, where there have been huge layoffs announced, and more due to come. Yet, when these layoffs were announced, not once did the hospitals confess that what really happened is that due to their huge spending programs and capital acquisitions after 1989, they no longer had the means to pay for these acquisitions and to pay their staff at the same time. As is so often the case, the employees came out on the short end of the stick. So that the hospitals could pay their mortgages, the employees were compelled to sacrifice their jobs. Of course, as is always the case, they had no say in the matter.

When these layoffs were announced to the public, the hospitals simply said that they had to do it because there had been freezes on Medicaid payments and other sources of public funding for hospital operations. Not once did the hospitals mention that they had goofed by their over expenditures after the legislature had lifted the certificate of need exemption for hospitals in 1989.

And there is yet another effect of which the public is unaware, and this is particularely true in Helena. After the lifting of the 1989 certificate of need exemption, St. Peter's hosital, in addition to extravagent renovation and reconstruction programs, actually acquired other capital assets in Helena, whch had the effect of removiong those properties from the tax rolls. The public is probably not aware that hospitals, as so-called non-profit corporations, enjoy tax exempt status for property taxes. Therefore, when St. Peter's hospital acquired the Helena Medical Clinic and the Triple A. building, and the Park Avenue Health Spa, these properties were taken off the tax rolls. In addition, St. Peter's Hospital has made other purchases of real estate, also taking these properties off the tax rolls.

The public doe not realize that when this happens, the taxes on residential property must go up to make up in effect, for the deficit created by taking the properties off the tax rolls that were purchased by St. Peter's Hospital. And there may be further property tax consequences beyond this, such as a decrease in the property tax base, but time does not allow me to elaborate. Suffice to say that the public took and is taking and will continue to take a real bashing and thrashing since the legislature, due to the immense lobbying effort of the hospitals, lifted the certificate of need requirement in 1989.

My concern is that unless the public finally says no to the skyrocketing health care costs, this state will remain as it is now, crippled. Perhaps it will become permanently crippled if the public does not say "no"--loudly and clearly. The public cannot say no if the sales tax proceeds will be used in part to bail out the hospitals from its extravagent spending on capital expenditures since 1989. And I do not for one minute underestimate the tremendous influence of the Montana Hospital Association. I will give two examples from the last legislatsive session.

The first example cocerns House Bill 145, introduced by Representative Cobb. Its purpose was to expand a Medicaid program to include certain women and children, and particularly pregnant women. The funding for the expansion was to come from a bed tax on the hospitals, the proceeds of which would be used to obtain fedral matching funds. I was present at the hearing. Before officially opening the hearing on the merits, Representaive Cobb announced that the Governor would not support the hospital bed tax as the funding mechanism, and therefore another means of funding would be required. This situation shows clearly that the Montana Hospital Association had an audience with the Governor and that it won him over to their views--no bed tax on the hospitals. I would doubt, however, that noone else had a chance to talk to the Governor to present counter arguments. Needless to say, House Bill 145 is not funded by a hospital bed tax.

The second example concerns two situations involving Senate Bill 285, the Montana Health Care Act, commonly referred to as the Franklin Bill. This bill was competing with Senate Bill 267, supported by Montanans for Universal Health Care, and sponsored by Senator Yellowtail. After the hearing on both bills, Senator Yellowtail announded that he would not pursue his own bill separately but instead would seek to incorporate important parts of his bill into Senate Bill 285. Senate Bill 267 had important provisions that would require health care providers, including hospitals, to be subject to a certificate of need requirement. However, before the final bill came out of the Senate, the Montana Hospital Association used its influence to eliminate any reference to hospitals being subject to a certificate of need study by the Health Care Commission that will be shaping the final legislation to be submitted to the 1995 legislature.

Fortunately, however, the Houce Committee was notified of this glaring defect, and wisely placed strong language in Senante Bill 285 that would also require hospitals to be subject to a study of certificate of need assessment to determine if they should be part of the final legislation as presented to the 1995 legislature. This language is still in the bill as signed by the Governor.

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And so we come full circle. If the sales tax passes the hospitals will be first in line to ask for a funding increase, much of will go towards payment of the huge capital expenditures made by the hospitals since the lifting of the certificate of need exemption. And if the sales tax does not pass, I assume the hospitals will still be standing in line for a rate increase, but perhaps they will then be more amenable to a hospital bed tax as the funding mechanism to generate the state money need to match the federal money. If a bed tax is accepted and passed,the result will be that of cost shifting whereby all who pay for hospitalization will be paying higher rates so that the hospitals can recover what they pay out on the hospital bed tax.

Sadly enough, a good part of the bill will be to pay for the huge mistakes in spending the hospitals made after 1989, for which the public is forced to pay. This is one reason, among many others, why the certificate of need exemption must be repealed by the next legislature as one of its first items of business.

As I indicated before, I would like these issues to have a public airing. Please let the public know where you stand. A large part of our economic health in this state depends on whether this state can contain the skyrocketing health care cases, many of which have been imposed on an unwitting public by a greedy hospital industry in its drive to acquire more, more and more capital assets, including the purchase of unnecessary major medical equipment, already duplicating the equipment in hospitals in the same city, such as the two MRI machines in Great Falls.

Sincerely,

Daniel J. Shea
800 Broadway
Helena, MOntana 59601

Enclosure; Letter to Senate and House Leaders
Dated April 22 1993

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Mental Health Association of Montana

An Affiliate of the National Mental Health Association

State Headquarters • 555 Fuller Avenue • Helena, Montana 59601
(406) 442-4276 • Toll-Free 1-800-823-MHAM

EXHIBIT # 12
DATE 8-10-93
HB HUMAN SERVI

COMMENTS TO THE APPROPRIATIONS COMMITTEE OF HUMAN SERVICES

AUGUST 10, 1993

PRESENTED BY JOHN M. SHONTZ
PUBLIC POLICY COORDINATOR

Chairman Cobb and Members of the Committee,

My name is John M. Shontz. I am the public policy coordinator for the Mental Health Association of Montana. The Association aggressively supported tax reform during the 1993 Session of the Legislature. The Association understood then and understands now the consequences of the failure of fundamental tax reform in Montana. We all face those consequences today. But the Legislature's options are limited.

Article XII, Section 3 of the Montana Constitution states in part;

(1) THE STATE SHALL ESTABLISH AND SUPPORT INSTITUTIONS AND FACILITIES AS THE PUBLIC GOOD MAY REQUIRE , INCLUDING HOMES WHICH MAY BE NECESSARY AND DESIRABLE FOR THE CARE OF VETERANS.

(3) THE LEGISLATURE MAY PROVIDE SUCH ECONOMIC ASSISTANCE AND SOCIAL AND REHABILITATIVE SERVICES AS MAY BE NECESSARY FOR THOSE INHABITANTS WHO, BY REASON OF AGE, INFIRMITIES, OR MISFORTUNE MAY HAVE NEED FOR AID OF SOCIETY.

The question, then is not if persons who are mentally ill, for example, will receive assistance from the legislature, but how the assistance can be delivered in the most cost effective manner; either in an institutional setting or in a community based setting.

During the past decade, the Mental Health Association of Montana supported and advocated for the development of community based services for mentally ill adults and children in Montana.

CHILDREN:

During the recent legislative session, the Association supported the Governor and Legislature's initiative to replace the heavy use of inpatient psychiatric care for Montana children in favor of developing a community based system of care for our emotionally and severely emotionally disturbed youth. The saving to the general fund as a result of this switch was several million dollars.

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This committee was instrumental in assembling a package that established the mechanisms which is making the development of the community based programs for Montana children possible. You might be interested to know that thanks in part to your efforts, Montana is one of, I believe, only four states in this country that requires state agencies to coordinate their services to severely emotionally disturbed children.

Do NOT reduce the current level budget for those programs. The result will simply be a return to institutionalized care for SED children in Montana at a tremendous increase in costs to the state's general fund.

ADULTS:

During the past decade, state services to mentally ill adult Montanans has undergone a great change. Scores of people moved from institutionalized settings into community based treatment programs. Advances in treatment and medications have also aided in the healing of thousands of people with mental illnesses. The Medicaid program and the Medically Needy program have been the primary vehicles used to fund the care of mentally ill indigent adults in community based settings.

Reduction or elimination of the optional services provided under Medicaid (including medication, day treatment, and therapy) will simply mean that adults will be served at Montana State Hospital at Warms Springs rather than at home. Specifically, reductions in the medically needy program limiting non targeted case management care to 22 hours of therapy per incident at community mental health centers and fifteen hours of day treatment per week will result in the speedy institutionalization of many Montanans at a high cost.

As I noted earlier, our state Constitution mandates that the Legislature provide assistance to persons in need. We point out that this committee, in reality, controls the general fund budget prepared by the Institutions Sub-committee because of your control of funding for community based programs through the medically needy program and the Medicaid program. The responsibility to minimize general fund spending for the care of mentally ill indigent Montanans rests with you.

Let me close with a clear financial example of what will occur if services to the mentally ill are reduced through the medically needed program and the Medicaid program.

Last year, these programs paid for treatment of 687 Montanans suffering from severe schizophrena. Of those, 630 persons were treated in Montana's five community mental health centers. If a "cap" of 22 hours of treatment in a community mental health center is put in place per person, then a large number of those persons will not be treatable in their community; they will

require institutionalization.

We again note that this point that, by federal law, CARE AT MONTANA STATE HOSPITAL IS FULLY FUNDED BY THE STATE'S GENERAL FUND: Medicaid cannot help.

The executive director of the least populated mental health region estimates that 100 persons who are currently being treated in their communities under the Medicaid program alone will require commitment to Warm Springs within a year. The cost to Montana's general fund will be about $1,650,000.00 for the treatment at Montana State Hospital for these persons. Currently, the region receives $140,000.00 in general fund money to serve those persons in their communities. The general fund money is matched with about $360,000.00 in federal money to fund the locally based treatment programs.

$140,000.00 in general fund at the local level verses $1,650,000.00 in general fund at Warm Springs. We note that if all 100 persons were permanently committed to Warm Springs the cost to the general fund would rise to well in excess of six million dollars. The choice clearly rests with you.

Do not demand small savings in community based services for the mentally ill by eliminating or reducing services under the medically needy or Medicaid options. Dramatic cost increases will result due to a certain dramatic rise in institutionalization.

SUMMARY:

The Montana Constitution mandates that services be provided to mentally ill indigent Montanans.

The mental health system in Montana is becoming more cost effective as institutional services are replaced with community based services. Patients are certainly better treated as well.

Development of adequate services to severely emotionally disturbed Montana children at the community level is just beginning. Funding reductions now will again commit the general fund to support very high cost institutional care.

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The same is true for Medicaid and medically needy service for mentally ill indigent adults in Montana. Consider the general fund cost of caring for persons at Warm Springs compared to the cost of care in the local community when you examine reducing the funding for the options that you currently fund.

We encourage this committee to again meet jointly with the Subcommittee on Institutions to address these issues. We encourage you to direct your staff and to request the executive to explore the general fund impacts of caring for Montanans in the event you choose to reduce the medically needy program and Medicaid funding for indigent mentally ill Montanans.

You ~~that you~~ will be appalled at the increased costs to general fund that will inure if the medically needy and the Medicaid optional services are cut or reduced at the community level.

Thank you.

EXHIBIT #13
DATE 8-10-93
HB HUMAN SERVICES

STATE OF MONTANA

Office of the Legislative Fiscal Analyst

STATE CAPITOL
PO BOX 201711
HELENA, MONTANA 59620-1711
406/444-2986

TERESA OLCOTT COHEA
LEGISLATIVE FISCAL ANALYST

June 9, 1993

Representative John Cobb
P.O. Box 388
Augusta, MT 59410

Dear Representative Cobb:

In response to your request concerning Department of Health and Environmental Sciences (DHES) and the allocation of its vacancy savings and budget balancing reduction, I obtained the following information.

The total, by fund type, of the vacancy savings and budget balancing reduction imposed in House Bill 2 for the department is:

	Fiscal 1994	Fiscal 1995
General Fund	$288,011	$288,229
State Special Revenue	56,069	68,120
Proprietary Funds	63,257	63,338

DHES has general fund appropriations of $3,294,301 in fiscal 1994 and $3,281,850 in fiscal 1995. If the same percent is applied to each general fund appropriation, an 8.8 percent reduction is necessary to meet the vacancy savings and the budget balancing reduction. This percent exceeds the 5 percent vacancy savings reduction and the 0.5 percent budget balancing reduction due to a decrease in general fund after the percentage reductions were determined.

The department submitted its operational plan to the Office of Budget and Program Planning (OBPP) with reductions allocated to the following programs (see Table 1). The reductions have been reviewed and approved by OBPP.

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Table 1
DHES Vacancy Savings & Budget Balancing Reduction Allocation

Funding & Program	Fiscal 1994 Appropriation	Fiscal 1994 Reduction	Fiscal 1994 %	Fiscal 1995 Appropriation	Fiscal 1995 Reduction	Fiscal 1995 %
GENERAL FUND						
Director's Office	$156,558	$3,300	2.1%	$157,378	$3,345	2.1%
Central Services	278,696	5,874	2.1%	264,685	5,626	2.1%
Environmental Sciences	369,843	7,796	2.1%	370,766	7,881	2.1%
Solid/Hazardous Waste	146,447	3,087	2.1%	147,111	3,127	2.1%
Health Services*	1,483,534	249,843	16.8%	1,482,059	249,972	16.9%
Family/MCH	243,153	5,125	2.1%	243,153	5,169	2.1%
Preventive Health	92,878	1,958	2.1%	92,878	1,974	2.1%
Health Facilities	523,192	11,028	2.1%	523,820	11,135	2.1%
Total General Fund	$3,294,301	$288,011	8.7%	$3,281,850	$288,229	8.8%
STATE SPECIAL REVENUE						
Water Quality	$2,768,652	$56,069	2.0%	$2,722,204	$68,120	2.5%
PROPRIETARY						
Central Services	$1,666,376	$63,257	3.8%	$1,570,379	$63,338	4.0%

*See Table 2

The general fund reduction in the Health Services Division is further allocated as shown in Table 2.

Table 2
Health Services Vacancy Savings & Budget Balancing Reduction Allocation

HEALTH SERVICES DIVISION	Fiscal 1994 Appropriation	Fiscal 1994 Reduction	Fiscal 1994 %	Fiscal 1995 Appropriation	Fiscal 1995 Reduction	Fiscal 1995 %
GENERAL FUND						
MIAMI**	$264,590	$106,000	40.1%	$264,590	$106,000	40.1%
Rural Physicians Residency	200,000	100,000	50.0%	200,000	100,000	50.0%
End Stage Renal Disease	125,000	25,000	20.0%	125,000	25,000	20.0%
General	893,944	18,843	2.1%	892,469	18,972	2.1%
Total	$1,483,534	$249,843	16.8%	$1,482,059	$249,972	16.9%

**Budget modification only

The MIAMI appropriation listed in Table 2 is for the Expand MIAMI Program budget modification. It does not include $170,454 per year of general fund for the current level appropriation for MIAMI in the Family/MCH Bureau.

The Expand MIAMI modification of $264,590 per year, resulted in general fund reductions of $361,794 in fiscal 1994 and $377,268 in fiscal 1995 in Department of Social and Rehabilitation Services (SRS) appropriation for medicaid hospital costs. If the MIAMI appropriation is directly proportional to the cost savings in medicaid hospital costs, then medicaid general fund expenditures may increase by $145,079 in fiscal 1994 and $151,284 in fiscal 1995 (40.1% of projected savings).

If I can provide further information, please call me.

Sincerely,

Lisa Smith
Associate Fiscal Analyst

LDS3:lt:rc6-10.ltr

MONTANA
HEALTH
CARE
ASSOCIATION

36 S. Last Chance Gulch, Suite A · Helena, Montana 59601
Telephone (406) 443-2876 · FAX (406) 443-4614

EXHIBIT #14
DATE 8-10-93
HB HUMAN SERVICES

July 30, 1993

Representative John Cobb, Chairman
Joint Appropriations Subcommittee on
Human Services
P.O.Box 388
Augusta, MT 59410

Dear Rep. Cobb:

Re: Committee meeting on possible Medicaid budget cuts

Thank you for your letter of July 25, informing us of the August 10 meeting of your subcommittee and seeking our input. I regret that I will be unable to attend the August 10 meeting, but I will be out of the state at that time. I hope these written comments will be of some help to the committee and that we will have an opportunity to provide additional information and comment on specific proposals which affect long term care at future meetings of your committee.

Comments on SRS/Administration Proposals

Since we are not yet aware of specific proposals by SRS or the administration with respect to Medicaid cuts, we are not able to provide comment or input at this time.

Specific Proposals for Controlling Medicaid Costs

We believe that long term care facility costs have been driven by:

1. expanded eligibility criteria
2. new regulations
3. inflation
4. increased level of care required by residents (because those

with lesser needs are being cared for in other settings)

5. increased number of individuals over the age of 80 in our population

Interestingly enough, all of these things are outside the control of our long term care facilities. And, only the first two are (or may be) within the control of the state legislature.

1. Eligibility Issues. The role of the Medicaid program is to provide necessary health care services to the indigent. Although originally intended to ensure access to health care for the poor, Medicaid has become the major payor of nursing facility care for the middle class. Medicaid is the principal payor for over 60% of patient days in nursing facilities. This burden on the Medicaid program results in part from the sheltering of financial resources by individuals (or their families) who are receiving nursing facility services at the expense of the Medicaid program. There is no doubt that Medicaid has become more than a program for the poor, when it comes to nursing home care. Almost anyone can qualify for Medicaid nursing home care if they plan ahead. "Medicaid estate planning" is a common occurrence whereby otherwise ineligible individuals plan for Medicaid to subsidize the cost of their nursing home care.

We believe that law changes currently being considered by Congress as part of the budget reconciliation process will allow the state of Montana, if it chooses, to effect cost saving measures through tighter restrictions on asset transfers and more aggressive estate recovery. We believe the state of Montana should take advantage of these changes at the earliest possible time. Specific provisions included in either the House or Senate version of the reconciliation act include:

Asset Transfer Provisions:

Eliminate the 30 month maximum cap on the penalty period triggered by asset transfers.

Allow states to look back 48 months.

Require that penalties for multiple transfers run consecutively, not

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concurrently.

Begin the penalty period on the date of application for eligibility.

Treat most grants or trusts as resources or illegal transfers.

Estate Recovery Provisions:

Require states to establish estate recovery programs.

Define "estate" to include all real and personal property plus other assets as defined under state inheritance laws; allow states to broaden definition to assets in which deceased had title or interest.

The Congressional Budget Office estimates that the asset transfer provisions will save $650-800 million over a five year period and that the estate recovery provisions will save $300 million over a five year period.

2. New regulations. Most of the new regulations governing long term care facilities have been imposed by the federal government and may be difficult to do anything about. However, an effort should be made to identify those that do not improve quality of care for our residents and create administrative and paperwork burdens. While dealing with this issue may not provide short-term savings, it has the potential of providing long term savings. We believe it is important to identify at all levels statutory and regulatory barriers to the efficient and economic delivery of health care.

It is also important to be aware of and deal with activities on the state level that may increase health care costs. For example, the Board of Nursing is currently considering the issue of whether the taking of verbal and telephone orders and serving as charge nurses are within the scope of practice of LPN's under the Montana Nurse Practice Act. LPN's are widely used throughout the state to perform these types of functions and have been doing these things for many years. If the Board decides that these duties are not within the scope of practice of LPN's or that LPN's need further education to perform them, there will be substantial increases in healthcare costs, including long term care costs, in this state. We would recommend that the legislature amend the nurse practice act

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to clarify that these are permissible duties for LPN's under the act, since they have been performing them safely for many years.

General Comments

While it is always easier reduce Medicaid costs by simply not paying the costs associated with providing the services, we do not believe that this is an appropriate way to reduce costs since the unpaid costs are simply shifted to other payers--and the eligibility and regulatory issues are never addressed. We believe that Medicaid should accomplish savings by limiting eligibility to those who are truly needy and by seeking changes to (or waivers from) statutes and regulations which form barriers to the efficient and economic delivery of health care.

I hope this information is of help to you. If you have any questions, please don't hesitate to contact me. I look forward to working with your committee and being of assistance in any way I can.

Sincerely,

Rose M. Hughes
Executive Director

RMH/db

Copy to: Rep. Betty Lou Kasten
Rep. Dave Wanzenried
Sen. Mignon Waterman, Vice Chair
Sen. Chris Christiaens
Sen. Tom Keating
Ms. Lois Steinbeck, LFA Office
Ms. Nancy Ellery, Administrator, Medicaid Division

EXHIBIT # 15
DATE 8-10-93
HB HUMAN SERVICE

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Helena, Montana 59601-4890
Telephone (406)443-4000 or In-State 1-800-MMA-WATS (662-9287)
FAX (406)443-4042

August 9, 1993
Monday

Representative John Cobb
Chairman
Joint Subcommittee on Human Services
and Aging
House Committee on Appropriations/Senate
Committee on Finance and Claims
Room 108, State Capitol Building
Helena, Montana 59620

Dear Representative Cobb:

May we take this opportunity to respond to your July 25 letter about the coming meeting of your committee scheduled for August 10 in Helena.

This Association commends you and the other members of the committee for your concern in approaching this very serious financial consideration of the state Medicaid program.

The members of this Association believe that essential services must continue to be provided and that cuts be considered in the optional service areas. We further believe that no cuts should be made for services provided children and pregnant women.

Your deliberations as to controlling costs and improving the system will indeed require very deep consideration.

In that physician reimbursement under Medicaid is 50% to 55% of billed fees, any lowering would have a drastic effect upon the program. We believe institution of provider taxes, essentially a discount in reimbursement, is not the proper course of action. The entire program and all beneficiaries must be considered as to reimbursement for essential services provided.

After this initial meeting and towards solution, please feel free to call upon this Association for physician input. We do thank you.

Sincerely,

G. Brian Zins
Executive Vice President

GBZ:le

EXHIBIT 7 16
DATE 8-10-93
HB HUMAN SERV

Comments re: SRS proposed recommendations for cuts in Medicaid services to speech and hearing impaired clients.

August 10, 1993

From: Robert B. Chaney, Jr., Ph.D. Consulting Audiologist SRS
To: Legislative subcommittee hearing on health and human services

For the past 5 years, I have served as a consultant to the SRS for the evaluation of claims for hearing aid services. When I started, I developed criteria for those services that resulted in a reduction of nearly one-third of their cost to the state. In the past year I was paid about $5,000 for my services, and saved the department nearly $25,000.

I wish to place before you some concerns about the process by which you are being asked to determine spending cuts that may become necessary if HB 671 is overturned.

I was informed last night at 5 p.m. of this hearing, and denied access to any of the SRS data on which they drafted their recommendations to you.

Because SRS has relied on consultants like me for their professional advice, it is possible that recommendations drafted without that input may be seriously flawed.

I understand the difficulties you face, and do not intend to try to dissuade you from making the necessary cuts. I do, however, strongly urge you to include in your deliberations the professionals most knowledgable and involved with those who will be affected by the cuts, so that maximum savings can be achieved with the least impact on the recipients.

As an example, I understand that by law, nursing home residents are to be exempted from these cuts. I would submit that hearing aids made available instead, to those recipients who could then be made employable is a better bargain than placing hearing aids on nursing home patients. I realize the nursing home population is required by law to be provided with access to communication, but this can be done with assistive listening devices, other than hearing aids, at far less cost, and with better results for the patients.

This is but one of many opportunities for savings that might be considered, but your needs and those of the State we all represent will be better served by including appropriate professional input.

Thank you.

EXHIBIT 11
DATE 8-10-93
HB HUMAN SERVI

MONTANA STATE PHARMACEUTICAL ASSOCIATION

PO Box 4718 · 1215 11th Avenue · Helena, MT 59604 · 406-449-3843

July 29, 1993

Representative John Cobb
P.O. Box 388
Augusta, Montana 59410

Dear Representative Cobb:

I am writing in response to your correspondence of July 25 requesting productive ideas for saving dollars in the Medicaid budget. The Montana State Pharmaceutical Association submits the following suggestions:

1) Institution of prior authorization of some drugs. You may be aware that the Medicaid Drug Utilization Review Program is now up and running, and already there are significant quantifiable cost savings as a result. In fact, first quarter results (which have not yet been verified fully), show a savings of at least $75,000. This was the first quarter, when the program was running at barely a crawl. We would project that once the program is fully functioning, the savings will be at least in the hundreds of thousands of dollars per year. It is important to note that the program is *retrospective* DUR. Institution of a *prospective* program would save more dollars still.

2) Elimination of payment for fertility drugs. I often hear pharmacists complain about Medicaid payment for fertility drugs. I know that at one time, it also paid for hair growth drugs, but I'm not sure if they still do. We realize that there are some social issues to consider in these matters, but these types of drugs may not be viewed by your committee as medically necessary.

3) Institution of formularies. Congress, through OBRA '90, restricted the use of formularies, but there is currently discussion of lifting that ban. Formularies are listings of drugs that must be used for certain problems, and they can really save a lot of money.

If you have more questions about the Drug Utilization Review program, I would refer you to Jeff Ireland with Medicaid or to Mark Eichler, R.Ph, who is the director of that program. Mark is employed by the Montana/Wyoming Foundation for Medical care. Also, please feel free to contact me if you need additional information or if I can be of help in any way.

Sincerely,

Bonnie L. Tippy

Bonnie L. Tippy
Executive Director, MSPA

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging SUBCOMMITTEE DATE 8/10/93

DEPARTMENT(S) _____ DIVISION _____

PLEASE PRINT PLEASE PRINT

NAME	REPRESENTING	
✓ Bob Hunter	Managed Care & Benefits Consultant	
✓ Stuart Klein	Mental Health	
Dan Shea	Non affiliated	
Christine Medina	Mt. Low-Income Coalition	
Neil Haight	Self	
John Shontz	Mental Health Association	
Mike Mayer	Summit Independent Living Center	
Mona Jamieson	Audiologists, Speech Pathologists + Physical therapists	
Paul Smetanka	Montana Podiatric medical Associat	
Paul Patterson	self	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.