# MINUTES

## MONTANA HOUSE OF REPRESENTATIVES
## 53rd LEGISLATURE - SPECIAL SESSION

## JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

**Call to Order:** By **REP. JOHN COBB, CHAIRMAN**, on November 18, 1993, at 10:10 A.M.

### ROLL CALL

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

**Members Excused:** NONE

**Members Absent:** NONE

**Staff Present:** Lisa Smith, Legislative Fiscal Analyst
Lois Steinbeck, Legislative Fiscal Analyst
Connie Huckins, Office of Budget & Program Planning
Alberta Strachan, Committee Secretary

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

**Committee Business Summary:**

Hearing: **CHAIRMAN COBB** stated that this hearing was being called to study an overview on the Department of Social and Rehabilitative Services, the Medicaid program and long term care.

EXECUTIVE ACTION: NONE

### HEARING ON THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES AND MEDICAID PROGRAM

**Dr. Peter Blouke, Director, Department of Social and Rehabilitation Services,** outlined the basic facts about Medicaid, a program of health care for low income persons. Eligible recipients include families receiving AFDC and SSI, developmentally disabled, blind, physically disabled, pregnant

women and their newborn infants who meet limited income and resource limits. The Medicaid program in Montana is jointly funded by the federal government (71 percent) and state government (29 percent). The federal government establishes most rules for eligibility and coverage. Medicaid will account for 16.5% of the total state government general fund spending for FY94. **Dr. Blouke** then talked about mandatory and optional services, the administrative costs of the Medicaid program and the relationship to federal regulations. Control of the growth of the Medicaid program will necessarily require adjustment in eligibility criteria and the availability of services to certain populations. Medicaid coverage of the medically needy population is an optional service under the Medicaid program. **EXHIBIT 1**

**Dr. Blouke** then spoke about expansion of Medicaid managed care which is the management of health services through an organized health care delivery system. There are a variety of approaches to managed care, all of which focus on how health care is delivered rather than merely on what each service costs. These include health maintenance organizations (HMOs) and primary care case management (PCCMs). **EXHIBIT 2.**

**Dr. Blouke** then gave a summary of Medicaid estate and lien legislation which includes asset transfers and trusts and recovery of Medicaid expenditures. In conclusion he said that in the present condition, economic realities do not permit the state the luxury of allowing individuals to avoid using their available assets to pay for the cost of their long-term care while the public picks up the tab. A recipient should be allowed to keep and exempt certain assets while the recipient's spouse, dependent children or certain close relatives depend upon the assets for their needs. These same economic realities demand that when such need no longer exists, these assets must be used to indemnify the public treasury for the recipient's Medicaid expenditures. **EXHIBIT 3.**

## OPTIONAL SERVICES

### TESTIMONY ON ADULT DENTURE AND DENTAL SERVICES

**Dr. Blouke** stated that the Medicaid program currently covers dental services and dentures provided to adults. This change would eliminate coverage of all dental services except extractions and related exams to adults who live in the community. Currently, the Medicaid program covers dental services and dentures for adults. This change would eliminate adult dental coverage of everything except extractions and related exams. The proposal would also eliminate composite fillings on posterior teeth for children and allow sealants only on permanent molars. This proposal was developed with the Dental Association as a replacement for total elimination.

TESTIMONY ON ADULT PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY SERVICES

**Dr. Blouke** said that the Medicaid program currently covers rehabilitative physical, speech and occupational therapy 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 medically necessary, therapy services could continue to be provided under outpatient hospital and home health care but at a greater cost. 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. There are 156 recipients and 70 providers for physical therapy, 23 recipients and 35 providers for speech therapy and 26 recipients and an unknown number of occupational therapists.

TESTIMONY ON PERSONAL CARE SERVICES

**Dr. Blouke** stated that 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. There are 132 recipients and 2 providers for this service.

TESTIMONY ON THE ELIMINATION OF ADULT PODIATRY SERVICES

**Dr. Blouke** stated that the Medicaid program currently covers podiatry services provided by licensed podiatrists. This change would eliminate coverage of these services to adults who live in the community. Minimal cost savings are anticipated if this services 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. There are 2,187 recipients and 30 providers of podiatry services.

TESTIMONY ON THE ELIMINATION OF ADULT HEARING AIDS AND AUDIOLOGY SERVICES

**Dr. Blouke** said that the Medicaid program currently covers hearing aids and audiology services provided by audiologists and hearing aid dispensers. No cost shift is anticipated from elimination of this service. There are 757 recipients and 50

audiologist providers and 40 hearing aid dispenser providers.

Questions by **SEN. WATERMAN, CHAIRMAN COBB, REP. WANZENREID, SEN. KEATING and REP. SQUIRES** were then answered by **Dr. Blouke.**

**Nancy Ellery, Medicaid Services Division, Department of Social and Rehabilitation Services** gave an overview of Medicaid long-term care. This includes long-term care for nursing homes, ICF-MRs, home and community service waiver, home health, hospice and personal care. The history of Medicaid long term community care was then discussed. The goal of the department is to expand the continuum of services available to allow more consumer choice and to contain Medicaid costs. It is not the intention of the department to eliminate skilled care provided in nursing homes and hospitals. There is significant potential for long-term savings if structural changes are made. SRS plans to start these structural changes by expanding the LTC continuum and revising requirements for LTC eligibility. In conclusion **Ms. Ellery,** said SRS will work with the Board of Nursing to change the nurse practice act to allow more delegation of RN/LPN duties; create a new licensing category for assisted living; create an LTC trust fund to use for developing expanded LTC continuum; implement a public information strategy to educate media, the public, attorneys, hearing officers and county eligibility staff on the importance of the new law; work with insurance commissioners office to strengthen LTC insurance as an alternative to Medicaid coverage; appoint a special work group to advise the Health Care Authority on changes needed to the long term care system to prepare for national health care reform. **EXHIBITS 4 and 5.**

**Roger LaVoie, Family Assistance Division, Department of Social and Rehabilitation Services** then presented information on Montana's welfare reform initiative. The new AFDC program will be divided into four key areas: AFDC self sufficiency program that incudes a family investment contract and a community services program; work assistance program; simplification and unification of AFDC and food stamp policy and the service delivery system enhancements. **EXHIBIT 6.**

**Patty Diverson, Director, Deer Lodge County Department of Human Services,** said that she had studied the issues and agreed that there was definitely a need to make some changes in the program. She supports welfare reform.

**Mary Ann Wellbanks, Administrator, Child Support Enforcement, Department of Social and Rehabilitation Services,** stated that she supported the reciprocal agreements.

TESTIMONY ON THE ELIMINATION OF ADULT PODIATRY SERVICES

**Paul Smietanka, Montana Podiatric Medical Association** said that services should be expanded to be more cost effective.

TESTIMONY ON THE ELIMINATION OF ADULT HEARING AIDS AND AUDIOLOGY SERVICES

**Darrell Micken, Montana Speech, Language, Hearing Association,** urged that the present level of services and the number of Montana citizens served be maintained because it is vitally important that those who cannot afford it receive audiometric evaluations for the detection of hearing loss and the diagnosis of ear pathology. Services to children, pregnant women, and nursing home residents must remain funded, by mandate. Elimination of services to the optional services group would save a minimum amount from the present overall budget but may ultimately cost the state in the loss of taxes and increase rehabilitation costs. Another group now receiving optional benefits is the adult handicapped, who, having been moved from the state hospital at Boulder, now receive special services in their communities. Many of these people use hearing aids purchased by Medicaid which are vital to their continued habilitation and rehabilitation. Funds should be kept available for the maintenance and reimbursement of hearing aids previously purchased and fit. **EXHIBIT 7.**

**Dave Cameron, Micken Hearing Services,** stated that this program has given him a higher quality of life because necessary hearing aid equipment provided has assisted him in pursuing a higher education. **EXHIBIT 8.**

**Jill Jenson, Montana Speech, Hearing and Language Association,** supports this program and objects the cuts.

**Sue Weingartner, Executive Director, Montana Optometric Association** suggested the replacement of eyeglasses every four years rather than every two years. Medicaid would cover the cost of eye examinations but not purchase the glasses. **Ms. Weingartner** also submitted written testimony from **Douglas A. Safley, O.D., Montana Optometric Association. EXHIBIT 9.**

TESTIMONY ON ADULT PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY

**Gary Lusin, Montana Chapter of the American Physical Therapy Association,** stated his opposition to the proposed cuts in this program.

**Donna Aline, Montana Chapter of the American Physical Therapy Association,** stated her opposition to this program.

**Rosemary Harrison, Montana Speech, Language and Hearing Association,** stated that the speech pathologists who serve Medicaid patients in an outpatient setting reluctantly agreed to go along with the 35-hour limit. This is the minimum and in many cases will not provide adequate care.

**Mona Jamison, Montana Speech Pathologists, Montana Audiologists and Montana Physical Therapists,** stated everything that she had heard was just "cutting the dollar by cutting the services" without hearing anything about how to still provide the services to those people who are in need in the most cost effective fashion.

TESTIMONY ON PERSONAL CARE SERVICES

**Ron Rothwater, Eastern Montana College student** stated that the funds would be staying here in Montana and the money would provide the quality of life to keep persons out of an institutional setting.

**Alex Wilkins, President, Montana Innovative Support Systems for Independent Opportunities Network** said that his organization housed many people who had spent their entire lives in institutions.

**Charles Post** said that an alternative would be to use the Workforce Program to supplement the Medicaid budgets. **EXHIBIT 10**

**CHAIRMAN COBB** then asked if there were opponents or proponents who wished to testify concerning any proposals in general.

**Paul Peterson, Coalition of Montanans With Disabilities,** stated that if the medically needy program had not been in operation he would not have had the opportunity to become a contributing citizen of the state.

**Wallace Melcher, President, Helena Industries** said that Helena Industries is a facility that provided vocational training to individuals with all types of disabilities. **Mr. Melcher** opposes the cuts in the state budget. The elimination of services will make it difficult for many individuals to realize their vocational and community living goals.

**Jim Smith, Montana Association for Rehabilitation, Montana Association for Rehabilitation Facilities and the Montana Head Injury Association,** said that these three organizations oppose the budget cuts.

**Sharon Hoff, Montana Catholic Conference** said that her organization could not possibly support cutting the services.

**Nova Bartsch, The Coalition**, said that she opposes the cuts in the Medicaid program. **EXHIBIT 11.**

**Jeffrey T. Ramey, a Butte resident,** stated his opposition to the cuts. **EXHIBIT 12.**

**Marilyn Barnes, a Butte resident** stated her opposition. **EXHIBIT 13.**

**Joe Roberts, The Advocacy Group for Developmental Disabilities Services,** said that optional Medicaid services are a critical component of community based services for the developmentally disabled. These services enable people to remain in a community setting rather than in institutional care.

**Christina Medina, Montana Low Income Coalition,** said that reform for the state does not mean cutting services nor does it mean reducing the medically needy program.

**Wayne Lewis, Montana Association of Social Justice**, said that every time the budget needs balancing it is human services which is cut. This time it is being extended to the Medicaid optional services and these services are not optional for those who need them.

**Evelyn Harzkjold, Hill County Aging Services** stated that the proposed Medicaid reductions are discriminatory towards the elderly individuals who are struggling to remain in their own homes.

**Harley Warner, Montana Association of Churches,** said that it was time the Human Services Subcommittee said no to all of the cuts proposed by the administration.

**Bruce Blatner, Accessible Space Incorporated,** stated that ten out of twenty people live at Eagle Watch require 40 hours of care per week or more. Cutting back the services to 35 hours per week would definitely result in these people returning to a rest home.

**Brad Gneer, resident of Eagle Watch,** said that residents in his housing project effectively utilize the resources they have.

## CO-PAYMENT

**Dr. Blouke** stated that federal regulations allow states to charge clients nominal co-payments or co-insurance. Co-payments were designed to increase client participation in the cost of their health care. Federal regulations exclude the following groups from co-payment: children, pregnant women and persons residing in institutions or those seeking emergency care. The provider cannot deny services due to the clients' inability to pay the co-payment. Co-payments are deducted from provider reimbursement and providers must then collect the co-payment from the client. Co-payments are at or near the maximum allowed by the federal government.

TESTIMONY ON INCREASED Co-payment OF BRAND NAME DRUGS

**Jim Ahrens, Montana Hospital Association,** stated that hospitals would not be reimbursed the $3.00 per day per patient and inevitably each hospital would write off such debts.

INCREASE FAMILY Co-payment LIMIT

No testimony was given by opponents or proponents.

INCREASE Co-insurance ON INPATIENT HOSPITAL STAYS

No testimony was given by opponents or proponents.

TESTIMONY ON MEDICALLY NEEDY COVERAGE

**Dr. Blouke** stated that the program covers individuals who have incurred medical expenses that reduce their income to levels that make them eligible according to state income standards. Two charts were presented on the medically needy changes and some basic facts regarding medically needy. **EXHIBIT 14, 15.** 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. There are 2,000 elderly and disabled persons in the community with 170 people in nursing homes.

**Jim Ahrens, Montana Hospital Association,** said that hospitals lost $70 million last year. Hospitals can only absorb so much. There will come a point in time when hospitals cannot absorb any more. This is the reason why hospitals are closing.

**Paul Peterson, Coalition For Montanans With Disabilities,** said that if the legislature wanted to know where to get money, it would be to tax cigarettes because they kill people and make them sick; tax alcohol which also kills people and makes them sick; put a penny a gram on fat, tax caffeine, and tax the money the legislature is fighting about.

**Kathy McGowan, Montana Council of Mental Health Centers,** said she opposes the cuts for the population of mentally ill people.

**John Shontz, Montana Mental Health Association,** said that cost shifting is not the answer and at some point it is going to stop.

**Neil Hague** spoke on the reduction of federal funding.

**Sharon Hoff, Montana Catholic Conference,** said that the medically needy program in this community is in a very vulnerable and poor situation.

**Christina Medina, Montana Low Income Coalition,** stated that there are many families which will going to be affected by this reduction.

TESTIMONY ON THE REDUCTION OF OUTPATIENT HOSPITAL REIMBURSEMENT

**Dr. Blouke** stated that 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. Outpatient hospital services have steadily increased due to the rising caseloads and the shift from impatient programs to treating patients in the less restrictive outpatient setting. The state's current reimbursement system of paying costs may also be contributing to the increase. The Department is presently in the process of awarding a contract for the study of the Medicaid outpatient hospital reimbursement system. The study will include a comprehensive analysis of provider costs and charges. There are currently 40,000 recipients for this program with 56 hospital providers.

**Jim Ahrens, Montana Hospital Association,** said that the association opposes this measure. **Mr. Ahrens** also stated that this reduction is in violation to the Borne Amendment.

TESTIMONY ON THE CAPITATION OF ALL MENTAL HEALTH SERVICES TO ADULTS

**Dr. Blouke** stated that 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. Community mental health centers are cost based, and private providers are reimbursed on a fee-for-service basis. Under this option, MCD would competitively bid for providers to provide all inpatient and outpatient mental health service which is 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 that quality care is provided.

Written testimony was also provided by **Joseph E. Julian, EXHIBIT 16; Montana Podiatric Medical Association, EXHIBIT 17; Robert B. Chaney, Jr., EXHIBIT 18; The Coalition of Montanans Concerned With Disabilities, EXHIBIT 19; Patricia Bonacci, EXHIBIT 20;** and **Carol** (no last name given), **EXHIBIT 21.**

**ADJOURNMENT**

**Adjournment:** 5:10 P.M.

**REP. JOHN COBB,** Chairman

ALBERTA STRACHAN, Secretary

JC/AS

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING SUB-COMMITTEE

ROLL CALL DATE 11-18-93

| NAME | PRESENT | ABSENT | EXCUSED |
|---|---|---|---|
| REP. JOHN COBB, CHAIRMAN | X | | |
| SEN. MIGNON WATERMAN, VICE CHAIR | X | | |
| SEN. CHRIS CHRISTIANS | X | | |
| REP. BETTY LOU KASTEN | X | | |
| SEN. THOMAS KEATING | X | | |
| REP. DAVID WANZENRIED | X | | |
| | | | |
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EXHIBIT 1
DATE 11-18-93
SB HUMAN SERVICES

# BASIC FACTS ABOUT MEDICAID

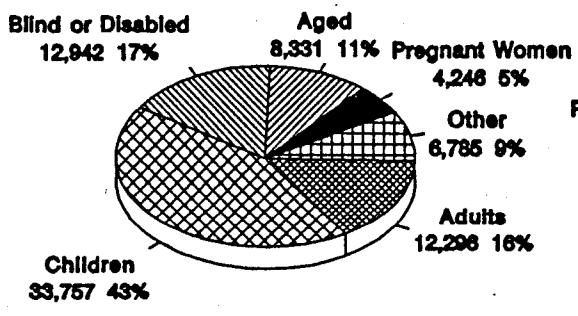
Medicaid pays for health care for low income persons. Eligible recipients include families receiving AFDC and SSI, developmentally disabled, blind, physically disabled, pregnant women and their newborn infants who meet limited income and resource limits.

The Medicaid program in Montana is jointly funded by the federal government (71 percent) and state government (29 percent). The federal government establishes most of the rules for eligibility and coverage.

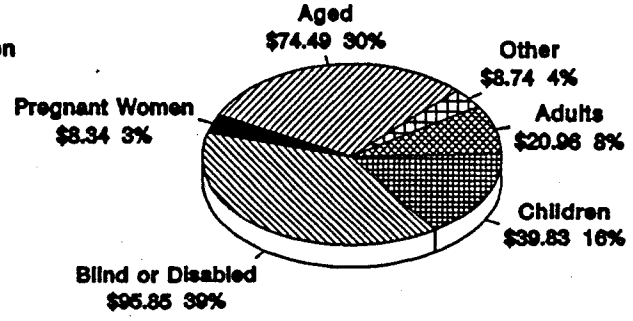
Medicaid will account for 16.5% percent of the total state government general fund spending in Fiscal Year (FY) 1994.

## Table 1

**Medicaid Recipients and Cost in 1992**




Number of Clients




Cost in Millions of Dollars

**There were over 100,000 persons eligible for Medicaid services in Fiscal 1992 of which 78,357 received services. Medicaid Expenditures were $248.2 million in Fiscal 1992 compared to $152.96 million in Fiscal 1989 or an increase of 62.27 percent in 4 years.**

Medicaid mandatory and optional services.

## MANDATORY SERVICES

Inpatient and outpatient hospital
Physicians
Nursing facility and home health for age 21 or older
Rural health clinics and federally qualified health centers
Laboratory and X-ray
Nurse practitioners
Early and periodic screening, diagnosis, and treatment (EPSDT) for those under 21
Family planning services and supplies
Nurse-midwife services

## OPTIONAL SERVICES NOT PROVIDED IN MONTANA

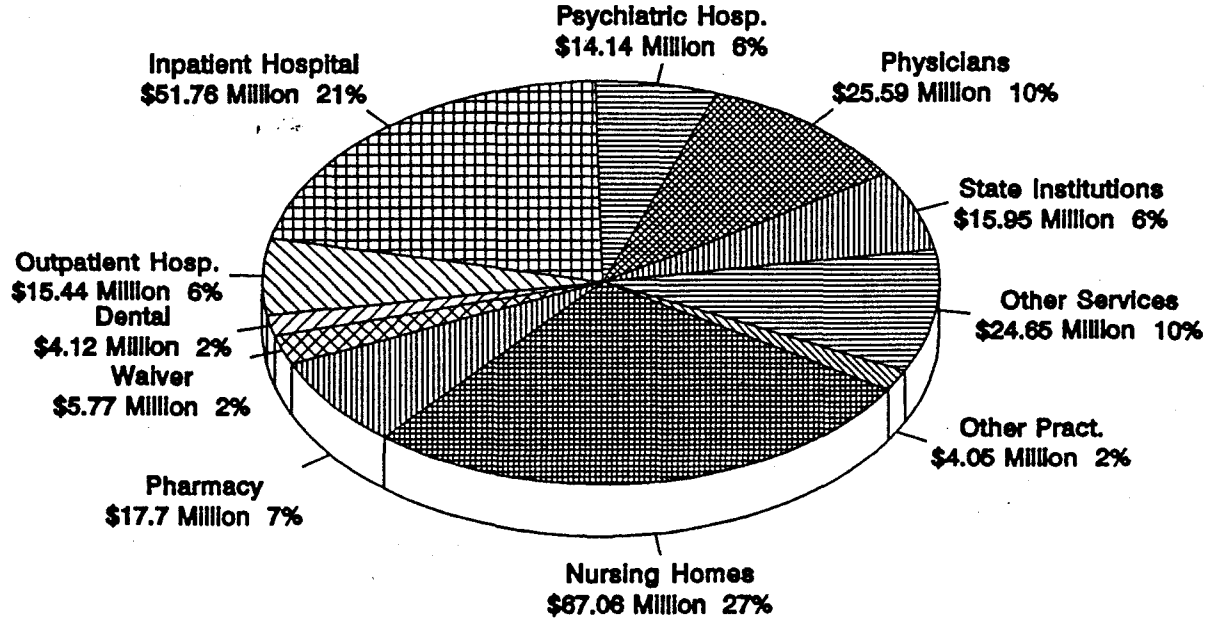
Respiratory Care
Christian Science nurses
Christian Science sanitoriums
Chiropractic services
Psychiatric hospital (under age 21)

## OPTIONAL SERVICES AVAILABLE IN MONTANA

Podiatrist
Optometrist & Eyeglasses
Prosthetic devices
Clinic
Dental & Dentures
Physical therapy
Occupational therapy
Institution for Mental Disease(Age 65 & Over)
Case management
Speech Therapy
Personal Care
DME
Prescribed drugs
Psychologist
Private duty nursing
Diagnostic
Screening
Preventive
Rehabilitative
ICF/Mentally Retarded
Transportation
Audiology
Hospice
Licensed Social Workers

## Table 2

**FY 1992 Medicaid Benefits Expenses by Category**



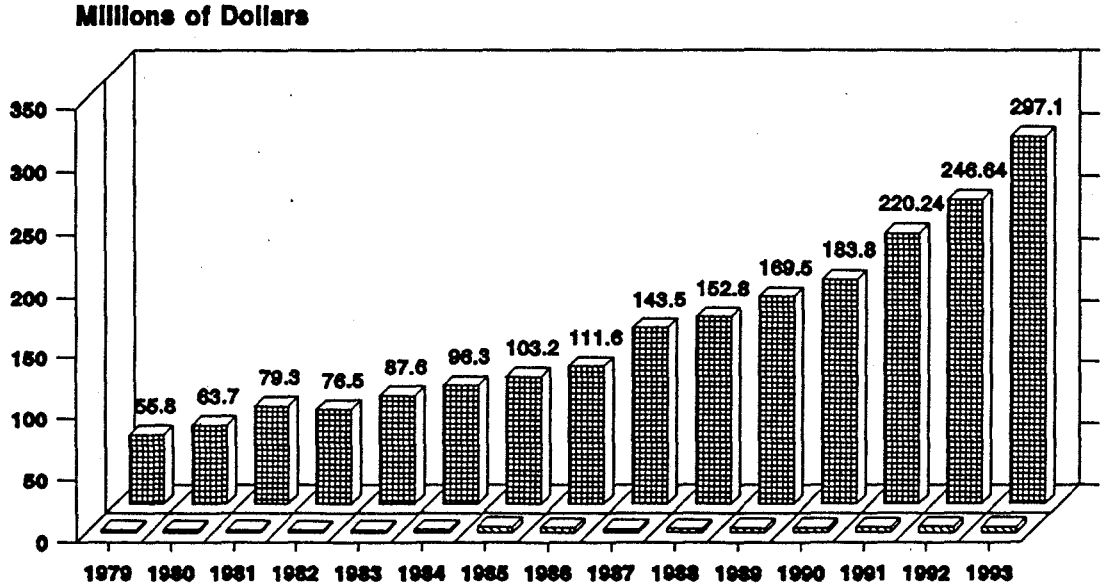

**Based on Medicaid Paid Claims through November 1992.**
**Total Medicaid expenditures in Fiscal 1992 was over $240 Million.**

# ADMINISTRATIVE COSTS OF THE MEDICAID PROGRAM

The following table shows the relationship between Montana's Medicaid expenditures for benefits to Montanan citizens and the administrative costs of the program.

## Table 3

**Benefits/Administration: Cost Comparison From 1979 to 1993**




| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Admin | 3.66% | 3.57% | 2.72% | 2.57% | 2.27% | 2.39% | 4.31% | 3.44% | 1.86% | 1.79% | 2.07% | 1.97% | 1.78% | 2% | 1.53% |
| FTE | | | | | | | | | | 38.5 | 38.5 | 41.5 | 41.5 | 46.5 | 46.5 |

Administration Benefits

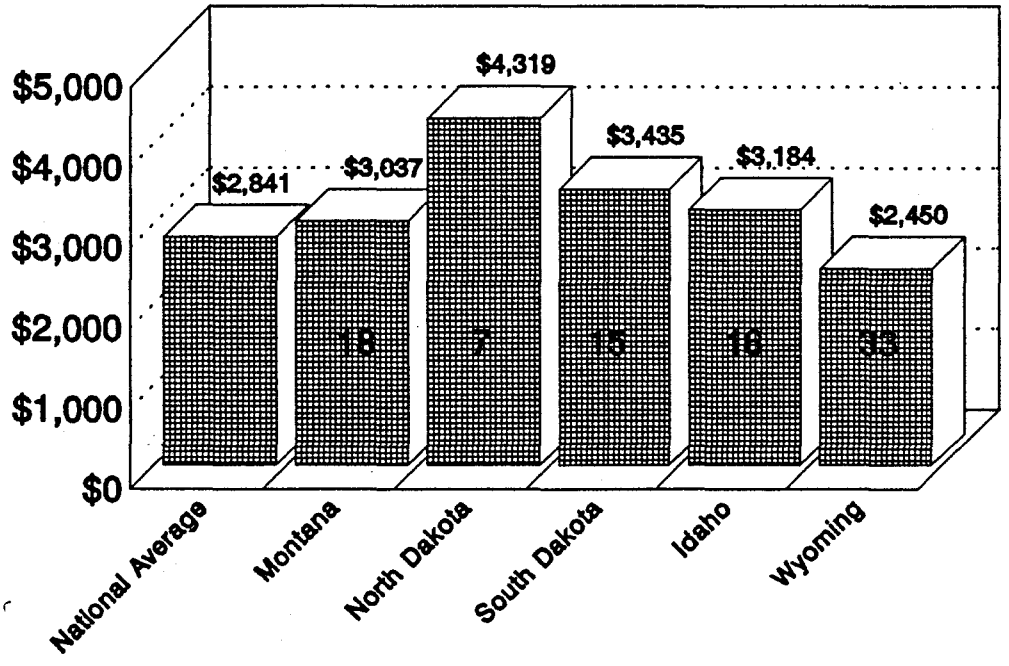
EX 1
11-18-93
HUMAN
SERVICES

As shown in the table below, Montana's Medicaid program ranked 18th in per recipient spending in Fy 1991. Major reasons include:

- Provider reimbursement (Montana ranks nearly the highest in the nation in hospital reimbursement);
- A comprehensive benefit package, covering 27 out of 31 optional services (only 6 states cover more); and
- Few limits on the amount, duration, or scope of medical services.
- Caseload growth, particularly among the elderly and disabled
- General health care inflation

## Table 5

**Average Medicaid Per Recipient Spending (National Ranking)**




| Cost per Recipient | $2,841 | $3,037 | $4,319 | $3,435 | $3,184 | $2,450 |
|---|---|---|---|---|---|---|
| National Ranking | | 18 | 7 | 15 | 16 | 33 |

EX 1
11-18-93
HUMAN SERVICES

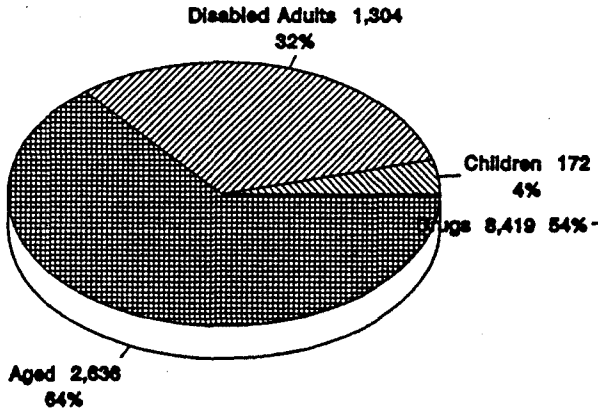
# THE MEDICALLY NEEDY

Control of the growth of the Medicaid program will necessarily require adjustment in eligibility criteria and the availability of services to certain populations.

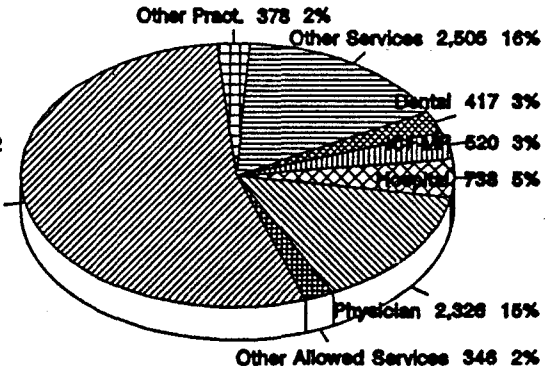
Medicaid coverage of the Medically Needy population is an optional service under the Medicaid program. The following table presents the distribution of the medically needy population by category and by services received.

## Table 6

**Medically Needy Program by Recipients and Services for Persons Living in the Community**




Medically Needy Recipients by Category




Medically Needy By Service Category

**Cost analysis does not include services for institutionalized persons or those over 65 years old. Physician Services, Pharmacy Services, Tagreted CM, Lab & X-ray and other allowable services will still be available after the Medically Needy reduction.**

EXHIBIT 2
DATE 11-18-93
SB HUMAN SERVICES

# EXPANSION OF MEDICAID MANAGED CARE

Managed care is defined as the management of health services through an organized health care delivery system. There are a variety of approaches to managed care; all of which focus on how health care is delivered rather than merely on what each service costs. Approaches include Health Maintenance Organizations (HMOs) and Primary Care Case Management (PCCMs) models.

Current System - Montana Medicaid implemented the Passport to Health Program in January '93. This program is based on the Primary Care Case Management (PCCM) model of managed care. Under Passport, primary care providers (physicians and mid level practitioners) provide primary and preventive care and authorize most physician and hospital services for Medicaid clients enrolled with them.

Almost 300 Passport providers are enrolled in 15 counties around the state. As of November 1, 1993, approximately 25,000 clients are enrolled in the Program. Currently SRS eligibility specialists inform clients applying for Medicaid about the Passport program. Client enrollment in Medicaid is processed by one FTE in Helena. A pamphlet is given to clients and providers explaining the program. A toll-free telephone number is also available for clients and providers to ask questions about the program. Because of staff constraints, minimal efforts have been made to educate clients about the program and recruit additional Passport providers. Reimbursement to providers is based on fee for service plus a $3 per month incentive fee for each enrolled client.

Proposed Expansion - Montana Medicaid is proposing to expand the options under managed care in two ways.

1. Enroll Health Maintenance Organizations (HMOs). HMOs control the organization, delivery and financing of care. They charge a fixed fee (or capitation amount), payable in advance to cover each person's care.

- Under the proposed expansion, Medicaid clients could choose a Passport provider or HMO to receive their health care. The HMO will be reimbursed monthly on a pre-determined capitated basis for each client enrolled. This capitation amount is actuarially based on historical usage of Medicaid recipients. The capitation rate is based on a level less than what Medicaid reimburses on a fee for service basis. For example if Medicaid had historically spent $1,500 per year for an AFDC adult, the capitation rate could be set at $1,425 per year or $119 per month which is 95% of what would have been spent on a fee for service basis. The managed care provider would be at risk for expenditures exceeding the capitation rate. They would retain the savings if actual expenditures were less than the capitation rate. The capitation rate would cover all Medicaid benefits except long term care (which includes nursing homes, ICF-MRs and waiver services) mental health services for adults, and Medicare deductibles and co-insurance.

- SRS would initiate a competitive procurement process through which qualified vendors would be selected. (Currently, Blue Cross/Blue Shield is the only licensed HMO in Montana but that is expected to change as the industry prepares for national health care reform.) SRS would have to pursue a waiver from the federal government to implement this option. Depending on the regulations the federal government allows the state to waive, the HMO could offer expanded benefits and guaranteed periods of eligibility.

2. Mental Health Capitation. SRS would initiate a competitive procurement process to select qualified mental health providers to provide mental health services for adults. (Children would continue to be served under the fee for service system with case management being provided through the Managing Resources Montana program. They would be phased into a capitated system in 3 to 5 years.) Providers would be responsible for providing or arranging all inpatient and outpatient mental health care on a capitated basis. The providers would seek to ensure access to mental health care in the most clinically appropriate and cost-effective setting. Department of Corrections and Human Services is exploring the feasibility of providing non-Medicaid care under this model as well.

   Mental health capitation is being pursued separately from the HMO and Passport models because most primary care providers do not have experience in providing the more intensive mental health services needed by adults with severe and disabling mental illnesses. This separation of functions has proven effective in other states.

GOALS AND OBJECTIVES

1. To improve access to and availability of preventive and primary care.

2. To improve quality, continuity and appropriateness of care.

3. To reduce rate of growth in Medicaid per capita from expenditures.

4. To increase the number of clients enrolled in managed care.

5. To provide clients and providers with a variety of health plan and provider choices.

6. To work with contracted providers to ensure they are providing quality of care.

Resources Required

To implement managed care expansion, the department will seek a contractor to perform the following functions:

1) develop a capitated rate for HMO and Mental Health providers;
2) develop a request for proposal for the managed care contractors;
3) develop the required federal waiver;
4) provide enrollment and outreach services to ensure clients make informed choices about managed care participation and select the most appropriate managed care provider from among those available.

The contract provider would conduct a health assessment with the client in person or by phone and provide client with information about HMOs and Passport providers in their area. Clients who do not choose an HMO or Passport provider within 30 days would be assigned one.

Implementation Date - July '95

EA —
11-18-93
J.S.- HUMA
SERVICES

**Montana Medicaid Managed Care Options**
Projected Timeline

November 16, 1993

| Target Date | System Design | System Implementation |
|---|---|---|
| November 24, 1993 | Issue Request for Information | |
| December 22, 1993 | RFI Response Deadline | |
| January 7, 1994 | Determine parameters of actuarial/system design study. | |
| | (6 weeks) | |
| February 18, 1994 | Issue RFP for actuarial/system design study. | |
| | (6 weeks) | |
| April 1, 1994 | Proposal receipt deadline. | |
| | (2 weeks) | |
| April 15, 1994 | Select contractor. | |
| | (12 weeks) | |
| July 8, 1994 | Report due. | Determine preliminary parameters for managed care/capitated system. |
| | | (4 weeks) |
| August 5, 1994 | | Issue RFPs for system management. |
| | | (3 months) |
| November 7, 1994 | | Proposal receipt deadline. |
| | | (2 months) |
| January 6, 1994 | | Select system management contractors. |
| | | (6 months) |
| July 1, 1995 | | Managed care/capitated system implementation. |

EX 2
11-18-93
HUMAN
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# MONTANA MEDICAID MANAGED CARE OPTIONS
# ADMINISTRATIVE COSTS
# AND PROJECTED SAVINGS

Summary:

FY 94:

| | Total | GF | FFP |
|---|---|---|---|
| 1 FTE for HMO option(1/2 year) | $ 19,277 | 9,638 | 9,638 |
| Acturial/consultant contract | 500,000 | 250,000 | 250,000 |
| TOTAL COSTS | 519,277 | 259,638 | 259,638 |

FY95:

| | | | |
|---|---|---|---|
| 2 FTE for HMO option | 68,106 | 34,053 | 34,053 |
| 1 FTE for mental health program | 35,553 | 17,777 | 17,777 |
| Actuarial consultant costs | 50,000 | 25,000 | 25,000 |
| MMIS revisions | 150,000 | 15,000 | 135,000 |
| TOTAL COSTS | 303,659 | 91,830 | 211,830 |

FY96:

| | | | |
|---|---|---|---|
| Projected savings from capitating mental health services net of any contract administrative cost | 622,789 | 186,837 | 435,952 |
| Actuarial consultant costs | 50,000 | 25,000 | 25,000 |
| Projected savings from managed care options (HMO) net of any contract administrative cost | 3,806,561 | 1,141,968 | 2,664,593 |
| TOTAL SAVINGS | 4,379,350 | 1,303,805 | 3,075,545 |

FY97:

| | | | |
|---|---|---|---|
| Projected savings from capitating mental health services net of any contract administrative cost | 701,628 | 210,488 | 491,140 |
| Actuarial consultant costs | (50,000) | (25,000) | (25,000) |
| projected savings from managed care options ( HMO) net of any contract administrative cost | 4,347,093 | 1,304,128 | 3,042,965 |
| TOTAL SAVINGS | 4,998,720 | 1,489,616 | 3,509,105 |

EXHIBIT 5
DATE 11-18-93
SB HUMAN SERVICES

## SUMMARY OF MEDICAID ESTATE AND LIEN LEGISLATION

The proposed bill would implement changes in federal law which prevent individuals from becoming eligible for medicaid long term care benefits by giving away or sheltering substantial assets. The bill would implement changes in federal law which require expanded recovery of medicaid expenditures from estates of deceased recipients and allow recovery of medicaid expenditures from the recipient's property passing outside the probate estate. The bill would require SRS to place a lien upon real property owned by certain medicaid recipients to preserve the property for later recovery of medicaid expenditures.

### Asset Transfers and Trusts

Previous federal law required a period of medicaid ineligibility for nursing facility and other long term care services when a person disposed of resources for less than fair market value during a certain time period. However, the federal law left several gaping loopholes. These loopholes have been exploited by individuals to intentionally impoverish themselves so that medicaid pays for their long term care. The law also failed to adequately address multiple transfers and other issues. The result was that the penalties for uncompensated transfers were not significant enough to accomplish their purpose.

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) amended the transfer of assets law to close certain loopholes, to increase the "look back" period from 30 months under previous law to 36 months (or 60 months if the transfer is to a trust) under the new law and to address certain inadequacies in the penalty provisions of the law.

Previous federal law also allowed an individual to transfer assets to a trust, which made the assets "unavailable" and permitted the person to qualify for medicaid. Upon the individual's death, the assets in the trust passed outside the person's estate and thus were not recoverable by the medicaid program. OBRA '93 requires that, for medicaid eligibility purposes, assets in trusts be treated as available income or available resources, or as assets which have been transferred for less than fair market value.

The proposed bill would require SRS to adopt rules which deny eligibility when a person has disposed of assets for less than fair market value, and to adopt rules providing for treatment of trusts as required by new federal law. The bill is drafted to clearly express legislative intent that SRS adopt rules to deny eligibility to the greatest extent allowed by federal law. The bill allows SRS flexibility to adopt and amend its rules to respond to new eligibility planning strategies and to implement future federal changes without the need to await further state legislative action. The bill provides for an "undue hardship" exception as required by federal law.

### Recovery of Medicaid Expenditures

SRS currently operates a program to recover medicaid expenditures

from estates of deceased recipients. OBRA '93 expands the medicaid expenditures which states must recover from estates. OBRA '93 also allows the state the option of recovering property of the deceased recipient which upon death passes outside the probate estate (for example, property held in joint tenancy with right of survivorship). This closes a significant loophole which allowed persons to avoid estate recovery by transferring assets to forms of ownership which bypass the probate estate. The proposed bill would amend the current MCA section to implement the OBRA '93 mandatory changes and to require SRS also to recover from property of the deceased recipient which passes outside the probate estate. The bill would continue, with certain modifications, current exemptions and would provide an "undue hardship" exception as required by federal law.

Even though SRS may recover from recipient's estates, often there are no assets in the estate to recover. Under federal law, even though a recipient resides in a nursing facility, the recipient's home is an exempt resource as long as the person expresses a subjective intent to return home. This is so regardless of the medical likelihood of a return home. Recipient's homes often are transferred (for example, through a joint tenancy arrangement) and become unavailable for later recovery of medicaid expenditures, even after the recipient and their spouse have died and there are no dependent child. The proposed bill would implement federal law which allows the state to impose a lien upon the recipient's real property when the recipient is institutionalized and is not expected to return home. This lien would allow SRS to track the property for later recovery through the estate, or for recovery upon a sale or transfer of the property.

Currently, nursing facility residents are allowed to keep a certain amount of their monthly income for personal needs. Often this money goes unused and accumulates in a trust account or with a relative or friend. Also, recipients are allowed an exemption, for medicaid eligibility purposes, for burial plots and for designated burial funds. Portions of these funds are often unused for burial purposes and simply are returned to relatives or friends. The proposed bill also would require payment of these funds to SRS to apply toward repayment of medicaid expenditures.

## CONCLUSION

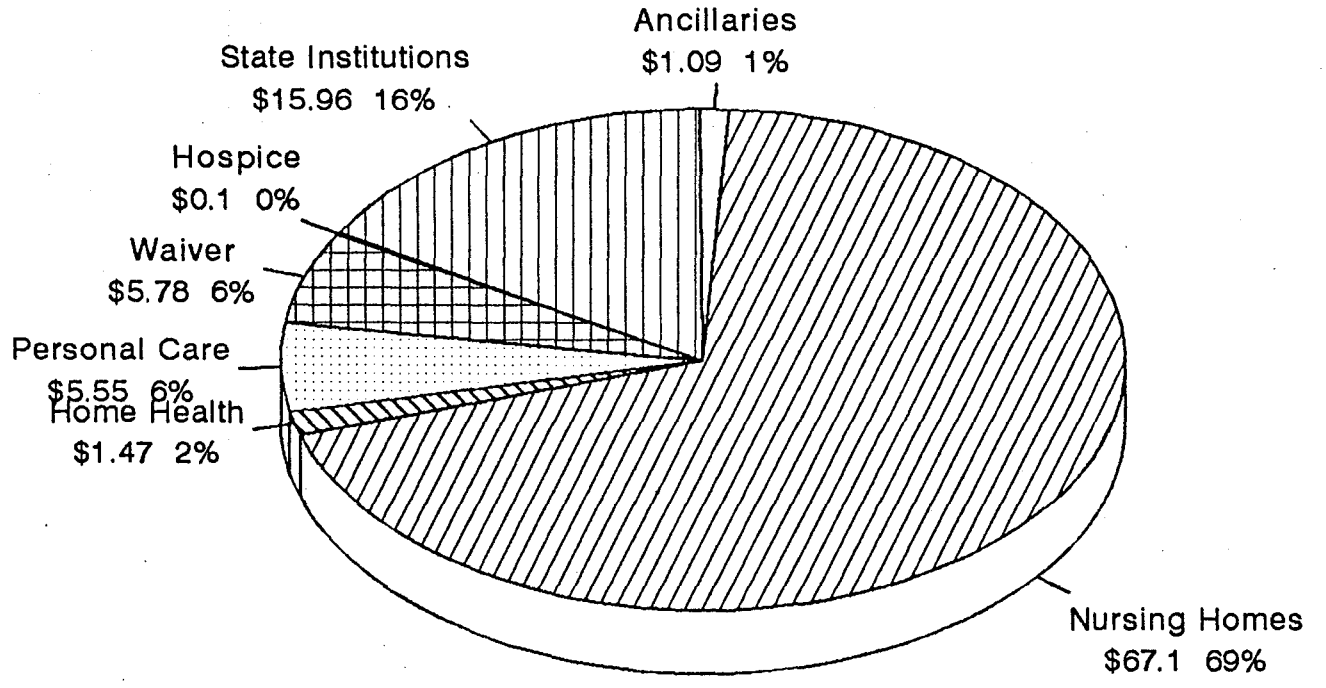
Present economic realities do not permit the state the luxury of allowing individuals to avoid using their available assets to pay for the cost of their long term care, while the public picks up the tab. A recipient should be allowed to keep and exempt certain assets while the recipient's spouse, dependent children or certain close relatives depend upon the assets for their needs. But these same economic realities demand that when such need no longer exists, these assets must be used to indemnify the public treasury for the recipient's medicaid expenditures. The proposed bill addresses these economic realities while preserving public benefits for the truly needy.

# OVERVIEW OF MEDICAID LONG TERM CARE (LTC)

- Long term care includes Nursing Homes, ICF-MRs, Home and Community Service Waiver, Home Health, Hospice and Personal Care.
- In FY 92, Medicaid spent $97 million for Long Term Care services.
- In Montana, institutional care accounts for 85% of the Long Term Care budget and home care accounts for 15%.
- In Oregon, the percentage of home care has nearly doubled since 1986. It has gone from 23% of total long term care costs in 1986 to 41% in 1993.
- The per capita cost of care under the waiver in FY 92 was 60% of the cost of nursing home care ($7,525 vs. $12,598).
- Nursing home care accounts for 39% of the entire Medicaid budget but is only used by 12% of Medicaid recipients.
- Montana Medicaid pays for 62% of nursing home beds compared to the national average of 73% in 1991.

EXHIBIT 4
DATE 11-18-93
SB HUMAN SERVICES

# Medicaid Long Term Care
## Services by Amount and Percent for FY 1992




Amounts shown in this chart are for 1992 and paid as of 11/30/92

Amounts are shown in Millions of Dollars

# HISTORY OF MEDICAID
# LONG TERM COMMUNITY CARE

- Montana was one of the first states to implement a home and community services (HCS) waiver in September 1983.

- The average monthly caseload for the waiver has grown from 215 in FY 86 to 482 in FY 92 (124% increase).

- The average per capita cost of a waiver case has grown from $4,341 in FY 86 to $7,525 in FY 93 (73% increase).

- Waiver services are available in 35 counties.

- There are currently 152 individuals on waiting lists for the waiver.

# WHY DO WE NEED TO CHANGE?

- HB 2 mandated SRS to develop a continuum of care designed to limit the growth of long term care expenditures and present a plan to the 54th legislature that provides individuals with a choice of a cost-effective range of services that reflects their personal preference and treatment needs. It also provided $100,000 general fund for a model waiver for persons with traumatic brain injuries (TBI).

- Medicaid LTC expenditures are growing at a rate of approximately 8% while state revenue is growing at a rate of less than 5%.

- In CY 92, Medicaid spent over $14 million on persons with TBI. TBI cases accounted for half of the top 10 highest cost recipients.

- 17% of our population is elderly compared to 13% nationally. The elderly population is projected to increase by 25% over the next four to five years. One of the fastest growing populations are those over age 85 of which almost one third are now in institutions.

- OBRA 93 mandates substantial revisions to LTC eligibility policy.

- Montana needs to begin to plan for National Health Care Reform that may significantly change the delivery of LTC Institutional and Community Services.

# HOW DO WE GET THERE?

- Our goal is to expand the continuum of services available to allow more consumer choice and to contain Medicaid costs.
- It is not our intention to eliminate skilled care provided in nursing homes and hospitals.
- Savings are not immediate. There is significant potential for long term savings if structural changes are made.
- SRS plans to start these structural changes by expanding the LTC continuum and revising requirements for LTC eligibility.

# PLAN TO EXPAND LTC CONTINUUM

- Governor Racicot appointed broad based council called SAIL (Select an Independent Lifestyle) representing government, private agencies, medical providers and consumers. The SAIL Council will assist SRS to study and develop an expanded LTC continuum.

- Develop assisted living. Assisted living combines specialized housing and services to assist people in staying as independent as possible. It implies home-like buildings, single occupancy units with baths and cooking capacity, privacy, independent decision making and skilled support services as needed. Examples include personal care facilities with independent units, HUD-funded housing, retirement communities and foster homes.

- Develop special program for persons with Traumatic Brain Injury.

- Develop Medicaid reimbursement for Personal Care Facilities (Level A & B)

- Develop sub-acute care. Sub-acute care is care provided in a nursing facility that includes nursing and special services for complex cases who no longer require acute care. Examples are brain injured victims, ventilator dependent patients, etc. Costs for sub-acute care can be less than half the cost of care provided in acute care facilities.

# PLAN TO REVISE ELIGIBILITY REQUIREMENTS FOR LTC

- Goal is to ensure that limited resources go to those who truly need LTC services and can not afford to pay privately.
- Estate planning does exist in Montana (cite examples)
- Implement OBRA 93 changes relative to transfer of assets and trusts (effective 8-10-93).
- Introduce changes to state law to expand recovery of Medicaid expenditures from the property of deceased recipients and place a lien upon real property owned by certain Medicaid recipients (effective January 94).
- Implement special income limit for nursing home and waiver eligibles to contain future program costs (effective January 95).
- Contract for a state of the art Recipient Asset Management (RAM) system to identify all pertinent recipient assets, track the assets and recover the value of assets at time of sale or by filing a claim against the estate. The contractor would also be responsible to develop and conduct an extensive public education campaign designed to educate the public, private attorneys, and others. The goal of the media campaign is to maximize the cost avoidance savings SRS can achieve from persons seeking alternatives to Medicaid financing.
- Estimated general fund savings for the biennium (net of administrative costs) are $156,312. Total biennium savings are $708,056.

# WHAT CAN WE DO NOW?

- Work with Board of Nursing to change the Nurse Practice Act to allow more delegation of RN/LPN duties.
- Create a new licensing category for assisted living.
- Create a LTC trust fund to use for developing expanded LTC continuum.
- Implement recommendations of the contract study relating to changes in LTC eligibility and estate recovery.
- Contract for a public information strategy to educate media, the public, attorneys, hearing officers and county eligibility staff on the importance of the new law.
- Work with Insurance Commissioners Office to strengthen LTC insurance as an alternative to Medicaid coverage.
- Appoint a special work group to advise the Health Care Authority on changes needed to the Long Term Care system to prepare for National Health Care Reform.

# COST CONTAINMENT/QUALITY OF CARE ISSUES

- Need to address concern that offering new programs will result in increased demand which reduces potential savings.
- Develop evaluation models to document the cost-effectiveness of community alternatives to institutional care.
- Require screening at intake to restrict eligibility to only those at risk of institutional care.
- Identify duplication in existing long term care programs (Medicaid and Non-Medicaid) and develop plan to better coordinate services through single point of access and case management.
- Develop competitive rates through procurement or selective contracting.
- Ensure that licensing requirements provide for quality of care and monitoring.

# Medicaid Services Division

| Description | General Funds | Fy 1994 Federal Funds | Total Funds | General Funds | FY 1995 Federal Funds | Total Funds | General Funds | Biennium Federal Funds | Total Funds |
|---|---|---|---|---|---|---|---|---|---|
| **Option 1: Assisted Living (3 Funding Options)** | | | | | | | | | |
| A: If $1,000,000 in General Fund were available per year. | | | | | | | | | |
| Expenses: Salaries and Benefits for 1 Grade 15 FTE (1/2 year in 1994) | $8,217 | $8,218 | $16,435 | $16,435 | $16,435 | $32,870 | $24,652 | $24,653 | $49,304 |
| Other Administrative (Rent, Travel, Supplies, etc) | $900 | $900 | $1,800 | $1,800 | $1,800 | $3,600 | $2,700 | $2,700 | $5,400 |
| Equipment | $2,000 | $2,000 | $4,000 | $0 | $0 | $0 | $2,000 | $2,000 | $4,000 |
| Total Administrative Expenses | $11,117 | $11,118 | $22,235 | $18,235 | $18,235 | $36,470 | $29,352 | $29,353 | $58,704 |
| Benefits: 190 persons at $17,162 per year (1/2 for 1994) | $472,487 | $1,157,903 | $1,630,390 | $961,930 | $2,298,850 | $3,260,780 | $1,434,417 | $3,456,753 | $4,891,170 |
| Total Expenses for Option 1A | $483,604 | $1,169,021 | $1,652,625 | $980,165 | $2,317,085 | $3,297,250 | $1,463,769 | $3,486,106 | $4,949,874 |
| General Funds Available | $1,000,000 | | | $1,000,000 | | | $2,000,000 | | |
| Balance | $516,396 | | | $19,835 | | | $536,231 | | |
| B: If $2,000,000 in General Fund were available per year. | | | | | | | | | |
| Expenses: Salaries and Benefits for 1 Grade 15 FTE (1/2 year in 1994) | $8,217 | $8,218 | $16,435 | $16,435 | $16,435 | $32,870 | $24,652 | $24,653 | $49,304 |
| Other Administrative (Rent, Travel, Supplies, etc) | $900 | $900 | $1,800 | $1,800 | $1,800 | $3,600 | $2,700 | $2,700 | $5,400 |
| Equipment | $2,000 | $2,000 | $4,000 | $0 | $0 | $0 | $2,000 | $2,000 | $4,000 |
| Total Administrative Expenses | $11,117 | $11,118 | $22,235 | $18,235 | $18,235 | $36,470 | $29,352 | $29,353 | $58,704 |
| Benefits: 380 persons at $17,162 per year (1/2 for 1994) | $944,974 | $2,315,806 | $3,260,780 | $1,923,860 | $4,597,700 | $6,521,560 | $2,868,834 | $6,913,506 | $9,782,340 |
| Total Expenses for Option 1A | $956,091 | $2,326,924 | $3,283,015 | $1,942,095 | $4,615,935 | $6,558,030 | $2,898,186 | $6,942,859 | $9,841,044 |
| General Funds Available | $2,000,000 | | | $2,000,000 | | | $4,000,000 | | |
| Balance | $1,043,909 | | | $57,905 | | | $1,101,814 | | |
| C: If $2,500,000 in General Fund were available per year. | | | | | | | | | |
| Expenses: Salaries and Benefits for 1 Grade 15 FTE (1/2 year in 1994) | $8,217 | $8,218 | $16,435 | $16,435 | $16,435 | $32,870 | $24,652 | $24,653 | $49,304 |
| Other Administrative (Rent, Travel, Supplies, etc) | $900 | $900 | $1,800 | $1,800 | $1,800 | $3,600 | $2,700 | $2,700 | $5,400 |
| Equipment | $2,000 | $2,000 | $4,000 | $0 | $0 | $0 | $2,000 | $2,000 | $4,000 |
| Total Administrative Expenses | $11,117 | $11,118 | $22,235 | $18,235 | $18,235 | $36,470 | $29,352 | $29,353 | $58,704 |
| Benefits: 475 persons at $17,162 per year (1/2 for 1994) | $1,181,218 | $2,894,757 | $4,075,975 | $2,404,825 | $5,747,125 | $8,151,950 | $3,586,043 | $8,641,882 | $12,227,925 |
| Total Expenses for Option 1A | $1,192,335 | $2,905,875 | $4,098,210 | $2,423,060 | $5,765,360 | $8,188,420 | $3,615,395 | $8,671,235 | $12,286,629 |
| General Funds Available | $2,500,000 | | | $2,500,000 | | | $5,000,000 | | |
| Balance | $1,307,665 | | | $76,940 | | | $1,384,605 | | |
| **Option 2: Provide additional waiver slots for 39 Traumatically Brain Injured persons with remaining funds going to the Assisted Living program.** | | | | | | | | | |
| A: If $1,000,000 in General Fund were available per year. | | | | | | | | | |
| Expenses: Salaries and Benefits for 1 Grade 15 FTE (1/2 year in 1994) | $8,217 | $8,218 | $16,435 | $16,435 | $16,435 | $32,870 | $24,652 | $24,653 | $49,304 |
| Other Administrative (Rent, Travel, Supplies, etc) | $900 | $900 | $1,800 | $1,800 | $1,800 | $3,600 | $2,700 | $2,700 | $5,400 |
| Equipment | $2,000 | $2,000 | $4,000 | $0 | $0 | $0 | $2,000 | $2,000 | $4,000 |
| Total Administrative Expenses | $11,117 | $11,118 | $22,235 | $18,235 | $18,235 | $36,470 | $29,352 | $29,353 | $58,704 |
| Benefits: 39 persons at $84,900 per year (1/2 for 1994) | $479,778 | $1,175,772 | $1,655,550 | $976,775 | $2,334,326 | $3,311,100 | $1,456,553 | $3,510,097 | $4,966,650 |
| Benefits: Insufficient funding to serve persons in assisted living | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Total Expenses for Option 1A | $490,896 | $1,186,890 | $1,677,785 | $995,009 | $2,352,560 | $3,347,570 | $1,485,905 | $3,539,450 | $5,025,354 |
| General Funds Available | $1,000,000 | | | $1,000,000 | | | $2,000,000 | | |
| Balance | $509,104 | | | $4,991 | | | $514,095 | | |
| | | | | | | | | | |
| B: If $2,000,000 in General Fund were available per year. | | | | | | | | | |
| Expenses: Salaries and Benefits for 1 Grade 15 FTE (1/2 year in 1994) | $8,217 | $8,218 | $16,435 | $16,435 | $16,435 | $32,870 | $24,652 | $24,653 | $49,304 |
| Other Administrative (Rent, Travel, Supplies, etc) | $900 | $900 | $1,800 | $1,800 | $1,800 | $3,600 | $2,700 | $2,700 | $5,400 |
| Equipment | $2,000 | $2,000 | $4,000 | $0 | $0 | $0 | $2,000 | $2,000 | $4,000 |
| Total Administrative Expenses | $11,117 | $11,118 | $22,235 | $18,235 | $18,235 | $36,470 | $29,352 | $29,353 | $58,704 |
| Benefits: 39 persons at $84,900 per year (1/2 for 1994) | $479,778 | $1,175,772 | $1,655,550 | $976,775 | $2,334,326 | $3,311,100 | $1,456,553 | $3,510,097 | $4,966,650 |
| Benefits: 198 persons at $17,162 per year (1/2 for 1994) | $492,381 | $1,206,657 | $1,699,038 | $1,002,432 | $2,395,644 | $3,398,076 | $1,494,814 | $3,602,300 | $5,097,114 |
| Total Expenses for Option 1A | $983,277 | $2,393,546 | $3,376,823 | $1,997,442 | $4,748,204 | $6,745,646 | $2,980,719 | $7,141,750 | $10,122,468 |
| General Funds Available | $2,000,000 | | | $2,000,000 | | | $4,000,000 | | |
| Balance | $1,016,723 | | | $2,558 | | | $1,019,281 | | |
| | | | | | | | | | |
| C: If $2,500,000 in General Fund were available per year. | | | | | | | | | |
| Expenses: Salaries and Benefits for 1 Grade 15 FTE (1/2 year in 1994) | $8,217 | $8,218 | $16,435 | $16,435 | $16,435 | $32,870 | $24,652 | $24,653 | $49,304 |
| Other Administrative (Rent, Travel, Supplies, etc) | $900 | $900 | $1,800 | $1,800 | $1,800 | $3,600 | $2,700 | $2,700 | $5,400 |
| Equipment | $2,000 | $2,000 | $4,000 | $0 | $0 | $0 | $2,000 | $2,000 | $4,000 |
| Total Administrative Expenses | $11,117 | $11,118 | $22,235 | $18,235 | $18,235 | $36,470 | $29,352 | $29,353 | $58,704 |
| Benefits: 39 persons at $84,900 per year (1/2 for 1994) | $479,778 | $1,175,772 | $1,655,550 | $976,775 | $2,334,326 | $3,311,100 | $1,456,553 | $3,510,097 | $4,966,650 |
| Benefits: 297 persons at $17,162 per year (1/2 for 1994) | $738,572 | $1,809,985 | $2,548,557 | $1,503,649 | $3,593,465 | $5,097,114 | $2,242,220 | $5,403,451 | $7,645,671 |
| Total Expenses for Option 1A | $1,229,468 | $2,996,875 | $4,226,342 | $2,498,658 | $5,946,026 | $8,444,684 | $3,728,125 | $8,942,900 | $12,671,025 |
| General Funds Available | $2,500,000 | | | $2,500,000 | | | $5,000,000 | | |
| Balance | $1,270,532 | | | $1,342 | | | $1,271,875 | | |

EXHIBIT 2
DATE 1-18-93
SB Human Services

EXHIBIT 6
DATE 11-18-93
SB HUMAN SERVICES

November 18, 1993

TESTIMONY OF DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES
PRESENTED BY ROGER LA VOIE, ADMINISTRATOR
FAMILY ASSISTANCE DIVISION

**MONTANA'S WELFARE REFORM INITIATIVE**

Over the past several months, the Governor's Welfare Reform Advisory Council has been diligently working to meet the charge of Governor Racicot's executive order to develop a comprehensive welfare reform proposal. It is with pleasure that I report to you the findings of that Council.

The Council was in unanimous support of changing the basic structure of the AFDC program, from an entitlement to a transitional program. From the time a family enters our system until they are able to leave it, the message of recipient responsibility, with SRS support will be clear. To forestall anxieties about getting minimum wage or service industry jobs, the Council is recommending that SRS build incentives "outside" the normal welfare stream. Those incentives include child care and medical assistance.

Our "new" AFDC program and its various components have yet to be named. For the purposes of discussion, this new program will be divided into four key areas:

1) AFDC Self-Sufficiency Program that includes a Family Investment Contract and a Community Services Program (i.e., time-limited assistance).

2) Work Assistance Program to keep people from having to enter the AFDC program and/or to enable people to leave the AFDC program.

3) Simplification and unification of AFDC and Food Stamp policy.

4) Service delivery system enhancements.

## 1. AFDC SELF-SUFFICIENCY PROGRAM

For families requiring temporary cash assistance, job skills, or training to begin on the road to self-sufficiency, the AFDC Self-Sufficiency Program is available. This program runs for up to 24 months for a single parent family, and up to 18 months for a two parent family. Entry into this program is conditional upon

completion of child support enforcement activities and a Family Investment Contract. Parents who do not wish to complete either the child support requirements or the contract requirements (without good cause) will receive a child only grant (if otherwise eligible).

This program will offer a variety of components depending upon the adult participant's needs. Education, entry into job search, job skills classes, work experience are possible components.

Families who acquire employment while in the Self-Sufficiency Program will be given a $100 plus 25% of the remainder earned income disregard.

If, at the end of the 24 month period, the family has not obtained employment, or has not left the AFDC program, the second part of the program will begin.

**1a. COMMUNITY SERVICE PROGRAM**

For families who do not successfully transition from the AFDC program in 24 (or 18) months, the Community Service Program is available. Under this program, the child only grant is always given. However, the adults must "earn" their portion of the grant by completing community service work which averages 20 hours per week.

Activities which will qualify as community service have yet to be defined. However, it has been agreed that if no program or service work exists, or day care is not available, the full grant will be issued.

There is no set period of time as to how long a family can remain on the Community Service Program.

**2. WORK ASSISTANCE PROGRAM**

For low income families who are working, the Work Assistance Program offers a number of supports: sliding scale day care, sliding scale medical, enhanced child support activities as well as Food Stamps and LIEAP. This program is designed to help low-income working families avoid the AFDC program. The Council heard many times that child care costs and medical costs are the two biggest reasons that families are forced to leave employment or cannot accept employment.

Attachment 1 is a chart which shows an overview and flow of the AFDC Self-Sufficiency Program, Community Services Program and Work Assistance Programs.

## 3. SIMPLIFICATION/UNIFICATION OF POLICIES

The Council also found that many of the AFDC and Food Stamp policies are complex, confusing and conflicting. This causes client confusion and increases staff time spent for administration. In that vein, a number of simplification policies were agreed to. The major changes are:

**a. Elimination of the deprivation requirement.** Currently, all single parent families who are income and resource eligible can receive AFDC. All two parent families where one parent is incapacitated (has a condition which substantially reduces the ability to care for or support a dependent child) and who are income and resource eligible can receive AFDC.

For the rest of the two parent households, one of the parents must be able to meet the definition of "unemployed." The primary wage earner, the parent who has earned the most in the past two years, must have either drawn unemployment compensation within 1 year prior to application, or made at least $50 in 6 of the 13 quarters ending within 1 year of the application date. Further, that primary wage earner must have been unemployed at least 30 days prior to applying for AFDC, or must be considered as "underemployed," working less than 100 hours per month.

**b. Elimination of the 100 hour rule.** Currently, if a two parent family qualifies for the unemployed parent program, the family will lose AFDC eligibility if the primary wage earner works more than 100 hours per month, no matter how little they earn.

**c. Elimination of all monthly reporting and retrospective budgeting.** Montana just eliminated monthly reporting and retrospective budgeting for all households except those with earned income. Under this proposed change, earned income households will be treated as all other households for budgeting purposes. Quarterly reports will be required for this group to ensure that wages are being prospected correctly.

**d. Uniform resource standard of $3000 per household.**

**e. Disregard of one vehicle for each household.**

**f. "Cashing out" Food Stamp benefits for AFDC households with a strong recommendation that Montana pursue Electronic Benefit Transfer (EBT) as the benefit delivery method for AFDC and Food Stamp benefits.**

Please see Attachment 2 for a complete listing of the simplification/unification policy changes being recommended.

## 4. SERVICE DELIVERY SYSTEM ENHANCEMENTS

As mentioned at the beginning of this testimony, the local welfare office would be restructured in accordance with this welfare reform initiative. The major focus of our offices will be to assist families toward self-sufficiency. Assistance to find employment and secure child support will be our primary goal. Providing cash assistance will be secondary.

Any help given will be with a "partnership" effort from the recipient as well as SRS. All families will be required to complete a "Family Investment Contract" which will clearly outline each family's and the agency's responsibilities. For example, all families will be required to complete the recommended health screenings for their children. Families who choose not to comply with that responsibility will lose the adult portion of the AFDC grant.

This report to the Human Services Appropriations Subcommittee has been very brief. A copy of the final recommendation document presented from the Governor's Welfare Reform Advisory Council to Governor Racicot will be sent to this committee.

reformrep.pmr

# WELFARE REFORM PROPOSAL

**Applicant for AFDC**
**Case Manager Informs Applicant**
**of Options for Assistance**

## WORK ASSISTANCE PROGRAM

- Sliding Scale Day Care
  - Up to 125% of poverty
- Sliding Scale Medical
  - Up to 125% of poverty
- Enhanced Child Support Collections
- Food Stamps
- LIEAP

## TRANSITIONAL MEDICAID

- First six months no client participation
- Next six months, reduced services and client financial participation

## AFDC SELF-SUFFICIENCY PROGRAM

- Case managers establish Family Investment Contract at entry identifing actions to be taken to achieve self-sufficiency
  - Adult portion of grant would be sanctioned if actions not performed
- Enhanced Child Support Collections
- Program limited to 24 months
  - Teen Parent would be exempt until 18
  - Two Parent Families limited to 18 months
  - ? Other exemptions
- Employment & Training
  - Increased funding for JOBS and support services
- Disregards
  - $100 plus 25% of earned income disregard (no time limit)
- Simplification
  - Eliminate Deprivation for UP's
  - Eliminate 100 hour rule for UP's
  - Many other simplifications
- AFDC/Food Stamps EBT

**Recipient has exausted 24 month period**

## COMMUNITY SERVICE

- Receive child's portion as grant
- Pay after performance for adult portion with 20 hours per week of Community Service
- Exemptions
  - No Community Service Available
  - No Day Care Available
  - Employed 20 hours per week or more

ATTACHMENT 1

## SIMPLIFICATION/UNIFICATION POLICIES

### APPLICATION PROCESSING

1. Allow FS certification to be continuous - re-evaluate with yearly redetermination.

2. Eliminate requirement to reschedule missed appointments.

3. Simplify verification requirements. Make use of IEVS & SAVE optional.

4. Require applicants/recipients to apply for other potential sources of income or third party liability such as Child Support, Unemployment Comp., etc.

5. Eliminate requirement that each adult sign declaration of citizenship.

6. Conform AF & FS policies re: eligible/ineligible alien status requirements.

7. Cash out Food Stamps for AFDC recipients. Paying cash instead of coupons eliminates the cost of producing, transporting, storing, protecting, insuring, issuing, monitoring the use of food coupons, and finally, destroying them.

8. Issue Child Support payments directly to client. The payment will be counted as unearned income to the household.

9. Conform Notice of Adverse Action requirements, i.e., 10 day rules.

### CHANGES & BUDGETING

1. Conform AF to FS policy re: adding new household members.

2. Change and conform temporary absence rule - 90 days.

3. Eliminate deprivation requirement for AF & AF/MA. The children in the household must be needy. Needy is determined by family income tested against the AFDC gross monthly income limit. (BIA-GA is a prior resource to AF) Intact families will be subject to a shorter eligibility period (18 months) than single parent households (24 months). Intact family is defined as: 2 parent household, step-parent household, common law household, and any household with common children, regardless of marital status.

3a. Eliminate 100 hour rule for AFDC/UP Households.

4. Simplify the income disregards for AFDC - eliminate 30 1/3 concept and $90 work allowance. Allow $100 disregard for earned income and child support. Allow an additional 25% disregard from earned income.

5. Create Standard Medical Allowance (SMA) for current qualifiers similar to Standard Utility Allowance - actual expenses optional.

6. Standardize dependent care deduction - $200/month/child.

7. Allow dependent care deduction "when incurred" regardless of when due or paid.

8. Allow Standard Utility Allowance (SUA) for all FS households. Actual expenses can only be chosen if the client can prove average monthly expenses exceed SUA.

9. Disregard any energy payment based on financial need, i.e., HUD utility payments.

10. Eliminate penalty for late monthly report.

11. Disregard all earned income of dependent children attending school through the month of the 19th birthday or when graduated from high school/equivalency, whichever is earlier.

12. Allow a deduction for legally-binding child support payments made to non-household members.

13. Exclude gifts of money for special occasions such as Christmas, Birthday, Graduation, as an example, not to exceed $50 per person.

14. Disregard all educational income of students.

15. Lump sum payments - Divide the amount of the lump sum by the established resource limit ($3000) to determine a period of ineligibility for each program.

16. Eliminate monthly reporting for all households. All cases will be change reporters/prospective budgeting. Earned income cases will be subject to a quarterly review, and will continue to be prospectively budgeted.

**RESOURCES**

1. Establish a standard resource limit for all programs - $3000.

2. Standardize vehicle evaluations: a. Exclude one vehicle. b. Evaluate all other vehicles for equity value. c. Exclude all income producing vehicles.

3. Exclude cash value of life insurance policies.

**EMPLOYMENT & TRAINING**

1. Combine JOBS & Job Search programs - one program with same requirements, exemptions & penalties to serve AF & FS recipients.

2. Job Search disqualification, JOBS sanction and Job Quit penalties & conciliation procedures conformed.

3. Disqualify any adult applicants or recipients, regardless of head of household or primary wage earner status, for non-compliance with employment & training programs, and job quit without good cause.

EXHIBIT 1
DATE 11-18-93
SB HUMAN SERVICES

1

To: Joint Appropriations Subcommittee

From: The Montana Speech-Language-Hearing Association - Darrell Micken

Re: Medicaid Audiological/Hearing Aid Services

The Montana Speech-Language-Hearing Association (MSHA) would like to acknowledge that our professional organization is well aware of Montana's present financial crisis and would like to extend our assistance in coming to solutions for the fair distribution of services to the hearing impaired. We believe that our past association with Medicaid representatives demonstrates our willingness to cooperate and in 1987-88 led to a reduction of overall costs to the program in excess of 60%.

In 1987, Joint committees of MSHA and Medicaid representatives proposed the following regulatory controls, which, when implemented greatly increased efficiency within the program and led to dramatic hearing aid cost reductions. These were:
1) Elimination of binaural fitting except when justified by an audiologist.
2) Increased hearing levels for qualification.
3) Decreased dispensing fees.
4) Contraction for audiological consultant.

Hearing is fundamental to participation in our society. Habilitation and rehabilitation, at any level, demands sensory input, whether it is visual and/or auditory. Hearing is not a quality of life issue but an essential element of communication, education, vocation and socialization. We, as a profession therefore feel that the continuation of the services is vital to thousand of Montana citizens young and old. Either Montana provides for these detection and rehabilitative costs at this administrative point or the cost increases dramatically to educational components and to elderly care. There is also the potential for loss in taxes by failing to rehabilitate potentially productive citizens.

It is our understand that approximately 900 individuals received either audiometric or hearing aid services in 1992 out of a total of approximately 78,000 Montanans receiving Medicaid care of some type or approximately 1% of all Medicaid qualified recipients. The total cost of these services was approximately $186,000 of which $132,000 (71%) was generally funded and $54,000 (29%) was state funded.

Within the present system three groups of individuals will continue to receive audiological and/or hearing aid services by federal mandate. These are:
1. Children under the age of 21.
2. Pregnant women
3. Nursing home residents

Our present information suggests that these groups represent

approximately one-half of the total funding ($26,000 of state funds) or perhaps 400 recipients.

The remaining 400, or "other" groups would be classified into an "optional services" category and they represent the only category of individuals who would be cut from the existing roles. However, a very strong argument can be mounted to maintain services to this latter group in particular. This group contains the individuals such as single parents, students, and young adults who, when rehabilitated, will return to the job market and to the tax roles. If only one-half of these people (200) return to the job market, it would far more than offset the amount of money spent to diagnose their hearing and provide them with hearing help.

In summary, our group strongly urges that the present level of services and the number of Montana citizens served be maintained because:

1. It is vitally important that those who cannot afford it receive audiometric evaluations for the detection of hearing loss and the diagnosis of ear pathology. This is our best prevention against future problems, at all ages.
2. Services to children, pregnant women, and nursing home residents must remain funded, by mandate.
3. Elimination of services to the "optional services" group would save a minimum amount from the present overall budget but may ultimately cost the state in the loss of taxes and increase rehabilitation costs.
4. Another group now receiving "optional" benefits is the adult handicapped, who, having been moved from the state school at Boulder, now receive special services in our communities. Many of these people use hearing aids purchased by Medicaid which are vital to their continued habilitation and rehabilitation.
5. Funds should be kept available for the maintenance and repair of hearing aids previously purchased and fit.

MSHA supports efforts to reduce the cost of these services, however, and suggest the following options:

1. Introduce a hearing aid replacement policy; the standard hearing aid life is approximately 5 years. Hearing aids should not be replaced sooner without written justification from an audiologist and authorization from the audiological consultant.
2. Purchase hearing aids through cooperative buying efforts or have the state Medicaid program bid their hearing aid services. The state's fiscal evaluation of this type of program indicated a $3000 saving or approximately 5.7% of the current state audiological budget.
3. Evaluate hearing aid loss insurance to determine if it would be cost effective. This would be particulary useful for high risk individuals such as children and nursing home individuals and proves to be cost effective over time.
4. Eliminate the need for physician referral since an audiological examination by a licensed audiologist is mandated

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and the audiologist is university trained to discern medically correctable hearing losses. The requirement for a physician is redundant and unnecessarily costly.

5. Purchase of behind-the-ear hearing aids, which are often reuseable, whenever possible.

Our request is that every effort be given to reduce the cost without reducing the scope of the program or without reducing the number of eligible recipients.

Thank you.

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HUMAN SERV

ADDENDUM

Elimination of optional services for hearing aids and audiological services.

Considerations;

1. Without this funding this particular group of Medicaid recipients would have no way to obtain hearing evaluations or hearing aids.

2. This particular group is probably the most rehabable and likely to return to the job market. This could lead to slightly increased tax revenues for the State of Montana.

3. Funds need to be available for the maintenance and repair of previously fit hearing aids.

4. This type of intervention is preventative, ultimately reducing future spending.

5. The adult mentally and physically handicapped who are also hearing impaired must bave these services to be able to interact in our communities.

EXHIBIT 8
DATE 11-18-93
SB
HUMAN SERVICES

MICKEN HEARING SERVICES
1008 NORTH 7TH AVENUE
BOZEMAN, MONT. 59715
(406) 586-0914

SEPTEMBER 10, 1993

My name is Dava Cameron, I am a 41 year old single parent and currently enrolled at Montana State University in Bozeman and will graduate this August in Health and Human development Family Sciences. I have also been offered a job in my field upon completion of my program. I have been a recipient of vocational Rehabilitation services and medicaid.

The medicaid program is a necessary element in our health care system and has been necessary to my personal educational goals.

It is possible that a restructuring of the medicaid guide lines should aid in focusing on preventive medical issues and encourage the poor to work, volunteer, or attend training or college this would help, because the better educated a person is the more self awareness one has the more incentive one becomes thus producing a better person, better community, a better state, and so forth.

Because the medicaid program has helped me a great deal raising my family. with the high cost of medical care and low wages, I could never have made it. This program has given me a higher quality of life because it has provided me with the necessary hearing aid equipment that has assisted me in pursuing a higher eduction. Without this necessary equipment I could never attempted a college career and the chance of competing for a Bachelors degree in Health and Human Development Family Science. Like so many other handicapped persons today, I have been given this opportunity to better my life and become a productive tax paying citizen of Montana.

Thanks to Social Services agencies and the Medicaid programs for a better chance at life.

Eternally grateful,

Dava Cameron

DATE 11-18-93
HUMAN SERVICES
SB

# MONTANA OPTOMETRIC ASSOCIATION

36 SOUTH LAST CHANCE GULCH, SUITE A • HELENA, MT 59601 • TELEPHONE (406) 443-1160 • FAX (406) 443-4614

Mr. Chairman and members of the Committee, for the record my name is Sue Weingartner, executive director of the Montana Optometric Association.

In September, Dr. Doug Safley and I met with SRS personnel to explore all possible means of cost reductions in the Medicaid adult eyecare program. While some of the program limitations we discussed are certainly not what our profession recommends or advises, a couple of the recommendations we suggested we believe are worthy of your consideration as an alternative to eliminating the adult eyecare services.

SRS projects that elimination of the adult routine eyecare and eyeglasses would result in a savings of $315,400.

> **Recommendation: Replace eyeglasses every 4 years rather than every 2 years.** SRS projects a savings for this recommendation would be $81,000 per biennium.
>
> **Recommendation: Medicaid would cover the cost of eye examinations but not purchase the glasses.** SRS projects a savings of $163,000. Often times, it is not possible to determine until an examination is done whether a patient's symptoms are the result of lack of adequate eyeglasses correction or if the problem is a serious and in some case sight-threatening eye condition or disease. This recommendation would provide the examination, serious conditions or disease could be diagnosed and treated, while recipients of the service needing correctional lenses could then choose to purchase the lenses, not to purchase or maybe delay a purchase if the correction is minimal. Many optometrists are willing to work with their needy patients and many have budget glasses for patients with limited funds.

Trying to function without needed vision correction, at the least, can be very frustrating and disheartening. In addition, for the Medicaid patient, their chances or employability and ability to improve skills and education is greatly hindered without needed vision correction and/or eye health.

I am handing you a letter from Dr. Doug Safley, a Havre optometrist, with some comments about Medicaid patients he sees in his practice. Some of his Medicaid patients are students at Northern Montana College, who are struggling to get an education and for whom the ability to focus and function with visual efficiency are imperative to their success in the classroom and eventual completion of their education.

As an alternative to total program elimination, we urge your consideration of these two recommendations.

November 18, 1993

MONTANA OPTOMETRIC ASSOCIATION
36 SOUTH LAST CHANCE GULCH, SUITE A • HELENA, MT 59601 • TELEPHONE (406) 443-1160 • FAX (406) 443-4614

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TO: REPRESENTATIVE JOHN COBB, CHAIR
MEMBERS, HUMAN SERVICES APPROPRIATION SUBCOMMITTEE

FROM: DOUGLAS A. SAFLEY, O.D., F.A.A.O.
MOA THIRD PARTY CHAIR

DATE: NOVEMBER 17, 1993

SUBJECT: **POTENTIAL BUDGET REDUCTIONS PROPOSED ELIMINATION OF OPTICAL SERVICES AND EYEGLASSES**

I represent the Third Party Committee of the Montana Optometric Association. In recent meetings with the Department of SRS in an effort to explore means of budget reductions in the Medicaid Optical Services and Eyeglasses program, we made several suggestions to the Department as follows:

| Recommendation | SRS Projected Savings per Biennium |
|---|---|
| **Recommendation 1.** Increase the copayment requirement for eyeglasses and examination. | -0- Copayment is currently at maximum allowable by Federal Govt |
| **Recommendation 2.** Allow full eye examinations every 4 years rather than every 2 years but allow annual eye screenings. | -0- |
| **Recommendation 3.** Replace glasses every 4 years rather than every 2 years. | $81,000 |
| **Recommendation 4.** Cover cost of eye examinations but do not purchase glasses. | $163,000 |

**The total general fund biennium savings of elimination of visual services including eyeglasses is projected by SRS to be $315,400.**

While our profession cannot endorse these proposals as recommended eye care, we urge you to first consider these measures as an alternative to elimination of the program.

Some of my Medicaid patients are students at Northern Montana College. Many of these students are without funds for vision services, yet without this service they would be nearly incapable of successfully completing their studies. For instance, an individual can have a severe amount of nearpoint stress due to their inability to focus the printed material clearly with any degree of efficiency. Many times this stress comes from the fact that the person is very

(over)

farsighted and as a result has to do a lot of extra focusing to make things clear. As a result of eye stress, this individual may experience headaches, be unable to read for any length of time, and concentration and comprehension is likely to be poor. All of these symptoms may lead to failure in the classroom, and that individual is then unable to complete an education. This and other similar scenarios are commonly seen by optometrists who provide services in communities with institutions of higher learning.

Another example is that of an individual seeking employment. An individual's chances of obtaining almost any kind of employment is dependent upon his or her ability to see well. Without correctional glasses, it may be at best difficult and in some instances it may be impossible to obtain employment.

Recommendation 4, which would cover the cost of the eye examination but not the purchase of glasses, would allow patients who may have a serious, sight-threatening eye condition or disease to be examined, diagnosed and, if necessary, obtain appropriate treatment. While this recommendation would not cover the cost of glasses, many optometrists are willing to work with their needy patients and many have budget glasses (frames and lenses) for patients with limited funds. The recommendation would provide the exam, serious conditions could be diagnosed and treated, and recipients of the service could choose to purchase, not to purchase or maybe delay a purchase of eyeglasses. In some instances, the patient's dioptric changes may be slight and the patient is able to function efficiently with their existing prescription.

As an alternative to total program elimination, we urge your consideration of the above comments.

EXHIBIT 10
DATE 11-18-93
SB HUMAN SERVICES

10

November 18, 1993

~~LADIES AND GENTLEMEN:~~ Chairman ~~Hearing body~~ members of the committee

Let me introduce myself. My names is Charles Post.

First let me say thank you for the opportunity to share my views with you.

What I would like to do is offer you an alternative to the budget cuts that seem inevitable to the welfre/medicaid programs.

What I believe to be a practical solution is simply this.

As you all know the Workfare Program is a very large workforce in this state.

Simply, what I propose is using that workforce to supplement the medicaid/welfare budgets.

The first part of the plan deals with the expansion of the base of eligible users to include hospitals, cemeteries and other non-profit organizations that are currently ineligible for the community service program.

A federal waiver may or may not be needed.

What this expansion will provide is competition for our large and capable workforce.

~~Without this expansion of participants this proposal is sure to fail~~.

What I propose for the second part of the plan is this: charge a stipend to each participating organization in the workfare program.

If there was a stipend of $10.00 per week charged to each

participating organization for each community service person payable directly to Medicaid fund it would amount to $520 per year per person.

As you can see if you multiply this by the amount of workfare people statewide, it is quite a large sum returned to the taxpayers.

Additionally, if these organizations are charged a further stipend of $.50 per hour, per person, payable to the welfare fund at the present mandatory 16 hour work requirement, it would generate $416 dollars a year return per person participating in the workfare program. Another sizable sum if generated statewide.

The combined return for one workfare person would be $936 a year. A healthy return of funds to the taxpayer. This should also offset the proposed cuts and save federal matching funds from being cut.

Also, if you set up further guidlines such as any one user having 3 workfare personnel, and if they wish to use more, they must hire one workfare person part-time for the 16 hours or more a week at minimum wage. Thus you have further savings in the welfare budget due to the reduced size of the grant to the new part-time employee while at the same time it would add funds to our eroded tax-base. In order for this or a similar plan to be feasible there would have to be additional guidelines. One of these guidelines I believe to be the most important, is that all participating organizations must keep their current number of paid employees. Any number of cuts

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to their current workforce would be matched at the rate of each paid person laid off, and 2 workfare people must be let go or the loss of participation entirely, in case of abuse. Another guideline might be that they have to use the workfare people as a supplemental force only. And keep them in the lower echelon such as maintenance. For example, if a person has payroll and bookkeeping skills in order for them to be used they would be required to use these skills. They must hire that prson as they apparently have the need of a person with that particular skill.

I personally believe a plan such as this would be more beneficial than a tax cut. This plan or one similar would have many benefits. First, it would lower the burden of the taxpayer while boosting the medicaid/welfare funds. At the same time it would help the tax base by adding jobs. A part-time job is better than no job. And it would meet the requirements that fámilies are not put out in the streets and retain millions of federal matching dollars. At the same time, at a proposed rate of $18.00 per week per person charged to the participating organizations, I don't see how it can be anything but beneficial to everyone. Why give away tens of thousands of man hours free?

Thank you again for letting me share my views with you.

EXHIBIT 11
DATE 11-18-93
SB HUMAN SERVICES

Mr. Chairman:

Members of the Committee:

I'd like to thank the committee and it's members for allowing THE COALITION'S testimonies to be heard today.

My name is Nova Bartsch. I'm 29 years old and have been married 13 years to a disabled, dislocated hardworking man. During the first 6 years we decided not the have children, because we couldn't afford the medical cost, cost of food, a good education and other necessities. In the 7th year we decided that if we waited till we could afford it we would never have any. We now have 2 very special children and we have God and the Medicaid program to thank for their health. With the cost of living and medical expenses increasing, I have found it very difficult to provide my family their basic needs on and LPn wages or the AFDC benefits we're currently receiving. Everyone has decisions to make and it's not always easy. Mine was to continue my education in hopes of finding a good paying job. I've maintained many jobs from waitressing, driving truck, working the orchards to butchering cows. I've paid hundreds of dollars in taxes, and it didn't bother me a bit that I was helping to pay for programs that helped the community or the less fortunate.

Now I'm one of the less fortunate and without the help from the AFDC and the medical programs (& my grandparents), I would not be able to finish my education, which is at a standstill because my major (registered nurse) is not available in Butte and I can't find it in my heart to pull my kids out of school and make them move from the town we

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were born and raised in, or desert my 85 year old grandparents that desperately need my help.

I will not let this stop me and I will soon accomplish my goals, I'm very anxious to start working again. I work part-time at the Red Cross as a volunteer for my AFDC benefits. It is very hard to juggle time and the roles of being an employee, student, mother, wife, and granddaughter (not to mention) peacemaker. counselor, and provider. It's particularly hard when you have to explain to your kids that they can't have a (quoting my 6 year old) "Bag of chips, apple, and candy bar in my lunch like the rest of the kids". Because its the end of the month and there isn't any foodstamps or money left to but it, and no savings to withdraw. Pat

My ultimate end is:

1. A good job to provide my family their basic needs.
2. Money to put my kids through college so they won't need to be dependent on welfare or even worse homeless.
3. The ability to pay my community back for it's support.

and last: To convince Montanans to continue their support and help our needy, particularly the children, elderly, mentally handicapped and others with medical needs. I've heard some of the opposition's ideas and myths that have circulated about welfare. Such as "more kids, more money". I have recently obtained custody of a teenage girl and the extra money we received did not cover her necessities such as bus fare to school, personal items, and the extra power bill. (Believe me! Curling irons and blow dryers use a lot.) not to mention food for the last week because the foodstamps ran out in the 3rd week.

EXHIBIT 12
DATE 11-18-93
SB HUMAN SERVICES

Mr. Chairman, (Representative Cobb)

Committee Members,

I am Jeffery T. Ramey of Butte, Montana.

I would like to speak against the proposed cuts in the AFDC and medicaid.

I realize there needs to be reductions, but not if it affects the future of Montana, and the people who have gave their time and energies to make this state great, the elderly have gave most of their lives to support this state and its government.

Now their reward is for you to take or reduce the basic needs of medical for them, and the people who are needy. These are not just people looking for a hand out, but a hand up to live with a degree of dignity. We need jobs and training! Something to get us off the system. Not busy jobs, but one's where we can support our families, we need the medical cards and welfare to feed the young mouths and elderly in our families.

As you go home to your Thanksgiving dinner, just image if you didn't have food on your table, or your sick child cries, but medical services are no longer for them. or elderly parents → from pain

Put yourself in the place we are in! As the old saying goes: Judge me not till you have walked a mile in my moccasins.

I hope I've gotten you to think a little bit, of what these cuts would mean to low income people and the elderly.

If you do, I have done what I've come to convey.

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**There's always some that will abuse the system. I hope it doesn't affect those of us that don't!**

**I'd like to ask all the legislators here today that in the process of making their decisions, they picture a hungry child, an elderly person, or even a common man that's down on his luck with no where to turn**

EXHIBIT 13
DATE 11-18-93
SB HUMAN SERVICES

Mr. Chairman:

Members of the Committee:

I am Marlyn Barnes from Butte, Montana. My husband is on Supplemental Security Income that we live on 434.00 a month. In January I fell and broke my ankle in 3 places and it is still broken. I was told no medical insurance - no surgery. I have high doctor and hospital bills. I pay $50.00 to the hospital, and $50.00 to the doctor a month. In the month of August I paid a total of $163.00 for prescriptions. That set us back. Since then I haven't been able to afford my medication and also keep up with household expenses. I am very angry and upset. Under a lot of stress. No matter where I turn, I can't get help. I applied for SSI and can't get help their either. I don't think it is fair. I have to live in so much pain. If I should step just right, I won't be able to walk. In January when SSI gets a raise, our water rates are going up. Montana Power rates are raising, our foodstamps will be cut back because of the raise. We currently receive $124.00. How much do you spend in your home for food a month? I would challenge anyone of you to come live on what we do for a month. Be in the spot we are! A few years from now we will be on Social Security Retirement. What do we have to look forward to. Just stay home and die? If we fall, break something or have a heart attack, because we can't afford a doctor or hospital. We own are home. And we do pay taxes. We have lived most of our life in Montana and you want more cuts!

In Closing: What do I tell my grandchildren? We have a wonderful life here in Montana, or when you grow up, you'd better

**leave Montana because Grandma and Grandpa don't already have any tomorrows.**

14

# MEDICALLY NEEDY
# CHANGES

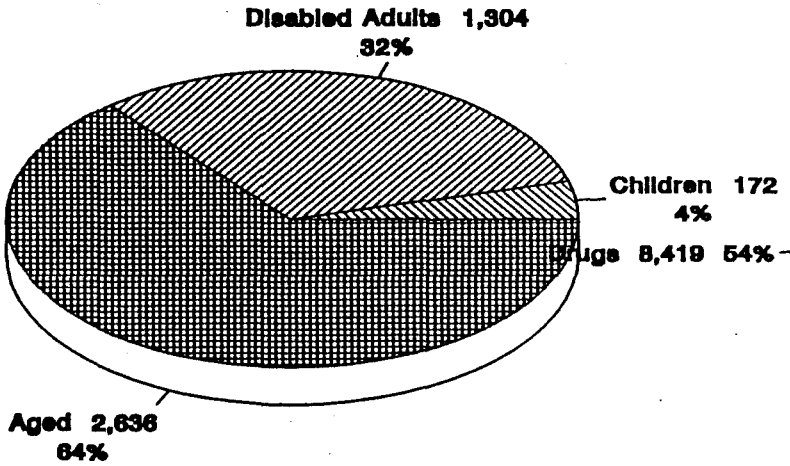
| CURRENT BENEFITS | | PROPOSED BENEFITS EFFECTIVE JANUARY 1994 |
|---|---|---|
| PHYSICIAN | DENTAL (INCLUDING DENTURES) | PHYSICIAN |
| MID-LEVEL PRACTITIONER | THERAPIES (PHYSICAL, SPEECH, & OCCUPATIONAL) | MID-LEVEL PRACTITIONER |
| LAB AND X-RAY | PERSONAL CARE | LAB AND X-RAY |
| PRESCRIBED DRUGS | DIAGNOSTIC | PRESCRIBED DRUGS |
| TARGETED CASE MANAGEMENT | SCREENING | TARGETED CASE MANAGEMENT |
| FAMILY PLANNING | PREVENTIVE | |
| HOSPITAL - INPATIENT & OUTPATIENT | REHABILITATIVE | |
| NURSING FACILITY | AUDIOLOGY (INCLUDING HEARING AIDS) | |
| RURAL HEALTH CLINICS | TRANSPORTATION | |
| FEDERALLY QUALIFIED HEALTH CENTERS | PROSTHETIC DEVICES | |
| HOME HEALTH | DURABLE MEDICAL EQUIPMENT | |
| PODIATRY | HOSPICE | |
| OPTOMETRIC (INCLUDING EYEGLASSES) | LICENSED PROFESSIONAL SOCIAL WORKERS & COUNSELORS | |
| PSYCHOLOGICAL SERVICES | | |
| PRIVATE DUTY NURSING | | |
| CLINIC | | |

NOTE: Federal regulations state that if a state chooses to have a medically needy program, it must provide all services to pregnant women, children, and persons in institutional or waiver services.

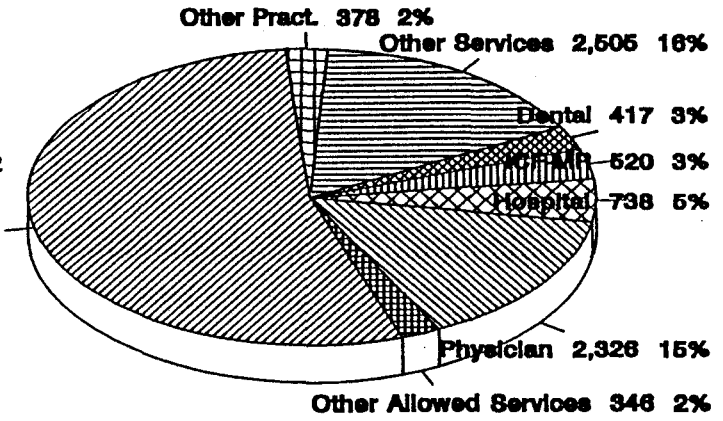
# BASIC FACTS ABOUT MEDICAID

**Table 6**

**Medically Needy Program by Recipients and Services for Persons Living in the Community**




**Medically Needy Recipients by Category**




**Medically Needy By Service Category**

**Cost analysis does not include services for institutionalized persons or those over 65 years old. Physician Services, Pharmacy Services, Tagreted CM, Lab & X-ray and other allowable services will still be available after the Medically Needy reduction.**



EXHIBIT
DATE 11-18-93
SB HUMAN SERVICES

EXHIBIT 10
DATE 11-18-93
SB HUMAN SERVICES

November 18, 1993

To the Committee on Medicaid Cuts:

Since 1983 I have been on a welfare roller coaster. In that year I used to be a nurse's aid but injured my back. Forty percent of my once strong back has been damaged by an upper scapula nerve entrapment. Which means it comes and goes. Since then I have not kept a job longer than six months because of the pain. My children need this medical aid to help them through the growing years. Years of exposure in school to many of today's diseases and new diseases that have been found out. I have been actively seeking work since my graduation from the Butte Vo-Tech as a drafter. I found many part-time jobs or jobs that are temporary and usually very far to travel to. These jobs only offer medical and plans to full-time employees, and hire only for those spots that they know will be completed by a certain time and not have to worry about these benefits. I do not want welfare, or these benefits that go with it for myself, but for my children. They need these things. And until an opening comes from a firm that will hire me full-time, and keep me on the payroll. We will use these benefits to survive. There are other people in this world that are not as fortunate as I, and need the services that you have considered cutting. These programs, if eliminated, will only cause more damage. Without these benefits, that so many have come to depend on, you may be putting a lot of lives in jeopardy. By excluding these people from medical treatment, treatment that is already hard

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enough for someone who is working to afford you are pushing on what dignity they have left. You will still pay for it in the end.

Thank you for your time.

Joseph E. Julian

EXHIBIT 17
DATE 11-18-93
SB HUMAN SERVICES

Montana Podiatric Medical Association Proposal to Place Limits on Certain Podiatric Services

A proposal to limit the coverage of orthotics and routine foot care was received by the Department November 8. We were unable to complete the analysis of their proposal in time to include it in your packet, but we are now proposing to substitute this proposal for the one entitled "Eliminate Adult Podiatry Services" in your handouts.

Further details of the program are noted below:

**LIMIT ADULT PODIATRY SERVICES**

Description of Change - The Medicaid program currently has no limit on the number of orthotics or the frequency of routine foot care services provided by licensed podiatrists. This change would limit coverage of orthotics to once every two years and routine foot care to once every 60 days. This proposal was developed in conjunction with the Podiatric Medical Association as an alternative to total elimination of the program.

Considerations - This service is covered by the State Employee Health Plan and on a limited basis by Medicare. A total of 16 states do not provide podiatry services under their Medicaid program.

Cost Shift - No cost shift is anticipated.

Number Affected

| | |
|---|---|
| Recipients | 2,187 |
| Providers | 30 |

| Net Savings | FY 94 | FY 95 | Biennium |
|---|---|---|---|
| General Fund | $1,866 | $ 4,470 | $ 6,336 |
| Federal Fund | 4,572 | 10,681 | 15,253 |
| Total Funds | $6,438 | $15,151 | $21,589 |

EXHIBIT 18
DATE 11-18-93
SB HUMAN SERVICES

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

November 18, 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. 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 nursing home residents are to be exempted from these cuts. I would submit that hearing aids made available to those recipients who could then be made employable, is a better bargain for the state than placing hearing aids on nursing home patients. I realize this 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 preserving the small amount we invest in speech and hearing services for the greater gain derived from the improved employability of the recipients.

Thank you.

Bob Chaney

EXHIBIT 14
DATE 11-18-93
SB HUMAN SERVICES

**THE COALITION OF MONTANANS CONCERNED WITH DISABILITIES**
**CMCD POSITION STATEMENT:**
**1993 SPECIAL LEGISLATIVE SESSION**
**PROPOSED BUDGET CUTS**

CMCD has serious concerns about the proposed reduction and/or elimination of many services currently being provided to people with disabilities in Montana. Potentially, the elimination or reduction of a wide range of Medicaid optional services would be particularly devastating to Montanans with disabilities currently living relatively or completely independently in the community. Limitations in the provision of many of these services, especially reductions in personal care services and limiting the Medically Needy program to primary and preventive care, will be extremely damaging to the disability community, and will cause many to be forced into institutions; this is both puzzling and destructive, as institutionalization represents a much greater cost to the State of Montana than community-based independent living and as the community is the setting in which the vast majority of people with disabilities prefer to live. The following suggestions represent our response to those cuts which have been proposed prior to the Legislative special session as outlined in the Governor's Executive Budget and previous budget submissions to the Governor:

1. Special Education/School Equalization: Briefly, our understanding of the effect of school equalization on Special Education students includes the following observations: Currently, full-time Special Education students are not included in the state's ANB count (average number of bodies), which is used to calculate school funding levels. Special Education funds come from the state and county separately. Under HB 667, Special Education students would be counted in the ANB beginning in FY 95, which would increase the total budget by $4.6 million. Under SB 348, this would be delayed until FY 96, which further delays this funding increase by one year. Because of the increased costs which will be associated with bringing Montana's schools into compliance with the Americans with Disabilities Act of 1990 (as well as substantially unfulfilled obligations under the Rehabilitation Act of 1973)., this proposal would further strain public education budgets and, in our view, illegally delay implementation of these laws even more than they have been thus far. . Unless, under the proposal currently being considered, Montana is able to get back on track with compliance efforts with regard to the above federal laws while simultaneously providing adequate public education opportunities under the Individuals with Disabilities Education Act (IDEA), we would oppose this proposal and urge the Legislature not to delay the funding which is planned under HB 667.

2. The Montana Health Care Authority: Because of the tremendous efforts required of the Health Care Authority by SB 285, we would oppose any reduction in the appropriation attached to this bill. We further strongly assert that the integrity of

SB 285 must be maintained in its entirety, including the mandate for the development of both single-payer and regulated multiple-payer proposals. Finally, all mechanisms for consumer input must be fully maintained, including adequate funding for travel for the Health Care Authority and Regional Planning Boards, as well as full public hearings on regional and state plans.

3. **Medicaid "optional" services:** While these services may be optional in the eyes of the Federal government, they are anything but optional to the people who are in need of them. And while the dollar figures for these services have increased steadily because our health care system both nationally and at the state level has gone out of control, the actual level of service being provided to Montanans with disabilities has steadily decreased throughout the eighties and into the present.

We would, therefore, strongly oppose any and all reductions in funding for adult podiatry services, hearing aids and audiology services, physical, occupational, or speech therapy, eyeglasses and optical services, adult denture and dental services, personal care services, mental health services (including the number of day treatment services for people with mental disabilities), as well as the proposal to limit the Medically Needy program to primary and preventive care. We also emphatically oppose the proposed changes concerning increasing pharmacy copayments, increasing copayment limits, increasing coinsurance for inpatient hospital stays, reducing outpatient hospital reimbursement (if doing so would have any detrimental effect on quality or availability of care for people with disabilities), or implementing special income limits for nursing home eligibility.

We strongly believe that any of the above reductions would have a devastating and discriminatory impact on Montanans with disabilities, and that these measures violate both the spirit and the letter of the Americans with Disabilities Act and other federal and state legislation protecting the rights of citizens with disabilities because of the disparate impact such funding reductions would have on the disability community in Montana. Until critically significant and meaningful health care reform measures are undertaken which are both equitable and effective for people with disabilities, full funding of these services is essential.

4. **Human Rights Commission staff:** While this proposal is not found in the Governor's Executive Budget, a previous budget proposal suggested reducing staff in the Montana Human Rights Commission. The Commission represents the only legal avenue available to many Montanans with disabilities for redress of acts of discrimination. Considering the extremely low level of staffing presently available to the Commission, it is difficult to imagine how they are able to maintain any effectiveness to Montana's citizens at all. To their credit, they are nonetheless able to do so, even though cases often take quite some time to

resolve. For this reason, we would oppose any and all funding reductions being considered regarding the Human Rights Commission.

5. Legal Services staff: In the Governor's Executive Budget, mention is made of eliminating an attorney's position because of a transfer within the division. Because of similar reasoning applied to potential reductions in the Human Rights Commission above, we would oppose any similar reductions in Legal Services staff. Legal Services are stretched to the limit as it is, and they are usually only able to take only the most pressing cases. Our experience is that Legal Services do an excellent job in Montana, but their resources are extremely inadequate at present. Their resources must not be reduced any further.

6. PCA program reform and other general reforms: We are currently collecting information with regard to substantial reform of the personal care program, including potential cost-savings proposals, and plan to present our recommendations to those state agencies responsible for administering the program as well as to the Legislature for possible action during the next regular legislative session. Because of ongoing problems with both the administration of the program and the quality and integrity of personal care being provided through the state's single vendor for Medicaid consumers, we strongly feel that this system is long overdue for fundamental change. We are currently investigating options for a multiple vendor system with a true self-directed component, third-party grievance procedures, pay scales and training and certification for personal assistants. Changes will also be required in statutes related to the Department of Labor as well as the Nurse Practice Act. Further, a system should be implemented for the evaluation of all current and future nursing home placements for potential placement in the community. Finally, a system for mail-order and bulk purchasing of prescription (non-emergency) drugs for Medicaid consumers should be considered as a further cost saving measure. We will plan to make these recommendations available as soon as possible.

The above suggestions reflect our strong conviction that these services are primary examples of the kinds of activities in which government has a moral obligation to engage. We also feel that the State of Montana, under the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act of 1990, has a legal obligation to consider the substantial adverse impact that the above reductions and eliminations in services would cause Montanans with disabilities to experience. Both of these federal laws impart specific legal remedies to people with disabilities who can prove discriminatory treatment either directly or indirectly, or as a class, through adverse impact. We are aware of a large number of individuals who receive the above services and are justifiably very disturbed that these funding reductions are being considered. In addition to the substantial human suffering that would occur if these cuts were made, we feel it is possible that many lawsuits could ensue if they were implemented.

We feel that fundamental change in the way in which Montana delivers human service programs in general is required, as long as any such changes increase the freedom, independence, autonomy, and choice of citizens with disabilities in Montana.

DATE 11-18-93
SB HUMAN SERVICES

# *Myths of Welfare*

## *Testimony of A Recipient*

*by*
*Patricia Bonacci*

EXHIBIT 21
DATE 11-18-93
SB HUMAN SERVICES

Mr. Chairman:

Members of the Committee:

I'm worried about where I'll live. In my home or on the street?
If I'll be able to eat? I just don't think it's right for to have to decide if I eat today or do I buy my medicine.
I'm really worried about these things.
AM I TO BE IN A HOME OR ON A HOMELESS LIST.
Thank you,
CAROL

~~I'm starving about now and I'll have~~

if in my home or in the street, if I'll be able to have my med's, if I'll be able to eat, I just don't think its right, for me to have to decide do I eat today or do I buy my medicine. I'm really worried about these things, am I to be in a home, or in a homeless list.

Thank you

Coral

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| Rosemary Harrison | MT. Speech, Lang. & Hearing Ass. | |
| Jill Jasmer | MT. Speech Lang & Hearing Ass | |
| Darrell Mackey | Mackey Hearing Montana Assoc. MT - Speech-Lang-Hrg Assn | |
| Darrell Mackey | Montana Spch-Lang-Hrg Assn | |
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